Better health by addressing the social determinants

Updates on telehealth and NDIS

For Aboriginal girls – opportunity to write a better future

14 pages of Conference highlights

Aboriginal and Torres Strait Islander readers are advised that this newsletter may contain images of people who have died.
GOOD HEALTH AND WELLBEING IN RURAL AND REMOTE AUSTRALIA
EDITORIAL
THE TREASURER’S VEGETABLES

To have a decent debate about taxation and public spending, and to hold our governments to account, we need some understanding of the taxation system. Recent discussions have been corrupted by the drive for simplicity and by the 30-second media grab. At a critical time the public is in danger of being sold a fiscal pup.

Think of Australia’s taxation and public spending system as a rainwater tank and a veggie garden. The tank is the pool of available spending, the veggie garden is the public sector, the individual vegetables in it are specific programs.

The Head Gardener is the Treasurer. Advised (usually) by his gnomes, the Gardener decides how much water will be collected, by what means, and how it will be distributed to various plants in the garden.

The water collection system is based on two inalienable principles: simplicity and gravity. Water, just like taxation revenue, is prone to find leaks in the system. Therefore the less complicated the system, the better the capture. Let the rain tumble down a sloping roof into a well-maintained gutter and thence by the most direct route possible into the rainwater tank.

Gravity is important for two reasons. First, water usually runs downhill. And secondly, as was unhappily demonstrated in 1991, a Treasurer with insufficient gravity is unlikely to last.

The bulk of the scarce resource will find its way to the rainwater tank from the roofs of the main building on the property. In taxation terms, one of the main roofs is corporate tax, the other personal income tax. Roofs with smaller surface areas (garage, hay shed, back veranda) collect less water but it is all directed to the one location: to the Gardener’s equivalent of the national treasury.

The purpose of collecting the water is to do good things in the garden of life. The Head Gardener will have priorities for the application of what is a scarce resource: potatoes and pumpkin for nourishment, before frivolous things such as hollyhocks and foxgloves.
These priorities are dynamic: as the family changes and ages, so do the vegetables that are good for them and demanded by them. The Gardener takes advice; next year, he will grow a first crop of Gonski and a couple of rows of NDIS.

He can make way for these either by reducing the areas set aside for pumpkins and carrots, or he can extend the scope of the garden. The total amount of water in the tank and the weather for the next month or two will be considerations in this decision. If the tank is low and the forecast is for a dry spell, he is well advised to take the former course and replace some of the old staple crops with those newly in demand.

If on the other hand the Gardener decides to increase the overall size of the garden, he can mitigate the risk of not having enough water to keep everything thriving by connecting the roof of the bike shed to the rainwater tank. The bike shed has a roof of modest size (roughly 126 cm²) but in a downpour will contribute meaningfully to the total - assuming that the plumbing is well done.

Interested neighbours will ask the Gardener whether the integration of the bike shed roof into the catchment system is to provide specifically for the new crops of Gonski and NDIS. The answer (of water course) is no: the bike shed initiative is to maximise collections in order to increase the Gardener’s options. If it remains dry, the new crops may have to be grown at the expense of some of the carrots. If there is a downpour, the bike shed will contribute to saving the carrots.

The Gardener and his neighbours will understand that it is not possible or even necessary for the particular droplets of water collected from the bike shed roof to be applied particularly to the new crops. That would constitute hypothecation - a no-no in taxation and watering systems - and a word taken from the Greek word for ‘pledge’.

And, dear reader, I give you this pledge: it won’t be long before you will again hear commentators quizzing the Gardener about his new crops and his bike shed – as if the two were closely reticulated.

NRHA

The Productivity Commission Report, Disability Care and Support, released on 10 August 2011, asserted that disability care and support in Australia was “underfunded, unfair, fragmented and inefficient”. It went on to confirm that these problems are compounded for people with a disability who live in rural and remote areas.

For this reason – and for the sake of equity – it is vital that, when it is finally in place as a full-blown national scheme, the NDIS provides good service, equivalent to what’s available in the cities, to people living with a disability and their carers in rural and remote areas.

The special consideration will need to begin with the launch sites starting on July 1 this year. Participant plans will need to be developed for all those with a disability and it cannot be assumed that all eligible people are already in receipt of disability services, particularly in rural areas. There is anecdotal evidence that a number of people living with a disability in country areas have not been receiving any disability services, due either to a longstanding lack of information or the knowledge that there are not any services locally. The NDIS Transition Agency will need to be cognisant of these people and provide them with opportunities to become participants in the NDIS. This may require extra targeted publicity for the scheme in rural and remote areas.

A smooth and effective transition to the NDIS will obviously include close consultation with people and organisations already involved in the disability sector. In rural and remote areas this might include some individuals and agencies not already on the disability radar. The NRHA is keen to play a role in communication with people in rural areas about the new scheme.

It has received funding from FaHCSIA under the Practical Design Fund (PDF) to report on the special considerations which are likely to make the new scheme effective in rural areas. A project reference group has been established and the NRHA seeks information from anyone who has particular views or experience relating to living with a disability and disability services in rural areas.

The challenges involved in making the NDIS effective in rural and remote areas will not be easily overcome. There is a parallel with Medicare, which underpins Australia’s public health system and is supposed to provide universal access to no cost or low-cost general practitioner care.
In fact, as is well-known, there is a Medicare deficit in rural areas of over $1 billion a year. In rather the same way, with the ‘marketisation’ of disability services, even when every eligible person has at their disposal an amount of money commensurate with their need for support, the demand for services in more remote areas will still be thin because of the scattered population.

One of the general ways in which this challenge should be approached will be to ensure there is close collaboration between the disability, health care and aged care sectors. If each of these three sectors has sufficient demand within a local area for one third of a speech pathologist, between them they can provide work for someone in a full-time position. This will of course require close collaboration across sectors and probably between levels of government - and the challenges on this latter front are currently being amply demonstrated - once again.

The early advice received by the Alliance on these matters, including from its newly established reference group, includes the following:

- The context and premise for work on disability should be based on rights - as distinct from welfare.
- The NDIS must accommodate cultural distinctions, relating not only to Aboriginal people and Torres Strait Islanders but also to people of culturally and linguistically diverse backgrounds. There are also rural cultural issues to be dealt with: making sure that people living with a disability in more remote areas recognise their equal and identical rights.
- Everyone potentially involved with the NDIS will need detailed information, provided in an appropriate language and style, and other support to navigate what will be a new and potentially complex system.
- The scheme will have to recognise the higher costs of providing disability and other relevant services in rural and remote areas. This will need to be accommodated from the very beginning of the launch sites.
- Affordability of services for individuals will depend both on real costs and ability to pay. With respect to the last, employment for those people living with a disability is a critical element that should be specially supported, not just for the sake of income but also for social inclusion.
- A successful NDIS in rural and remote areas will utilise technological means for communication and work with and through existing agencies already active in those areas such as the University Departments of Rural Health.

The Alliance has a discussion paper on these issues at www.ruralhealth.org.au and Partyline readers are invited to contribute their experiences and ideas to nrha@ruralhealth.org.au

NRHA

A report has been published from the world’s first randomised control trial on singing and older people. The study, which started in January 2010 and finished at the end of 2011, involved over 200 participants over the age of 60. Half were allocated to one of five singing groups, meeting weekly over a period of twelve weeks. The other half acted as a control group. Members of the study completed a succession of standardised health measures before (and after) the program of singing and on a three month follow-up. Later in the year, interviews were held with some of the research participants to learn more about their experience. Measures of health were consistently higher among the singing group following the singing program than among the non-singing group.

Sidney De Haan Research Centre for Arts and Health

www.canterbury.ac.uk
Multi-Purpose Services (MPSs) are well designed for people who live in rural and remote areas. Alpine Health, based in North East Victoria, has a long history of meeting the health needs of communities through its flexible approaches and its flexible funding arrangements. This innovative service model goes way beyond what other health services can deliver to individuals.

One person whose needs were met was Clinton Le Blanc, who passed away on November 16, 2011. Clinton died peacefully, just as he planned, in the Alpine Health Bright hospital with his mum, Diann, by his side. He was just 37 years old.

Not many of us know exactly when and where we will die - but Clinton did. He understood more than anyone that surviving each day was a challenge. When Clinton was 18 months old he was diagnosed with type 1 diabetes. Over the years complications developed and he lost his sight, had poor circulation in his body and later developed renal failure which required Haemodialysis three days a week. After Clinton suffered a heart attack and stroke in 2007 he was transitioned from Wodonga hospital rehabilitation into Alpine Health Hawthorn Village; a nursing home in Bright. He was then only 33 years old.

His illness and various treatments had brought with them many burdens but he never lost heart. He was eager to facilitate his own rehabilitation and independence. For Clinton, this was a way of restoring a sense of empowerment over what had been happening both physically and emotionally in his life.

“One of his greatest fears was that he would not gain his independence,” said Diann. “He was so excited when a collaborative approach to supporting him was taken by Alpine Health, Alpine Shire and the local community of Bright.”

