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Welcome to Kaurna Country

Dr Uncle Lewis Yerloburka O’Brien

Uncle Lewis Yerloburka O’Brien was born at Point Pearce mission, on the Yorke Peninsula, South Australia, on 25 March 1930. Although born on Narungga country, Uncle Lewis is a Kaurna man. His family relocated there in the nineteenth century, after the loss of the landholdings of his great, great grandmother, Kudnarto, in the northern-most reaches of Kaurna country, near the Clare District.

Uncle Lewis terms his childhood ‘difficult’. He had a weakening jaundice till ten, was separated from most of his siblings and became a ward of the state at twelve. From then, until eighteen, he passed through a succession of foster homes, boy’s homes and hostels. In 1946, at a time when it was rare for an Aboriginal boy to be in secondary education at all—and despite the barriers he faced—Uncle Lewis gained his Intermediate Certificate. He then succeeded in a competitive process to gain an apprenticeship as a fitter and machinist with the SA railways.

As a Kaurna Elder, Uncle Lewis has provided three decades of cultural and pastoral support to Aboriginal children, families and inmates. His face-to-face work has been complemented by substantial contributions to scholarly and creative domains, particularly with respect to the maintenance and promotion of Kaurna language and culture. His tertiary-level contributions have involved Kaurna language support at the University of Adelaide, research support at the University of South Australia and student support, as a visiting Elder, at Flinders University. At the University of South Australia, he consulted on integrating Indigenous knowledge into science and engineering programs, an Australian first.

Kuma Karro Dance Group

Jack Buckskin was the 2010 Young South Australian of the Year. Jack is a Kaurna man and the only young Aboriginal person teaching the endangered Kaurna language. Jack started officially learning the Kaurna language in 2006 and began teaching it in schools in 2008.

He teaches more than 100 students aged from 5 to 62, both Aboriginal and non-Aboriginal, at the Adelaide School of Languages, Croydon, Kaurna Plains School, Le Fevre High and Salisbury High. He also teaches youth in juvenile detention.

Jack speaks at numerous schools, health and government conferences and workshops. He also gives dance lessons at the Kaurna Plains School and has organised a family dance group, the Kuma Karro, which translates to One Blood.
Welcome

The 12th National Rural Health Conference in Adelaide is for all who care about improving the health and wellbeing of the people of rural, regional and remote Australia.

The Conference theme—Strong Commitment, Bright Future—recognises that the people of rural Australia are optimistic and forward-looking when it comes to health and wellbeing. This Conference will encourage you to immerse yourself for three days in debate, dialogue, friendship and networking that will equip you to take many optimistic and forward-looking ideas back to your workplaces and communities.

Whatever your interest in healthy, sustainable and resilient rural communities, and whatever your vocation, you are very welcome at this event. And you will be useful: it is an opportunity for consumers, health professionals, researchers, managers, policy makers, students and others to share and exchange views from different standpoints on the same challenges.

This is a health Conference, but it is one that recognises the broad determinants of health and the critical role played in rural health and wellbeing by education, rural industries and a wide range of sectors and professions. Global economic uncertainty and our two-speed national economy pose challenges for the delivery of publicly funded services, including in health and education. There has been widespread discussion of how to ensure that the benefits of Australia’s economic growth are shared fairly between various communities, industry sectors and professions. And thanks to the make-up of the current Federal Parliament, there has been an intriguing if somewhat faltering focus on rural issues. Part of the faltering has been due to confusion between the interests of people in rural and remote areas and another important but quite distinct issue: a regional approach to government in all parts of the nation.

We are pleased you are here to share your views on the enormous range of issues the Conference will canvass. Everyone here is committed to a bright future for the health and wellbeing of rural communities. Together, we can be a voice to politicians and policy makers on behalf of all rural and remote Australia. Please take advantage of the opportunities provided for delegates to submit proposals for recommendations to make our views known; this process allows some of the networking and talk to be converted to action.

It is a privilege for the National Rural Health Alliance to host you at this Conference. We appreciate and value the contributions that are made by so many people from so many professions, interest groups, locations and communities to the Conference’s content and atmosphere. We appreciate the effort and cost you have all contributed in order to be present here in Adelaide in support of the communities of rural and remote Australia.

Lesley Barclay
Chairperson, NRHA
Welcome

I would like to extend a very warm welcome to the delegates of the 12th National Rural Health Conference.

My congratulations go to the National Rural Health Alliance for an outstanding Conference program—a program that will address the important issues at the heart of better health and wellbeing in country Australia.

The Alliance plays an important role in improving health services in rural and remote areas. It has been a tireless advocate for improving health outcomes for country Australia, and has given a voice to the consumers, health professionals and services providers it represents. It also deserves recognition for its contribution to public debate, in particular the welcome advice it has provided the Government on policy and investment.

There is no doubt that the health challenges facing rural communities are complex. Our shared commitment to improving access, equality and health outcomes for all Australians is stronger than ever.

Over coming days, you will have an opportunity to talk about improving access to oral health, mental health and aged care services. You will also discuss current efforts to reduce tobacco consumption, and be given updates on the roll out of Medicare Locals and the effect of the National Broadband Network. These initiatives that benefit rural and remote communities are an important part of the Government’s commitment to national health reform.

The Conference is an opportunity for you to share your own experiences and network with colleagues, consumers, industry representatives, health professionals and policy makers. I appreciate how valuable it is for people living and working in rural and remote communities to have the opportunity to meet face to face. I too am looking forward to the opportunity of meeting with you in Adelaide.

I wish all of you the very best for the 12th National Rural Health Conference and I look forward to hearing the outcomes of your discussions.

The Hon. Tanya Plibersek
Minister for Health
Welcome

It is a privilege to welcome all of you to the 12th National Rural Health Conference.

As your MC, I’m aware that I am following in the footsteps of a number of highly skilled people, including some with well-known comedic capacities such as Jean Kittson and Julie McCrossin, and high-profile media personalities such as the ABC’s Robin Williams.

Even more challenging is the fact that I know that James Fitzpatrick, the Conference’s MC two years ago, did such a fantastic job. Clearly I have big boots to fill and I’ll do my utmost to look after you and make you feel very welcome in Adelaide.

In working to meeting this challenge, I take some solace from the fact that my lifetime’s work and commitment is closely related to that of the Conference. As National Editor for ABC Rural Australia—one of the largest groups of specialist rural journalists in the world—I share with you an understanding of the fantastic contribution of rural and remote areas to Australia, and the belief that its people deserve a standard of health and wellbeing that is the best it can be and no worse than that experienced by people in the nation’s major cities.

I am looking forward to meeting with you and developing a better understanding of Australia’s rural and remote health sector.

The Conference theme—Strong Commitment, Bright Future—reminds us that there is so much natural strength and resilience in rural and remote areas that we know that a bright future lies ahead. We know, however, that it can only be assured with strong commitment from the people who live in those areas, the public and private sectors that serve them, and the local, State and Federal Governments on which many of those services depend.

In this federal election year, the information the sector provides to decision makers, including through the recommendations from this Conference, will take on a special relevance and importance.

It is a delight for me to know that the Conference and its delegates will have the opportunity to explore and understand more about Adelaide and South Australia. Adelaide is my home and I know you will enjoy being here and trust you may have time for some local and regional exploration.

Welcome to the 12th Conference and I trust I can make a contribution to both your enjoyment of the event and to its value in improving the lot of people who live and work in rural and remote areas.

Leigh Radford
Conference MC
Welcome

Having spent my entire life in rural South Australia, it is a special pleasure for me to welcome you to Adelaide for the 12th National Rural Health Conference.

I am also an experienced participant in these biennial events, so I know just how valuable it will be for delegates and how potentially valuable for the wellbeing of the people of rural, regional and remote Australia.

In my time as President of the Country Women’s Association of Australia, and as a member of Council of the NRHA, it was often necessary to travel to various parts of the country to do the work that was required of someone in those positions. I understand well the personal and family costs of travelling far from home to get things done, so the first thing I want to do is to acknowledge the effort and commitment that all of you have made to be here.

All of us involved hope that you find the 12th Conference to be an enjoyable and energising event. In my experience it’s always encouraging to meet with people from different parts of the country who share the delights and the challenges that we are familiar with from our home territory. So I know that all of you will be pleased to be among friends in the Convention Centre, even though many of them are friends you are yet to make.

This Conference does not belong to the National Rural Health Alliance but it is relevant to remind you of the vision of that organisation. Its vision is ‘Good health and wellbeing in rural and remote Australia’, based on principles of fair go and equity. The Alliance’s specific goal is equal health for all Australians by 2020—something that I know we all support.

There is a very strong Conference program based on the submission of a record number of abstracts. This augurs well for the ongoing interest in rural and remote health issues but we know also that governments are crying poor and need to be directed in their priorities.

I encourage you to take every opportunity during the Conference to have your say (including through the Sharing Shed), to visit the exhibition and to enjoy the social activities. Let’s make every post a winner as we continue the journey towards an even brighter future for rural areas.

Marie Lally AM
Conference Convenor
Committees

Conference Advisory Committee

The National Rural Health Alliance would like to express its special thanks to the members of the Conference Advisory Committee (CAC) for their valuable support and advice over the past twelve months.

- Marie Lally, Convenor, CAC, farmer, Lock, SA
- Greg Cocks, dentist, Broken Hill, NSW
- Dean Crabb, Policy Manager, SA Farmers’ Federation
- James Lyons, Rural and Regional Health Australia, Department of Health and Ageing
- Lesley Fitzpatrick, CEO, Australian Rural Leadership Foundation
- Ellen McIntyre, Director, Primary Health Care Research & Information Service (PHCRIS), SA
- Geri Malone, National Coordinator of Professional Services, CRANAplus
- Mitch Milanovic, National Rural Health Students’ Network, medical student at Notre Dame, Sydney
- Stephanie Miller, Executive Director, Health Consumers Alliance of SA
- Helen Chalmers, Chief Operating Officer, Country Health SA
- Stewart Roper, Remote Area Nurse/photographer, SA/NT
- Ruth Smiles, Curator, Conference arts and health, SA
- Amy Stephenson, Dietitian, Clare, SA; and Future Health Leaders Council
- Nicole O’Reilly, NRHA Treasurer; Community Health, NT; President, OT Australia
- Pauline Glover, Chair, Friends of the Alliance; Flinders University, SA
- Tanya Lehmann, NRHA Council; Principal Consultant Allied Health, Country Health SA; President, SARRAH
- Tim Kelly, NRHA Council; CEO, Adelaide to Outback GP Training Program.

Conference Organising Group

- Di Bennett, Finance Manager, NRHA
- Peter Brown, Project Officer (Arts), NRHA
- Audrey Clarke, Office Manager, NRHA
- Millie Clery, website and design, NRHA
- Leanne Coleman, Conference Manager, NRHA
- Phil Dalley, Travel Makers
- Gordon Gregory, Executive Director, NRHA
- Penny Hanley, Media Adviser, NRHA
- Helen Hopkins and Susan Magnay, Conference Program coordination, NRHA
- Frank Meany, Peter Lale and Huw Ollerenshaw, One Vision
- Dane Morling, Conference Project Officer, NRHA
- Debbie Phillips, DP Plus
- Lexia Smallwood, Coordinator, Conference Recommendations Group, NRHA
- Kellie Sydlarczuk, Conference Coordinator, NRHA
- Andy Tattum, Plaspress
- Michael Wearne, IT Manager, NRHA

And special thanks to Country Arts SA, for their valuable advice and support in the lead-up to the Conference.
### Member Bodies

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>ACHSM</td>
<td>Australasian College of Health Service Management</td>
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<tr>
<td>ACN (RNMF)</td>
<td>Australian College of Nursing (Rural Nursing and Midwifery Faculty)</td>
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<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
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<td>AGPN</td>
<td>Rural sub-committee to Australian General Practice Network</td>
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<td>AHPARR</td>
<td>Allied Health Professions Australia Rural and Remote</td>
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<td>AIDA</td>
<td>Australian Indigenous Doctors’ Association</td>
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<td>ANF</td>
<td>Australian Nursing Federation (rural members)</td>
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<td>APA (RMN)</td>
<td>Australian Physiotherapy Association Rural Member Network</td>
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<td>APS</td>
<td>Australian Paediatric Society</td>
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<tr>
<td>APS (RRPIG)</td>
<td>Australian Psychological Society (Rural and Remote Psychological Interest Group)</td>
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<td>ARHEN</td>
<td>Australian Rural Health Education Network Limited</td>
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<td>CAA (RRG)</td>
<td>Council of Ambulance Authorities (Rural and Remote Group)</td>
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<td>CHA</td>
<td>Catholic Health Australia (rural members)</td>
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<td>CRANAplus</td>
<td>The professional body for all remote health</td>
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<td>CWAA</td>
<td>Country Women’s Association of Australia</td>
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<td>ESSA (NRRC)</td>
<td>Exercise and Sport Science Australia (National Rural and Remote Committee)</td>
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<td>FS</td>
<td>Frontier Services of the Uniting Church in Australia</td>
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<td>HCCRRA</td>
<td>Health Consumers of Rural and Remote Australia</td>
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<td>ICPA</td>
<td>Isolated Children’s Parents’ Association</td>
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<td>NACCHO</td>
<td>National Aboriginal Community Controlled Health Organisation</td>
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<td>NRF of the</td>
<td>National Rural Faculty of the Royal Australian College of General Practitioners</td>
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<td>RACGP</td>
<td>Rural Dentists’ Network of the Australian Dental Association</td>
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<td>NRHSN</td>
<td>National Rural Health Students’ Network</td>
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<td>PA (RRSIG)</td>
<td>Paramedics Australasia (Rural and Remote Special Interest Group)</td>
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<td>PSA (RSIG)</td>
<td>Pharmaceutical Society of Australia (Rural Special Interest Group)</td>
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<td>RDAA</td>
<td>Rural Doctors’ Association of Australia</td>
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<td>Rural Pharmacists Australia</td>
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<td>RHEF</td>
<td>Rural Health Education Foundation</td>
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<td>RHW</td>
<td>Rural Health Workforce</td>
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<td>RIHG of the</td>
<td>Rural and Indigenous Health-interest Group of the Chiropractors’ Association of Australia</td>
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<tr>
<td>ROG of OAA</td>
<td>Rural Optometry Group of the Optometrists Association of Australia</td>
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<tr>
<td>SARRAH</td>
<td>Services for Australian Rural and Remote Allied Health</td>
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Sponsors

PRINCIPAL SPONSOR

SA Health

SA Health is made up of a portfolio of Local Health Networks and other health services, including the Country Health SA Local Health Network. Overseeing the rural public health system in South Australia, Country Health SA provides health services across a vast distance of 983 776 square kilometres or 99 per cent of South Australia. We are one of the largest Local Health Networks in Australia incorporating 65 hospitals and 240 health services sites.

The Country Health SA Local Health Network is proud to be transforming health care and actively delivering health benefit so that rural and remote South Australians live healthy lives. With 7925 staff, we are committed to increasing and improving services across county South Australia, treating country people closer to home.

For more information on South Australia’s health services visit www.sahealth.sa.gov.au

SILVER SPONSORS

Australian Primary Health Care Research Institute

The Australian Primary Health Care Research Institute’s mission is to provide national leadership in improving the quality and effectiveness of primary health care through the conduct of high-quality, priority-driven research and the support and promotion of best practice. It focuses on important sectoral questions relating to the organisation, financing, delivery and performance of primary health care, including its interaction with public health and the secondary and tertiary health care sectors.

02 6125 0766 [ph]
02 6230 0525 [fx]
aphcri@anu.edu.au
www.aphcri.anu.edu.au
National E-Health Transition Authority

The National E-Health Transition Authority was established in 2005 by the Council of Australian Governments (COAG) to help transform Australia’s health system by building the foundations for a national eHealth infrastructure.

NEHTA’s purpose is to lead the uptake of the eHealth systems of national significance and to coordinate the progression and accelerate the adoption of eHealth by delivering urgently needed infrastructure and standards for health information.

In the year ahead NEHTA, in collaboration with consumers, health care provider organisations, industry and governments, will continue to drive the national uptake of eHealth. In particular, building on the progress achieved to date with the 12 eHealth sites NEHTA will continue to focus on driving take-up and transitioning the sites to national adoption.

NEHTA will also further enable the improved continuity and coordination of care; medications management; the use of diagnostic information to enhance specifications and standards development.

In 2013 NEHTA will:

- continue to develop and rollout the national infrastructure and adoption support required for eHealth in Australia, as mandated and funded by COAG
- support the health sectors transition to the effective use of eHealth
- develop specifications and standards for other conforming health sector participants to connect the national eHealth records system.

The aim of this effort is to meet the national objectives for stakeholder adoption of NEHTA foundations and clinical solutions.

NEHTA is proud to support the 12th National Rural Health Conference in 2013.
02 8298 2600 [ph]
02 8298 2666 [fx]
www.nehta.gov.au

DINNER SPONSOR

HESTA

For 25 years, HESTA has focused on helping those in the health and community services sector reach their retirement goals.

We now have more than 750,000 members, 119,000 employers and more than $21 billion in assets.

HESTA’s size means we can offer many benefits to members and employers. These include: low fees, a fully portable account, easy administration, access to low-cost income protection and death insurance, limited financial advice (at no extra cost), super education sessions and transition to retirement options.

We also provide access to great value health insurance, banking and financial planning.

For more information visit hesta.com.au or free call 1800 813 327.
ARTS AND HEALTH SPONSORS

Arts SA

A rich cultural heritage, a thriving arts community and flagship companies make South Australia a leader in the arts.

Adelaide is renowned for having some of the best arts and cultural festivals in the world, attracting thousands of visitors to the state to enjoy the energy and the performances. It is the perfect city for staging international festivals such as the Adelaide Festival, Adelaide Fringe and the Adelaide Cabaret Festival.

The cultural boulevard of North Terrace is a uniquely Adelaide landmark. Along this tree-lined thoroughfare are the state’s major public institutions—the Art Gallery of South Australia, the State Library of South Australia and the South Australian Museum.

The arts are a vital and fundamental part of South Australia’s culture, and the South Australian Government, through Arts SA, fosters an innovative, sustainable arts sector that is interconnected with, and supported by, a range of initiatives that underpin our cultural activity and development.

Country Arts SA

Country Arts SA is intricately involved in all aspects of art in regional South Australia. We present, produce, fund and facilitate art in order to champion, create and connect people, places and cultures.

Our vision for a better life for all South Australians reflects the role arts play in improving wellbeing, expanding opportunity and fostering creativity and innovation. It also recognises the significant contribution country communities make in growing prosperity for themselves and for the whole of South Australia.

We know that as an organisation we have the knowledge, expertise and experience to work with communities to make arts and culture come alive in their region, but we also realise that we cannot do it alone. We must nurture and invest in positive partnerships so that we can work closely with community to explore their needs and desires to make a better life for themselves and their fellow community members.

Country Arts SA
2 McLaren Parade
Port Adelaide SA 5015
08 8444 0406 [ph]
www.countryarts.org.au
SPONSORS

Department of Health and Ageing

The vision of the Department of Health and Ageing is ‘Better health and active ageing for all Australians’. The Department is responsible for achieving the Government’s priorities for population health, aged care and population ageing, as well as medical services, primary care, rural health, hearing services and Indigenous health. The Department administers programs to meet the Government’s objectives in health system capacity and quality, mental health, health workforce, acute care, and biosecurity and emergency response. The Department supports the Australian community’s access to affordable private health services and is responsible for policy on Medicare and the Pharmaceutical Benefits Scheme.

Information about health and aged care programs with a rural focus is available from Rural and Regional Health Australia’s consumer information service. This service can be accessed by telephone (freecall from landlines 1800 899 538) and the internet (www.ruralhealthaustralia.gov.au).

Australian Indigenous Health InfoNet

The Australian Indigenous Health InfoNet is an innovative, unique web resource that aims to inform practice and policy in Indigenous health by making the evidence base freely accessible via the Internet (www.healthinfonet.ecu.edu.au). The HealthInfoNet is helping to ‘close the gap’ in health between Indigenous and other Australians. Their translational research aims at providing the knowledge and other information needed for practitioners and policy makers to make informed decisions. The HealthInfoNet supports information-sharing among practitioners, policy makers and others working to improve Indigenous health with free online yarning places. This not-for-profit service is funded primarily by the Department of Health and Ageing.

www.healthinfonet.ecu.edu.au

Adelaide Convention Bureau

The Adelaide Convention Bureau is the official ‘non-profit’ organisation responsible for promoting Adelaide and South Australia as an exceptional host destination for conventions, incentive travel and other business events.

The Bureau represents over 200 members within the business event sector. Bureau staff are destination experts who provide free and impartial advice tailored to your event requirements. It’s the Bureau’s role to assist in creating a smooth-running, successful and memorable conference experience.

Some free services offered by the Bureau include:

- providing tailored destination bid proposals
- advice on marketing your conference
- hosting site inspections
- facilitating relationships between clients and local industry experts.

Aston House
Level 1, 15 Leigh Street
Adelaide SA 5000

08 8237 0100 [ph]
www.adelaideconvention.com.au
Adelaide Convention Centre

The Adelaide Convention Centre is a sophisticated world-class conferencing facility that is internationally recognised for its innovative approach, meticulous attention to detail, service excellence and exemplary commitment to sustainable operations. The centre’s exciting two-stage redevelopment will significantly increase capacity and flexibility. This expansion will provide three distinct and individually iconic interlinked buildings with total area increasing to approximately 14 000 m², a new plenary hall and up to 20 new meetings rooms being added by the completion of stage 2 in 2017. Due to a carefully designed construction process it will be business as usual, so contact us now to book your event.

www.adelaidecc.com.au
Want to know more about South Australian rural health services?

You are at the right place. At the Country Health SA Local Health Network, SA Health, we believe in engaging with health practitioners and sharing ideas. As the principal sponsor of the 12th National Rural Health Conference we want to help you to do the same.

As you attend this year’s rural health conference make sure to visit our stand to learn more about rural health services in South Australia.

If you have a special interest, review the themes for each day to meet one of our health professionals, or see us on the stand to connect to the right person.

Monday 8 April 2013 – Clinical
Tuesday 9 April 2013 – Mental Health
Wednesday 10 April 2013 – Aboriginal Health

For more information
Country Health SA Local Health Network
SA Health
Telephone: (08) 8226 6120
Email: chsa@health.sa.gov.au
www.sahealth.sa.gov.au

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DV-alert is a nationally-run accredited training program that provides skills to:

- **recognise** the signs of domestic and family violence
- **respond** with appropriate care
- **refer** people experiencing or at risk of domestic and family violence to appropriate support services

Enrol now in Lifeline’s free accredited trainings available through an e-learning course or face-to-face workshops held across Australia.