Help consisted of finding him a one-bedroom unit in Bright, providing him with a range of flexible support options including help with shopping, cleaning, and outings in the community. The Bright Lions Club and Bright Rotary Club funded a ramp for his wheelchair access. Funding was secured by an Alpine Health case manager for a Department of Human Services individual support package.

Diann indicated that Clinton’s quality of life was vastly improved by all the services that were put in place. He was able to live independently, participate in the community and enjoy the social outings with Diann, sister Joelene, brother-in-law Nick, and his adored niece and nephew Amelia (Millie) and Archer. He loved spending time with his mum and family friend Karen who he called ‘Auntie’, playing with Amelia and Archer and going down the street for lunch, sitting outside in the sun chatting to people going by. Other activities he enjoyed were inviting his friends and family over to watch DVDs with him while he listened to the movies.

Clinton’s health began to deteriorate in October 2011 and he was admitted to the Alpine Health Bright hospital. He realised that his quality of life was declining and discussed options with his family, doctors and hospital staff. Diann said everyone including Alpine Health staff did their best to make sure Clinton’s last days went just as he wished. Instead of mourning he held a party, invited his friends and family, gave them presents and said his goodbyes.

As the dawn was breaking on November 16, 2011, so too were the hearts of family, friends, Alpine Health staff and all those who knew Clinton as he quietly passed away.

Jane Newland, Alpine Health
The NRHA’s activity on the social determinants of health

The NRHA has always had a broad remit and has tried to make a contribution to improvement of the social determinants of health for people in rural and remote areas, as well as being concerned about the availability, cost and quality of health services more closely defined. Common sense tells us that it is better to try to prevent people from becoming ill and needing the services of a doctor or a hospital, rather than working only to increase the number of doctors or hospital beds available.

There is some complexity in this argument, as mortality and morbidity prevented today means a greater number of older and potentially more complex conditions to be treated and cared for tomorrow - when costs are likely to be higher!

However the general truth of the contention is represented in a number of widely quoted beliefs. The simplest, understood by the very young, is that it’s better to put a fence at the top of the cliff than to have an ambulance waiting at the bottom. (Lemmings may have a view.) At the level of health financing, it is regarded as an indictment of Australia’s otherwise very good health system that only something like 3 per cent of the total health budget is spent on prevention. (That statistic is neither here nor there if one takes a real view of the social determinants of health, since such things as preschool through to secondary education, public housing and transport, civic design, and food and alcohol taxation policies can all be seen as health promotion or illness prevention strategies.)

The Alliance’s involvement in these upstream determinants of health status in rural and remote areas has included public positions on regional development, access to high-speed broadband and National Competition Policy, as well as forays into tax zone allowances, national food policy and the regulation of licit and illicit substances.

The national focus on the social determinants of health has been sharpened by the Senate’s Inquiry, won in part by the advocacy of Catholic Health Australia, into what Australia’s domestic response should be to the World Health Organisation’s recently released Commission on Social Determinants of Health report Closing the gap within a generation. Many organisations, including the Alliance, made submissions to that Inquiry and the Alliance has pushed on to further pieces of work in what is a rejuvenated agenda on the matter. The submission can be found on the Alliance’s website www.ruralhealth.org.au

The issue is broad and complex and, at an academic level, requires consideration of contextual determinants (such as racial discrimination, social exclusion and isolation), distal determinants (including education, income, housing, food security) and proximal determinants (such as self-esteem, individual and community empowerment and control over one’s life choices and events).

On Thursday 7 February the new Social Determinants of Health Alliance (SDOHA) was launched in Canberra (http://socialdeterminants.org.au). Speakers included Martin Laverty, Fran Baun, Sharon Friel, Stephen Duckett, Lin Hatfield Dodds and Social Inclusion Minister Mark Butler, and information on the event is available on the Alliance website. SDOHA is a collaboration of like-minded organisations from the areas of health, social services and public policy established to work with governments to reduce health inequities in Australia.

The Alliance will contribute in a number of ways to national efforts to improve the social determinants of health, particularly as they affect people in rural...
areas. It will continue to advocate for patient centred care and promote the idea that every health professional has a role in health promotion, health literacy, health system navigation and increasing knowledge of the health system. Through its efforts and directly through its Member Bodies, the Alliance will argue that health professionals should take a holistic approach to patient care that encompasses emotional wellbeing, life circumstances, housing and transport and work with other service providers and sectors to empower individuals to address such issues.

Health professionals can also be encouraged to consider taking on roles in local government or in other community development activities such as Regional Development Australia Committees and can engage with schools to encourage young people to enter health careers.

A renewed focus on social determinants also increases interest in the effectiveness of the Health in all Policies activity in South Australia and Tasmania and, in the case of rural people, strong interest in how it has affected them.

At the Commonwealth level, it is worth recalling that when Nicola Roxon addressed the closing session of the 11th National Rural Health Conference in Perth in 2011, she said of Rural and Regional Health Australia:

“... I do recognise that we must continue to deliver improvements to our regional health system. For example, we are in the process of establishing a rural health agency. And beyond the public advice role envisaged in the Agreement with the Independents, I consider that the agency must have the seniority of leadership and status to co-ordinate funding and policy as well as argue the benefits of regional health funding across government.” ([http://11nrhc.ruralhealth.org.au/closing-address](http://11nrhc.ruralhealth.org.au/closing-address))

The challenge for that agency remains - and the time has never been righter.

NRHA

“Some of these nurses are truly unsung heroes,” said Annabelle Brayley, the editor of Bush Nurses, just published by Penguin Books. “They don’t think they’re anything special. But personally, I think the bush runs on nurse power!”

Penguin publishers had sent out the call for stories about nursing in the outback and rural areas generally, enlisting the support of the National Rural Health Alliance to send the message out through our far-flung networks. Through sources such as CRANAplus (the professional body for all remote health), the ABC’s Bush Telegraph, Facebook and the momentum of word-of-mouth, Annabelle Brayley found rural nurses all over Australia willing to share their stories.

Nurses are often reluctant to talk about themselves; they are modest and pragmatic, wanting simply to get on with the job that needs doing rather than talk about it. But with Annabelle’s encouragement the tales began coming in and she found an incredible variety of stories, “all of them fantastic in their own way.”

A favourite was Alice Martin, who worked in Victoria’s high country, riding her horse everywhere she went. Annabelle said that some of the stories are hair-raising, some funny and some really sad. “All of them are significant,” she said, “in that they represent the contribution nurses have made to the sustainability of the outback.”

Annabelle (an ex-nurse herself) was keen to work on this project for several reasons, but the main one was to celebrate nurses who work in rural and remote areas. She said that most of the time, their own communities and districts did not know the wonderful things they do, let alone the broader community. Nurses are often the only trained health professionals locally available and this was even more pronounced in previous generations when communication was more difficult.


**PHOTO: SDOHA**

Mark Butler, Minister for Social Inclusion, at the SDOHA launch.
Aboriginal perinatal and infant mental health training program

St John of God Health Care (SJGHC) will be providing free two-day training sessions for health professionals working with Aboriginal families to promote emotional, physical and social wellbeing in Victoria and New South Wales.

It is known that Aboriginal women experience perinatal mental health issues at a higher rate than non-Aboriginal women. Some of this stems from intergenerational issues relating to loss of family, culture and identity. Perinatal anxiety and depression can affect infant development and attachment and cause ongoing social and emotional issues for Aboriginal families and their communities.

As part of its commitment to Social Outreach and Advocacy, St John of God Health Care is keen to share its knowledge and experience in the provision of perinatal and infant mental health (PIMH) services to improve outcomes for Aboriginal families. The PIMH training has already been delivered in four regional locations across Western Australia and Victoria; developing the workforce in a way which recognises and promotes Aboriginal culture, traditions and child rearing practices.

Participant’s feedback:
“It is the best training ever – not to have people come in and tell us how to do things but to assist in identifying strengths and resources and facilitate the process has been refreshing and enlightening.”

Funding from the Department of Health and Ageing through Rural Health Continuing Education Stream 2 (RHCE2) has enabled us to develop, deliver and evaluate this training for people working with Aboriginal families in rural and remote locations. The training endeavours to raise Aboriginal PIMH awareness for medical practitioners, allied health professionals, midwives, Aboriginal health workers and child health nurses.

SJGHC is working with a number of Aboriginal communities and government health agencies to ensure it is developing a culturally appropriate, community-focused practical approach to this training. The aim is to support the workforce to:
- have confidence in engaging Aboriginal mothers, fathers and families;
- develop a greater understanding of perinatal and infant mental health and attachment; and
- identify appropriate pathways to care.

The training will incorporate local culture, traditions and beliefs and we will utilise local resources and expertise. The first of the two-day education program was delivered in Geelong on February 20 – 21 and the response was overwhelming. The next training will be Moruya (NSW) on March 19 - 20. The training is free.

For further information contact Louise Brooks on 08 6103 5595 or Louise.Brooks@sjog.org.au
The Australian College of Rural and Remote Medicine (ACRRM) received Commonwealth funding in 2011 to develop a Telehealth Standards Framework to support the roll out of the new Medicare funding for telehealth services. ACRRM’s TeleHealth Advisory Committee (ATHAC) is helping with the development of this standards framework and of associated guidelines and support tools. Tim Kelly represents the NRHA on ATHAC and provided this background for readers of Partyline.

ACRRM’s TeleHealth Advisory Committee includes representatives of around 30 organisations with an interest in telehealth, including various peak bodies for medicine, nursing, health consumers, government and standards.

In the context of the MBS Telehealth initiative, the term ‘telehealth’ refers to live (‘synchronous’) consultations that have a video component. It does not include ‘store and forward’ (asynchronous) videoconferencing or modalities such as file transfer, email or the health record (PCEHR).

The position of the National Rural Health Alliance on telehealth is based on considerations relating to access and equity. Telehealth provides tremendous opportunities to increase the access of those in rural and remote settings to medical care. There needs to be certainty that the quality of the consultations and experience is appropriate, which underlines the importance of a standards framework. And it is vital that telehealth is used to augment, rather than replace, locally delivered services. [See the letter on page 39 of this edition - Ed.]

There are natural barriers to the rapid adoption of telehealth. Some people hesitate to try new things. Sometimes when telehealth is tried and the quality of the connection or software is not great, it can put people off. So the first experience is key for both patients and practitioners. ACRRM has provided considerable free-of-charge support to clinicians who want to dip their toe in the telehealth water. It also provides a free directory of clinicians who have embarked on telehealth and the technology that they are using - this assists E-clinicians to ‘connect’.

It would be helpful if the Medicare item numbers were extended so that participation of a medical specialist was not required - allowing GPs, nurses and allied health professionals to collaborate via telehealth for the benefit of their communities.

It’s sometimes hard to predict what will work, but tele-Derm has been an outstanding success. This program, run by ACRRM, allows any rural doctor to forward a de-identified photo and case summary to a dermatologist for advice. The advice is free and a response is usually received in 24 hours. This compares with a wait of many weeks to see a dermatologist (not many of whom reside in a rural location!).

One of the key reasons for the success of tele-Derm, is that dermatologist, Dr Jim Muir, who has been involved from the start, is committed to the program and provides weekly cases to enable GPs to upgrade their skills.

In my view telehealth is sometimes actually better than face-to-face consulting. It can support a three-way conversation between a specialist, a patient and their primary practitioner, be that a nurse or a GP. It is so much better having a live conversation than referring a patient to a specialist with a letter and hearing back two months later via another letter, and finding out the specialist hadn’t actually provided the assistance you were seeking!

The role of the MBS in telehealth consultations should be widened further. This will be seen as increasing costs to the MBS, but it will reduce travel costs, improve access and, if done correctly, improve the quality of care for rural and remote communities.

One should have confidence in telehealth. Whenever a rural person is expected to travel for a specialist medical appointment, they should ask their GP whether it is something that can be done via telehealth.
Overcoming the isolation experienced by Aboriginal and Torres Strait Islander carers

There are 2.6 million carers in Australia. They provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, drug or alcohol issue or who are frail aged.

Aboriginal and Torres Strait Islander peoples are more likely than non-Indigenous Australians to take on a caring role. They are also more likely to care for more than one family member, to need assistance with their own care needs, and to experience socio-economic disadvantage due to caring. The pressures faced by Aboriginal and Torres Strait Islander people in their caring role often affects their own health and wellbeing, and that of other family members, and can lead to family breakdown. A large proportion of people living in rural and remote areas are Aboriginal peoples or Torres Strait Islanders.

Carers Australia has recently undertaken research to better understand Aboriginal and Torres Strait Islander carers: what their caring needs are and how these needs may be met. Research indicates that many Aboriginal and Torres Strait Islander peoples are less likely to seek assistance in their caring role because of:

- not identifying as a carer;
- cultural beliefs relating to the role of caring;
- socio-economic factors that impact on their ability to seek help;
- lack of awareness of services;
- lack availability of services;
- reluctance to use services that are considered culturally inappropriate;
- reluctance to relocate for services;
- over-complexity of the health care system;
- lack of choice between mainstream and culturally-specific services; and
- lack of availability of Aboriginal and/or Torres Strait Islander carer support and respite care staff.

The research also tells us that for Aboriginal and Torres Strait Islander carers there is a lack of uptake of supports such as Centrelink entitlements, the Home and Community Care Home Modification Program, and Medicare initiatives. There is a particular gap in the availability of flexible and responsive respite options for these carers, particularly in rural and remote communities. Respite refers to the opportunity for a short break or period of rest. Recent studies have recommended a range of approaches for improving access to respite, including community capacity building of respite services, mobile respite services, co-location of respite services with aged care, use of community facilities such as outstations as respite service locations, and training and paying community members to provide respite care. Evidence suggests that best practice initiatives for Aboriginal and Torres Strait Islander carers include providing choice between mainstream services, culturally-specific services, and community-controlled services.

Aboriginal and Torres Strait Islander carers have voiced a need for culturally appropriate programs including information and training on care provision such as: lifting techniques and the use of aids and equipment; managing home dialysis; and managing medication. There are few hardcopy educational resources available for Aboriginal and Torres Strait Islander carers, particularly those in languages other than English. It must be acknowledged that any development, implementation and evaluation of carer programs and resources should occur in conjunction with Aboriginal and Torres Strait Islander carer groups.

While the research shows that there are few culturally-specific programs available for Aboriginal and Torres Strait Islander carers, there are a number of programs offered by the state and territory Carers Associations. These programs include the nationally recognised Carers NT Remote Respite ‘Troopy’ (Troop Carrier) program, the award-winning Carers NSW ‘Looking After Ourselves’ program, the Carers ACT Aboriginal and Torres Strait Islander program, and the Carers SA partnership with the Council of Aboriginal Elders SA and the Aboriginal Health Council as part of the Aboriginal Carer Project in Port Augusta. Services are also offered for Aboriginal and Torres Strait Islander carers through community-controlled health organisations, for example a ‘Graniator Support Group’ through a New South Wales Aboriginal Medical Service, and a partnership between Carers Queensland and Wuchopperen Health Service in Far North Queensland where a carer counsellor is based.

Carers Australia is currently conducting further research into the situation for Aboriginal and Torres Strait Islander carers. For further information, visit www.carersaustralia.com.au or email info@carersaustralia.com.au

Jade Taylor
Research Officer, Carers Australia
Two very significant things occurred this year for me. Firstly I opted to complete my 5th year of medical school as a rural year and moved to Port Pirie in SA with three colleagues. And secondly, I passed my final exams. Hurrah!

Moving to Port Pirie in January was a big (and welcome) change from studying in the city where I had been for the previous four years. Starting from the mayoral reception when we first arrived, the four of us making the local TV news and front page of the paper with the heading ‘Mayor: I am in awe of you’, it was evident that this year of study would be like no other, and would hold both challenges and rewards for us. We were instantly included as part of the community, which was fantastic, but also a huge responsibility, whereas previously as medical students we had had very little responsibility. Activities such as supermarket shopping changed from a simple task to a social outing, and my capacity to remember names was certainly put to the test as everywhere I went I bumped into patients and other health professionals who were up for a chat. I was keen to get involved beyond the hospital walls, which was lucky because as soon as I established an interest in sport, I was head hunted by the local netball team, as well as the swimming club, touch football association and social basketball organisation. With coaching from the local nurses’ team I even tried my hand at lawn bowls in an attempt to unseat the doctors’ team from their position on top of the table - alas we were unsuccessful and they continued their reign.

This community attitude really flavoured the whole year for me and allowed me to enjoy my clinical placements substantially more, and also get a lot more out of them. Days started with ward rounds at the hospital, which is entirely run by GPs with visiting specialists plus a local general surgeon and specialist obstetrician. Once ward rounds concluded we rotated between parallel consulting at the various GP clinics around town, and sitting in with specialists and surgeons. This system was not something I had experienced before, and I found it to have both positive and negative aspects. Long waits for patients at GP clinics due to doctors being caught up at the hospital sometimes created difficult doctor-patient interactions, especially if the patient was then asked to see a student. On the flip side, however, by working as not only a GP but also as a hospital doctor, paediatrician, geriatrician and assistant surgeon, made for very interesting and varied work. I found this stimulating and it is a career path that would definitely be rewarding.

We were also given opportunity to work with various allied health groups ranging from physio to speech pathology, to Indigenous health. This was a valuable experience because rural health requires teamwork and collaboration between so many aspects of healthcare to achieve the best outcomes for patients, and it was good to experience this firsthand. I particularly enjoyed going on the ‘Rainbow Serpent bus’ to the surrounding areas to do health checks on any willing Indigenous families and school children.

Basically I had a fabulous year. I had been homesick living in the city and I loved getting back to the country ethos, even if it was a totally different area from the one I grew up in. I enjoyed the experience and although there were challenges, mainly related to confidentiality, professionalism, and avoiding hospital politics, I feel I rose to this and matured a lot as a student, a doctor and as a person. It renewed in me my desire to work in a rural area. I have my fingers firmly crossed that more full time rural internships are made available by the time I graduate.