You will receive:

- A nationally recognised [Certificate of Attainment](#) for the course
- Continuing Nursing Education (CNE) and Continuing Professional Development (CPD) points for nurses
- Financial assistance for travel and accommodation costs, and your practice can apply for support payments to assist with staff feedback
- An opportunity to network with other support workers in your region, and build on your knowledge of local resources

Visit [dvalert.org.au](http://dvalert.org.au)
Professor Chris Baggoley was appointed the Australian Government’s Chief Medical Officer on 29 August 2011. He is responsible for a range of professional health issues, including health and medical research, public health, medical workforce, quality of care and evidence-based medicine. Professor Baggoley represents the Department of Health and Ageing in key national health committees and medical organisations and has direct responsibility for the Department of Health and Ageing’s Office of Health Protection.

Prior to his appointment as the Chief Medical Officer he was the Chief Executive of the Australian Commission on Safety and Quality in Health Care, a body whose role is to lead and coordinate the improvements of safety and quality of health care in Australia. He was appointed to that role in December 2007.

Chris is a member of the World Health Organization High 5s Project Steering Group and is a member of the Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers’ Advisory Council. He also chairs the National Intensive Care Registry Steering Committee and is a member of the Health Care Committee of the National Health and Medical Research Council. Chris is a

Professorial Fellow of the School of Medicine, Faculty of Health Sciences, Flinders University of South Australia (FUSA).

Prior to his appointment as Chief Executive of the Australian Commission on Safety and Quality in Health Care, Chris was Chief Medical Officer and Executive Director of Public Health and Clinical Coordination in the South Australian Department of Health.

His other medical positions were Professor/Director of Emergency Medicine at the University of Adelaide/Royal Adelaide Hospital and Director of Emergency Medicine at Flinders Medical Centre in Adelaide.

Chris’s other key roles in health have been as Censor-In-Chief and President of the Australasian College of Emergency Medicine, Chair of the Committee of Presidents of Medical Colleges and Chair of the Board of the National Institute of Clinical Studies. Apart from his university degrees in medicine from the Flinders University of South Australia, he holds an Honours degree in Veterinary Science from Melbourne University and a degree in Social Administration, also from FUSA. His awards include the Order of the International Federation for Emergency Medicine.

Emma Beech

Emma started making shows for her mum in her bedroom when she was six. Since then, she has graduated from Flinders Drama Centre and gone on to become an actor and theatre maker who does stand-up documentaries. In the past seven years, Emma has performed and created new work in Denmark with Carte Blanche and Group 38. In Australia, she worked as an actor on screen with several local filmmakers, and hosted the television series Artshow with ABC and the Australia Network. For theatre, she has had the pleasure of creating and performing with Last Tuesday Society, Cab Sav, Real TV, Patch, Monkey Baa, Playwriting Australia. Emma collaborates regularly and vigorously with Sarah John and is a proud founding member of the Australian Bureau of Worthiness. Emma also plays Fatima alongside Stephen Sheehan in Dating the World.
Michael Bishop

Michael Bishop is the Executive Director of Rural Health and Aged Care for the Darling Downs Hospital and Health Service in Queensland.

He has worked nationally and internationally with health services aimed at improving both the scope and quality of allied health professional services. As a result of this development and review work, he is acknowledged as an allied health professional leader by peers (the Queensland SARRAH Network Coordinator, Australian Chair, AHLANZ).

As a rural health service advocate he has sat as an active member of the Management Boards; a founding member of the Mental Health Council of Australia, the National Rural Health Alliance, the Australian National Art Therapy Association, Mackay Centre for Research On Children and Community Services, The Australian College for Child and Family Protection Practitioners and of course SARRAH.

He has a Human Rights Commendation for work in destigmatising mental illness. Michael was chair of the Editorial Board of the Australian Journal of Rural Health and convened several Australian Rural and Remote Scientific Health Conferences. Michael is the Deputy Chair of the Darling Downs and South West Queensland Medicare Local.

Robyn Brogan

Since 2002 Dr Robyn Brogan has worked in rural/remote north-west Tasmania as a palliative care medical specialist for the Tasmanian Health Organisation NW. Since 2009, Robyn has been the clinical lead for the Living Well and Dying Well Project in aged care. This project supports aged care staff and the primary health care teams to deliver 'person-centred care' and 'dignity promoting' approaches to advance care planning, for aged care residents and their families. This approach enables staff to align their delivery of care with each person’s values, wishes and preferences.

Robyn has worked as a doctor for more than 30 years, including in family general practice (Adelaide) with experience in psychiatry and family therapy, then for the past 20 years Robyn has been working and teaching in palliative care—in Adelaide, Brisbane, Hobart, and then north-west Tasmania based in Burnie.

In 2002 Robyn became a senior lecturer in palliative medicine with UTAS, then in 2009 senior clinical lecturer in the UTAS Rural Clinical School’s undergrad medical program. Since mid-2012 Robyn has more focused her involvement in teaching within aged care settings (RNs, ENs, carers, kitchen and hotel staff) and also with GPs and allied health professionals.

Tom Calma

Dr Tom Calma is an Aboriginal elder from the Kungarakan tribal group and a member of the Iwaidja tribal group in the NT. He has been involved in Indigenous affairs at a local, community, state, national and international level and worked in the public sector for 40 years and is currently on a number of boards and committees focusing on rural and remote Australia, health, education, justice reinvestment and economic development.

Dr Calma, a consultant, is the National Coordinator, Tackling Indigenous Smoking where he leads the establishment and mentoring of 57 teams nationally to fight tobacco use by Aboriginal and Torres Strait Islander peoples.

Dr Calma’s most recent previous position was that of Aboriginal and Torres Strait Islander Social Justice Commissioner at the Australian Human Rights Commission from 2004 to 2010. He also served as Race Discrimination Commissioner from 2004 until 2009.

Through his 2005 Social Justice Report, Dr Calma called for the life expectancy gap between Indigenous and non-Indigenous people to be closed within a generation and laid the groundwork for the Close the Gap campaign. The Close the Gap campaign has effectively brought national attention to achieving health equality for Indigenous people by 2030 and the need to address the social determinants of health to achieve equality.

Dr Calma is a strong advocate for Indigenous rights and empowerment.
and has spearheaded initiatives including the establishment of the National Congress of Australia’s First Peoples and Justice Reinvestment.

In 2010, Dr Calma was awarded an honorary doctor of letters from Charles Darwin University and in 2011, an honorary doctor of science from Curtin University.

In the Queen’s Birthday 2012 Honours Awards Dr Calma was awarded an Order of Australia; Officer of the General Division (AO) and in December 2012 he was announced as the ACT Australian of the Year 2013.

Alison Fairleigh

Alison is a mental health consumer advocate and avid user of social media, who lives in the abundant agricultural region of the Burdekin in north Queensland. In September 2008, while Alison was working as Student Services Manager at the Burdekin Campus of the Australian Agricultural College, she was closely affected by the loss of three local men to suicide within the space of three weeks.

Determined to develop a better understanding of the issues surrounding suicide and the effect it has on rural communities, Alison became a volunteer team leader with the local CORES (Community Response to Eliminating Suicide) Program to help educate local people on how to recognise the signs of someone who may be contemplating suicide. From her involvement in this program, Alison began to see the powerful impact negative perceptions about agriculture and farming have on rural people and decided that she could do something about this.

Through the popular medium of social media, Alison created a stage for rural advocacy; co-founding ‘RuralMH’ in 2010—a platform aimed at raising awareness of mental health issues in rural communities; in 2011 forming ‘Farming is the New Black’—aimed at bringing sexy back to Australian agriculture; and founding the ‘Great Cafe Challenge’ in 2012—a campaign that aims to bring rural and urban communities closer together by asking cafes across Australia to carry weekly rural newspapers for their customers to read.

In January 2012, Alison began work with the Mental Illness Fellowship of NQ Inc. where she is currently the North Qld Regional Coordinator for ‘Living Proof’—a mental illness education program reaching into rural and regional schools to help reduce stigma and discrimination; improve mental health knowledge and literacy; encourage early help seeking behaviour; and support individual and community recovery.

James Fitzpatrick

Dr James Fitzpatrick is currently a paediatric advanced trainee at Princess Margaret Hospital for Children, a researcher at the Telethon Institute for Child Health Research, Perth; Director of Patches Paediatrics and a PhD candidate with the University of Sydney. In 2001 James was named Young Australian of the Year for his longstanding dedication to addressing rural and Indigenous health issues.

James is the founder of True Blue Dreaming, an Outback Youth Mentoring Program working with communities in the WA Wheat-belt and Kimberley regions, with a vision to expand the program throughout Western Australia and then nationally.

He currently sits on the National Aboriginal and Torres Strait Islander Health Equality Council that advises the Federal Minister for Indigenous health.

He recently led a federally funded project aimed at improving the lives of children living in remote Indigenous communities in the WA Kimberley, in partnership with local community organisations and national research institutes. The work involved estimating for the first time in Australia the prevalence of foetal alcohol spectrum disorder (FASD) in the 40 remote communities of the Fitzroy Valley. Having documented the prevalence of FASD, James is now working with health and education partners to develop a child health clinic run in schools to help young people to reach their educational potential.

James has been a rabble-rouser and activist for some time. As the chairman of the National Rural Health Students Network in 2000, James shifted the focus of this organisation of 5000 medical and allied health students to deliver community service activities to some of Australia’s most remote communities. In that year he helped to establish the Carnarvon Children’s Festival in Western Australia in response to alarming rates of youth suicide. Through the Children’s Festival members of the Indigenous and non-Indigenous communities were encouraged to come together and celebrate the value of young people within the community.

Honoured with the title of Derby Bush Poetry champion in 2009 and 2011, James captures his life’s experiences in verse with a blend of deep thoughtfulness and rogish irreverence.
Jan Ferguson

Jan Ferguson is the Managing Director of Ninti One and the CRC for Remote Economic Participation. She has a long-term connection to the Northern Flinders Ranges in remote Australia and a strong commitment to improving the lives, communities and prospects of remote people.

Jan was Managing Director of the Desert Knowledge Cooperative Research Centre from 2005 to 2010. She lived for many years in the small Flinders Ranges community of Beltana, in the north of her home state of South Australia, where she maintains close links with the local Adnyamathanha people. Jan was in senior change management roles in several large South Australian infrastructure departments. Jan is a previous winner of the Telstra Businesswomen’s award for her innovative approaches to public sector reform.

Jane Hall

Jane Hall is the founding Director of CHERE and Professor of Health Economics in the Faculty of Business at UTS. She is a Fellow of the Academy of Social Sciences in Australia. In 2012 she was jointly awarded the Research Leadership Award in the Vice-Chancellor’s Awards for Research Excellence, University of Technology, Sydney. In 2011 she was awarded the inaugural Professional Award made by the Health Services Research Association of Australia and New Zealand, for her outstanding contributions to research, developing the field and mentoring others. Her research is focused on the development of health reform in Australia and the evaluation of policy; and she is leading a new program exploring the economics of primary care. Her work has encompassed many areas of health services research, including the evaluation of health service delivery programs, priority setting, and health technology assessment. She has held many advisory and Board positions, and is currently a member of the Board of the NSW Bureau of Health Information and also is a Board member of the Independent Hospital Pricing Authority. Jane has represented Australia in many international health policy forums. She is actively involved in policy analysis and critique, and is a regular commentator on health funding and organisational issues in Australia.

Dougie Herd

Dougie Herd works for the NDIS Launch Transition Agency as the Branch Manager with responsibility for research and engagement in the national office. Dougie joined the agency in October 2012.

Before joining the agency Dougie worked for two years as Project Manager of the NSW Industry Development Fund, managed by National Disability Services NSW, six as the Executive Officer of the Disability Council of NSW (the State’s official advisory body) and five years as the EO of the Physical Disability Council of NSW (a state peak and systemic advocacy organisation). Since arriving in Australia in late 1999, therefore, Dougie has acquired work experience in the non-government disability advocacy and service provider sectors, state government advisory roles and now, through the NDIS, in the Australian Public Service.

Dougie was born in Glasgow, Scotland and has been a wheelchair user for 29 years.

Marie Lally

Marie Lally is Convenor of the 12th National Rural Health Conference.

Marie is a fourth generation Australian farmer, married to Kevin, with two married farming daughters and five grandchildren.

Her positions have included South Australian Country Women’s Association President (1996–1999), National President of the Country Women’s Association of Australia (2000–2003) and a Member of Council of the National Rural Health Alliance.

In 2002 Marie was a Member of the Prime Minister’s Diplomatic Delegation to the 3rd World Congress of Rural Women in Madrid. In 2003–2004 she was a Member of the National Drought Review Panel for the Federal Minister of Agriculture. From 2003 to 2008 she served on the Regional Women’s Advisory Council to the Deputy Prime Minister. Between 1989 and
2007 Marie attended eight world conferences of the Associated Country Women of the World.

In 1998 Marie was awarded Citizen of the Year for the District Council of Elliston. In 2003 she was awarded the Centenary Medal of Federation of Australia (for outstanding service to women in rural Australia).

Marie was appointed a Member in the General Division of the order of Australia (AM) in June 2004.

In 2011–12 she was a Director on the Board of the Australian Year of the Farmer.

Marie is still heavily involved in farming and community activities at Lock and Tumby Bay. Among other things she is President of the Hospital Auxiliary at Tumby Bay.

Tanya Lehmann grew up on a small farm in Wagin, Western Australia. She trained as a dietitian at Curtin University, and in 1998 she ventured across the Nullabor to take up a new graduate position in the Riverland of South Australia. Stumbling across the best rural retention strategy known to the health system, Tanya met and married a local, and the rest, as they say is history. With their two children they live in a rammed earth house overlooking the Katarapko National Park, where they enjoy spectacular sunsets, falling asleep to the sounds of frogs and waking up to the morning chorus of kookaburras, pelicans and magpies.

Tanya has worked in the Riverland for most of her career, as a community dietitian, team leader, and manager of Service Development and Community Health. She also enjoyed a brief stint as a public health nutritionist in Carnarvon WA before the lure of the beautiful Murray River saw them return to the Riverland.

Since 2008, Tanya has been the Principal Consultant Allied Health for Country Health SA Local Health Network (CHSALHN). In this capacity, she has managed a number of significant projects, including initiatives related to recruitment, retention, clinical governance, workforce redesign, clinical supervision and professional development. Tanya’s creativity, persistence, strategic thinking and partnership building skills enable her to find creative solutions to seemingly insurmountable problems.

Tanya joined the Services for Australian Rural and Remote Allied Health (SARRAH) family at the 2008 SARRAH Conference, became a Board member in 2009 and President in 2012. She has been SARRAH’s delegate to the Council of the National Rural Health Alliance (NRHA) since 2011. Tanya is a rurally-passionate, solutions-focused, bundle of energy, passionate about improving the lot of rural and remote allied health professionals and the communities they serve.

Sue Middleton is a Councillor with the COAG Reform Council. She has diverse business, policy, project development and change management experience ranging from national-level work to developing projects in local settings in rural and regional Australia. Sue has played an active role in community development roles in Queensland and Western Australia where she lives and works in the Wheatbelt. Sue co-manages a diverse farm enterprise and runs a rural community development consultancy business from the farm.

In addition to a wealth of consulting experience, Sue has been actively involved in many leadership roles across all levels of government and community decision making. Current roles include Deputy Chair of the Western Australian Royalty for Regions Trust Fund Board, Fruitwest, and Chair of the Institute for Agrifood Security at Curtin University. Past roles include the Chair of the West Midlands Group a local research and development farmer organisation, National Rural Advisory Council, Wheatbelt National Resource Management Board, National Regional Women’s Advisory Council, the Australian Research Council, and Regional Solutions Board.

For her work Sue has been awarded the Centenary Medal for Service to Regional Australia in 2002, and has been awarded the 2010 RIRDC Rural Woman of the Year for Australia and Western Australia.

Rob Oakeshott has been in public life since 1996 when he became the youngest member of the NSW Parliament at age 25. He was NSW Shadow Minister for Sport, Racing, Gaming, Ports, and Fisheries and a member of the highest statutory committee, the NSW Public Accounts Committee. He continues to push for accountability standards in the public sector and how good
oversight bodies, like the Auditor-General, can operate more effectively in the public sector.

Since joining Federal Parliament in September 2008, Rob has invested in committee work—the often overlooked 'engine room' for effective government—including chairmanship of the Joint Standing Committee on the National Broadband Network and the Public Accounts and Audit Committee. Rob is also serving on the Selection Committee, the Infrastructure and Communications Committee, the Joint Select Committee on Australia’s Immigration Detention Network and the Joint Select Committee on the Parliamentary Budget Office as well as being a member of the Panel working on the Constitutional Recognition of Indigenous Peoples and a member of the Working Group on Water, Soil, Food.

Rob helped re-establish the Parliamentarians Amnesty International Group, and is a co-convenor.

A White Ribbon Ambassador, Rob is Australia’s Parliamentary representative on the all-male Asia-Pacific Parliamentary Group of the United Nations Development Program that is working to minimise violence against women and girls within the region where DV rates are some of the highest throughout the world.

Rob has a Bachelor of Arts (Hons) in Government and Law and views non-metropolitan disengagement in education as one of the key economic failures for Australia. He continues to work on turning this around.

Rob is 43 years old, married to Sara-Jane and has four children—Sophie (8), Olivia (6), Angus (4) and Benjamin (2).

Tanya Plibersek

Tanya Plibersek was elected to the Australian Parliament as the Federal Member for Sydney at the 1998 federal election.

In her first speech to House of Representatives, Tanya spoke of her strong interest in social justice and her conviction that ordinary people working together can achieve positive change. Tanya became a Shadow Minister after the 2004 federal election and for the next three years was responsible for a range of portfolios including childcare, work and family, women, youth, human services and housing.

Following the election of the Rudd Government in 2007, Tanya was appointed Minister for Housing and Minister for the Status of Women. As Minister for Housing, Tanya delivered a wide ranging reform agenda, including significant new investments in affordable rental housing. Tanya was also responsible for a Homelessness White Paper that set out a comprehensive national strategy to tackle homelessness in Australia. As Minister for the Status of Women, Tanya was responsible for development of the National Plan to Reduce Violence against Women and their Children. Following the 2010 federal election, Tanya was appointed Minister for Human Services and Minister for Social Inclusion. On 14 December 2011, Tanya was appointed to Minister for Health.

Tanya lives in Sydney with her husband Michael and children Anna, Joseph and Louis. Tanya is fond of bushwalking and 18th Century novels.

Mick Reid

Mick Reid has had many years of experience in both the public and private sectors. In Australia, in the public sector, he has been Director-General of Health in two states. For five years until 2002, he held the position of Director-General of New South Wales Health. More recently, until 2010, he spent three years as Director-General of Queensland Health.

Between these two appointments he held three others positions. Firstly, he was Director of the Policy and Practice Program at the George Institute for International Health, principally working with the Chinese Ministry of Health. From 2006 to 2008 he was appointed as Director-General of the Ministry for Science and Medical Research in New South Wales with responsibility for planning and coordinating science, innovation and medical research.

In 2008 he took up the position as Chief of Staff to the Australian Minister for Health, primarily to initiate the current impetus in national health reform.

In 2011 Mick held a position of Special Adviser to McKinsey and Company. He was principally engaged in the introduction of electronic health records in Australia, a major diabetes coordinated care trial and hospital and health system reform.

Mick is now engaged as National Healthcare Markets Leader at Pricewaterhousecoopers (PWC).

When not engaged in the public sector, Mick has been Managing
Director of a consulting company, which undertook numerous health and science projects throughout Australia, for governments in Asia and the Pacific and with UN organisations. He spent two years in Geneva at World Health Organization working in the Global Program on Aids.

Broad areas of consultation have related to macro health systems development and evaluation, clinical services planning, health workforce reform and performance analysis. He holds Adjunct Professorships in the Faculty of Medicine at the University of Sydney and the Faculty of Health Sciences at the University of Western Sydney. He is Deputy Chair (currently acting Chair) of the Royal Flying Doctor Service of Australia and is on the board of the National Health Performance Authority.

Stewart Roper

Stewart Roper was born in Scotland and immigrated to Australia with his parents when he was six years old, settling in Elizabeth to the north of Adelaide.

Stewart’s original tertiary studies were in zoology and biochemistry. After several years travel and work in a variety of areas he embarked on a nursing career, becoming a registered nurse at the Royal Adelaide Hospital (RAH) in 1984.

Following several years at the RAH, Stewart commenced work at Flinders University, Adelaide, in 1988 as a biology lecturer in the undergraduate and postgraduate nursing courses.

In early October, 1990, Stewart finished packing the back of the Valiant ute, pulled over the tarpaulin and farewelled family and friends. His destination was Amata in the remote north-west of South Australia, 1500 km away. He had never driven further north than Port Augusta, only 300 km from Adelaide.

Following orientation with Nganampa Health Council in Alice Springs, Stewart headed south for hundreds of kilometres on corrugated dirt roads to Amata, where the people were nearly all dark-skinned and spoke another language, yet he was in his home state of South Australia. Everyone he approached seemed indifferent to him when he introduced himself as the new nurse, but very interested in how much he wanted for the ute.

Stewart’s original intention was to stay for six months to a year. He eventually left after nine and a half years full time as a community health nurse. Stewart still works with Nganampa Health Council and returns regularly some twenty years after his arrival. He’s not completely sure how this happened, but somehow the character of the people and magic of the landscape overcame the challenges of living and working in such a remote location.

In addition to nursing duties, Stewart has also been involved with the health service and communities in interventions to reduce petrol sniffing and promote sexual health. He is currently employed as a projects officer with a wide variety of duties including entering and updating biographies, and assisting with child health and immunisation, ophthalmology, audiology and sexual health programs.

Paul Rosair

Paul Rosair is the Director General of the Department of Regional Development and Lands (WA).

The Department of Regional Development and Lands (RDL) was formed on 1 July 2009, combining key areas of the public sector to bring a new focus to regional Western Australia.

The Department is responsible for the administration of the Royalties for Regions policy and program, managing key initiatives such as the Ord Irrigation Expansion, Pilbara Cities and SuperTowns projects, and is responsible for regional development matters, including the state’s Crown and pastoral lands administrative functions.