Emma Dawes

MEDICINES IN THE BUSH

Pre-Conference Multi-Disciplinary Workshop – Adelaide, Sunday, 7 April 2013

Do you think pharmacists should prescribe? Do you think your profession should prescribe? Come along, have your say and represent your profession.

Inquiries to: Lindy Swain on 02 6620 7389 or email lindy.swaian@psa.org.au

Information and registration for this and other pre-Conference events: nrha.org.au/12nrhc
If the concurrent sessions at the Conference are the five courses in the banquet of ideas provided, then the load-bearing trusses of the banqueting hall itself are the keynote or plenary sessions. They provide the shape of the room in which all diners will meet, the strength of the surroundings, and the context for individual selections from the menu.

There are seven plenary sessions. The first is about shaping a bright rural future based on social justice and inclusion. The very special guests who will be leading the session have not yet confirmed - so watch this space.

The second plenary session will provide confidence about the safe hands we are in for the future. Good things are astir, with some success on the illness prevention front, including on an issue as fundamentally important as the impact of smoking on the health of Aboriginal and Torres Strait Islander people. Louise Sylvan, CEO of the Australian National Preventive Health Agency, is among those who will speak.

The third will focus on the system change we need for health improvement in rural and remote areas. Sue Middleton, COAG Reform Councillor, will discuss the importance of monitoring progress and having an early warning system on key issues. Mick Reid will give insights into some interstate collaboration which is enhancing health care in remote areas.

In the fourth plenary session Conference delegates will hear from national, state and local leaders on how rural and remote regions can be assured of their fair share of public resources. One of the speakers will be Paul Rosair, Director-General of the West Australian Department responsible for the Royalties for Regions program; another will be an experienced rural local government manager.

The fifth pillar will hold up for inspiration some of the leaders of the rural health sector. A longstanding friend of the Alliance, Michael Bishop, will join palliative care specialist from Tasmania, Robyn Brogan, Dougie Herd from the NDIS Transition Agency, and rural mental health advocate from North Queensland, Alison Fairleigh. This session will also include special presentations to celebrate some of the sector’s community and research leaders.

The penultimate plenary session will deal with the evidence, the economics and the national authority needed for a bright rural future. Bob Wells will tell us we have the evidence we need.

Jane Hall, Prof of Health Economics at UTS, will talk about the economics of Medicare Locals, Local Hospital Networks and activity-based funding. In the final keynote session on the afternoon of Wednesday 10 April the Conference will turn its attention to agreeing priority recommendations for action for improving rural health. Health Minister Tanya Plibersek will present the closing address, after which Robert Petchell and Emma Beech, with the friends they have made at the Conference, will present to the world for the first time their unique and inspirational sound and conceptual tapestries. By afternoon tea, everyone should know what it is that ‘Makes Their Day Worth It’ - with commitment to a bright rural future playing a major part.

Friends hamper – a chance to show off your local community!

Calling all Friends of the Alliance

Tea towel, tea spoon or tea bags? Jam or juice? Wine or wool? Honey or herbs? When you come to Conference what will you bring from your local area to go into the Friends hamper?

A lucky Friend will win the hamper in the final plenary session.
It is arguable that part of the inequity between well-resourced and struggling communities is their differential access to grant application writing skills. The Alliance would like to make a contribution to a more level playing field in this respect.

Robyn Aitken and Adrian Schoo, who were both on the independent Assessment Panel for Rural Health Continuing Education Stream Two (RHCE2), will run an interactive workshop based on a RHCE2 application form to give participants:

- preparation tips and steps to follow when writing a grant application;
- advice on how to provide relevant, concise and accurate information to address the grant funding and eligibility criteria; and
- suggestions on the type of information and references that should be supplied to demonstrate the need for and priority of the proposed CPD activities.

Although the examples will relate to the RHCE2 system, the skills and learning discussed will have more general application. The workshop is scheduled for Wednesday 10 April, starting with breakfast at 7.00am, and with the workshop itself running from 7.30-8.30am. If you are planning to attend, please advise Conference organisers.

The partnership approach ensures the needs of pregnant Aboriginal women are considered holistically. This has led to improved community engagement, better statistics for Aboriginal births and morbidity rates including a reduction of sick babies and mothers, decreases in low birth weight of babies, and women presenting earlier in their pregnancies.

To learn more, meet the team at the 12th National Rural Health Conference on the SA Health stand on Monday 8 April or Wednesday 10 April. Or for more information see a short film about the program by visiting sahealth.sa.gov.au/sahealthawards and click on the 2012 research and education award.

Country Health SA Local Health Network, SA Health
Email: chsa@health.sa.gov.au
www.sahealth.sa.gov.au

The Aboriginal Family Birthing Team with their award for the initiative ‘Country Health SA Local Health Network Aboriginal Family Birthing Program’.
STUDENTS AT THE CONFERENCE

The 12th National Rural Health Conference has much to offer students: a broad ranging academic program; a packed social program; opportunities to scribe and help frame recommendations from the concurrent sessions; and the chance to network with rural health practitioners, health organisations and other students from all over Australia.

Among the vast range of topics covered by the Conference there are several sessions focusing on education, training and preparation for rural practice.

Pre-conference events include a Writing for Publication workshop presented by members of the editorial team of the Australian Journal of Rural Health.

Don’t miss the Conference dinner. Historically students have participated with enthusiasm – this year’s dress code is your choice of bright colours. There is the traditional special student recovery breakfast the next morning.

For RAMUS scholarship holders there will be a luncheon networking event for all the RAMUS scholars, mentors and alumni attending the Conference.

On the Saturday evening before the Conference starts, ACRRM will host a dinner for students attending the Conference.

Judging from the feedback from students about previous National Rural Health Conferences, the 12th Conference will provide a fantastic perspective on life and health care in rural Australia and will open your eyes to the opportunities available in a rural health career. Make sure you don’t miss this opportunity to brighten your future.

WELCOME TO THE SHARING SHED

The Sharing Shed will make its debut at the 12th Conference in Adelaide. It’s an on-line forum where Conference delegates can share their ideas and make recommendations for improving rural and remote health and wellbeing.

One of the strengths of the biennial National Rural Health Conference is its capacity to generate recommendations from the rural and remote health sector. When widely supported and agreed, these can lead to action at various levels, including through local, state or national governments, professional associations, universities and/or community groups.

The process for generating recommendations is as open and inclusive as practicable. Delegates will be able to access the Sharing Shed via their personal laptops, tablets and smart phones as well on a number of computers located in the Convention Centre. Delegates will be able to progressively view recommendations as they come in and allocate their ‘votes’ to indicate support for particular ones.

A Conference Recommendations Group, chaired by Lesley Fitzpatrick, will frequently visit the Shed during the Conference and use what they find there as the basis for developing a set of priority recommendations which will be approved and ‘signed-off’ by delegates and subsequently presented to the Minister for Health and others, such as the Minister for Mental Health and Ageing. The ideas will also be presented formally to the Federal Coalition as it goes about the business of developing policies for the coming Federal Election.

The Sharing Shed is publicly accessible on the 12th Conference website and all interested people are welcome to visit to see what ideas are running – but only 12th Conference delegates are enabled (via password) to make recommendations, comment and vote. To have your say in the Sharing Shed make sure you register now and attend the Conference. nrha.org.au/12nrhc
There will be a Sound Therapy Workshop at the Conference. The Woden Valley Youth Choir will perform in the Closing Session. You can also hear inspiring Arts and Health papers in the concurrent sessions. To take just two examples, Lisa Philip-Harbutt will reflect on the growth of arts and health and Christine Putland will discuss the evidence base for its effectiveness. The evidence is strong and becoming increasingly well accepted by both health professionals and arts practitioners. For instance there is medical evidence of measurable reductions in stress, depression and anxiety as well as lower pain levels and blood pressure.

There will be dancing at the Conference as well, such as the Move through Life dance workshop led by Joanne McDonald. So come and let your voice be heard, move your body to the music and start feeling better about everything!

What are you waiting for?

REGISTER NOW at the Conference section of www.ruralhealth.org.au
FMC ARTS AND HEALTH

24 HOURS - INSTALLATION

Delegates will be able to experience key elements of the popular and highly regarded arts in health program developed by the Flinders Medical Centre (FMC) in Adelaide. In their usual setting, the FMC programs see patients, staff and visitors share their stories through simple interactions with artists, creating artworks and conveying their thoughts and feelings.

One recent element of these programs has been 24 Hours which will be re-located during the 12th Conference to the Exhibition Hall. It includes felting, sound, movement, photography and film reflecting the continual activity of the hospital environment. 24 Hours profiles areas of the hospital which are frequently unseen, such as laundry, kitchens, mailroom, operating theatres, maintenance, central sterilisation department, and laboratories.

THE ART TROLLEY

The famous Flinders Medical Centre Art Trolley will be in the Exhibition Hall so that delegates can drop in to experience this creative outlet which is regularly available to FMC patients, staff and volunteers.