Paul was responsible for establishing the administrative arrangements for the State’s Royalties for Regions program. He has previously held the positions of Director of Regional Operations with the Department of Water and the Department of Environment.

Paul started his career as a hydrographer and has also spent time as a qualified IT professional. He has worked for well over 30 years in senior government roles across environment, water, land management, aboriginal affairs, infrastructure, planning and natural resources management portfolios.

He also has extensive experience working across the state and a broad perspective on issues of particular importance to regional Western Australia.
Paul speaks regularly at state and national events and conferences.

**Jack Snelling**

Jack Snelling holds office as Minister for Health and Ageing, Minister for Mental Health and Substance Abuse, Minister for Defence Industries and Minister for Veterans’ Affairs.

He was first appointed to the Rann Labor Ministry on 25 March 2010.

Jack’s other portfolio responsibilities have included Treasury, Workers’ Rehabilitation, Employment, Training and Further Education, Science and Information Economy and Road Safety.

Jack was first elected to the South Australian Parliament in 1997 as the Member for Playford, representing the people of Ingle Farm, Para Hills, Pooraka and Walkley Heights.

Jack is married to Lucia with six children—Molly, Helena, Frank, Joe, Peter and Thomas. He enjoys cooking, reading, playing chess with his children, listening to classical music and training at the Para Hills Amateur Boxing Club.

**Louise Sylvan**

Louise Sylvan is the Chief Executive Officer of the Australian National Preventive Health Agency (ANPHA).

Formerly, she served as a Commissioner of the Australian Productivity Commission and Deputy Chair of the Australian Competition and Consumer Commission (ACCC).

Prior to this she was Chief Executive of the Australian Consumers’ Association (CHOICE) and President of Consumers International.

Active in consumer and economic issues, nationally and internationally, for over 20 years, Louise is well known for her work in a range of areas such as health, food safety issues, financial services, as well as in competition and consumer policy.

Louise’s strong impact on the issues of the day was recognised in her inclusion as one of Australia’s 20 True Leaders in 2002 by the Australian Financial Review’s BOSS magazine.

Currently, Louise chairs Bush Heritage Australia, and is a member of the Board of the newly-formed Australian Social Enterprise Fund. She has served internationally on the OECD Consumer Policy Committee, chairing their Economics for Consumer Policy work, and on the International Consumer Enforcement and Protection Network.

Louise has a BA and MPA from universities in her original homeland of Canada and immigrated to Australia in 1983.

**Bob Wells**

Bob Wells is the Director of the Australian Primary Health Care Research Institute at The Australian National University. He has a broad role to work across the ANU in the areas of health research and policy analysis, including a number of projects in the fields of primary health care and workforce policy. He participates in national committees advising governments on research and medical training. Bob is a former first assistant secretary in the Department of Health and Ageing where he was involved in research policy, Commonwealth/State relations, health workforce, rural health programs, safety and quality and programs for better management of major diseases such as cancer, diabetes and mental health. Bob managed the Commonwealth’s health workforce programs from the early 1990s. He chaired the Medical Training Review Panel and represented the Commonwealth on the Australian Medical Workforce Advisory Committee (AMWAC), the Australian Health Workforce Officials Committee (AHWOC) and the Australian Medical Council (AMC). He has chaired a number of workforce committees established under the auspices of the Australian Health Ministers Council, including working parties on national medical registration and specialist medical training and has represented Australia internationally on medical workforce matters.
Concurrent and poster presenters

Roshan Abraham
Dr Roshan Abraham has been working in NSW public dental services since 2001. He worked in the Sydney South West Area Health Services until 2007, in between doing a one-year secondment in Pambula and the Katungal Aboriginal Medical Services in Bega. He was also Clinical Associate Lecturer at Sydney University.

Since becoming a senior dental officer in the North Coast Area Health Services in 2007, he has been instrumental in bringing assessment waiting lists down to near zero, introducing comprehensive dental treatment to all public dental patients in Port Macquarie, conducting Saturday Teen Dental Clinics to provide the intended benefit of the Teen Dental Vouchers, developing, conducting and managing various preventive programs including the Smile Wide with Pride program and the Booroongen Djugun Aged Care Oral Health Outreach program. Roshan has been a clinical mentor of the NSW International Dental Graduate program since 2008.

He is passionate about public dentistry. In the 2010 North Coast Area Health Services Quality Awards Ceremony, he received a commendation for his waiting list management project and won the category for the Teen Dental Program. In the 2011 Mid North Coast Local Health District Quality Awards, he won the following category awards—runner up for the Comprehensive Dental Treatment Program, winner for the Booroongen Djugun Aged Care Outreach Program and the Smile Wide with Pride program. The Smile Wide with Pride program went on to win the overall award.

Roshan was a finalist in the Achievement by an Individual category at the 2011 NSW Premier’s Awards.

He is now leading an oral health development project at an Aboriginal primary school in Greenhill, Kempsey, and is hugely involved with the use of the LHD’s new dental van in residential aged care facilities in the mid-north coast, in addition to his normal clinical duties.

Robyn Aitken
Associate Professor Robyn Aitken is the Academic Leader Remote Health Education with the Centre for Remote Health, a UDRH and joint Centre of Charles Darwin University and Flinders University. Robyn has achieved significant success in securing grant monies, being instrumental in attracting over $3 million for education and infrastructure projects over the last two years. In addition to grant writing experience, Robyn also has experience assessing grant applications. She brings to this workshop her most recent experience as the chair of the NRHA administered Rural Health Continuing Education 2 (RHCE2) grants panel.

Timothy Amos
Timothy Amos is a final year extended rural cohort medical student at the University of Melbourne. During 12 months of training at the rural clinical school in Wagaratta, he and Holly Bannon-Murphy assisted with data collection and analysis for the Orthopaedic-Geriatric study. Tim is currently based at Cobram Medical Clinic for the extended rural cohort year and enjoys the challenges and experiences that come with rural medical practice. Prior to medicine, Tim studied a Bachelor of Science (majoring in physics)/Bachelor of Engineering and worked as a civil engineer in construction with McMahon in Western Australia, and mining with BHP in South Australia. During his degree, he spent a year studying German and physics at the University of Heidelberg in Germany. For the last three years he has been a volunteer ski patrol at Mount Hotham.

Tim has recently travelled to West Africa, India and Pakistan following his interests in developing world health and has volunteered abroad in India at the Bombay Leprosy Clinic. Tim is interested in a career in intensive care and public health and is looking forward to working in areas of health care need in the future.

Amarjit Anand
Amarjit Anand has been an audiologist for over 30 years. Her career as an audiologist commenced in India where she was employed as an audiologist and speech pathologist at a large public hospital.

In 1992 Amarjit moved to Sydney and subsequently to Darwin in 1996 working for the NT Department of Health (DOH) where she practiced as a clinician initially and was then appointed as principal audiologist and manager for the NT-wide hearing services.

During this time she has been involved in the development of guidelines aimed at improving the hearing health of Aboriginal people in the NT. She also completed her Masters in Public Health in 2002.

Some of her career highlights have been:

- Involvement in a number of research projects, in particular the Darwin Child Care Project which was a collaborative project with Menzies School of Health Research and Territory Health Services Communicable Diseases.
- Membership of a working party to develop the OATSIH ‘Recommendations for clinical care guidelines for the management of otitis media in Aboriginal and Torres Strait Islander populations’ and subsequent review of the guidelines in 2010.
- Aboriginal Rural and Remote portfolio representative for the ASA.

- Led the national working party that reviewed the Audiology Society of Australia’s (ASA) General Guidelines for Audiology Practice for Indigenous Australians. This has resulted in the development of COMHeLP Chronic Otitis Media and Hearing Loss Practice which was launched in August 2012.

- Developed an effective student clinical placement program in the NT through an ongoing working relationship with teaching universities.

- Member of the NT DOH Allied Health Reference Group.

- Managed the roll out of Newborn Hearing Screening across the NT in 2010.

Phil Anderton
Ph.D.

Phil Anderton retired from academic life at the UNSW School of Optometry and Vision Science in 2005. After moving to Manilla in northern NSW he found himself working as a part-time clinical optometrist, responding to a high level of demand from the community, local GPs and local ophthalmologists to provide optometry services in this area of northern NSW.

He has been a locum clinician in Gunnedah and, together with regional Aboriginal eye health coordinators, has run clinics for Aboriginal communities in Gunnedah, Tamworth, Caroona, Quirindi, Coonabarabran, Baradine, Toomelah, Narrabri, Inverell and Goondiwindi. These clinics were sponsored by the International Centre for Eyecare Education (ICEE), now the Brien Holden Vision Institute.

He currently has a private eye and vision clinic at Manilla Health Service, and recently received funding through the National Rural and Remote Health Infrastructure Program to upgrade the equipment there to include digital fundus photography, OCT and digital slit-lamp image and motion capture. These facilities have greatly enhanced the level of service offered, and much of his work is collaborative with local GPs and Tamworth ophthalmologists.

Twice a year he travels to Wilcannia and Menindi in western NSW, contributing to four-day clinical sessions as a part of the Outback Eye Service team.

He is an adjunct senior research fellow at UNSW School of Optometry and Vision Science. He contributes to the ophthalmology program of the University of New England Joint Medical Program. He is the convenor of the Rural Optometry Group of the Optometrists Association Australia, and sits on both the council and board of the National Rural Health Alliance, of which the ROG is a constituent member.

Sue Arwen

Sue Arwen is a manager within SHine SA (Sexual Health information, networking and education South Australia), South Australia’s leading sexual health agency. Sue has a nursing background and a 25-year history of working within primary health care and has significant project experience. Currently Sue is the Manager of the Close the Gap team which has developed and implemented the Yarning On program, an initiative to address the inequitable relationship and sexual health outcomes for young Aboriginal people living in rural and remote communities in South Australia.

Larissa Ashton

Larissa Ashton is a clinical senior speech pathologist in CHSA, based at Port Augusta Hospital and Regional Health Services. She works with children under five years old and adults with swallowing and communication difficulties. She also provides clinical supervision for speech pathologists in the region. Larissa graduated from a Bachelor of Speech Pathology at Flinders University in 2006. She began work for CHSA in Whyalla and developed an interest in creating high quality allied health services that are accessible for people in rural areas. She spent two years in the United Kingdom working in a variety of roles, developing her clinical skills and interests further. Drawing together her interests in dysphagia (swallowing difficulties) and paediatric early intervention, she has enjoyed working clinically with paediatric feeding and working to improve services through her role in the CHSA Paediatric Feeding Portfolio Group.

Kate Astbury

Kate Astbury is currently the Extended Care Program Manager for Grampians Community Health (GCH), Victoria, where she manages health promotion, community development, community care packages, psychiatric disability rehabilitation support services, and early intervention in chronic disease. Other support services provided by GCH include drug and alcohol, gambling, youth, counselling, housing, and family violence. Kate is based at and manages the Ararat site which is one of three sites from which the organisation provides services to nine surrounding local government areas.

Prior to her current position, Kate worked with the Grampians Pyrenees Primary Care Partnership where she was the Partnership Development Officer. Kate’s role was to support the 32 member agencies and other relevant service providers to facilitate system redesign which would improve the coordination of services in the area.

Kim Atkins

Kim Atkins is Rural Health Program Manager within the Department of Health and Human Services (Tasmania), where she provides policy analysis and project management relating to rural and remote health services. She is also adjunct Associate Professor of Philosophy at
Jenni Baker

Jenni Baker has worked extensively across both health and employment sectors in Australia and the UK. She has a broad range of experience in managing health, training and recruitment programs delivering to targeted stakeholder groups. As a registered nurse, Jenni’s expertise is underpinned by clinical experience, which has informed her work in health recruitment, program management and service planning in both the public and private sectors.

Jenni is completing a Masters in Public Health at La Trobe University where she is majoring in health policy. She has worked at Rural Workforce Agency Victoria (RWAV) for five years where she managed the outreach specialist programs (MSOAP) and progressed into policy and health program planning. Here she divides her time between the RWAV policy and research team, and RWAV’s commercial subsidiary, Primary Health Planning Services (PHPS). Some of the projects she has been responsible for include rural workforce scoping studies, Close the Gap program consultations, international migration research, and needs analyses for bushfire-affected communities.

She is currently working on two Health Workforce Australia funded research projects: one a demand analysis of the GP procedural workforce in Victoria; and the other a nurse and allied health retention study.

Jenni’s introduction to the issues impacting upon the GP procedural workforce began in 2010 when she developed an issues paper, ‘Future of the GP Proceduralist Workforce’, for the RWAV board; and later a submission for Health Workforce Australia. RWAV annually collects data around the Victorian GP workforce and this is used to advocate for health workforce issues at a state and national level. This data has informed the development of the GP Proceduralist Workforce in Rural Victoria: Future Demand Analysis project. Jenni is a co-author of the study with Veronica Fil, RWAV policy analyst.

Stephen Ballard

Stephen Ballard undertook early schooling in Adelaide, then Gawler, matriculating to Adelaide University, with MBBS awarded in 1978. He did his internship and residency at QEH, doing a number of generally unpopular rotations that stood him in good stead over the years (ICU, pediatrics, pharmacology, cardio-respiratory medicine). Residency at the old Lyell McEwen hospital for three years, A&E and Dip Obs, before moving to Port Lincoln as GP, with hospital privileges, remaining there for almost 13 years.

Stephen developed interests in critical care, anesthesia and emergency transport medicine, and increasingly Aboriginal health, until worn out by the private/public and high work-load. He saw an opportunity to continue to work in rural areas, with different emphases, through...
RFDS and Port Augusta Hospital, moving there in December 1995.

Stephen worked as part of a three, then four, doctor group, providing all the traditional services that the public associate with RFDS. Provision of anesthesia and resuscitation/critical care services has progressively increased over the years, maintaining currency with respect to offering advanced retrieval type services both within and potentially outside traditional service areas.

The last couple of years has seen his practice evolve away from the direct provision of primary care services (excepting remote consulting) to increasing administrative duties, which he had not expected. However, he continues in a role of primary care coordinator, which includes direct and indirect mentoring and supervision of GP registrars, and an increasing number of medical students.

Holly Bannon-Murphy

Holly Bannon-Murphy is a final year extended rural cohort medical student at the University of Melbourne. She is currently studying at Cobram Hospital and GP, and is enjoying the challenges and experiences that come with rural medical practice. Prior to studying in Cobram, she and Tim Amos were placed at the Wangaratta Base Hospital for 12 months, where they assisted with data collection and analysis for the Orthopaedic-Geriatric study.

Prior to starting medical school, Holly studied a Bachelor of Arts, majoring in politics and psychology, and minoring in Arabic. In 2007–08, she was the Australian Rotary Ambassadorial Scholar to Ghana where she led the rehabilitation of the occupational therapy department at Pantang Psychiatric Hospital and studied developing world politics at the University of Legon, Accra. She currently works part time for the Disability Liaison Unit at the University of Melbourne.

Holly is interested in travelling and developing world health and has travelled and volunteered abroad, including in India at the Bombay Leprosy Clinic and Uganda with the NGO Volunteer to Support Children. She is enthusiastic about intensive care and emergency medicine and looks forward to working in areas of health care need in the future.

Frances Barraclough

Frances Barraclough is a registered nurse with a distinctive and wide-ranging background in nursing, education and management across rural areas. Frances has a Masters in Nursing Education, senior leadership experience and has designed and evaluated professional development programs for all levels of nurses, and teaching and supervising nursing students.

Frances is currently employed by the University of Sydney as part of the University Centre for Rural Health (UCRH), North Coast. Her role at the UCRH is the Program Manager, Clinical Education.

The research presented in this session is part of Frances’ MPhil describing the roles of nurse practitioners in the primary health care setting in rural Australia.

Elizabeth Barrett

Dr Elizabeth Barrett has a medical degree from the University of NSW and further qualifications in family planning and health management and a Masters degree in Public Health. She is a fellow of the Faculty of Public Health Medicine.

After clinical practice, Elizabeth worked in public health and senior health management positions in rural and metropolitan NSW. She is currently a medical adviser with NSW Rural Doctors Network and a surveyor for the Australian Council on Healthcare Standards.

Elizabeth’s previous commitments include President of Quality Management Services, membership of the Optometrical Board of NSW, membership of the Charles Sturt University (CSU) and University of Western Sydney Advisory Councils and the CSU Ethics Committee. She has been engaged in research for the Australian Medical Workforce Advisory Committee, the National Health Strategy and Hepatitis B prevalence and management in western NSW. Dr Barrett has undertaken rural health consultancies in China and Queensland and occasionally works as a relief hospital Director of Clinical Services.

Christine Bartel

Christine Bartel is employed as a nurse/midwife clinical facilitator. Chris graduated as a registered nurse in 1980, and went on to obtain midwifery qualifications in 1993. Since then she has worked in several states of Australia and the Northern Territory. Chris has worked in Queensland in Maryborough and Hervey Bay, Western Australia in Perth and Port Hedland, and the Northern Territory in Alice Springs and Darwin. This has given her considerable knowledge of health care in rural Australia.

Andrew Bell

Dr Andrew Bell is public health physician and general practitioner who currently works as a part-time senior rural medical practitioner with the NT Department of Health, and until recently worked with Aboriginal Medical Services Alliance NT (AMSANT) as a public health specialist with a focus on regional health service development.

Dr Bell has worked with remote Aboriginal communities for over 20 years in both NT Government and Aboriginal community controlled health services, including eleven years as Medical Director of Katherine West Health Board Aboriginal Corporation.

Dr Bell has a longstanding interest in primary health care reform, Aboriginal community control of health services.
and health systems improvement. Dr Bell is also a director and deputy chair of Northern Territory General Practice Education Ltd (NTGPE).

David Bell
Dr David Bell is a psychiatrist who works in a range of positions. These include as the psychiatrist for the Lower North Shore Community and Crisis Mental Health team at Royal North Shore Hospital in Sydney, as a clinical lecturer at the University of Sydney and running a small private practice. He also flies weekly to Narrabri and Moree in the north-west of New South Wales as a visiting medical officer. A previous career as a military engineer helps provide an interesting experience mix.

David’s interest in humour derives from the search for the establishment of meaningful connections between health workers and those suffering from mental illness. Bringing together the complexities of the mind, particularly in relation to mental illness, with the breadth and depth of humour, produces fascinating and powerful insights into human relations. David has conducted extensive research into humour, including a world first randomised controlled trial on the effects of humour on therapeutic engagement on an acute mental health ward.

In the rural settings where he works, David is endeavouring to inspire creativity and a focus on the individual amongst the grind of the health system and its impersonal nature. With limited health resources and the enormous difficulties rural populations face, the power of strong connections in health settings, assisted by the power of humour, can help people suffering get better.

Pele Bennet
Pele Benet is a proud Waggadaggam woman of the Torres Strait Islands. She is currently the Health Promotion Manager, Queensland Aboriginal and Islander Health Council (QAIHC), continuing to lead the way in innovation and building effective, multidisciplinary primary prevention capacity within the community controlled health sector. Previous to these positions, Pele has been an Indigenous health worker and has worked in alcohol, tobacco and other drugs prevention for Queensland Health for many years; and has also gained qualifications in Bachelor of Health Science—Aboriginal Community Development from the University of Sydney.

Kevin Bird
Kevin Bird is the Healthy Lifestyle Coordinator for Miwatj Health Aboriginal Corporation in East Arnhem Land, NT.

Miwatj’s healthy lifestyle program, which is part of the Federal Government’s Closing the Gap program, focuses on Yolngu girls and boys aged 12 to 18 years. It supports Yolngu kids to make healthy choices in terms of the western lifestyle while still retaining their cultural identity and security.

Before coming to Nhulunbuy, Kevin and his wife had worked for many years in community education, employment and training with Indigenous communities in NSW, Victoria and the NT. When they decided it was time to retire, they bought a mobile home and headed off the beaten track around Australia.

It was a short-lived retirement. After around 12 months on the road, Kevin and his wife were both offered jobs with Indigenous youth in East Arnhem Land. The opportunity to work again in community was too good to pass up—the mobile home was put in storage and they made their home in Nhulunbuy.

In his role with Miwatj, Kevin coordinates healthy lifestyle activities for East Arnhem Land. He takes a holistic approach to developing and implementing programs—believing that programs need to address heart, mind, body, spirit and cultural security to be successful.

The Miwatj role is an opportunity for Kevin to apply his long years of experience with Indigenous communities—but it’s not a one-way street. He says the best part of his job is that the Yolngu kids are teaching him all the time—about culture, behaviour and values—and that he is blessed to still be learning. The mobile home will stay in storage for a while yet.

Peter Birkett
Peter Birkett is the Chief Executive Officer of Hesse. Peter has successfully merged a career in nursing, midwifery and commerce working in both metropolitan and rural sectors. Over the past 19 years he has developed Hesse into a rural integrated care facility. He holds degree and Masters qualifications in Business and is a sitting board member on Maryville Aged Care, a denominational aged care service in Geelong.

Melanie Bish
Melanie Bish has recently completed a PhD (Nursing) with her dissertation focusing on fostering rural nurse leadership. She is a senior lecturer in rural and regional nursing at La Trobe Rural Health School and is the Academic Manager for the Department of Rural Nursing and Midwifery across four rural campuses—Bendigo, Shepparton, Mildura and Albury/Wodonga. Melanie is published internationally and is a reviewer for the Journal of Nursing Management. Having presented at national and international nursing conferences, Melanie is an active researcher with particular interest in leadership, structural empowerment, rural workforce planning and participatory action research. In 2012 Melanie was a finalist for the Blue Scope Distribution Leadership and Innovation Award, Regional Achievement and Community Awards. Melanie coordinates and teaches in subjects in the undergraduate nursing program and co-convenes and teaches into the Initial Registration for Overseas Nurses program.
Jenny Biven

Jenny Biven trained as an occupational therapist and commenced as a community practitioner in inner city Redfern, NSW, in the late 1970s. Exposure to such a diverse community fuelled her interest to continue working in community settings and seek roles in which her skills could support others to explore their potential and build capacity towards fulfilling roles important to them within the context of their lives.

With this in mind, Jenny’s working life has ranged from running recycling depots with unemployed youth; developing rehabilitation and skills training programs for people with disabilities on an avocado farm in NSW; developing rehabilitation programs with people with chronic mental illness as an AVI in Sri Lanka; and life after School programs for special schools in the Philippines and Bhutan. Also working in rural and remote health services, elder abuse, and work rehabilitation have given her an appreciation of the role of social health determinants in health outcomes.

The last seven years has reflected Jenny’s interest in how health determinants, meaningful, purposeful activity and self efficacy can influence a person’s health and wellbeing mentally, physically, emotionally and socially.

Currently as a rural Do It For Life lifestyle advisor, Jenny supports people who want to change lifestyle behaviours such as smoking, risky alcohol use, poor eating habits, stress, and lack of physical activity, that increase their risk of acquiring preventable chronic diseases such as diabetes, heart disease, some cancers, and respiratory conditions. With the incidence of weight gain, smoking, poor eating habits, lack of physical activity and a high incidence of diabetes with mental health clients there has been close collaboration between Do It For Life and rural mental health teams to reduce clients’ risk of chronic disease and encourage sustainable healthy lifestyle behaviours.

Georgina Black

Georgina Black completed a Master of Psychology (Clinical) in 2010 at the University of Adelaide and currently works in the field of child protection. She has previously conducted research regarding rural adolescent depression and her research interests are child and adolescent mental health and trauma.

David Blenkiron

David Blenkiron has been with the Veterans and Veterans Families Counselling Service (VVCS) for five years as the Outreach Program Coordinator. He is social work trained with a diverse background including Military service, SA Police and the Department of Veterans’ Affairs. His current roles include contract management, program coordination and project management duties.

The VVCS provides counselling and group programs to Australian veterans, peacekeepers and their families. It is a specialised, free and confidential Australia-wide service. VVCS staff are qualified psychologists or social workers with experience in working with veterans, peacekeepers and their families. They can provide a wide range of treatments and programs for war and service-related mental health conditions including post traumatic stress disorder (PTSD).

Mark Booth

Mark Booth has been with the Department of Health and Ageing since May 2010, where he has undertaken several Branch Head roles working in workforce distribution, rural health services and policy development, the latter assuming responsibility for the development and implementation of the Medicare Locals initiative. Mark is currently First Assistant Secretary of the Primary and Ambulatory Care Division. The Division aims to provide Australians with access to high-quality, cost-effective primary care that is evidence-based and coordinates with other types of care, such as aged care services and hospital specialists.

Mark has worked in health policy areas in the UK and New Zealand and was a 2006–07 Commonwealth Fund Harkness Fellow in Health Care Policy. While working in New Zealand he spent a year as senior health advisor to the New Zealand Minister of Health.

Mark’s original background is as a health economist and he has postgraduate qualifications in health economics, public administration and public health.

Melissa Boucher

Melissa Boucher has a Bachelor of Social Science and a Masters in Communication Management and has worked for the NSW Rural Doctors Network (RDN) for over 12 years in a variety of roles. These include local health project research, coordination of RDN’s state-wide GP education conferences, the establishment and management of public relations for RDN, researching and co-authoring Easy Entry, Gracious Exit—a guide to assist rural communities to design and implement innovative approaches to medical recruitment and services.

After two years exploring New Zealand with her husband and three young children, and surviving two major earthquakes and six months of aftershocks, in 2011 she relocated back to the relative tranquility and safety of the Hunter Valley in NSW and began developing and coordinating the RMFN Bush Friends Mentoring Program. Melissa loves to lead a healthy, active lifestyle and enjoys mentoring family and friends in their quest to lead healthier, more active lives as well.

Lisa Bourke

Associate Professor Lisa Bourke is a rural sociologist in the Rural Health Academic Centre, University of Melbourne. Lisa has over twenty years’ experience conducting national, state and community projects in
rural and remote communities in the US and Australia. Lisa’s key research interests include rural health as a discipline, the wellbeing of rural young people, rural community resilience, and social research methods. Her current research projects address theoretical understandings of rural and remote health and young people’s access to rural sexual health services.

Claire Bowditch

Claire Bowditch is qualified as a dietitian and also recently completed a Master of Social Science. With a strong interest in Aboriginal health, she moved from Sydney in 2012 to work on an Aboriginal food security project in the rural Wheatbelt region of Western Australia. Claire applies her knowledge of health and community development with personal values of sustainable living to her work, with an aim of improving availability, access and utilisation of food for the Wheatbelt Aboriginal community.

Madeleine Bower

Maddy Bower has been working with The Fred Hollows Foundation for just over three years as a program officer. She is currently studying with Community Management and Development at Curtin University.

Maddy has worked and lived in Katherine most of her life, and has contributed to improving Indigenous health through various primary and secondary health arenas and working with community members.

Laura Boyce

Laura Boyce is a lecturer in pharmacy with the University of Newcastle Department of Rural Health in Taree, NSW. She also works for the Manning Rural Referral Hospital pharmacy department as a hospital pharmacist and is accredited to perform home medicines reviews.

Laura studied at Charles Sturt University, Wagga Wagga. She started her hospital pharmacy career as an intern and then registered pharmacist at Prince of Wales and Sydney Children’s Hospital, Randwick. She returned home to Taree in 2008 to pursue a career in rural pharmacy practice. Laura has a special interest in medication safety and the transfer of medicines information at transitions of care.

Lyn Boylan

Lyn Boylan coordinates a number of rural primary health and specialist outreach services across the Hunter New England Local Health District in NSW, funded by the Department of Health and Ageing. These outreach programs provide medical specialist and multidisciplinary teams in maternal and child health, cardiology, respiratory, diabetes and nurse-led chronic disease clinics to rural communities, in particular to Aboriginal communities. She also oversees the rural primary health program which delivers health promotion, early intervention chronic disease and community capacity building programs along with allied health clinics to very small rural communities. She also works with health managers and other key stakeholders, including Medicare Locals to review and implement new models of care that meet the needs of rural communities such as telehealth nursing clinics and group-based diabetes education delivered by generalist community nurses.

Previously Lyn worked as a clinical nurse consultant in clinical research in reproductive health in Sydney before moving to the Taree hinterland 20 years ago, where she completed her Bachelor of Health Services Management (Information Management). She has undertaken a variety of positions for the local health service including project and performance management, clinical redesign, and information management within the IT service.

Jo Brown

Jo Brown is Manager Health and Wellbeing at Southern Grampians and Glenelg Primary Care Partnership (SGGPCP) in Hamilton, western Victoria. SGGPCP works with twenty partner agencies (including local government, large health and small rural health services, bush nursing centres, community service agencies and Aboriginal and community health agencies) across the Southern Grampians and Glenelg shires in south-west Victoria.

Jo has extensive experience in community development and a strong interest in behaviour change and community wellbeing. She has worked in the disability sector, tertiary education, emergency management and community health and holds a degree in arts (disability) and postgraduate qualifications in education.

Jo has a strong social justice philosophy which influenced her initial work in the disability sector, teaching and then managing a continuing education department for adults with an intellectual disability in Melbourne. This led to an interest in staff development and a position teaching in the community services and welfare studies sectors at Northern Metropolitan TAFE in Preston, Melbourne. On return to country Victoria, Jo continued TAFE teaching and began a community development and education role with the Country Fire Authority where she worked closely with communities to prevent loss of life from both bushfires and bushfires.

For the past four years, Jo has worked with SGGPCP with a focus on health promotion and climate change. After leading a demonstration trial around local climate change adaptation in a small rural community, SGGPCP have built strong partnerships with leading climate and health experts including the Victorian Climate Change Centre for Adaptation Research, National Climate Change Adaptation Research Facility, the Climate and Health Alliance, Sustainability Victoria and a number of sustainability networks and research agencies.
Jo lives with her husband and teenage sons in Hamilton, Victoria, where she has settled to enjoy the country life after living and studying in Melbourne.

**Leanne Brown**

Dr Leanne Brown is a senior lecturer and academic team leader at the University of Newcastle, Department of Rural Health (UoNDRH). She is an advanced accredited practising dietitian with experience working as a clinical dietitian in a variety of hospital settings.

For the past 10 years, Leanne has been working in an academic role that involves teaching, research and clinical work. She completed her PhD in 2009, her research investigated the barriers to best practice dietetic service in rural areas. She has published papers in nutrition journals and presented her research at national and international conferences.

**Susan Brumby**

Clinical Associate Professor Susan Brumby is the founding director of the National Centre for Farmer Health—an innovative partnership between Deakin University and Western District Health Service, Hamilton, Victoria. Sue leads the implementation of five key strategies to improve the health, wellbeing and safety of farm men and women which includes inventive and award-winning service delivery models, farmer research, agroclinics, novel education and the farmer health website (www.farmerhealth.org.au).

In 2010, the National Centre for Farmer Health hosted the Opening the Gates of Farmer Health conference where the Hamilton Charter for Farmer Health was developed and endorsed. Sue’s background blends both a theoretical and practical understanding of agriculture, health, management and rural communities. She has been recognised with personal awards for her outstanding experience in farming and rural communities, managing the family property of performance recorded beef cattle and self-replacing fine wool flock for twelve years. Sue is the principal investigator of the award-winning Sustainable Farm Families™ (SFF) project which has been delivered in all states of Australia. She has also been chief investigator on Australian Research Council, NHMRC, RIRDC, and beyondblue grants. She has previously been awarded a Victorian Travelling Fellowship to the USA and the EU looking at farmer health and decision making.

**Steve Burton**

Steve Burton originally hails from the Aboriginal community of Warrabri in the Davenport Ranges, south of the Barkly Tablelands, and credits this and growing up in a nomadic family—which included eight years in Papua New Guinea—as giving him a somewhat different perspective on life.

Steve returned to Australia to complete his final year of schooling (Year 12), moving on to studying nursing, midwifery, child and family health, and counselling, before then studying building and working as a building estimator for several years.

In 2001, Steve took over as Manager of the Primary Health Care teams in Bourke and Brewarrina (far-western NSW). This was followed by an 18-month project position as the nursing workforce officer for the then Far West Area Health Service based in Broken Hill.

Some time later, Steve accepted a position in the field of his major health-interest—population health—and works in a solo position in health promotion in the far-west, with projects targeting obesity, falls prevention in the elderly, physical activity, and smoking cessation at a population level.

Steve believes that there is a urgent need for the health industry and society generally to embrace prevention in a more dedicated and encompassing way to address the chronic health issues that are increasingly looming large and placing huge strain on acute health services.

Steve is also a CrossFit instructor, a CrossFit kettle bell instructor, a certified movement and mobility trainer, and motivation and goal-setting trainer. He holds the opinion that anyone who is involved in the health industry should lead by example and follow the lifestyle we expect of others.

He is the current Chair of Active Broken Hill Inc, a community-based organisation working innovatively to address lifestyle issues in far-western NSW.

**Wendy Cabot**

Wendy Cabot is the regional manager for The Benevolent Society in northern NSW. In this role she is responsible for a range of program areas, including mental health and child and family programs across the New England region, and has a passion for integrated service delivery and the benefits to consumers.

Prior to commencing with The Benevolent Society, Wendy worked as a registered nurse for over 30 years in both acute and community settings, and as a child and family health manager responsible for various programs, including child and adolescent mental health and Aboriginal health to name just a few.

Wendy is a member of numerous professional organisations including the Mental Health Coordinating Council, the peak body for non-government organisations.

**Melissa Cameron**

Melissa Cameron is Director of Policy at Rural Health Workforce Australia (RHWA). Melissa leads the national rural and remote health workforce policy function for RHWA and its member agencies (Rural Workforce Agencies). Prior to this Melissa was co-director of workforce programs at RHWA, managing national
workforce programs that recruit and retain health professionals to rural and remote Australia.

Melissa has extensive experience in public health, having spent 10 years at the Cancer Council Victoria. Melissa worked as a researcher in the Centre for Behavioural Research in cancer, undertaking research into tobacco control, obesity and population cancer and as the Executive Officer for the Victorian Cooperative Oncology Group—Clinical Cancer Network, leading 600 independent cancer clinicians.

Cath Cantlon

Cath Cantlon has practised professionally in a range of art forms for 36 years. Originally a theatre designer, she has also worked as an exhibiting artist, a project artist in community cultural development and in arts administration. In 2001, she received the Australia Council’s Ros Bower Award for her contribution to community cultural development in regional areas and in 2012 she received a state government Ruby Award for her lifetime achievement in community arts work.

With Country Arts SA, Cath is currently creative producer of a three-year arts, health and environment program rolling out in the southern regions of South Australia.

Raelene Carroll

Raelene Carroll is currently managing Midwifery Group Practice that forms part of the maternity services in Alice Springs. Over the years she has worked in numerous rural and remote settings and has spent the majority of the last 11 years in Alice Springs. In 2007, Raelene went to work at the Women’s and Children’s Hospital in Adelaide as part of the Midwifery Group Practice to gain experience in a continuity of care midwifery model. Raelene is passionate about the role of providing women centred care, continuity of care and partnerships, and brings this thinking to her current work in managing a service that meets the needs of pregnant women from both remote and rural settings.

Dean Carson

Dean Carson lives in Burra in the mid-north of South Australia. He works for the Flinders University Rural Clinical School as Professor of Rural and Remote Health, for the Poche Centre for Aboriginal Health in Alice Springs, and for The Northern Institute at Charles Darwin University. Dean has degrees in sociology, history, communications, geography, and environmental science and management. His research is focused on the changing human geography of rural and remote towns—who lives there, who works there, who visits there—and the causes and consequences of such change.

Dean has worked in central Queensland, the Northern Territory, Victoria’s La Trobe Valley and the northern parts of South Australia, and is committed to developing opportunities for academic researchers to live and work in rural and remote areas. Significant pieces of research Dean has been involved with include the National Rural General Practice Study, research into tourism in outback Australia, development of new approaches to demographic modelling of small towns, development of new strategies to increase Indigenous participation in the health workforce, examination of Indigenous homelessness in the Northern Territory and South Australia, and research into the social and demographic futures of remote Indigenous communities.

Dean has visiting research fellowships at the University of Applied Sciences, Krems, and Salzburg University in Austria, Umea University in Sweden, Scottish Rural University College, and Wilfrid Laurier University in Canada.

Fred Chaney

The Hon Fred Chaney AO was born in Perth in 1941. He practised law in New Guinea and Western Australia, including time in-house with the Hancock-Wright prospecting partnership, and subsequent private practice with emphasis on mining-related work until he entered the Senate in 1974.

Fred was involved in the Aboriginal Legal Service in a voluntary capacity in the early 1970s. He was in the Senate until 1990 and was Leader of the Opposition in the Senate from 1983 to 1990. He was Member for Pearce in the House of Representatives from 1990 to 1993. Among his Ministerial appointments were Aboriginal Affairs, Social Security and Minister Assisting the Minister for National Development and Energy.

After leaving Parliament he undertook research into Aboriginal Affairs policy and administration as a research fellow with the Graduate School of Management at the University of Western Australia from 1993 to 1995. He was appointed Chancellor of Murdoch University in 1995 and continued in that capacity until 2003.

In 1994 he was appointed as a part-time member of the National Native Title Tribunal, a full-time member in April 1995 and was Deputy President from 2000 to 2007. In January 1997 he was appointed an Officer of the Order of Australia.

He served as co-Chair of Reconciliation Australia Ltd from 2000 to 2005 and continues as a Director on the Board. In 2005 he was appointed Chairman of Desert Knowledge Australia. In 2007 he chaired the Consultation Committee on a Human Rights Act for Western Australia. He served as a member of The Expert Panel on Constitutional Recognition of Indigenous Australians and currently serves as Chair of Central Desert Native Title Services.

Tracy Cheffins

Dr Tracy Cheffins is a public health physician working with the Townsville-Mackay Medicare Local (TMML) on
population health planning. She has extensive general practice clinical and academic experience in South Australia and north Queensland. A Queensland medical graduate, she did her early medical practice in Townsville, then joined a general practice in the Adelaide Hills in 1988. She undertook public health medicine training in Adelaide, before joining James Cook University School of Medicine in 2001. Her roles at JCU included teaching at undergraduate and vocational levels, as well as establishing a general practice research network. She has published several clinical research projects completed by the network. From 2007 she also worked part time as a medical adviser for the Townsville GP Network, and since 2011 has focused on the population health planning role with TMML. Her interests are assessing the health care needs of rural and remote populations, and improving the integration of primary health services.

Andrea Church

Andrea Church is the Program Manager of the Out of Hospital Strategy for Country Health SA Local Health Network. Her role involves developing and implementing initiatives that increase the capacity of country health services to provide greater support to people in the local community, to avoid unplanned presentations or admissions to country hospitals. Andrea has a Master of Public Health and has worked in the health sector for more than 20 years, initially as a university-based researcher, before moving into primary care and general practice. Six years ago Andrea moved to Kangaroo Island with her family and joined Country Health SA Local Health Network. She feels incredibly fortunate to have the opportunity to live in a remote country community and be supported to initiate and change the way health services are provided in country South Australia, to improve client outcomes.

Richard Clark

Richard Clark graduated from the University of Southampton with a BSc (Hons) in Physiotherapy in 2002. He worked within the UK National Health Service, prior to emigrating to Australia in 2005. He completed an MSc in Manipulative Physiotherapy (Curtin) in 2007 and specialised in the management of chronic musculoskeletal pain. In addition to managing complex chronic pain patients, Richard also has a special interest in the use of simulated learning environments to assist in clinical education. In 2011 he was successful in assisting Western Australia to secure Health Workforce Australia funding to increase simulated learning across the state. Richard and colleagues established the Clinical Simulation Support Unit (CSSU) for Western Australia. In addition to increasing capital assets for WA, the unit has also recently established a centralised maintenance unit for simulation equipment for WA Health and is in the process of creating interprofessional elearning packages to enhance undergraduate and newly graduated staff improve their communication skills.

Scott Clark

Scott Clark is a senior registrar who is currently completing generalist advanced psychiatry training and has recently been appointed as a clinical academic at the Queen Elizabeth Hospital. He worked as the STP senior registrar assisting to set up the Mount Gambier Intermediate Care community mental health team from 2011–12. He has been the co-Chair of the Adelaide Metropolitan Clozapine Working Group for the last three years. Scott completed a BSc in Psychology at Flinders University in 1994, followed by an Honours in Medical Science at the Centre for Neuroscience at Flinders University in 1995. He studied medicine in Adelaide completing his MBBS in 2004, and followed with a PhD in Health Informatics at Adelaide University, supported by a NHMRC Dora Lush Grant. His thesis focused on the development of computer-based alerting systems designed to improve the quality of health care.

Kate Clarke

Kate Clarke has been involved in regional, rural and remote organisations for over 25 years. She is a member of the Australian Institute of Company Directors, a fellow of the Australian Leaders Foundation and has qualifications in business administration, applied science and nursing. She has worked as a nurse and midwife in hospital and community settings, primarily in South Australia, during which time she completed an undergraduate degree in nursing, a Bachelor of Nursing and qualified as a midwife after completing midwifery training in Scotland. Kate has undertaken roles as a clinical nurse, nurse manager, health promotions officer, and community health manager. Following a range of roles, she adapted her community development and community engagement skills to work within primary industries in South Australia.

Kate was the General Manager for the Eyre Peninsula Natural Resources Management Board from 2004 to 2011. After spending a year travelling, volunteering and consulting, she was appointed to the role of CEO, South West WA Medicare Local in July 2012.

Kim Clarke

Kim Clarke is currently employed as the Advanced Clinical Lead Speech Pathologist for Country Health Local Health Network in South Australia. She has had over 20 years’ experience working as both a clinician and manager in Australia and the United Kingdom. Prior to commencing her role as the Advanced Clinical Lead Speech Pathologist in October 2011, Kim managed a large inpatient speech and language therapy service in North Bristol, UK. During her time in the UK, Kim was a clinical advisor for the Royal College of Speech and Language Therapists. As a part of this role, she held membership of the UK Intercollegiate Stroke Working Party for six years where her particular clinical interest
was in the area of swallowing disorders (dysphagia). During this time she contributed to three revisions of the internationally renowned UK Intercollegiate Stroke Working Party Clinical Guidelines for Stroke.

In addition, Kim co-wrote the UK position paper for Royal College of Speech and Language Therapists on modified barium swallows which was published in 2007. Kim also cowrote the UK position paper for Royal College of Speech and Language Therapists on the provision of speech and language therapy services in critical care which was also published in 2007.

Since commencing her role as the Advanced Clinical Lead Speech Pathologist for Country Health South Australia, she has travelled extensively throughout country South Australia establishing a firm understanding of the communication and swallowing needs of rural clients and their families. She has also sought to improve clinical and service standards in the delivery of safe, effective and efficacious speech pathology care for clients with communication and/or swallowing difficulties. Kim is a passionate advocate for improving access to high quality speech pathology care for all rural and remote South Australians.

Christy Clothier

Christy Clothier graduated from the University of South Australia in 2008 with a Bachelor of Applied Science in Occupational Therapy. Christy has a passion for rural health having grown up in country SA, and since graduating has been working for Country Health SA in Clare. During this time, she has undertaken a variety of roles, most recently as an early intervention therapist within the Healthy Families team. During her time with the team, Christy has been a key contributor in moving towards a transdisciplinary model of practice. This model recognises and provides a platform for families and children to engage with service, and for service to engage with them in a way that is fluid, responsive and integrated. In particular, Christy is passionate about how transdisciplinary practice as a service delivery model can support rural families to access specialist services that are stretched as demand outweighs supply. Christy also has special interest in attachment theory, childhood feeding issues, and neurodevelopmental impacts of trauma on child development.

Annamarie Cohen

Annamarie Cohen is a social worker who has spent most of her career working in the child protection arena as a counsellor, FaCS manager and currently as Mid-North Coast Family Referral Services Manager. She is currently completing a MSW (Forensic Studies) at Monash University. Annamarie has a special interest in neuroplasticity and using this research in particular with children and adults who have experienced trauma.

Michelle Coleman

Michelle Coleman joined the School of Public Health in September 2012, as part of the ‘Community-based Health Promotion and Prevention Studies Group’, and is primarily involved in evaluating Department of Health and Ageing ‘Healthy Community Initiatives’ for Aurukun (Cape York) Shire Council and the Tablelands Regional Council; and following up the Queensland Police Service’s Return to Country project. Michelle studied a Bachelor of Criminology with a minor in both health and contemporary studies at Sir Wilfrid Laurier University graduating in 2012 with honours. Her interests in criminology, youth, and Aboriginal law include: transitional phase for youth re-entering the community programs and incentives, community-based programs/interventions for you, restorative justice among First Nation populations, and reintegrative shaming techniques used in First Nation communities.