HIGHEST RANKED ABSTRACT

The findings of a collaborative project exploring the challenges and opportunities associated with building common assessment processes across three diverse services for older people entering the aged care system is the subject of the highest ranked abstract submitted for the 12th National Rural Health Conference.

The paper by Sue Cowan and Fiona MacPhee, ‘Building an integrated aged care assessment process for rural older people of North East Victoria’, focuses on the final stage of the project which explored the experience of assessment processes and practices from the perspective of key stakeholders. These stakeholders included the line managers, CEOs and practitioners of the three agencies and a cohort of current or past recipients of services.

CROAKEY AT THE CONFERENCE

Croakey, the independent on-line health blog, will be present at the 12th National Rural Health Conference to keep Croakey readers informed about its events, highlights and recommendations. Freelance journalist Marge Overs – who has a longstanding commitment to rural health, including as a former editor of Australian Rural Doctor magazine – will provide reports from the Conference for Croakey and via Twitter.

The NRHA will pay Croakey for this service but articles will not be vetted by the NRHA prior to publication. In the interests of transparency articles published as part of this arrangement will be clearly badged (using the logo). Croakey is trialling this innovative form of reporting as a service to its readers and to test new models for the funding and production of journalism, and the sustainability of Croakey.

More information: melissa@sweetcommunication.com.au or 02 4841 0601
CONFERENCE HIGHLIGHTS

SOCIAL ACTIVITIES

Conference Dinner: This wonderful evening of dancing, celebration and good food will also recognise winners of the Rural Health Research Awards, the Friends Unsung Hero, the Des Murray Scholarships and SA Health’s Gary Stewart Award. Dress code is your choice of bright colours.

Early morning exercise walks will be conducted by the Heart Foundation on Monday and Wednesday morning.

Delegates can take the Country Health SA pre-Conference bus tour to visit Strathalbyn and Mount Barker in the picturesque Adelaide Hills. The Mount Barker health facility provides a range of acute and community services to this district. The tour will visit Strathalbyn Rehabilitation Unit - gym, aged care facility, memorial garden, Positive Mental Health and Wellbeing Task Group, and the Health Promotion in the Community Program.

Delegates are invited to join Aboriginal Elder, Ivan Copley, on an Aboriginal culture walk around Adelaide on Sunday morning, taking in many local Aboriginal cultural sites.

GET YOUR MANUSCRIPT PUBLISHED

NOW IN ITS 21st YEAR OF PUBLICATION, AJRH Publishes six issues per year of high quality peer reviewed research on rural and remote health issues. This is an important body of work which adds to the evidence base that underpins efforts to improve health outcomes in rural and remote areas.

As part of its ongoing commitment to strengthening professional practice and fostering new and existing authors, AJRH is again offering its pre-Conference Writing for Publication workshop on Sunday 7 April. AJRH Editor David Perkins and Deputy Editor Jeff Fuller will work with participants to help them understand the key steps to getting their research papers published.

The workshop is designed for new researchers and writers, and anyone who wants to know more about the process of publishing research in a peer reviewed environment is welcome. Registration: nrha.org.au/12nrhc

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The National E-Health Transition Authority (NEHTA) was established seven years ago and it has now completed the design and build of many of the ‘Building Blocks’ for eHealth. These include the Healthcare Identifiers (HI) Service; national infrastructure specifications for eDischarge, eReferral, eSpecialist letters and the Electronic Transfer of Prescriptions; and the National Clinical Terminology and Information Service.

1 July 2012 marked the formal start of the Personally Controlled Electronic Health Record or national eHealth record system. Consumer registrations have started and work is now in train to register clinicians - starting in General Medical Practice but noting the need to connect the whole clinical community in due course.

Key target groups who will benefit from the sharing of health information include those with specific needs such as older Australians, those with chronic or complex diseases, mothers with newborn babies, Aboriginal and Torres Strait Islander people, and Australians living in more remote communities.

NEHTA is now building on these important developments. Already it has brought together multiple IT platforms, such as medical software programs produced by different companies, and over time, the range of hospital, pharmacy, pathology, radiology software programs so that they can all read from and write to the national eHealth record system in the same way. This is a massive change in use of technology and a great leap in ‘joining up the dots’ in the healthcare sector.

NEHTA’s focus in 2013 is to continue to develop and rollout the national infrastructure and adoption support required for eHealth in Australia and to support the health sector’s transition to the effective use of eHealth. It will also continue to develop specifications and standards for other conforming health sector participants to connect to the national eHealth records system.

None of this would be possible without the dedication and collaboration of our partners, core funders and stakeholders.

From January 2011 to July 2012, NEHTA facilitated or was involved in over 730 meetings, workshops and conferences, communicating with thousands of people from around 500 different stakeholder organisations.

I would like to thank all those who contributed in workshops, forums, focus groups, reference groups or were just advocates of our work. We look forward to continuing a respectful, responsive, collaborative approach to improve our understanding of our stakeholders’ needs and to support them in contributing to and being part of the national eHealth agenda.

Now the journey continues – to strive for better healthcare, safer health outcomes, and meaningful use of the emerging eHealth record system.

The above is adapted from a communication to NEHTA stakeholders from its Head of Clinical Leadership and Stakeholder Management - Dr Mukesh Haikerwal AO
The importance of employment

With regard to the current work for people with a disability, I would like to point out the importance of supported employment and strategies to improve inclusive work places: perhaps there could be tax considerations for those businesses which provide employment for people with a disability.

So many positive outcomes result from having a paid job, especially in terms of emotional and mental health.

Where disability plans are being developed then I believe there should be an employment component.

On a separate note, the risk management which is likely to result from recent climate change reports will be yet another priority diverting funds from NDIS and its implementation.

Lynne Strathie, Darwin

NDIS – pointers for rural implementation

There is currently much interest in exactly how the National Disability Insurance Scheme (NDIS) will be implemented for people with disabilities and their carers. One of the greatest challenges is implementing the new system in rural and remote areas where there are distance and resourcing issues. Some critical service delivery issues will have to be addressed to ensure the success of a universal NDIS.

There will need to be client centred co-ordination – locally based, consistent co-ordination – to ensure that the person with the disability and their carer have the opportunity to establish a trusting relationship with their co-ordinator/provider, and provide one of the bases for continuum of care.

Appropriate transportation is essential for those living with a disability in order for them and their carer to access the necessary facilities, programs and other resources. If this transportation exists in a rural and remote area, it is often only available for limited periods (e.g. business hours) due to resourcing issues.

Adequate funding allocations per person will need to take into consideration the cost of travelling for services not available locally – not just for health but also for training in the use of aids and other specialist education.

Communication systems and networks will have to be established to enable quick, effective responses to service changes required by the client and their carer as their needs change.

Camilla Rowland

Nothing beats face-to-face

I remain interested in the NRHA and read Partyline from time to time. The NRHA continues to do a great job in advocating for rural people. However my perspective on telehealth item numbers is different from that espoused by the NRHA.

The telehealth item numbers actually pay specialists 1½ times the usual Medicare rate for a telehealth consult. This is in effect a disincentive to those who are considering local service provision or outreach from a larger centre. The whole premise of telehealth is defeatist: that it is too hard to get rural specialists and too hard to get them to do outreach.

But better systems are possible. I have spent almost 20 years living in Northern South Australia and providing paediatric services. We are about to employ our fourth paediatrician and will have two registrars or paediatricians in training. We provide regular services to communities up to 800km away. We do not use telehealth.

My take on rural Australia is that the primary issue is human isolation.

We do not recommend TV and video as a primary form of socialisation for our children. Nor do I believe it is a primary form of healthcare delivery.

The introduction of telehealth provides a perverse incentive to practitioners in the urban setting and also to administrators, to see this as the total solution and to avoid doing the hard yards and supporting real consultations with real specialists in rural Australia. I would challenge the NRHA now that it has been successful with telehealth, to provide the same level of advocacy and support for local, on the ground GPs, nurse practitioners, Aboriginal health workers and communities. I look forward to the NRHA pursuing the solution of specialist health for rural people by providing real consultations and real practitioners.

Kindest regards,

Dr Nigel Stewart, Paediatrician
Head of Northern Regional Paediatric Unit
Port August, SA
The unique and significant role of Aboriginal and Torres Strait Islander Health Workers is the focus of two new programs that aired on the Rural Health Channel in February 2013. The Rural Health Education Foundation and Health Workforce Australia have collaborated to develop a multimedia DVD package in response to a recent report on the Aboriginal and Torres Strait Islander Health Worker profession. The report, Growing our Future, by Health Workforce Australia found that there were significant misperceptions concerning the role of Aboriginal and Torres Strait Islander Health Workers.

Filmed in locations across rural, remote and urban Australia, it features interviews and stories from:
- Wuchopperen Health Services in Cairns
- Karpa Ngarrattendi Aboriginal Health Unit in Adelaide
- Noarlunga’s Nunga Lunch in Adelaide and
- Wurlu Wurlijang Health Service in Katherine

“While travelling around Australia we have met many dedicated and inspiring health workers who are making a real difference in their communities through their leadership and expertise,” said Helen Craig, CEO of the Foundation.

The panel looked at the broad scope of practice of Aboriginal and Torres Strait Islander Health Workers, the national registration scheme, and the various approaches to registration taken in different States. The program also saw discussion of the value to individuals and organisations when Aboriginal and Torres Strait Islander Health Workers are a natural part of an inter-professional health team, and strategies to ensure that their full potential is available to help close the health gap.

A multimedia DVD will package the two programs and a range of filmed case studies and interviews, printable resource materials including a comprehensive learning guide to help further understand the vital role of Aboriginal and Torres Strait Islander Health Workers. Around 2,000 copies of the DVD will be available free to health professionals and organisations across Australia.

For more information about the programs or to order the DVD visit the Rural Health Education Foundation website www.rhef.com.au or call (02) 6232 5480.
Mental health services for rural and remote Australia

For Australians living in rural and remote areas, it’s often a real challenge to get an appointment locally with a specialist such as a mental health professional. Now, thanks to the Department of Health and Ageing, many of those needing help with mental health issues are being spared long journeys for treatment.

The Department funds two programs that directly target this demand for primary mental health services: Access to Allied Psychological Services (ATAPS) and the Mental Health Services in Rural and Remote Areas program (MHSRRA).

ATAPS, coordinated and managed at regional level by Medicare Locals, is a gateway for access to effective, low-cost treatment for Australians with mild to moderate mental disorders. ATAPS provides up to 12 sessions annually with a mental health professional for patients referred by a GP. Additional funding of $205.9 million over five years from July 2011 is aimed at people in hard-to-reach locations or population groups, including those in rural and remote areas.

MHSRRA aims to improve access to mental health services for residents of rural and remote regions with a mild to moderate mental condition. The program funds Medicare Locals, Aboriginal Medical Services and the Royal Flying Doctor Service to deploy mental health nurses, occupational therapists, psychologists, social workers, Aboriginal health workers and Aboriginal mental health workers. Referrals can come through GPs, health clinics or an Aboriginal Medical Service. MHSRRA provides services in more than 200 rural and remote communities throughout Australia.

The Australian Government is also investing in e-Mental health which allows those with internet access to consult a mental health professional online. As well as being especially convenient for patients in rural and remote areas, internet consultations can also allay privacy concerns that might otherwise be a barrier to seeking help.

In July 2012, the Australian Government released its e-Mental Health Strategy. Developed with advice from an expert committee, the strategy envisages an accessible, high-quality and integrated system to further establish online care as a regular feature of the healthcare system. The strategy is available at www.health.gov.au One of its key components is a single online gateway to make it easier to find credible mental health information. The Mindhealthconnect gateway, launched on 1 July 2012, connects patients to innovative and effective online services. Mindhealthconnect can be accessed at www.mindhealthconnect.org.au

In December 2012, MindSpot, another investment under the strategy, became operational. Mindspot provides free real-time cognitive behavioural therapy from a counsellor, either on the phone or online – which is highly convenient for patients in rural and remote areas. Mindspot can be accessed at www.mindsport.org.au

Teleweb (the Telephone, Counselling, Self Help and Web-based Support Programs) can also be a great help to those living in rural and remote areas. It offers phone and online mental health programs for people with common mental health disorders and those in psychosocial crisis. Teleweb started in July 2006 and includes initiatives such as Lifeline, Kids Helpline, Anxietyonline and ReachOut.com

The national headspace initiative can also help young Australians in rural and remote areas. Focusing on youth mental health and related drug and alcohol problems, headspace aims to improve access for young people aged 12-25 to the right services and ensure those services are better coordinated.

Of the 70 headspace sites announced or established to date, 35 are outside metropolitan areas. By 2014-15, there will be 90 headspace sites across Australia. eheadspace offers phone and web-based support for young people with, or at risk of developing, a mild to moderate mental illness.

In November 2012, the Report to Tackle Suicide in Rural and Remote Areas confirmed the need to deal with the high rates of suicide in rural and remote Australia – 20 to 30 per cent higher than in metropolitan areas.

The Australian Government funds community-based suicide prevention projects through the Taking Action to Tackle Suicide package and the National Suicide Prevention Program. Projects such as Farm-Link and Community Broadcasting Suicide Prevention are aimed at rural and remote areas.

Farm-Link helps farmers and their families by increasing the training and support available to mental health practitioners in their areas. Community Broadcasting Suicide Prevention uses satellite and local radio to promote messages of support and wellbeing to a wide range of listeners.

Funding is also provided for the national expansion of the Wesley LifeForce project and the StandBy service, which will help rural and regional communities prevent suicide, and help those bereaved by suicide.

More information on these projects can be found at: www.health.gov.au/internet/main/publishing.nsf/Content/mental-progs
Nursing student Ella Bouman has a clear goal in life – and she’s determined to get there. “In 10 years from now I hope to be farming my own land and breeding my own cattle whilst nursing in a rural town, improving the health of my community,” she says.

Helping her on the way is one of the new Give Them Wings scholarships, provided by the Royal Flying Doctor Service Victoria in partnership with Rural Health Workforce Australia. The $2,500 scholarship, targeted at country students interested in health careers, has helped towards the costs of Ella’s first year university studies.

Ella comes from Panmure, a small dairy farming community near Warrnambool in southwest Victoria. Before enrolling in nursing at Deakin University’s Warrnambool campus, she completed a Diploma of Agriculture at Glenormiston College.

But it was a health scare in 2007 that crystallised her thinking about the future. Back then, Ella was diagnosed with post-viral aplastic anaemia which resulted in her receiving a bone marrow transplant from her eldest sister. “Although challenging, my time at the Royal Children’s Hospital was a positive experience,” she recalls. “I received the most amazing, uplifting and supportive care.”

It was this quality of care which inspired Ella to take up nursing: “I believe caring is the essence of nursing and to do my part in my lifetime to improve the lives of others is a truly humbling opportunity – and one I will not take for granted.”

The other winner of the inaugural Give Them Wings scholarships was physiotherapy student Kara Hazelman, who literally learnt the hard way about her chosen profession.

Trips to the local physio to treat sports injuries were a regular occurrence for this avid netballer from Kyabram, Victoria. Looking back, those twists and scrapes from the asphalt courts were rites of passage for what is now a commitment to care for others.

“I want to help reduce the inequalities faced by rural communities when it comes to healthcare,” says Kara, who is studying health science and physiotherapy at the Bendigo campus of La Trobe University. She intends to work in the country once she graduates, specialising in rehabilitation.

Giving country students a flying start in health careers is the philosophy behind Give Them Wings, explains Greg Sam, CEO of Rural Health Workforce Australia. RHWA represents the national network of not-for-profit state and territory Rural Workforce Agencies which attract and support doctors, nurses and allied health professionals to work in rural and remote communities.

“The bush needs more health workers of all kinds and a contribution like this can make a huge difference for a young person leaving a small town to attend university,” he says. “We think these scholarships will help because students from a rural background are more likely to return to the country to practise once they graduate.”

The next round of Give Them Wings scholarships opens soon. The scholarships are available for Victorian rural students enrolled in first year nursing or allied health courses. Contact scholarships@rhwa.org.au for further details.

Tony Wells, RHWA
I’m Mark Leddy from Camperdown Clinic in Victoria. As the Practice Manager I am responsible for ensuring that appropriate staffing levels are met to provide a service to our client base. I am writing this article to tell you about my work and the benefits that have come through discovering the Nursing and Allied Health Rural Locum Scheme (NAHRLS).

The Camperdown Clinic has been providing ‘cradle to grave’ health care to a client base from the Great Ocean Road through to Mount Elephant and Lismore in Victoria. The practice has been employing registered nurses in the role of practice nurses for approximately seven and a half years. We are also geared towards education of doctors and medical students and therefore recognise the need for professional development and maintenance of skills. The local hospital is manned by the General Practice doctors and has a highly proficient nursing staff caring for the inpatients.

Camperdown is located in the Corangamite Shire and is known as the Lakes and Craters region. The township has a steady population of around 3700 whilst the Shire has a population of 18000. We are two and a half hours west of Melbourne and one and a bit hours south of Ballarat. The Great Ocean Road is a 30-40 minute drive away. Our community is primarily farming and small business with a small percentage of welfare based families and an increasing percentage of elderly patients.

Prior to utilising NAHRLS, it was always necessary to ask other staff members to adjust their lifestyle to do the backfill whenever someone was away.

I heard about NAHRLS purely by chance, so I was glad that the initial conversation took place. The assistance, guidance and professionalism they offered were at the highest level. The whole transition was undertaken with clear advice and, surprisingly, minimal paperwork. The high quality of candidates put forward allowed management to select the most appropriate for the locum cover position. If I had been recruiting a practice nurse all three of the candidates would have been on an interview short list.

One of the great benefits of NAHRLS is that there are no fees and charges. Our only financial commitment was to pay an hourly rate commensurate with that of the staff member being covered. NAHRLS covered costs associated with transport, accommodation and meals.