Sharon Condon

Dr Sharon Condon is employed as a Research Fellow at the Rural Clinical School in Burnie, Tasmania. Her current research projects involve the evaluation of an electronic advance care plan (eACP) for residential aged care facilities (RACFs) and bushfire preparedness. Her interests are in social network analysis (SNA) using qualitative comparative analysis (QCA) methodologies.

Sue Conrad

Sue Conrad is a PhD candidate with the Australian Longitudinal Study of Women’s Health. Her current research systematically examines associations between health outcomes and women’s perceptions of neighborhood connectedness, attachment, trust and safety. Sue’s previous professional experiences were in the drug and alcohol sector. There her passion for integrating practice-based evidence, and evidence-based practice, found her involved in the development and provision of training for regional drug and alcohol workers, and contributing to the development of postgraduate course work. Her research interests focus on the ways social, psychological and biological factors interact in manifestations of health and disease.

Sarah Constantine

Sarah Constantine works as a health services development consultant for Health Workforce Queensland. Sarah is a registered nurse and has 16 years of work experience in the health industry, working in clinical and administrative positions in the public, private and not-for-profit sectors. Sarah’s project management role provides the opportunity for firsthand consultation with rural communities all over Queensland and she enjoys working with individuals and organisations that advocate for, and work towards, sustainable health services and workforce solutions.
Ivan-Tiwu Copley
Ivan-Tiwu Copley is a Peramangk/Kaurna man who was raised around Plympton and the sand hills of Glenelg North in South Australia. His achievements working with Aboriginal and non-Aboriginal peoples for reconciliation and recognition were honoured in 2005 with the Premier’s Award for Community Achievement, and again in 2009 when he received the South Australian of the Year Award. More recently, Ivan received the Order of Australia Medal (OAM) in 2012. Ivan works tirelessly around all parts of South Australia as the Aboriginal and Torres Strait Islander Engagement Manager—SA, Indigenous Community Engagement Strategy, Australian Bureau of Statistics. He currently holds positions as Chairman for the Campbelltown Council Reconciliation Advisory Committee and the Aboriginal Centre for Information and Arts in SA Inc (ACFIA) and only stepped down last year from a seven-year term as Chairman of The Indigenous Information Network of SA (TURKINDI Inc). He is an Executive Board Member of Reconciliation SA, the National Indigenous Sport Academy, and National Coordinator of the National Sorry Day Conference in Adelaide. Ivan is also a recognised artist, author, and advisor for Indigenous protocol and cultural appropriateness, and a sought-after speaker for conferences, seminars, and political events.

Kate Cornick
Dr Kate Cornick is the General Manager, Health and Education at NBN Co, the company rolling out the National Broadband Network. In this role Kate is working with the health and education sectors to drive adoption of broadband applications and services that will result in improved services to consumers.

From 2009 to 2012, Kate was the inaugural Executive Director of the Institute for a Broadband-Enabled Society (IBES)—an interdisciplinary research institute established at the University of Melbourne focused on broadband applications, including in health and education. During this time, Kate was also the General Manager of the Centre for Energy-Efficient Telecommunications at IBES, a joint venture between the University of Melbourne, Victorian State Government and Alcatel-Lucent. In July 2011 she was awarded the prestigious Australian Communications Industry Young Achiever Award in recognition of her work at IBES and CEET.

Previously, Kate was the Senior Telecommunications Adviser and Deputy Chief of Staff to Senator Stephen Conroy, the Minister for Broadband, Communications and the Digital Economy. Her roles included advising on the National Broadband Network policy, consumer issues and regional telecommunications.

Kate Cornick undertook her PhD in optical telecommunications at the University of Melbourne and, as part of her studies, spent time at AT&T Research laboratories, USA.

Jennifer Cottrell
Jennifer Cottrell is the Coordinator of the South Australian Rheumatic Heart Disease Program and is passionate about improving health outcomes of Aboriginal people through partnerships and taking a holistic approach. With a speech pathology degree from Flinders University and a Master of Public Health from the University of Adelaide, she has worked in Australia and abroad in government and non-government organisations. Jennifer has experience in a variety of health organisations such as community health, cancer prevention, and tobacco control, where her professional focus has been policy integration and health promotion.
activities with Aboriginal communities; specifically promoting prevention measures and early detection of disease. Jennifer has sustained a strong interest in rural health and Aboriginal health throughout her career. This is reflected in her choice of thesis topic, cancer profiles in South Australian Aboriginal people, and her enthusiasm for this role which encompasses both of these areas. She is committed to increasing awareness of rheumatic heart disease in SA through education, engagement with local health services and collaboration with the Northern Territory.

Sue Cowan

Sue Cowan joined the John Richards Initiative in July 2011 as a research officer and is involved in a number of JRI projects including community-based aged care assessment service mapping, and social inclusion and information and communication technologies. She has a clinical background across all age tiers of mental health and is currently working with the older persons cohort in community-based programs. Her additional role within mental health complements her research focus with the JRI. Sue’s past research focus has included the exploration of vicarious trauma of refugee advocates, and the further study of the wide psychosocial implications of intimate partner rape which informed recent state-wide legislative reforms. Sue is an accredited member of the Australian Association of Social Workers.

John Cowell

John Cowell has a background in health, education and accounting. He has worked as a MICA paramedic and has been a paramedic for over 20 years. He has been involved in the training and education of paramedics.

Libby Coy

Libby Coy completed a Bachelor of Applied Science, Speech Pathology, in 1979 at Sturt College of Advanced Education, South Australia. Her strong interest in ‘closing the gap’ is based on over thirty years’ experience working as a speech pathologist for government health and education services with various Aboriginal communities in the Northern Territory, New South Wales, and South Australia.

In the early years, her focus was on ear health and the effects that middle ear disease can have on the language-learning development of Aboriginal children. Over time this has expanded to include the effects of all aspects of health and wellbeing on Aboriginal child language-learning development.

Libby has actively pursued—both in and outside of employment—the development of a respectful understanding of Aboriginal community, culture and world view; including cultural awareness and training workshops, and travelling through Country with Aboriginal leaders. Her experiences have built a strong understanding of both the positive and adverse factors that influence Aboriginal child development and family engagement with health and education services.

Libby currently works as a speech pathologist on the Murray Mallee Community Health Service’s Children and Families team, based in Murray Bridge, South Australia. In 2011, she was successful in her submission to utilise Communities for Children FHCSIA funding to facilitate local implementation of Aboriginal child well health checks as recommended in the SA Aboriginal Health Care Plan 2010 to 2016. This project continues.

Beth Cronin

Beth Cronin is a social worker with 16 years’ postgraduate experience including work in both Australia and the United Kingdom. Beth has worked as a practitioner and manager in various fields including children and families, sexual assault, and mental health. She is currently the Regional Manager of Central West NSW for The Benevolent Society. Beth has a passion for mental health and community work and is excited about the Recovery framework within the mental health sector and its potential to transform societal and community sector views of mental distress and illness and to support more empowering and inclusive ways of working with people and communities. Beth is also a massage practitioner, aromatherapist and infant massage instructor. Her holistic view of health contributes to her excitement about Recovery-oriented practice and the way it honours the wisdom that people with lived experience bring and creates more space for people to reconnect to their power to shape their own lives and wellbeing and that of their community.

Carlie Darling

Dr Carlie Darling is a team member from the Rural Adversity Mental Health Program of the University of Newcastle’s Centre for Rural and Remote Mental Health (CRRMH).

The Centre for Rural and Remote Mental Health is based in Orange and is a major rural initiative of the University of Newcastle, Faculty of Health, and the NSW Ministry of Health. CRRMH aims to bring quality education and research programs to all rural areas of NSW through effective partnerships. The Centre improves the mental health of rural and remote communities through academic leadership, collaboration and achievements in research, education, service development and information services.

The Rural Adversity Mental Health Program (RAMHP) is managed by the Centre and commenced in 2007. The key aim of the program is to build individual and community capacity that supports the mental health and wellbeing of rural and remote communities during periods of adversity. RAMHP emphasises building community resilience through partnerships with local services and agencies in alignment with the aims of the CRRMH.
Carlie is the acting State-wide Projects Coordinator for RAMHP. Carlie has a PhD and Honours degree in psychology, and a background in health, mental health and social science disciplines. She also has a strong research and publication record reflecting her interests in neurophysiology and mental health. It is Carlie’s interest in mental health and access to services and support in rural and remote NSW which led to her joining the RAMHP in early 2012.

In her role as State-wide Projects Coordinator, Carlie works with the program team to develop project concepts and implementation models which increase the preparedness of rural and remote communities in NSW to maintain good mental health in the times of adversity.

Sarah Davies

Sarah Davies immigrated to Australia in 1997. Her nursing experience spans 22 years working in three states across Australia and in the United Kingdom. Arriving as a surgical nurse specialising in urology, she worked at St Vincent’s Sydney. In 1999 urology was merged with haematology/bone marrow transplantation. This initiated a passion for haematology/oncology nursing that has been ongoing, and led to a Graduate Certificate in Cancer Nursing at the College of Nursing in 2007.

In 2007, and 5000 km later, Sarah relocated to the Kimberley region in Western Australia. A year in the remote town of Derby established a passion for the Kimberley and its people. Following a further two years in Wollongong to hone her oncology skills, the opportunity then arose to combine her two passions and she was appointed Regional Cancer Nurse Coordinator for the Kimberley in late 2011.

Deborah Dean

Debi Dean qualified at St Bartholomew’s Hospital, London, in 1980 as a state registered nurse and, after initially following a critical care nursing pathway, became very interested in chronic disease management in primary care. In 2000, Debi was engaged as the Professional Lead for Coronary Heart Disease for Newcastle-under-Lyme Primary Care Trust, Staffordshire, and responsible for the implementation of the Department of Health Coronary Heart Disease National Service Framework within the local population.

In 2008 Debi immigrated to Cairns and was recruited as the Project Officer for the Diabetes Centre in July 2010 to develop a telehealth model of care for people with diabetes in rural and remote districts. This post provided a unique opportunity to explore Queensland from the comfort of a typing chair—particularly useful as Debi’s previous experience of rural had been the end of the Central Line in London’s Underground; and remote—the other side of the River Thames.

Fully conscious of the current disparity and inequality of care often available in the remote setting, Debi is firmly committed to the development of telehealth services to remedy this situation.

Pascale Dettwiller

Pascale Dettwiller is Associate Professor and Director at the Katherine Campus of the Rural Clinical School Campus of the Flinders University NT Medical Program, Katherine, Northern Territory.

She holds a Doctorate of Pharmacy from the School of Pharmacy, Joseph Fourier University, Grenoble (France), and several Bachelor and Diploma awards in teaching, business, nutrition and herbal medicine. She has held senior clinical pharmacist positions in regional health centres in New Caledonia, Tasmania and Victoria. Between 2009 and 2011 she was Academic Lead for the Pharmacy Discipline, Course Coordinator, and Allied Health Leader (Multidiscipline) at Charles Darwin University in Darwin.

Pascale has vast experience in teaching and mentoring of interdisciplinary student groups nationally and internationally, especially in rural medical schools and best health practices.

She has been a member of the Pharmacy Boards of Tasmania and Victoria and member of Human Ethics and Research Committees in Tasmania and is a scientific advisor to the Menzies School of Human Research in Darwin.

Her major area of research is in medication management and safety, drug usage evaluation and innovation in education. Her current appointment is a great opportunity for the development of projects related to these areas. Part of Pascale’s role is to develop these partnerships and ensure appropriate feedback from the projects’ outcomes is provided to the partners. Her experience stems from project management in New Caledonia while leading education and community development for the communities of the district she was involved with over seven years.

Since 2006, she has attracted approximately $243 000 in grants for studies involving dosage formulation modifications and evaluation of student placements in rural and remote health centres with the latest grant from the Smith Family to develop interagency collaboration in the context of the Community For Children at the Katherine Region.

Pallavi Dham

Dr Pallavi Dham is a young psychiatrist working with Rural and Remote Mental Health Services, Country Health SA, since 2011. She completed her psychiatry training in India and is now on her pathway to fellowship.

While in India, Pallavi was closely involved with a community research project on mental health service needs and utilisation patterns in urban areas in India,
followed by a lead role in community mental health service delivery. For the last one and a half years in Australia, she has worked with the Older Persons Mental Health Service, Country Health SA, as the psychiatry registrar assisting with provision of mental health care to older consumers living in rural and remote regions of South Australia.

Pallavi has maintained her interest in research alongside the demands of clinical work and study. She aspires to work on efficient models of easily accessible, quality mental health care in areas of limited resources. Her interest in telepsychiatry stems from her earliest experience as a junior trainee in India where the department assisted with mental health services from Trivandrum, the southern most tip of India to Ladakh, the northern end of India, isolated by extreme climatic conditions and with one GP to provide all medical needs of the residents. She endeavours to evaluate this mode of service delivery among the older consumers of South Australia often marginalised owing to their age and residence in remote regions. She hopes this will contribute towards improving service delivery and access.

Xenia Dolja-Gore

Xenia Dolja-Gore has conducted statistical investigations in areas associated with health services for over 20 years. Xenia is currently undertaking her PhD while working with the Research Centre of Gender, Health and Ageing at the University of Newcastle. Xenia’s work involves statistical modelling using data linkage across large scale datasets. Both her PhD and her current work are based on mental health service utilisation using data from the Australian Longitudinal Study on Women’s Health linked with Medicare’s MBS and PBS datasets.

Bernadette Doube

Bernadette Doube is an innovative project manager with international experience as an organisational development specialist and a company director. Bernadette’s career started as a speech and language therapist transitioning over time from clinical practice to clinical research and into health sector management. Throughout her career she has worked across a variety of settings in rural and urban areas and has been involved in organisational learning and development in the public, private and voluntary sectors.

Bernadette has been involved in tertiary teaching in the UK and New Zealand and she has organised and contributed at international conferences. Her commitments include directorships of several organisations and she has developed a special interest in the governance and leadership of NGOs.

Currently, Bernadette runs her own consultancy business focusing on governance development, change management projects, strategic planning and implementation. She has a strong interest in rural health and community development and is currently involved in trialling sustainable solutions for rural health care delivery. More recently she has been involved in service and governance reviews within and across the health and disability sector.

Wendy Ducat

Dr Wendy Ducat is a psychologist and senior project officer at the Allied Health Education and Training Department, Cunningham Centre, Darling Downs Hospital and Health Service, Queensland Health. Wendy’s role includes coordinating and providing professional supervision training and peer group supervision training to rural and remote allied health professionals as well as coordinating support for mentoring and supervision arrangements across distance.

Wendy is also involved in managing research and evaluation activities in the area of rural and remote allied health training and professional support. Wendy coordinated the recent evaluation of the Allied Health Rural and Remote Training and Support (AHRRTS) program in collaboration with the International Centre for Allied Health Evidence (ICAHE) and is currently lead author on a systematic review of the experience and effects of professional supervision for rural and remote allied health professionals and their clients. Prior to this role, Wendy was involved in coordinating a number of clinical research projects at the Alcohol and Drug Service, Queensland Health, including the Young People at Risk project (2007) and Mindfulness for Substance Use project (2009), as well as delivering clinical training to multidisciplinary health professionals.

Wendy completed her PhD in Clinical Psychology in 2009 (Griffith University, Queensland) investigating the links between relationship behaviours and psychological wellbeing, and has published her research in the Journal of Relationships Research, Journal of Adolescence, Archives of Sexual Behaviour as well as the Australian Psychological Society (APS) Conference Proceedings. Wendy has presented peer-reviewed papers at national and international conferences, including the APS Psychology of Relationships Conference (2010), Australian Winter School (2010), The World Congress of Behavioural and Cognitive Therapies (WCBCT) in Barcelona (2007), and the Third International Conference of Self-Determination Theory in Toronto (2007). Wendy’s ongoing research interests are in the fields of health workforce training and support, and relationships psychology.

Donisha Duff

Donisha Duff is an Aboriginal and Torres Strait Islander woman from Thursday Island in the Torres Strait. Her family are descended from Moa and Badu Islands (Torres Strait) and the Yadhaigana and Wuthathi people (Cape York).

Donisha is the National Governance Project Officer at the National Aboriginal Community Controlled Health Organisation (NACCHO). She was a former Adviser
Donisha is completing her Master of Business Administration (ANU) and was a 2011 Roberta Sykes Fellow to Harvard University, USA. Donisha is currently a Board Trustee, Roberta Sykes Indigenous Education Foundation Board, and 2013 Diversity Scholarship Recipient, Australian Institute of Company Directors (AICD).

Rohena Duncombe

Rohena Duncombe is a social work practitioner with Byron Bay Community Health Centre and academic working for Charles Sturt University. Rohena works across the social work modalities of research, community development, and casework, and is an experienced clinician and group worker. She is experienced in community development especially in the areas of child protection and homelessness. Her major research interests are in service entry systems and the ways in which they create barriers to entry for the most needy, and in evaluating the use of empowerment approaches to anxiety management.

Andrea Dunlop

Andrea Dunlop is the Corporate Services Manager at Hesse Rural Health. Andrea has worked in the public health sector for 23 years in a variety of clinical, project and management roles. Originally trained as an occupational therapist Andrea has a Master of Health Science majoring in Community Health.

Michael Edwards

Michael Edwards has a computing science degree from the University of Western Sydney. He is an accredited project manager with 13 years’ experience managing and delivering IT projects to a variety of industries including finance, manufacturing, telecommunications, and health.

His IT experience has included a progression of roles from programmer, team leader, project manager, IT strategy and project consultant. Over two years ago, Michael moved into rural health and has had the privilege of working as a project officer at the NSW Rural Doctors Network to help plan, implement and administer outreach services to rural, remote and Aboriginal communities across NSW.

Trish Eerden

Trish Eerden spent her formative years living in rural South Australia, from the west coast to the mid-north and then back again. She is number six in a family of eight, which is probably why she’s very good at negotiating for what she needs. That’s probably also why she decided to only ever have two children. Today, Trish and her family live in the Riverland of South Australia around three hours from Adelaide.

In August 2000 Trish and her husband and their son welcomed a new bundle of joy to their family; Jaime. It became apparent quite early that Jaime wasn’t progressing in quite the same way as other babies and what followed was a journey of epic proportions. At 10 months Jaime was ‘developmentally delayed’; at 12 months she had ‘epilepsy’ and ‘ataxic cerebral palsy’, by the time she was about two she was ‘intellectually disabled’; at three she stopped eating. There is no end to this journey, it has no destination. There is just a road that needs to be travelled to the best of everyone’s ability.

Trish rejoined the workforce when Jaime was two and took on the task of managing a full-time job, a husband, a son and a daughter with profound disabilities. The fractured and ‘silo’ like services available to families supporting a child with a disability in rural SA meant that over Jaime’s lifetime, Trish has negotiated with somewhere in the vicinity of 12 different organisations and countless departments. It’s fair to say that she is an expert in navigating the ‘system’.

Trish is always ready to use her experiences to influence change and advocate for improvement and last, but certainly not least, to remind service providers that every last person has the capacity to make a difference in the life of even one family.

Bronwyn Ellis

Bronwyn Ellis is an Adjunct Research Associate in the University of South Australia’s Centre for Regional Engagement. She is a member of the Centre for Rural Health and Community Development, a research centre based at the University’s Whyalla Campus. Her previous work includes tertiary language and academic skills development, and school teaching in Australia and abroad. Her research interests include: lifelong learning; regional, rural and remote educational and other issues; cross-cultural interaction; and university–community engagement.

Isabelle Ellis

Professor Isabelle Ellis works in a conjoint role between the University of Tasmania and the Department of Health and Human Services, Tasmania. She has a background in nursing and midwifery specialising in remote area nursing. Isabelle’s research interests are around improving access to a range of specialist health services for people living in remote and rural areas, in particular the development of telehealth services. She is the Chair of the UTAS eHealth Research Centre.

Colin Endean

Colin Endean is a dentist working in private dental practice, in the public dental sector and in remote Aboriginal communities in SA and WA. He began his
journey to remote Indigenous communities and practice in remote primary oral care in 1985 and has remained engaged and committed to improving oral health for all.

He has worked as a dentist for Aboriginal Community Controlled Health Services (ACCHS) for over 28 years, firstly for the Nganampa Health Council on the APY Lands of SA, thence for the Ngaanyatjarra Health Council on the Ngaanyatjarra Lands of WA, and for the last seven years for the Tullawon Health Service (THS) in Yalata, SA. Since 2010 Colin has been involved with establishing an outreach dental program for the Kakarrara Willurrrara Health Alliance (KWHA–East-West Health Alliance), an alliance connecting the small ACCHS of Oak Valley (SA) and Tjuntjuntjara (WA) and extending services and developing programs with the THS.

Through this work with the KWHA and the extensive years of dental service delivery in much of the remote regions of SA and WA, Colin has developed an understanding of what Closing the Gap might really mean for oral health in the context of these remote Aboriginal communities.

Colin has also worked with Adelaide University and the Menzies School of Health Research on the Strong Teeth for Little Kids project that has provided insights and opportunities for early intervention and prevention of early childhood caries (ECC).

Colin has been a co-author on the papers that have been published from the Strong Teeth for Little Kids study and as a lead author of ‘Anangu oral health: the status of the Indigenous population of the Anangu Pitjantjatjara lands’ (Aust J Rural Health 2004, 12, 99–103) and presented at the 2001 National Rural Health Conference, Canberra.

Sharan Ermel

Sharan Ermel has over 20 years’ nursing experience, with the past six years in the emergency department at Bendigo Health. She joined the Collaborative Health Education and Research Centre at Bendigo Health in 2004, and has since contributed to a variety of projects, education and research activities. Through her previous role with the Victorian Stroke Clinical Network, Sharan facilitated the development and introduction of the stroke thrombolysis protocol at Bendigo Health, and led the local collaborative Emergency Clinical Network transient ischaemic attack management and secondary stroke prevention in the emergency setting project. Sharan has since undertaken a concurrent role as the Victorian Stroke Telemedicine project coordinator role at Bendigo Health. In 2011 she commenced work as a project officer on the Allied Health Assistant Remote Supervision Workforce Project which was a partnership between Bendigo Health and two rural health agencies. More recently Sharan has continued work in the allied health assistant arena as she is one of the cluster coordinators for the Department of Health initiated Allied Health Assistant Implementation Program in rural and regional areas.

Veronica Fil

Veronica Fil has an educational background in labour economics and public finance. She began her career at Commonwealth Treasury, specialising in labour market and social policy. Despite the intensive and rewarding work environment, Veronica eventually moved to Melbourne in search of good coffee and nightlife.

Working in the Melbourne branch of the Productivity Commission, Veronica played a key role in the production of the first Indigenous Expenditure Report—a project auspiced by COAG to measure the amount of public funding spent annually on Indigenous-specific programs. She also produced sections of the Overcoming Indigenous Disadvantage report, focusing on health, welfare, and labour market outcomes.

Veronica moved to Rural Workforce Agency Victoria (RWAV) in 2011—a not-for-profit organisation working with communities that have under-serviced health needs. Here, she divides her time between the RWAV Policy and Research team (working on health workforce policy and advocacy), and RWAV’s commercial subsidiary, Primary Health Planning Services (PHPS).

In 2012, PHPS were contracted by Health Workforce Australia to undertake research into the GP procedural workforce as part of their 2012–13 research program. ‘Future of the GP procedural workforce in rural Victoria’ presents some of the key findings that came out of this project.

Veronica is also a professional writer and freelance consultant.

Karin Fisher

Karin Fisher is a Tamworth-based research academic at the University Department of Rural Health, University of Newcastle, and Adjunct Senior Lecturer at University of New England School of Health and Rural Medicine. Karin has been involved in a number of research projects that used both quantitative and qualitative research designs since receiving her Doctorate in 2008. Her PhD consisted of a mixed methodology that involved quantitative analysis of surveillance data, as well as analysis of qualitative individual interviews using grounded theory. Karin’s Masters thesis consisted of a qualitative study using grounded theory methodology. She has authored a number of peer-reviewed journal articles plus refereed and non-refereed research-based national and international conference papers. Karin has also supervised PhD students as well as health service staff who have undertaken research at their workplace. Her current research interests include health workforce, primary health care and public health issues.

Marea Fittock

Marea Fittock is the Northern Territory (NT) Coordinator of the NT Rheumatic Heart Disease (RHD) Control Program. She has a background working as a
remote area nurse for over 16 years in remote Indigenous communities across the NT, but spent most of her time in Borroloola in the Gulf of Carpentaria managing the local health service. Marea has always worked in health areas specific to improving Indigenous health outcomes across the NT. Some of those areas are: public health nurse roles with the NT Preventable Chronic Disease Program; and professional practice nurse with the NT quality and safety unit which applied improving administrative and primary health care systems in the health service settings. In recent times Marea has worked on a project with Menzies School of Health research organisation for three years as coordinator of a RHD continuous quality improvement project aimed at increasing the four-weekly secondary prophylaxis prevalence rates for rheumatic fever and RHD patients in six sites across the NT. Marea has been the Coordinator of the NT RHD Control Program for three years and is committed and encouraged to support the SA RHD Control Program with the development of their program.

Les Fitzgerald

Les Fitzgerald is the Head of the Department of Rural Nursing and Midwifery in the La Trobe Rural Health School with campuses at Albury/Wodonga, Bendigo, Mildura and Shepparton in Victoria, Australia. His teaching and research is focused on eLearning, evidence-based practice and clinical education to advance the practice of nurses in the acute care setting, as is his work on the experience of men in nursing and midwifery and ethics of love and human caring. Les is currently working with higher degree students on the impact of workplace education on clinical practice outcomes, the influence of communities of professional practice on clinical performance of nurses and the role of men in birth suite. He is interested in transformation research that focuses on innovative models of service delivery and clinical practice change with current projects on interdisciplinary health system education, implementation of a nurse practitioner aged care link model of service delivery. He has and continues to support the development of a range of online blended delivery curricula using new technologies as well as examining the phenomena of love and human caring for nurses.

Lisa Fitzgerald

Lisa Fitzgerald is a registered dental therapist and has worked in the oral health field for more than 19 years. Lisa has a love for oral health promotion which has seen her take on the role of Hunter New England Local Health District NSW Oral Health Promotion Coordinator permanently six years ago.

Lisa has an enthusiasm for encouraging the integration of oral health into the general health and wellbeing of the community by being involved in many community-based health initiatives. She enjoys providing oral health professional development to many health professionals as well as fostering the oral health message to students.

Lisa is based in Tamworth, NSW, but has worked in many small rural communities throughout her career including working extensively with the Aboriginal population across the area.

The Health Tums, Healthy Gums program employs novel approaches to providing health messages to vulnerable groups. Lisa and Jodie are delighted to share their learnings from this collaborative nutrition and oral health program which can be applied to a variety of settings, with the model also adaptable to programs with integrated health education.

Lesley Fitzpatrick

Dr Lesley Fitzpatrick is the Chief Executive of the Australian Rural Leadership Foundation. Lesley has a commitment to building sustainable and resilient communities, industries and services in rural, regional and remote Australia.

Lesley has worked in many sectors, specialising particularly in human services and health, leadership, philanthropy, and in developing individuals and programs that can work effectively in regional, rural and remote contexts. Her early career experiences in regional and rural community development and capacity building have shaped her understanding and approach to her work.

Lesley's academic background as a sociologist underpins her professional practice which draws on her understanding of the impacts of political and social systems, community sustainability and resilience, cultural values, and their inter-relationship. She has significant experience in leading organisations, senior management, corporate governance, strategic planning, research, policy development and advocacy. This broad platform informs her approach to developing effective strategies to address complex issues through intersectoral collaboration, addressing structural and policy issues, and developing and enhancing programs that contribute to the resilience of rural, regional and remote Australia.

Lesley has a Doctorate and a Masters degree in Sociology. She is a fellow of the Sir Gustav Nossal International Fellowship for Leadership in Health Reform and was a state finalist in the Telstra Business Women’s Awards. She is the winner of an Innovation Award from the Australian Institute of Management and a member of the Australian Institute of Company Directors. Lesley has worked in many sectors, specialising particularly in human services and health, leadership, philanthropy, and in developing individuals and programs that can work effectively in regional, rural and remote contexts. Her early career experiences in regional and rural community development and capacity building have shaped her understanding and approach to her work.

Martin Fox

Martin Fox is the Psychologist with the Adult Mental Health team of Tweed Byron Mental Health Service based in Mullumbimby. He has experience in crisis intervention, rehabilitation, and psychiatric case management. Martin was recruited to Byron Bay to
initiate the Acute Mental Health Service for the Area. Currently he sees people in a non-acute setting for one-on-one therapy and co-facilitates the Beginners' Guide to Anxiety Management. He has wide-ranging professional interests including treating men and outreach to traditionally under-serviced populations.

Karen Francis
Professor Karen Francis is the head of the School of Nursing, Midwifery and Indigenous Health, Charles Sturt University. She is recognised nationally and internationally for her contribution to the development of the discipline of rural nursing. Her research and publication agendas have focused on exploring the realities of nursing in rural environments, health workforce, preparation for practice, emergent contexts of practice, and rural population health issues. Karen contributes to the development of nursing, in particular rural nursing, through her role as Chair of the Australian College of Nursing Rural Nurses and Midwives.

Sally Francis
Sally Francis is Arts Coordinator, Arts in Health at FMC, Flinders Medical Centre (SA), which integrates arts into the daily life of the hospital and enhances FMC's role as a leading health-promoting hospital. Arts in Health at FMC has been operating since 1996 and is one of the largest and most well-regarded hospital-based arts in health programs in Australia, known nationally and internationally for high quality and innovative programming.

Sally trained as a nurse in the UK and has a background in community health, visual arts practice and arts management. She is a keen advocate for developing state-based government support for arts in health and promotes the inclusion of hospital-based arts in health programs throughout hospitals in Australia. She has presented widely at conferences both in Australia and overseas.

She is a Director of the national Arts and Health Foundation, member of the Steering Committee of the Womens’ and Childrens’ Hospital Arts in Health program (Adelaide) and member of the Global Alliance for Arts in Health (US). In 2007 she was awarded a Churchill Fellowship to travel to the UK and Ireland to study hospital-based arts in health programs. In 2008 she assisted SA Health with the development of the South Australian Arts and Health Partnership Agreement and is currently working on the development of the national Arts in Health policy framework, led by SA Health and Arts SA.

Peter Fuelling
Peter Fuelling is from the Cunningham Centre within Queensland Health. He is the Principal Program Coordinator responsible for the Allied Health New Starter project and the Allied Health Rural Development Pathway. The Cunningham Centre provides a wide range of high quality innovative programs that meet the training and educational needs of rural and remote doctors, nurses, allied health professionals and Aboriginal and Torres Strait Islander health workers. Its purpose is to develop the capabilities of the rural and remote health workforce evidenced by positive health care outcomes in rural and remote areas of Queensland.

Christian Fulton
Christian Fulton has a background in management of the sales and marketing teams for a national marketing company, and has experience in training, team management and client liaison for the commercial sector.

Since October 2010, Christian has worked as a researcher for RWAV, undertaking extensive data analysis, project planning and management, and scripting of market research surveys. A major focus of his work at RWAV has been around workforce data and more specifically the National Minimum Data Set since 2010 has achieved its highest participation results in over 10 years.

Over the past years Christian has been involved in other research projects within the health care industry, including working with Medicare Locals, both state-wide and nationally.

Christian is an associate member of AMSRS (Australian Market and Social Research Society) and will further consolidate this into a full membership in future years.

Susan Furness
Susan Furness is a senior lecturer and Senior Profession Mentor for the Bachelor of Health Science and Master of Paramedic Practice course within the La Trobe Rural Health School, La Trobe University. She also holds the position of Regional Incident Controller for La Trobe University, and is central to the conceptualisation and implementation of university-wide student support and safety programs.

Susan has current and extensive operational and management experience in the area of paramedicine and emergency response, and maintains the qualification of operational Mobile Intensive Care Ambulance Paramedic with Ambulance Victoria. She has a strong interest in mentoring, resilience and professional development for both undergraduate paramedic students and qualified paramedics, and has completed a Masters dissertation exploring paramedic academic perceptions of mentoring.

In addition to her interest in mentoring and paramedic resilience, Susan has commenced research into the use of narrative in paramedicine, and the link between storytelling in the pre-hospital environment and resilience, cultural transference and education. Susan sees the concept of community paramedicine and the development of future-ready rural and regional paramedics of particular importance in Australia, and
consistently seeks involvement in projects related to this field.

Katherine Galligan
Katherine Galligan is a physiotherapist and the Community Rehabilitation Project Officer at the Mt Isa Centre for Rural and Remote Health, James Cook University. She manages the North West Community Rehab project which delivers a periodic neurological rehabilitation service in north-west Queensland, supported by students on clinical placement. After graduating from university, Katherine was keen for an adventure and moved bush to work as a remote area physio. It was here she developed an interest in remote health and rehabilitation, both of which are combined in her current role.

Francesca Garnett
Francesca Garnett is a sixth year medicine/arts and public health student studying at UNSW. Francesca is a former co-Chair of the NRHSN and the 2011 Westpac RDA Medical Student of the Year. She is currently enjoying her clinical training in Wagga Wagga in rural NSW and has continued her role on the NRHSN through the community and advocacy portfolio. Francesca has a particular interest in Indigenous health, and is pursuing this through ongoing placement at Riverina Medical and Dental Aboriginal Corporation. She has also been on remote placements in Quilpie, in south-east Queensland, and with Katherine West health service. Outside of health, Francesca enjoys running, hiking and singing with the Wagga Cantelina singers.

Susan Gauld
Susan Gauld has a Bachelor of Occupational Therapy from the University of Queensland, and has had extensive experience in community-based practice. She has worked as Rehabilitation Coordinator (OT) with the Acquired Brain Injury Outreach Service (ABIOS) in Queensland for the past 17 years, a community-based rehabilitation and case management service for adults with acquired brain injury. Postgraduate study in the area of remote health led to a three-year research project working with two remote Aboriginal communities, 2006–2009. This has continued to inform and influence further service developments in improving outcomes for Aboriginal and Torres Strait Islander people with brain injury, their families and communities. One major outcome has been a specific brain injury training program for Aboriginal and Torres Strait Islander health workers, developed in collaboration with health workers from a community in southern Queensland.

Mandy Gilbert
Mandy Gilbert is the Community Kitchen Project coordinator.

After moving with her family to the Dungog Shire in 1999, Mandy become involved in the Community Centre in 2001 because ‘I wanted to give back to the organisation that had helped me and my family when we needed a hand’.

Mandy started as a volunteer and has been involved in many facets of the community centres programs and services in this time. Most recently Mandy has been involved in the development and continued growth and success of the Dungog Community Kitchen. This program started in 2010 in response to the high number of community members seeking financial assistance for food and essentials.

The Community Kitchen concept is simple: bring people together over the creation of good, cheap, healthy meals and watch the learning, sharing and confidence grow.

‘This is our third year and we have packed so much in but the best thing of all is witnessing the ladies confidence grow and to see the healthy choices being made by them for their families’.

Mandy is passionate about giving people the support, skills and information to allow them to make the best decisions and choices for themselves and their families, and the community kitchen gives her the opportunity to encourage and support her fellow community members to do this.

Christine Giles
Christine Giles is a senior executive with considerable experience leading and managing rural and remote health services. She is passionate about the bush and achieving good health outcomes for the people and communities who share her love of the rural and remote lifestyle.

Chris entered the health arena as a nurse, then moved to midwifery working both as a clinical midwife and as a middle manager. Since the 1990s Chris has held a number of executive roles in health care organisations in Western Australia, Victoria and Queensland. She has also completed a Graduate Diploma in Health Management with the University of New England.

Recently Chris has commenced as the Chief Executive Officer of Portland District Health in south-west Victoria. Prior to this she spent three years living in the Torres Strait working as a district CEO for Queensland Health. During her three years in the Torres Strait, Chris has had the privilege of working with many groups and individuals who seek to find solutions to the health and welfare issues facing these remote communities.

Chris continues to mentor and work with individuals who seek to be health services leaders in their communities—strong individuals who will challenge corruption and misuse of power and manage for the benefits of the whole community.
Denis Ginnivan

Denis Ginnivan is a part-time policy consultant with the National Rural Health Alliance. He is currently working on a Commonwealth-funded project focusing on strategies to ensure rural and remote Australians obtain equity and access to the National Disability Insurance Scheme.

He recently completed an Alliance position paper on brain injury rehabilitation in rural and remote Australia, which describes the current inequities, and the variability of capacity between states and in availability of resources which are determined by how an injury is incurred. He is confident that the proposed National Injury Insurance Scheme will create opportunities for improved equity and access.

Since 1992, he has been the Director of the South West Brain Injury Rehabilitation Service. This service, based at Albury, covers a large rural/remote region of NSW, providing post-hospital brain injury rehabilitation for people who have had a traumatic brain injury. He has a leadership role as the co-Chair of the state-wide NSW Brain Injury Rehabilitation Program Directorate.

He is an Adjunct Associate Professor at Charles Sturt University, a role which reflects the importance of the collaborative rural brain injury rehabilitation research strategy. He is a foundation member of the NSW Lifetime Care and Support Authority Advisory Council.

Previously, when with the Rural Development Centre at the University of New England, Denis travelled to North America on a Churchill Scholarship to investigate ways, such as farm debt mediation, to support farming communities in serious financial and personal difficulties. He also worked as a rural counsellor in the Wimmera and Mallee regions of Victoria.

Denis has always lived in rural Australia, and is passionate about community, and creating opportunities for young people. He and Helen reside on a small farm near Yackandandah, which has the best folk festival in Australia. They raised their three daughters there.

Ian Goater

Dr Ian Goater, MBBS Melbourne University 1976, MPH Monash University 1989, Fellowship Australasian College of Occupational Medicine 1989. Clinically Ian initially worked in general practice and later as an occupational physician before becoming a rural general practitioner in 1999. He has been the Academic Coordinator, Bega Node, Rural Clinical School, ANU College of Medicine, Biology and Environment since 2004.

Sarah Goater

Dr Sarah Goater is an environmental scientist with 10 years’ multidisciplinary research and professional experience in environmental-related fields. Employed with the Minerals Industry Safety and Health Centre since early 2011, Sarah’s work has largely focused on mining-related health and safety collaborative research. Complimentary to this work, Sarah also maintains a position with the International Water Centre (IWC) as Masters Project Coordinator, facilitating the delivery of peer-reviewed, industry-relevant research projects.

Christine Goonan

Christine Goonan is part of the Youth and Family Education Resources (YFER) team, and is one of two program managers for the Core of Life (COL) program throughout Australia. Christine oversees the implementation of the COL program in Victoria, Tasmania, South Australia and the Northern Territory, and supports COL facilitators as they journey from the early experiences of being a newly-trained facilitator through to becoming experienced and dynamic youth education COL facilitators. Christine also provides COL youth education sessions to young people throughout Australia and has been doing so since the early days of the program’s inception in Victoria during the early 2000s.

Christine has an extensive and diverse history working with young people including working at the Royal Children’s Hospital in Melbourne, Barwon Health, Geelong, and with the Department of Human Services and Department of Education School Nursing Program. Christine is passionate about supporting all young people to have access to information related to pregnancy, birthing, infant feeding and early parenting and shall continue to strive to encourage others working with young people to be just as, or even more, enthused and passionate.

Gillian Gould

Dr Gillian Gould is a practising GP, a tobacco treatment specialist and an adjunct senior lecturer at Southern Cross University. She is currently on the executive committee of the Australian Association of Smoking Cessation Professionals. Gillian has over 10 years’ experience in smoking cessation and is currently undertaking a PhD on how to develop salient anti-tobacco messages for Indigenous smokers, with a focus on maternal smoking. She runs a Quit Clinic in Coffs Harbour. She previously worked with the UNSW Rural Clinical School as Head of Campus and senior research fellow, and was medical director of the ‘No Smokes North Coast’ Indigenous Tobacco Control Initiative from 2010–12.

She has been actively engaged with her local Indigenous community since 2005. Achievements include the collaborative research and development of initiatives for smoking cessation such as Give Up The Smokes Aboriginal Quit Café (smoking cessation groups), training of health professionals in cessation interventions for Indigenous smokers, a DVD for Indigenous smoking cessation, schools programs and maternal strategies.
Apart from her medical degree, Gillian holds a Graduate Diploma and a Master of Arts in Experiential and Creative Arts Therapy and a Diploma in Drama. She is a keen supporter of arts in health approaches to public health. She writes poetry, paints and is interested in the use of video for conveying health messages. She won a Royal Australian College of General Practitioners (RACGP) and Australian Primary Health Care Research Institute Indigenous health award in 2008, the Toowoomba Hospital Foundation and the Cunningham Centre ‘Infront Outback’ Research Award for Rural and Remote Health in 2009, and was co-awarded the 2010 Standing Strong Together Award from the National Aboriginal and Torres Strait Islander Faculty of the RACGP. She currently holds a National Health and Medical Research Council and National Heart Foundation Indigenous Postgraduate Research Training Scholarship.

Judy Gower

Judy Gower has worked at Queensland’s Discovery Coast Community Health Service as a family support worker and a community development officer. Judy has lived and worked in the small seaside community for the past 25 years and has seen this community of Agnes Water grow from just seven permanent families to a thriving town of approximately 2500 people. Judy was instrumental in lobbying government for Agnes Water’s first primary school and worked at the Agnes Water School for ten years. She was the president of the Parents and Citizens Association, raising much needed funds for the school. Judy also developed a number of sporting groups to assist families and to address community cohesiveness. Her passion for her local area and the people who live there has driven recent initiatives such as the Agnes Water 1770 Men’s Shed and a program called Talk and Tucker.

Judy has a Bachelor of Community Welfare and is in the final phases of a social work degree. She has a Diploma of Community Education and is a qualified parenting practitioner who guides parents in modifying children’s and teenager’s behaviours. Judy runs workshops and group sessions to address community issues and concerns and to support individuals, couples and families.

Judy has mastered the art of reproduction by contributing six adult children and (to date) 11 grandchildren to the Australian population. Judy believes that families are of the utmost importance and are the very foundation for building solid well-grounded adults.

Maggie Grant

Maggie Grant is Senior Lecturer, Rural and Remote Health, and Director of Students, School of Medicine and Dentistry, James Cook University (JCU).

Maggie has had a long interest in social justice, especially in health care and in the health of under-serviced populations. This interest developed in the 13 years she worked for Aboriginal Community Controlled Health Services in the Kimberly. Maggie became interested in teaching population health and prevention strategies, particularly in primary care settings to health professionals. Her interest in racism in health care evolved particularly with the JCU action research project ‘Bulletproofing Indigenous Health Students and Staff Against Racism’ and in JCU Faculty of Medicine, Health and Molecular Sciences activity that promotes cultural safety and promotes effective management of racism in class and health care settings.

She has recently become involved in the STAR Project, initiated by JCU Health Faculty staff and students. STAR stands for ‘Stand Together Against Racism’ in health. This project aims to focus attention onto racism in health care. The STAR Project is founded on the observation that most health staff abhor racism, but often feel constrained to deal with it when they see it.

Josephine Gwynn

Josephine Gwynn has had a long involvement in Aboriginal health beginning with living for a few years in East Arnhem Land in the Northern Territory. Her original background was in occupational therapy with a strong focus on rural and community practice, however around 12 years ago she migrated into public health and established and directed the Many Rivers Diabetes Prevention Program (MRDPP) from 2001 onwards. The MRDPP is a program of research and health promotion and is a partnership between the University of Newcastle and two Aboriginal Medical Services (AMS) on the north coast of NSW—Biripi AMS in Taree and Durri AMS in Kempsey. She now co-manages the project with Nicole Turner who is based at Durri AMS, and is Manager for Research and Evaluation. In partnership with the participating communities, Jo establishes and implements the research activities of the MRDPP. Her PhD was on the food intake and physical activity of rural NSW Aboriginal and Torres Strait Islander children, and she has published in these fields. Jo has been involved in the establishment of the Aboriginal Community Controlled Governance structures for the Many Rivers Project and also for the Centre for Rural and Remote Mental Health. Current activities include: the co-supervision of Aboriginal medical students undertaking a research year in rural NSW; the writing-up of results from a large NHMRC project (some of which are being presented here); the conduct of a range of health promotion initiatives on healthy foods and physical activity participation for rural Aboriginal children; and a photovoice project with rural Aboriginal children.

Christine Hallinan

Christine Hallinan has a research objective to provide rich and complex evaluations relating to the provision of care in general practice. The research involves an exploration of context on processes of care, and incorporates an examination of the organisational, structural and political milieus of general practice. Specifically, she is interested in the impact of policy.
instruments (such as general practice incentives) on
general practitioner behaviour and practice.