When a staff member needed to attend a Pap Smear update course that was being conducted five hours’ drive away, I phoned NAHRLS. Having someone in her position meant that she was able also to take the extra day required to meet the travel needs, including overnight stay. In this case without the ability to utilise NAHRLS the staff member’s accreditation may have lapsed as we could not otherwise cover her absence.

The ability to allow health providers a staffing resource through NAHRLS certainly encourages managers to support the endeavours of their staff in maintaining currency and competency.

The locum had a professional approach and performed all tasks required in an appropriate manner. Communication between admin and health providers was clear and concise. Medical notes were also well written. I am quite sure that the locum, although only here for a short time, enjoyed the experience.

NAHRLS is easy and professional and the locum provided was of high quality so I would not have any hesitation in recommending NAHRLS to others and using the service again in the near future.

Mark Leddy, Practice Manager from Camperdown Clinic in Victoria.
Birth of new peak body for older people

After ten years in the planning, a new national peak body promoting excellence in pastoral and spiritual care for older Australians has operations. Pastoral and Spiritual Care of Older People (PASCOP) honours the gift of the later years of life by offering a vision of fruitful, meaningful ageing.

Importantly, rural and remote communities stand to gain considerable benefit from the services and resources PASCOP will be developing.

PASCOP will develop and promote guidelines for best practice in the pastoral and spiritual care of older people; establish a network of communication and resources for aged-care organisations, their staff and carers; advocate for appropriate funding for research, training and for pastoral and spiritual care services; and increase social and professional recognition of the value of pastoral and spiritual care.

Rural and remote communities generally share the common problem of a lack of infrastructure and breadth of resources to provide complete holistic care. Consequently, many individual needs, such as pastoral and spiritual care or counselling, must often be met by carers and health professionals.

The resources being developed by PASCOP will better equip carers to confidently provide meaningful initial assistance and appropriate referral in a variety of situations.

“Many different organisations knew there was a great need for a centrally coordinated approach to this vital aspect of older people’s care and support. So they had a vision for a body like PASCOP,” said David Petty, PASCOP’s Executive Officer.

“Many organisations have already developed programs to ensure that quality spiritual care in the context of a diversity of faith and cultures is provided to those in their care. But at the same time they have recognised the need for a consistent, best-practice approach, one that all providers can access equally.”

Making research readily available to a variety of users and practitioners will be a key PASCOP strategy. To help achieve this, PASCOP already has a close working relationship with Charles Sturt University’s Centre for Ageing and Pastoral Studies (CAPS), a key research body in the area of pastoral and spiritual care of the aged. The new organisation also envisages establishing relationships with other research organisations.

PASCOP’s vision is founded on the tenet that an essential aspect of a well-functioning aged care organisation is that it will foster the potential for all older people to flourish by finding meaning and wellbeing. As essential elements of person-centred care these are the responsibility of all staff – pastoral and spiritual, nursing and care, life-style and other. Pastoral and spiritual care enable the individual to be recognised as a person of value and to experience quality of life through mind, body and spiritual health. Meaning and purpose and skilled pastoral care support peace of mind.

Membership of PASCOP is open to organisations that are involved in the support, care and/or accommodation of older people. Membership of PASCOP will also include a reciprocal membership of CAPS. PASCOP also aims to establish strong ties with other organisations in aged care, including peak and professional bodies.

Interim website: centreforageing.org.au/pascop/default.htm
Interim email: pascop@csu.edu.au
Telephone: 02 6272 6216
Note: in a previous life Dave Petty was Editor of Partyline.
Scholarships have been offered to 190 allied health professionals wanting to undertake postgraduate study in 2013 – more than double the number offered last year – by Services for Australian Rural and Remote Allied Health (SARRAH).

Offers to qualified allied health professionals included eight to paramedics, whose profession was added to the postgraduate scholarships program for the first time this year. Offers were also made to those working in physiotherapy, social work, dietetics and nutrition, pharmacy, sonography and speech therapy.

SARRAH CEO Rod Wellington said $3.6 million in funding under the Commonwealth’s Nursing and Allied Health Scholarship and Support Scheme was available for those taking up study places in 2013. The 190 scholarships offered this year compares with 85 offers made last year under the allied health component of the scheme, which is administered by SARRAH.

This year’s intake of scholars includes Jamieson Barnes, the sole radiographer at Atherton Hospital in far north Queensland, who was awarded $22,500 to study for a Master of Health Management.

“These scholarships have been hugely popular with allied health professionals who not only benefit personally, but bring a higher standard of care to patients in rural and remote Australia,” Rod said.

“Our scholars are having a huge impact on rural patients in crucial areas of need such as aged health care, mental health, early intervention and Aboriginal health.”

In addition, SARRAH awarded scholarships to 102 clinical psychologists across Australia, offering them financial support of up to $15,000 a year for two years of study. Rod Wellington said this year’s scholarship intake was flooded with applications from psychologists ranging from North Queensland to Tasmania and Alice Springs.

Previous scholarship recipients have included Kirsty Moore, who reduced her large caseload managing local mental health programs in the Barossa region of South Australia to study towards a Master of Psychology degree in 2012.

Kirsty (pictured) said her training was helping her to learn more about some of the key aspects of working in rural Australia, which include addressing the increased stigma of seeking help in small communities and the diverse range of issues she sees.

“When people come to my office they report feeling everyone is looking at them going to see the psychologist,” she said.

“Both in the Barossa and in Mannum, in the Riverland, where I am completing my final placement, we are unofficially the drug and alcohol service, the suicide intervention and response service, the postnatal depression clinic, relationship and family counsellors, and the gambling and addiction help service - amongst other things.”

“Often rural psychologists are lone clinicians, with very little clinical support,” she said.

It can be isolating for psychologists in rural and remote areas working through heavy caseloads without professional back-up.

Far North Queensland psychologist, Tim White, is another scholarship recipient who recently completed a Professional Doctorate in clinical psychology. Tim is employed by Alcohol Tobacco and Other Drug Services (ATODS) and is also the sole psychologist for the Far North Region Police Service which has been called on to provide services during major incidents such as the Lockhart River plane crash, Palm Island and Aurukun riots and cyclones. Tim also provides regular clinical services to remote communities throughout Cape York.

“Completing the doctorate program has enabled me to maintain a high level of professional competency that is comparable with psychologists employed in metropolitan areas,” Tim said.

Evidence shows that access to continuing professional development, peer support and clinical supervision all contribute to the job satisfaction, confidence, competence and retention of allied health professionals in rural parts of Australia.

SARRAH is the managing agency for the allied health component of the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS). In 2011/12, SARRAH managed a budget of $11.2 million for all five categories of the Scholarship scheme. These are:

- Clinical Placements Stream
- Clinical Psychology Stream
- Continuing Professional Development Stream
- Postgraduate Stream
- Undergraduate Stream.
Central Australia was the centre of attention late last year as the Northern Territory kicked off a national campaign of events encouraging health professionals and students to take the plunge and Go Rural.

Eight medical students from around Australia were treated to an action-packed week of activities in and around Alice Springs to showcase the career and lifestyle attractions of General Practice in the NT.

Hosted by the Northern Territory Medicare Local (NTML) in partnership with Rural Health Workforce Australia, the NT event was one of a national series of Go Rural events funded by the Commonwealth Department of Health and Ageing.

The clinic at Santa Teresa was next on the agenda and saw Jasmin Grajzman from the University of Notre Dame in Western Australia meet dialysis patient Des Smith. Des was very interested in Go Rural and the young visitors to the clinic. He liked the possibility that they might return to practise medicine in his community, saying, “That’s a good thing; we’d like to see more doctors coming here.”

The students also spent an afternoon at the Royal Flying Doctor Service (RFDS) hanger where they were able to view the aircraft and equipment. Marcus Hall from Monash University was a willing guinea pig, submitting to a demonstration of the specialised light weight gear.

“Visiting the RFDS was a great learning experience for me as I had heard a bit about them, but never had a clear idea of the services they provide,” Marcus said. “Hearing that the area they cover is roughly 7.3 million square kilometres really put it all into perspective and emphasised its importance.”

To conclude the program, the students participated in a day of Basic Emergency Skills Training, conducted by Dr Jim Thurley, Clinical Advisor to the NTML. Dr Thurley was impressed with the students’ enthusiasm and passion for rural medicine at such an early stage of their career.

The visit wasn’t all work though, with the students accepting an invitation from Alice Springs Mayor Damien Ryan to accompany a large group of residents on their regular Saturday morning walk around town, as part of a Heart Foundation Active Healthy Community activity.

NTML Chief Executive Officer, Debbie Blumel, said that the Go Rural – City to Centre event was an ideal way to showcase the career and lifestyle benefits of rural practice to young medical students.

“The Primary Health Care Workforce Sustainability branch of the NTML is dedicated to their mission to bring more health professionals to the NT and Go Rural is a great opportunity to plant the seed that will hopefully bear fruit once students graduate,” Ms Blumel said.

The Go Rural Australia campaign is in full swing, with a series of events designed to attract students and young doctors to careers in rural medicine.

Registrations are open now for the following events run by the national network of not-for-profit Rural Workforce Agencies:

- 5 April: Emergency skills for PGY1-3 doctors, Perth
  Contact: lorraine.tracey@ruralhw.com.au
- 12-14 April: Rural GP “Taster” weekend, Coles Bay TAS
  Contact: aholoway@healthrecruitmentplus.com.au

Find out more about Go Rural Australia at www.rhwa.org.au/gorural
The National Rural Health Students’ Network (NRHSN) welcomes a fresh leadership team - Daniel Faux, Katherine Humphreys and Jillian Ferrell.

Members of the new Executive represent more than 9,000 energetic and enthusiastic medical, nursing and allied health students who belong to 29 university Rural Health Clubs across the country.

“I firmly believe that the NRHSN and the clubs make a significant impact in inspiring people to pursue a rural health career by providing positive experiences, opportunities and networks,” says Daniel, Co-Chair for 2013.

Growing up in rural Western Australia and Queensland, Daniel is now a final year medical student at Griffith University and currently based in Toowoomba. He is passionate about rural communities and intends to pursue a Rural Generalist career after having spent the last year living in Stanthorpe on an extended rural clinical placement.

Katherine, the other Co-Chair for 2013, is equally committed to a career in rural health. “I developed a passion for living and working rurally from a young age having experienced country life each school holidays with my family,” she says. “I felt more at home in the red dirt than anywhere else, so began the journey to become a rural physiotherapist.” Studying physiotherapy at Curtin University in Western Australia and active within its Rural Health Club (WAALHIIBE) since day one of her degree, Katherine knows firsthand the opportunities and friendships that occur within NRHSN and the ability of the network to strengthen the future rural health workforce.

The network Secretary, Jillian, is a final year medical student originally from Canada. For Jillian it was a five-week clinical placement in Tennant Creek during her first year of medicine that solidified the choice to pursue a career in rural and remote health. This experience strengthened her commitment to her Rural Health Club at the University of Queensland, TROHPIQ, eventually leading to her role as the President in 2012.

The new Executive has been elected on a platform to increase the membership of Rural Health Clubs, strengthen and develop the NRHSN Alumni network, and to continue to advocate for greater rural health equality. In particular, they will continue to advocate for HECS Reimbursement to be extended to nursing and allied health graduates in return for working in rural areas.

In addition to these personal goals, the Executive will be working to ensure the core activities of the NRHSN continue. Currently, the network is abuzz with busy students working hard behind the scenes organising events for the year, including orientation week activities, multidisciplinary skills nights, Indigenous festivals, and rural high school visits.

An example of one of the great events from last year that clubs plan to run again in 2013 is the Spirit of Healthy Horizons - Indigenous Conference for Health students run by three Queensland clubs: HOPE4HEALTH, TROHPIQ and BUSHFIRE. The conference showcased positive practice and innovation in Aboriginal and Torres Strait Islander Health. The delegates were welcomed with an exhilarating performance by the Bundjalung Kunjiel Dance Troupe, which was followed by a line of exceptional speakers and leaders in Indigenous Health. Dr Chris Perry, Dr Tash Coventry, Dr Stephen Coventry and Associate Professor Janie Smith discussed the changes and associated positive health outcomes they have seen over the years in the delivery of health services to Indigenous Australians. Paul Pholeros from Healthhabitat, elaborated on housing as a social determinant of health. Tim Rowe demonstrated the benefits that sport and role models bring in an Indigenous community when he discussed the Indigenous Marathon Project.

Activities like these offer students positive experiences in rural locations and provide the first rural experience for some. This leaves students inspired and motivated to further improve the health outcomes of rural, remote and Indigenous Australians.

Mitchell Milanovic, Community and Advocacy Portfolio Representative, National Rural Health Students’ Network

The NRHSN is auspiced by Rural Health Workforce Australia, the peak body for the state and territory Rural Workforce Agencies.
The Australian Continence Exchange (ACE) is the Continence Foundation of Australia’s new online tool to assist health professionals seeking more information about best practice in continence health management. It has a wide range of resources and information in one central online location for easy and efficient access for health professionals.

ACE also provides a platform for professional discussion. The live forum allows specialist and non-specialist professionals to ask questions, gain peer support and advice, and learn about new research findings.


Fast facts

- In 2010, nearly 4.8 million Australians – more than a quarter of the Australian population aged 15 years or over – were living with incontinence.
- By 2030 the prevalence is estimated to increase to 6.5 million Australians (with urinary incontinence, faecal incontinence or both) – equating to 27 per cent of the population aged 15 years and above.
- Incontinence affects both men and women – regardless of their age or cultural background.
- Women are more likely to be incontinent than men – with the life stages of pregnancy and menopause major contributing factors.
- Despite common belief, over half of the women living in the community with incontinence are under 50 years of age (1.7 million).
- Incontinence is more prevalent than asthma (more than 2 million), anxiety disorders (2.3 million) and arthritis (3.1 million).
- In 2010, the total financial cost of incontinence was estimated to be $42.9 billion – or $66.7 billion including the cost of burden of disease.
- In 2010, the total productivity loss due to incontinence was $34.1 billion.
- In 2010, the opportunity cost of informal (unpaid) care provided by loved ones to those with incontinence was estimated to be $2.7 billion.

Information based on Deloitte Access Economics The economic impact of incontinence in Australia 2011, commissioned by the Continence Foundation of Australia. For the full report go to www.continence.org.au

About the Continence Foundation of Australia

The Continence Foundation of Australia is the peak national organisation working to improve the quality of life of all Australians affected by incontinence. The National Continence Helpline 1800 33 00 66 is staffed by continence nurse advisors who provide advice, referrals and resources to consumers and health professionals.

www.continence.org.au

New resources for Indigenous Health


There’s also a new Yarning Place called the National Indigenous Cancer Network (NICaN). NICaN is a national network that encourages and supports collaboration in the area of Indigenous cancer research and delivery of services to Indigenous people with cancer, including their carers and families. www.healthinfonet.ecu.edu.au/chronic-conditions/cancer

Easy-to-use reference guides to help treat young people with depression

BeyondBlue has developed four new ‘quick and easy’ reference guides to address depression in young people.

- Depression in young people – an interactive ‘e-guide’ for primary care health professionals which summarises the Guidelines and can be saved on a computer desktop for quick and easy reference;
- Depression in young people – a 16-page hard copy booklet which summarises the Guidelines for use alongside or in place of the ‘e-guide’;
- An eight-page, printed pamphlet to assist primary care health professionals with assessing and managing depression in young people; and

These new resources aren’t just for doctors, psychiatrists and psychologists. They can be used also by school counsellors, teachers and other adults who work with young people who may be experiencing mental health problems.

The reference guide and resources can be downloaded from www.beyondblue.org.au

RESOURCES

New online resource connects continence professionals

The Australian Continence Exchange (ACE) is the Continence Foundation of Australia’s new online tool to assist health professionals seeking more information about best practice in continence health management. It has a wide range of resources and information in one central online location for easy and efficient access for health professionals.

ACE also provides a platform for professional discussion. The live forum allows specialist and non-specialist professionals to ask questions, gain peer support and advice, and learn about new research findings.

Story competition for Aboriginal girls in remote Australia

Do you like to write stories? Would you like to be part of creating a more beautiful tomorrow?

This is your chance to get involved and maybe get your work published.

Tomorrowgirl is a short story competition for Indigenous high school girls in or from remote communities. It asks girls to tell stories on the theme of “My beautiful tomorrow”. The stories can be true or imagined, and the winner will receive a writer’s support package with a laptop, book vouchers and membership to a writer’s association.

The competition closes on 3 May 2013 at 5:00pm.

The stories will be shared with other remote communities, and across Australia.

For more information go to: www.tomorrowgirl.com.au or email tomorrowgirlaustralia@gmail.com or phone Ros on 0420 933 741.

Founder of tomorrowgirl is Ros Baxter, an author, mother and public servant who has mostly worked in Indigenous policy. Ros believes in the power of people to create their own beautiful tomorrow and is fascinated by the potential of stories to spread hope and lead to positive action.

The judges are Sue Woolfe, author of four novels, whose latest novel is about a white student linguist who searches for the Aboriginal woman who can reveal to her the ‘oldest song in the world’; Damian Amamoo, CEO of Inception Strategies, an organisation which develops social comics and apps for Indigenous Communities; and Danika Nayna, who works for Newslines Radio as a script-writer and journalist, telling good-news stories about Indigenous Australia.

Image courtesy of Tina Phillips/FredDigitalPhotos.net
Strong is our love for our rural town
And strong is our sense of pride
In where we live and who we are;
In strength we are side by side.

Commitment ensures that our people’s needs
Are met with determined care -
Commitment to service; commitment to team;
To support, to heal and to share.

Bright is the start of each new day
And bright is the set of the sun
And bright are the hours of day between
When community work is done.

Future beckons; the now constrains
But the future is built on today.
To build a future that’s bright and strong,
Commitment’s the country way!

-Lexia Smallwood

To register and for more information visit
www.nrha.org.au/12nrhc
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@NRHAAlliance, #ruralhealthconf