Christine has a background in statistics (Monash) and in
nursing (Lincoln Institute of Health Sciences), and has
completed a Master of Public Health with a major in
program/economic evaluation at the University of
Melbourne. She is currently a PhD student at the General
Practice and Primary Health Care Academic Centre at the
University of Melbourne. Last year Christine was awarded
an Australian Postgraduate Award (APA)—this award
enabled her to undertake PhD studies full time.

Christine’s home is in the Wimmera wheatbelt and she is
married to a fifth generation broad acre farmer. The crops
they grow include wheat, barley, lentils, chickpeas and
canola. They have four children between the ages of 19
and 5—she calls her two boys ‘the bookends’. Over the
past four years Christine has combined life in rural
Victoria with weekly overnight stays in Melbourne. This
has not only given her a greater appreciation of the rural
life she enjoys in the Wimmera, but also enabled her to
value the opportunities she has in academia, as well as the
many fabulous moments in the car listening to ABC
Classic FM. The research Christine is presenting at the
conference is a result of a microfinance grant received from
the Addressing Disadvantage and Inequity of
Education and Health (ADEIH) research theme within the
University of Ballarat.

Meredith Harper
Meredith Harper, DipHSc (Nursing), DipHSc
(Midwifery), BHSc (Nursing), MNursing, is the Palliative
Care Clinical Nurse Consultant for the Peel and Tablelands Clusters of the Hunter New England Local
Health District, based at Tamworth Community Health
Service. Meredith has held this position for the past five
years and responsibilities include providing clinical
leadership in the provision of palliative care by way of
consultation, liaison, education and support to health
professionals, palliative care clients, their families and
general community members.

On a background of predominantly rural and remote
community and hospital nursing and midwifery over the
last 25 years, Meredith found her place in nursing when
she accepted a position as palliative care clinical nurse
specialist in a rural community health setting. Now as
clinical nurse consultant, in response to the challenge of
supporting provision of palliative care, collaboration with
members of the health care team in developing accessible
and flexible care strategies and resources is a focus of
genuine professional interest.

Hazel Harries-Jones
Hazel Harries-Jones is Senior Lecturer in Radiography,
University of Newcastle Department of Rural Health
(UoNDRH). Hazel qualified as a radiographer at
Southampton School of Radiography, UK, in June 1976.

She took up her current post based in Tamworth, NSW,
in February 2011.

She has had a wide experience in radiography with
general x-ray, management and teaching positions
throughout the UK. Her previous post was
superintendent radiographer/lead advanced practitioner
in the emergency department at Poole Hospital NHS
Trust, which houses a major trauma centre on the south
coast of England.

She gained a Postgraduate Certificate in Clinical
Reporting in 2000 and led one of the first teams to
provide an independent radiographer reporting service in
the UK. She has lectured and been an invited speaker at
conferences both nationally and internationally during
her career.

She was council member to UK Society and College of
Radiographers from 2000 to 2007 and held the position
of President of the UK Society and College of
Radiographers from 2005 to 2006. She was also the UK
council member for the International Society of
Radiographers and Radiologic Technologists from 2003
to 2007. Hazel was awarded fellowship of the College of
Radiographers in 2006.

Her special interests include advanced practice,
radiographer reporting and education of student
radiographers in rural areas, interprofessional learning,
and supporting the role extension of nurses and GPs as
remote x-ray operators. She is also keen to see
radiographers expand their roles outside current
boundaries in order to help improve services to patients
in rural communities.

She is currently the radiographer representative to
SARRAH.

Julie Hassard
Julie Hassard is the National Programs Manager at Breast
Cancer Network Australia (BCNA), a consumer-based
organisation comprising over 70 000 members affected by
breast cancer. BCNA works to ensure Australians with
breast cancer receive the very best information, care and
support possible.

Over the past 20 years, Julie has managed a range of
national consumer engagement, advocacy, support and
capacity building programs for breast cancer consumers.
She has also managed state-based public health cancer
prevention programs and service delivery initiatives for
cancer consumers. Through her consulting business, she
assisted local, state and national health organisations with
strategic planning, capacity building and program
development and evaluation.

Chris Hawke
Chris Hawke is an experienced counsellor who has
worked with the family workers and local leadership in
Santa Teresa to provide relationship support (counselling)
over the past five years for individuals and families in crisis as well as working towards early intervention, prevention, and long term change. Chris lives in Santa Teresa during the week to help build and strengthen connections with the local community. In his work in Santa Teresa he works closely with a female counsellor to maximise the applicability of their work to all members of the community.

Katherine Hawkins

Katherine Hawkins has been with the Veterans and Veterans Families Counselling Service (VVCS) for two years as Deputy Director and is a registered psychologist who has previously worked in public health and correctional service settings. She has a particular interest in empowering families and communities as a preventative mental health strategy.

The VVCS provides counselling and group programs to Australian veterans, peacekeepers and their families. It is a specialised, free and confidential Australia-wide service. VVCS staff are qualified psychologists or social workers with experience in working with veterans, peacekeepers and their families. They can provide a wide range of treatments and programs for war and service-related mental health conditions including post traumatic stress disorder (PTSD).

Andrew Heath

Andrew Heath is currently the Primary Health Manager East Pilbara with WA Country Health Service, and is also a co-lead of the recently-launched WA Disability Health Network. Originally qualifying as a social worker in 1977, Andrew’s career has been largely spent in the health and human services sector in remote locations in Australia. Andrew holds a Master of Social Work degree from the University of Melbourne, with a particular emphasis on program evaluation and disability. The project that Andrew is presenting, Pilbara Healthy Kids Initiative, is the result of four years’ dedicated work by teams of allied health and community nursing staff in Newman and Hedland conducting outreach work into the Western Desert communities in the Pilbara region. The Pilbara Healthy Kids Initiative has been funded through a combination of Commonwealth and state funds and industry involvement, and is a multi-agency approach that includes the key health service providers in the region—representing the ideal partnership model in seeking better health outcomes for Aboriginal people in the Pilbara.

Fiona Heenan

Fiona Heenan has been the Director Primary Care at Heywood Rural Health, a small rural health service in southwest Victoria, since August 2009. The role encompasses the management of primary care services within the local district, in addition to special DoHA program funding that outreaches from Heywood to other agencies across the small rural communities of the LGA Glenelg Shire. The Rural Primary Care Services Program has a budget of $650,000 of which HRH has auspiced for the last nine years. This funding will soon be auspiced in the future by the Great South Coast Medicare Local as part of the Commonwealth Primary Healthcare Reforms.

Fiona graduated from the second school of nursing at Deakin University Geelong in 1992 with a Bachelor of Nursing. Fiona was a credentialed diabetes educator for ten years with an employment history including: project managing a Diabetes Best Practice project at Bairnsdale Regional Health Service, East Gippsland; as a clinical nurse consultant—diabetes education, Royal Melbourne Hospital and Broadmeadows Health Service; Manager Diabetes Education Services Southern Health—Monash Medical Centre, Dandenong Hospital and Moorabbin Hospital, Melbourne. Fiona until recently remained an active member of the Australian Diabetes Educator Association (ADEA) having been on the Board of Directors for ADEA for almost four years. Having returned to her home town for love and to start a family, she subsequently worked as a project officer with the local Primary Care Partnership—Southern Grampians Glenelg, for over five years pursuing her keen interest in rural health, Indigenous health and integrated chronic disease management—service coordination. She is currently undertaking a Master of Business (Adelaide University) and has a Bachelor of Nursing, Bachelor of Education, Grad Cert Diabetes Education and Grad Diploma Business (Management) and 23 years’ nursing experience in both Victorian metropolitan and rural areas.

Maryanne Hethorn

Maryanne Hethorn works as a midwife at Moree Plains Health Service (part time) and JHH (casually). Her role as a midwife in Moree includes facilitating ante-natal education sessions for both mainstream and Aboriginal women. She also coordinates the Maternal Fetal Medicine Clinic for high-risk pregnancy. This role includes liaising with MFM services from JHH, rural GP obstetricians, midwives and AMIHS services allied health services such as dieticians, diabetic educators in both Moree and Narrabri. This ensures women identified with a high-risk pregnancy receive appropriate referral and optimum care during their pregnancy and secure, safe birth plans.

Maryanne undertook her general and intensive care training at Royal Newcastle Hospital. Since relocating to Moree in 1989, she has undertaken a Bachelor of Arts (major sociology, UNE) and Diploma of Adult Education and training,(UNE) Diploma of Midwifery (CSU) and Master of Midwifery (UoN). She has worked in various roles from health educator at TAFE, Nursing educator for UDRH (UoN), nursing at the local AMS, hospital recovery unit, general wards, A&E department, AMIHS, immunisation nurse and currently in the maternity unit.

Her interest in midwifery is predominately caring for women from Aboriginal and NES backgrounds. Her belief in sharing evidence-based knowledge to women during their ante-natal period can ensures safe, women-
orientated birthing choices. Maryanne maintains that through enhancement of women’s knowledge, women can become empowered during their ante-natal, intrapartum and post-partum experience. Thus, education is seen as the key to improving birth outcomes and birth experiences in rural maternity units such as Moree.

**Gina Highet**

Gina Highet is the Practice Support Team Leader at the Adelaide Hills Division of General Practice. Gina is a registered nurse whose has a professional background in general practice nursing over the last seven years. She has extensive experience in health assessment nursing, establishing nurse-led chronic disease management clinics and the role of practice nurse manager.

Gina has a commitment to quality primary health care and supporting the general practice team by managing the nursing programs and services delivered to general practices in the Adelaide Hills Division of General Practice region.

Gina is currently involved in the national Diabetes Care Project as the local project lead for the Adelaide Hills Division, and the Department of Veterans Affairs Coordinated Veterans Care Program where she is conducting coordinated patient care for patients on behalf of their GPs. She is the manager of GPCare Health Assessments which provides a health assessment nursing service to local GPs in the area of over 75 years home health assessments and comprehensive medical assessments for residents in residential aged care facilities.

Gina completed a Graduate Certificate in General Practice Nursing in 2010 and is involved in the Nursing in General Practice Leadership program through the Australian Medicare Local Alliance for 2013. Her focus now is to expand the nursing service support to general practices to provide coordinated patient care across all domains and ensure that timely and primary care is maintained.

**Jenny Highlands**

Jenny Highlands has been a Practice Development Officer—Chronic Disease with Hunter New England Local Health District’s Community Health Strategy team for the past five years. Based in Tamworth, NSW, Jenny’s role involves working with primary and community health teams in rural facilities to develop and redesign clinical practice to support the delivery of chronic care across the continuum. Her current focus is on chronic care rehabilitation, diabetes models of care, smoking cessation, telehealth, chronic disease self-management, lifestyle modification and advance care planning.

For the past 17 years, Jenny has worked in rural and remote areas in both NSW and QLD in population health and community health roles ranging from community nutrition, childhood obesity, health promotion, rural primary health, youth suicide, and drugs and alcohol. Jenny has been involved in the development and delivery of training programs and group facilitation workshops in these various roles.

**Richard Hockey**

Richard Hockey is a data analyst for the Australian Longitudinal Study on Women’s Health in the School of Population Health at the University of Queensland. Previously he has been involved in injury research at the Queensland Injury Surveillance Unit and the epidemiology of cardiovascular disease at the University of WA. His research interests include statistical methods for longitudinal studies and other epidemiological issues and the epidemiology of women’s health, cardiovascular disease and injury. Richard joined ALSWH in 2004.

**Suzanne Hodgkin**

Dr Suzanne Hodgkin is a senior lecturer in social work and social policy in the La Trobe Rural Health School, La Trobe University, Albury-Wodonga campus. She lectures in social work research, practice skills, and law rights and ethics. Prior to working as an academic, she was a senior manager in the Department of Human Services, Hume Region. Her Masters research explored the problem of recruitment and retention of frontline rural child protection staff in Victoria.

Suzanne graduated with a PhD in social work and social policy in 2006. She has published findings from her doctoral research in several ERA ranked journals, such as Australian Social Work, Australian Feminist Studies and Australasian Journal on Ageing. She has also disseminated findings to several international conferences and was invited as a plenary speaker for the European Social Capital and Social Trust Conference, CINEFOGO network, in Denmark in 2009. She was recently invited to contribute to an international text, Social Capital: Theory, Measurement, and Outcomes.

During 2009–2010, Suzanne worked as a member of a major consultancy with the John Richards Initiative on a workforce mapping project into rural public sector aged care services. The design for this research has been published in the International Journal of Multiple Research Approaches. Suzanne, considered an expert in mixed methods research, has had her research design work published in the Journal of Mixed Method Research and in mixed methods research texts.

Suzanne is currently working on the following funded research projects: population ageing and its effect upon intergenerational care; and an ARC Linkages project that explores the relationship between rural living and wellness for older people. At this conference she is presenting findings from a current project funded by the Department of Health Victoria, which explores the retention of older health care workers in rural Victoria.
Kristi Holloway

Kristi Holloway is a lecturer and PhD candidate with Curtin University and a registered nurse. Kristi has clinical and research experience in rural and regional areas. She completed her Honours research on pain management in aged care and is completing a PhD focusing on chronic disease self-management in rural areas. Kristi has been involved in a number of national research projects, including the project manager for the recently completed Guidelines for a Palliative Approach for Aged Care in the Community Setting, and the EBPRAC Pain Management Project, both funded by the Department of Health and Ageing. Kristi also has experience as an educator at a tertiary and vocational level, providing education to people of various health backgrounds. She is passionate about rural health and the equalities of service delivery in these areas.

Mary Holmes

Mary Holmes is a founder member of the community-run health centre Health In Our Hands, which has been serving the Whyalla community for 10 years and is based in the Whyalla Hospital. She is secretary and an executive committee member of the centre management as well as a volunteer on a day-to-day basis. Mary's passion is in chronic condition self-management so the main focus of her work there is promoting, leading and training the Stanford Self-Management Programs (chronic disease, chronic pain and diabetes) as a peer leader in public courses, as a Master Trainer training leaders (health professional and volunteers) around the country and last year she went to Stanford USA to train as a T-Trainer enabling her to train Master Trainers.

Mary is also a trained co-facilitator for the American online self-management and diabetes self-management courses for the American National Council on Ageing. She also leads various activities at Health In Our Hands including tai chi and exercise programs and a walking group—all an important part of self-management—as well as helping organising the day-to-day activities and the welfare of the volunteers.

Mary is a community representative on the Health Advisory Council of the Whyalla Hospital.

As a retired person, Mary enjoys spending time away with her husband in their caravan. Family, painting and reading take up the rest of her spare time.

Paul Holmes

Paul Holmes, now retired, works as a volunteer at the Health In Our Hands centre in Whyalla, rural South Australia. He has been with this organisation since its inception in 2002 as part of the Federal Sharing Health Project and is currently its chairperson.

Paul has a deep interest in the concept of self-management and in particular how it can be implemented and utilised by consumer community groups such as Health In Our Hands. Paul has undertaken a range of training in order to pursue his interest, originally training in 2002 as a course leader in the Stanford (California) Chronic Disease Self-Management Program. He progressed on to become a Master Trainer, training at Stanford University in 2004. The next few years were spent training leaders, both community members and health professionals in the program for a number of organisations including Health SA and other interstate health services. In 2012 Paul took the final step in the Stanford CDSMP training ladder when he returned to Stanford University and trained as a T-Trainer and as such is now able to train leaders and trainers at all levels.

In his spare time Paul likes to travel with his wife Mary in their caravan and he has two major hobbies—photography and astronomy.

Having no medical qualifications at all, Paul’s working life was in the steel industry and engineering; this period of his life has been one long learning curve. It has been a very interesting time where he has seen firsthand how consumers such as himself can build networks and partnerships with health services and become so empowered that service provision for consumers by consumers is now a reality.

Mary-Jane Honner

Mary-Jane Honner is currently Manager of Health Services Programs for Royal Flying Doctor Service Central Operations based in Adelaide, accountable for primary health care programs, and assists in the development of future primary health care services.

Mary trained as a registered nurse working predominantly in theatre. She spent a number of years living and working in WA’s north-west. She worked in the community and aged care sector as program coordinator and manager of services to remote and rural towns and communities across both the Kimberley and Pilbara. Prior to leaving WA in 2011, Mary was operations manager of Port Hedland Regional Health Service.

Mary Hoodless

Mary Hoodless is a consultant with particular expertise in population health and strategic planning, workforce capability and redesign, research, and vocational and higher education. Mary embarked on a career as a consultant following 16 years in executive management which included research and education portfolios.

Mary contributes her expertise to the opportunities working in a multipurpose service in rural north-east Victoria. During that time she worked as an executive manager undertaking a range of responsibilities which included health planning, service development and evaluation, community engagement, leading significant quality improvement projects, managing the organisation’s registered training organisation, and
holding a part-time rural academic research position with the University of Melbourne.

Mary has a particular interest in rural health planning based on local, evidence and policy informed needs, which in turn informs strategic planning, services, workforce capability and organisational development. Her other interests include improving rural research capability to inform policy and practice, knowledge transition and local learning opportunities. She lectures in the Bachelor of Applied Management run by Wodonga TAFE in partnership with the University of Ballarat and recently commenced a Graduate Certificate in Tertiary Education.

Her career highlights include: a range of publications in peer-reviewed journals; graduating with a research Masters; President of Victorian Quality Improvement of Community Services Association (QICSA) Council (3 years); honorary appointment as a fellow within the faculty of Medicine, Dentistry and Health Sciences, University Of Melbourne; and the opportunity to live, work, love and learn in a beautiful part of rural Australia. Mary and her husband share responsibility for an embryo transfer beef enterprise on their property in the foothills of the Snowy Mountains.

Amanda Horne
Amanda Horne is a dietitian with the Hunter New England Local Health District in NSW. She graduated from the University of Newcastle in 2007 and over the past four years has been involved with both hospital and community services. Currently she is employed within the field of aged care, funded by the Home and Community Care (HACC) program. In 2010, Amanda commenced a three-year contract funded by the Commonwealth Regional Primary Health Service as the Dungog Eat Well (DEW) dietitian. The position provided an outreach dietetic service to the small rural town of Dungog and its surrounding communities, as well as community nutrition projects and community development. As a part of this position Amanda enjoyed facing the many challenges often encountered when providing a service to a rural population, with her work focusing strongly on increasing community capacity building within the Dungog Local Government Area.

Guinevere Hunt
Guinevere Hunt is a team leader in the Disability and Mental Health Section of the Australian Bureau of Statistics, working with a range of clients to support the development, analysis and use of ABS population mental health data. The ABS conducts three major surveys that provide data in this field: the National Health Survey; the National Survey of Mental Health and Wellbeing; and the Survey of Disability, Ageing and Carers. Guinevere’s role is to keep across contemporary and emerging mental health issues, and to provide advice on the inclusion of mental health topics in these surveys and other ABS collections, so that a broader range of characteristics of and outcomes for people with a mental health condition can be examined and added to existing research in the field. Guinevere sits on a number of national mental health information committees and reference groups in a statistical advisory capacity, and manages the provision of ABS mental health data to national and international government, research and community clients.

Rafat Hussain
Professor Rafat Hussain is a public health clinician with a PhD in Epidemiology and Population Health. She is the Deputy Head of School (Research) in the School of Rural Medicine at the University of New England. For the past 20 years, she has been involved in large-scale research projects, including both quantitative and qualitative study designs, funded by a range of international and national agencies including the National Institutes of Health (USA), the Harvard Institute for International Development (Harvard University), Family Health International (USA), Australian Research Council, WA Population Health, and the UNE-led Collaborative Research Network on Mental Health and Wellbeing in Rural and Regional Communities funded by the Australian Government. She has worked as a consultant to the World Bank, UNICEF, Family Health International, and the Australian Department of Veterans’ Affairs.

She has published extensively in international journals and has over 1000 citations for research papers (Google Scholar, January 2013). She has served on the Commonwealth panel of advisors for RQF (predecessor to the ERA), and has been a grant reviewer for NHMRC, National Science Foundation (USA), Queensland Health, Victorian Health Promotion Foundation and other agencies. She is a regular reviewer for a large number of highly ranked journals in health and medicine. Her research interests include disabilities, health and wellbeing including physical, mental and sexual health, rural health and research methodologies.

Salma Ismail
Since graduating as an optometrist, Salma Ismail worked in private practice for four years and then moved into public health optometry with Brien Holden Vision Institute, Public Health Division. Salma has worked in the NSW Aboriginal Program as a community optometrist and then moved into international project work. Salma’s current job role is as an education development officer working primarily on the development and implementation of Aboriginal eye care education programs. Salma recently graduated in Master of Public Health from University of New South Wales.

Vicky Jack
Vicky Jack has the unique position of Child Welfare Officer for the Norfolk Island Government and has held this position since its inception in September 2010. Prior to this position being established Vicky had worked tirelessly to introduce and enact into legislation the Child
Welfare Act 2009 for the care, protection and wellbeing of children and young people.

Vicky served the community of Norfolk Island in the Legislative Assembly for nine years and as Minister for Environment, Education and Social Welfare.

Vicky has single-handedly established a refuge and safe house for victims of domestic violence and children at risk, advocates for social justice and works towards equity of access to services for Norfolk Islanders.

While Vicky was born in New Zealand, educated in Australia, and lived in the Philippines for some years, Norfolk Island has been her home for the past 20-odd years raising her family and establishing successful businesses there. Vicky’s knowledge of local culture as well as an understanding of the diverse cultures that exist on this remote island supports her work within the community.

Vicky is a member of the Social Welfare Advisory Committee under the Minister for Social Services, provides training to service providers and community on child protection issues and raises awareness of these issues to the Norfolk Island community.

Janelle Jakowenko

Growing up in the bush meant telehealth made sense to Janelle Jakowenko from the moment she heard about it. She has been working in the health care industry for almost 20 years, initially as a medical photographer and more recently as a telehealth coordinator, researcher and advisor. She started working in the field of telehealth in 2002, when video conferencing was done via a number of telephone lines (ISDN) and the industry was only theorising about the uses of a personally controlled electronic health record. In recent years she has conducted research in the field of telehealth in developing countries, telepaediatrics, teledermatology and telecardiology. Since the inception of telehealth item numbers she has played a pivotal role in the development of telehealth primary health care. Janelle worked as a consultant to the Royal Australian Collage of General Practitioners (RACGP) and was part of the project team that supported the development of the RACGP Standards for general practices offering video consultations in 2011. At the RACGP she has been the primary author on the Advice of Skype statement, Telehealth Implementation Guidelines Version 3.0, the Telehealth Active Learning Module, six specialty telehealth guidelines and a number of other resources.

Since August 2012 she has headed up the telehealth program at the Australian Medicare Local Alliance. This program was funded by the Department of Health and Ageing under the Connecting Health Services Initiative. Thirteen telehealth support officers (TSOs) throughout Medicare Locals (MLs) around the country are part of this initiative. A further six MLs independently obtained funding through the same tender. Since their placement, beginning July 2012, valuable lessons have been learnt about uptake of telehealth in rural general practice. Video conferencing in rural general practice goes far beyond clinical benefits and MBS item numbers. Clinicians can link up with colleagues, education providers, provide remote mentoring and link collaborative care teams, leading to improved support of the rural workforce.

Stephanie Jelbart

Stephanie Jelbart completed her Bachelor of Public Health, followed by Graduate Diploma in Education, by 1999. She then occupied the roles of secondary teacher and school counsellor for eleven years both in Australia and for some part in England. Concurrently, she was also director of Melbourne-based youth and community organisation, Bridge Builders Ltd, for six years.

A mother of two, Stephanie works part time with Bendigo Loddon Primary Care Partnership (PCP) as the Program Leader of Health Promotion and Planning. Her portfolio consists of working with hospitals, community health, bush nursing, local government and other community services in the areas of problem gambling, prevention of elder abuse, and sexual and reproductive health, as well as undertaking health promotion strategic planning and reporting for the partnership. The Bendigo Loddon PCP covers the local government areas of Greater Bendigo and Loddon in central Victoria.

Reflecting her previous work as an educator, Stephanie continues to have a particular interest in, and passion for, the social determinants influencing the health and wellbeing of young people. The opportunity to invest in developing assets in young people as part of an upstream health promotion project for the prevention of problem gambling is a key component of the Make a Mark project being presented at the NRHA Conference 2013.

Claire Johnson

Research Assistant Professor Claire Johnson is a research fellow with the Cancer and Palliative Care Research and Evaluation Unit (CaPCREU) at the University of Western Australia. Having been a registered nurse and certified midwife, Claire brings her broad clinical experience to the development and evaluation of interventions to improve care for people with cancer and at the end of life. She managed a multi-site evaluation of a new palliative care needs assessment tool which is now being used in clinical practice in a number of health services to identify people who need palliative care intervention. She has undertaken evaluations of a number of health services in WA which have resulted in changes in health service practices. Claire is an investigator on several projects which evaluate new and innovative health service programs such as the implementation of an end-of-life care pathway and the standardisation of routine assessment of patients at end of life in rural hospitals, an evaluation of general practitioner’s preferences for involvement in the management of people with cancer and an evaluation of the WA Psycho-oncology Service. Prof Johnson is the...
Western Australian CI for the Palliative Care Outcomes Collaborative and, as such, plays an integral role in the evaluation and ongoing improvement of palliative care services in the state and nationally.

Kylie Johnson

Kylie Johnson is the National Program Manager for Starlight’s adolescent Livewire program (in-hospital and online community). Livewire uses a range of arts, entertainment, online applications and moderated member groups to connect, support, and empower young people at risk of their adolescent development being disrupted due to serious or chronic illness and/or disability. The program attracts significant numbers of young people living in regional and remote areas of Australia. Prior to her current role, Kylie worked on a range of different Starlight programs, most notably as project manager for 50 Towns in 50 Weeks, a Starlight initiative which saw the Captain Starlight program (costumed entertainers) delivered to 50 regional and remote hospitals and health centres across Australia. Before joining Starlight, Kylie worked for several years in the disability sector as a senior community educator after graduating with a Bachelor of Arts (Psychology). Kylie is passionate about the design and implementation of innovative programs which focus on enhancing youth psychosocial wellbeing and social inclusion.

Deb Jones

Deb Jones has worked in regional health in clinical, management and academic roles for over 30 years. Deb has worked in a variety of service settings focused on health service and workforce development, education and program evaluation. Deb is a staunch advocate of comprehensive primary health care and the educational and experiential needs required to develop Australia’s future health workforce.

Deb’s work focuses on remodelling health care systems and the role of education institutions in supporting rural and remote communities to address entrenched disparities associated with the social determinants of health and wellbeing.

Deb has led the development of a health career pipeline model that brings together regional youth and urban health science students to create an integrated and sustainable workforce model. This program provided Deb with the foundation for program expansion into the educational pedagogy of service learning. Service learning has enabled health science students from across multiple disciplines to play a critical role in addressing long-term health inequities experienced in the region.

As a comprehensive primary health care advocate, Deb has drawn on these experiences to extend the model beyond the health sector. The result has been the establishment of innovative collaborations across regional community organisations in far-western NSW, higher education institutions and government agencies in the development of cross-sectorial partnerships and programs. These collaborations have been underpinned by community empowerment, leadership and vision, political astuteness, place-based solutions and complex relationships that harness the expertise and resources of each partner. The model seeks to address regional disparities experienced across health, education, economic, and social indicators.

Michael Jones

Michael P Jones is Professor of Psychology and Deputy Head of the Psychology Department at Macquarie University, Sydney. He is also a member of the Centre for Research Excellence in Rural and Remote Primary Health Care (CRERRPHC). His primary training is in biostatistics and he has worked in epidemiology in a number of areas of medical research. Mike is particularly interested in the shortage of medical practitioners in rural areas of Australia and personal as well as structural reasons for the medical workforce shortage. Mike has productive collaborations with colleagues in the Monash School of Rural Health, the CRERRPHC and the Medical Schools Outcomes Database and Longitudinal Tracking Project (MSOD). Mike is currently involved in a number of studies of the connections between characteristics of the individual (personality, mood, etc) and rural workforce intentions where probabilistic methods play an important role.

Susan Jones

Susan Jones is currently a project nurse with the Integrated Cardiovascular Clinical Network (iCCnet) of Country Health SA Local Health Network. Susan’s project work examines barriers to the provision of primary and secondary health care strategies in country South Australia and develops and implements strategies to facilitate the appropriate provision of health care services to consumers as close as possible to their area of residence.

Susan graduated from the University of South Australia in 1991 with a Diploma in Nursing and has worked in country South Australia since this time. Susan completed postgraduate education in cardiac nursing and developed a passion for management of cardiac patients in the acute setting. It was also at this time Susan identified the value of secondary prevention for cardiovascular disease and became involved in the provision of outpatient cardiac rehabilitation.

Susan first undertook project work in 2003 when she had a site project lead role at Mount Gambier Hospital examining the use of patient incident reporting systems and practices in acute care. Susan co-authored a subsequent article published in BMJ Quality and Safety in Healthcare in 2007 titled ‘Views of Doctors and Nurses Following an Intervention to Improve Reporting Practices’.
Susan has held a number of senior and executive nursing positions in country South Australia. Roles held include quality and safety manager, clinical operations manager, nurse management facilitator and acting director of nursing positions.

Susan graduated from Griffith University, Queensland with a Masters in Health Service Management in 2009 and received an academic excellence award for this study.

Susan is currently on secondment from an acute care nurse manager role to undertake project work attached to the iCCnet, Country Health SA LHN. Project work to date has included implementation of the cardiac rehabilitation model of care for South Australia into country South Australia and respiratory services planning for country South Australia.

Len Kanowski

Len Kanowski is a senior advisor at the NSW Centre for Rural and Remote Mental Health and a visiting fellow at the National Centre for Indigenous Studies, Australian National University.

Len has worked continuously in the mental health and drug and alcohol fields as a clinician, manager and educator for over three decades, predominantly in rural and remote areas.

He has postgraduate qualifications in rural and international mental health, and a special interest and experience in Aboriginal and Torres Strait Islander mental health and wellbeing. His other professional interests are the mental health and wellbeing of emergency services personnel.

Len was Deputy Director of the Mental Health First Aid Training and Research Program at the University of Melbourne from 2005–2009. During his time with the Mental Health First Aid Program he undertook several cultural adaptations of the internationally acclaimed Mental Health First Aid Program (www.mhfa.com.au) developed by Betty Kitchener and Tony Jorm. A significant achievement was a cultural adaptation for Aboriginal and Torres Strait Islander communities. The adaptation was undertaken in conjunction with Aboriginal and Torres Strait Islander health workers, peak bodies and organisations across Australia.

Between 1993–2000 he developed the nationally recognised Djirruwang Aboriginal and Torres Strait Islander Mental Health Worker Education and Training Program (Bachelor of Health Science–Mental Health) in collaboration with Aboriginal community groups and organisations. The program is now based at Charles Sturt University, Wagga Wagga, NSW, under Aboriginal directorship.

His current role involves the development and implementation of strategies to assist Aboriginal communities and organisations in rural and remote NSW to deal with ongoing psychological adversity.

Len’s professional background is mental health nursing. He completed his nurse training at Kenmore Psychiatric Hospital, Goulburn, NSW, in the 1970s. He originally hails from Wagga Wagga and Coolamon, NSW.

Judy Katzenellenbogen

Originally trained as an occupational therapist, Judy Katzenellenbogen works at the Combined Universities Centre for Rural Health as an NHMRC research fellow. Her interest in epidemiology has underpinned a public health career comprising broad professional experience in South Africa, New Zealand and Western Australia. This has included experience working on rural health issues and health disparities in all three countries and from diverse perspectives, including disease-specific research and burden of disease analysis, health purchasing, needs assessment, program evaluation and strategic planning.

Her doctoral work, completed in 2008, involved the application of linked data analysis methods to estimating the burden of stroke in Western Australia. The emphasis of her current research is disparities in health care and outcomes, both for rural and remote residents and for Aboriginal people, with a major focus on cardiovascular disease. She is committed to building capacity in Aboriginal health and in developing upstream approaches to health.

Thomas Kavanagh

Thomas Kavanagh is a medical student at Monash University and is part of the Extended Rural Cohort program. In 2013 Tom is completing his 4th year of study in the Monash MBBS program in Mildura in north-west Victoria. Tom’s interest in rural health has seen him awarded a RAMUS scholarship that has given him many opportunities to further develop this interest.

Tom grew up in Ballarat in Victoria’s Central Highlands, completed his secondary schooling at St Patrick’s College in Ballarat and, prior to beginning his studies at Monash, spent a year working for a couple of local Ballarat businesses. Tom’s experiences growing up and working in Ballarat ignited his passion for the lifestyle of a regional city and led to his interest in rural health.

Tom saw the shortage of health professionals in regional areas as an opportunity for those like himself who would prefer to live and work outside of the major cities and enjoy the opportunities that are available to those who are happy to work in rural or regional centres.

Part of this opportunity is also the need to develop ways to make rural practice more sustainable and attractive for medical practitioners to take on, therefore benefiting the communities they serve. Through his RAMUS mentor Tom has had the opportunity to investigate different strategies and programs being employed by health services to achieve this.
Suman Kavooru

Suman Kavooru is an oral health promotion coordinator whose current role in public health includes the coordination and execution of remote and regional Aboriginal oral health promotion programs in western New South Wales. His current portfolio of health promotion projects includes the design and running of dental education and tooth-brushing programs in primary schools, mother’s groups and community organisations. Suman has previously held numerous positions in public health, including research officer and tobacco control officer. His qualifications include Bachelor of Dental Surgery (India) and Masters in Public Health (Australia).

Sheila Keane

Sheila Keane is currently Senior Lecturer in Allied Health at the University Centre for Rural Health in Lismore NSW and the University of Sydney Faculty of Health Science where she lectures in rural health. Her recent research has focused on recruitment and retention of rural allied health practitioners. Sheila also has a keen interest in progressing rural clinical service models such as the use of telehealth and VET sector qualified allied health assistants, and is actively involved in interprofessional clinical education and rural allied health workforce development. She is a board member of the North Coast Medicare Local and Services for Australian Rural and Remote Allied Health (SARRAH). She also chairs the SARRAH Research Alliance.

A practicing physiotherapist since 1981, Sheila is a recognised neurologic clinical specialist with a focus in stroke rehabilitation. Her clinical research interest is on effective treatment of spatial neglect syndrome. Sheila also lectures in stroke rehabilitation on behalf of the Australian Physiotherapy Association.

Jennie Keioskie

Jennie Keioskie is employed as a rural mental health promotional officer within the Southern NSW Local Health District (SNLHD) through the Rural Adversity Mental Health Program (RAMHP)—a program funded through the NSW Ministry of Health and coordinated by the University of Newcastle’s Centre for Rural and Remote Mental Health (CRRMH), in Orange, NSW. The key aim of the program is to build individual and community capacity that supports the mental health and wellbeing of rural and remote communities during periods of adversity. RAMHP emphasises building community resilience through building partnerships with local services and agencies in alignment with the aims of the CRRMH, which provides quality mental health education and research programs to rural NSW.

Jennie has a degree in psychology and a postgraduate degree in social work and has worked in the area of mental health and wellbeing for over 20 years. Being a country girl at heart Jennie has always lived and worked in rural Australia and has a passion for bringing high-quality services to those who live outside the major metropolitan and regional areas. Jennie has been employed with RAMHP since early 2010 and believes the success of the program is its ability to build on and support many of the strengths that are inherent in rural communities such as community connectedness and innovative and creative problem solving.

Paulette Kelly

Paulette Kelly is with the Rural Workforce Agency Victoria working within the Medical Specialist Outreach Assistance program to encourage provision of additional specialist services to rural Victoria via telehealth. The RWAV telehealth program is part of the Commonwealth’s ‘Connecting health services with the future: modernising Medicare by providing rebates for online consultations’ initiative. The aim of this initiative is to provide equitable access to specialist services for patients in rural, remote and outer metropolitan areas. The RWAV project aims to gain an improved understanding of specialists’ technology adoption behaviour.

Prior to joining RWAV, Paulette was an ehealth consultant with General Practice Victoria working with general practices to increase awareness of the Personally Controlled Electronic Health Record. Paulette spent four years in the academic sector, researching adoption issues in health information systems and earning a PhD for her efforts. This was preceded by seven years in senior ICT roles in the telecommunications industry working primarily in Europe.

Paulette’s professional and academic interests come from a desire to understand the positioning of ehealth in national health care reforms.

Paulette spent her formative years living in rural Victoria, the daughter of a rural doctor. Her interest in equitable access to health services for rural patients stems from this period.

George Khut

George Khut is an Australian artist and design-researcher working across the fields of electronic art, design and health. He holds a Doctorate of Creative Arts from the University of Western Sydney, Australia—for his research into biofeedback-based interactive artworks, and has taught interaction design and human-centred design methods at University of Technology Sydney, Faculty of Design, Architecture and Building, School of Design. He completed his undergraduate studies in fine arts at the University of Tasmania, Centre for Arts in 1994, where he studied painting, sculpture, ceramics, video and electronic music.

Tracy Kidd

Tracy Kidd is a nurse educator with a background in emergency and critical care nursing who works with the Collaborative Health Research and Education Centre at
Jacqueline King

Jacqueline King held executive positions as national sales manager and general manager of a large Australian organisation with over 1200 staff. Her illness forced a major change in her professional and personal life as she subsequently returned to rural NSW to intern at Orange Base Hospital before returning to Sydney to start specialist training. He has completed rural rotations to Dubbo and Lismore Base Hospitals.

Peter Kilby

Peter Kilby is currently working as a 4th year trainee on the Orthopaedic Surgical Specialty training program of the Australian Orthopaedic Association (AOA).

Peter completed high school at Orange, NSW, then rural entry scheme to UNSW medicine (class of 2005). He subsequently returned to rural NSW to intern at Orange Base Hospital before returning to Sydney to start specialist training. He has completed rural rotations to Dubbo and Lismore Base Hospitals.

Peter’s upbringing on a sheep and cattle farm in western NSW at Coonamble has led him to combine his medical pursuits with a love of rural lifestyle. Peter has seen the barriers faced by rural patients firsthand as a boy growing up in the country. He has also seen it firsthand when his sister broke her pelvis while chasing a wild boar on a quad bike and this inspired him to conduct this research.

Peter hopes that you all get a chance to visit Dubbo and the country beyond, and that this helps in future planning for orthopaedic resources and infrastructure.

Jacqueline King

Prior to diagnosis with post-traumatic stress disorder Jacqueline King held executive positions as national sales manager and general manager of a large Australian organisation with over 1200 staff. Her illness forced a major change in her professional and personal life as she wrestled with this crippling illness and her glass practice became a lifeline.

Jacqueline’s artistic vision is the exploration of two distinct and often divergent notions of the fragility and diversity of life, one being our natural environment and the other mental health, specifically PTSD.

Jacqueline’s work is held in many regional galleries and collections both private and public including the Dax Collection in Melbourne, the world’s third largest collection of work by those suffering mental illness or trauma.

Publications featuring Jacqueline’s work and/or her story include National Rural Health Alliance Partyline #43, Best of Worldwide Glass Artists (US), 'Sharing the Un-shareable', Education Centre Against Violence and NSW Government, Jacaranda Project Manual. Also her work has been featured in the Australian Art Collector magazine, Australian Artists magazine and the International Contemporary Masters Vol VII.

Jacqueline has recently presented at the Arts Activated National Conference advocating for artists living with complex PTSD. Awards include the Caldera Fellowship Award in 2012, People’s Choice Award in artVision 2012, Highly Commended in the prestigious Mortimore Prize plus numerous smaller awards and selections with her glass works.

Jacqueline is also the founder and project coordinator of the Artfelt Art Prize, an annual art prize raising awareness, funds and a platform of discussion for adult survivors of childhood sexual abuse. Her studio and home are now in far-north NSW.

Katherine King

Katherine King is a final year medical student at Deakin University. Katherine was the Community and Wellbeing Officer on the National Executive for the Australian Medical Students’ Association (AMSA) in 2012. She has been involved with her Rural Health Club since starting medical school and she spent a year in rural Victoria as part of her Rural Clinical School. As part of the John Flynn Placement Program, she also spends time in Bowen in far-north Queensland. Katherine is passionate about rural health and medical student health and wellbeing.

Anne Knight

Dr Anne T Knight has worked as a general/thoracic physician at Manning Rural Referral Hospital and in private practice in Taree on the mid-north coast of NSW, for the past 20 years. She is a Senior Lecturer in Medicine at the University of Newcastle, Department of Rural Health, also based in Taree. Other interests are junior medical officer education and training, and therapeutics.

Sabina Knight

Professor Sabina Knight is the Director of the Mount Isa Centre for Rural and Remote Health. She has an enduring association with remote and rural health and the National Rural Health Alliance, being the foundation deputy chair. A remote area nurse who strayed into medical school and she spent a year in rural Victoria as part of her Rural Clinical School. As part of the John Flynn Placement Program, she also spends time in Bowen in far-north Queensland. Katherine is passionate about rural health and medical student health and wellbeing.

Gail Kovatseff

Gail Kovatseff has been the Director of the Media Resource Centre since 2007. Prior to this, she worked at Arts SA for 10 years as the Senior Industry Officer.
Samantha Kozica

Samantha Kozica is an accredited practicing dietitian (APD) with an Honours degree in nutrition and dietetics. Samantha is completing a PhD in community evaluation of the HeLP-her Rural trial, receiving funding from the National Medical and Research Council. Samantha completed her Honours degree in nutrition and dietetics in 2009 and was involved in a large health-related behaviours project within the Women’s Public Health Research team. In addition to her research experience, Samantha has worked as a clinical dietitian in both the public and private sectors (2008–current) across numerous areas of nutrition but primarily in obesity management. Samantha also holds a sessional teaching position with the Nutrition and Dietetics department at Monash University. Samantha’s long-term ambition is to pursue an academic research career combined with clinical dietetics, focusing on translational and public health research.

Sue Kruske

Sue Kruske is a midwife and child health nurse with clinical, teaching and research experience in maternal, child and cross-cultural health particularly with remote Indigenous communities in Australia. Currently she is Director at the QLD Centre for Mothers and Babies. She has many years’ experience working in the remote Indigenous communities and her primary areas of interest and research are in collaboration, supporting the health workforce in working more effectively with women and cross cultural child rearing practices.

Bernadette Lack

Bernadette Lack is a Bachelor of Midwifery graduate currently working as a midwife within the Alice Springs Midwifery Group Practice (MGP). Prior to this she worked as a remote outreach midwife providing midwifery services to remote Aboriginal communities up to 600 km out of Alice Springs. Bernadette is studying her Masters in Public Health with a major in health promotion, as well evaluating the Alice Springs MGP through an Honours degree. In 2012 she was elected to sit on the Board of Directors for the Australian College of Midwives (ACM) after holding the NT ACM President position. Bernadette believes that every woman should have access to a known midwife. She is also passionate about returning birth services closer to women’s homes and increasing the Indigenous midwifery workforce.

John Lang

Dr John Lang began working life as a mathematics/PE teacher in 1979 before studying for his Masters degree in Sports Science in Canada. He completed his PhD in Neuromuscular Physiology in the Monash University Medical Faculty in 1989 and obtained his Diploma in Business Management from the Australian Institute of Management in 1992. Subsequent to this John has been the CEO/MD of numerous health management companies including HBA, National Mutual/AXA and Mayne.

Other relevant aspects of John’s professional background include:

- Founding President of the Health and Productivity Institute of Australia (HAPIA), the peak body for workplace health service providers (2007).
- Oversaw the development of the Best Practice Guidelines for the corporate wellness industry.
- Represented the industry on the Clinical Advisory Taskforce for WorkHealth in Victoria (a $218 million initiative to provide health checks to over one million working Victorians).

During his 26 years in the workplace health arena, John has developed and implemented preventative health programs for numerous large companies, including organisations such as Woolworths, Westpac, IBM, Boral, Federal Treasury, NSW Public Service, CBA, ANZ, Telstra, Lend Lease, MLC, Sydney Water, Nestlé, Freehills, Energy Australia and others.

He was appointed Managing Director of Alere Health in 2010.

Sarah Larkins

Sarah Larkins is an academic general practitioner, Associate Professor in General Practice and Rural Medicine and Director of Research and Postgraduate Education at the School of Medicine and Dentistry, James Cook University. She has particular skills and experience in Aboriginal and Torres Strait Islander health research and health services and workforce research. She has more than 40 published papers to date and well over $1 million in grant funding. Methodologically her strengths are in the use of participatory/action research methodologies and mixed methods to design, implement and evaluate new programs or health services. She has a research interest in community participation in rural health service development, and in community/health sector partnerships in rural areas. Her particular focus is on collaborating to improve equity in health care services for under-serviced populations, particularly rural, remote and Indigenous populations, and on training a health workforce with appropriate knowledge, attitudes and
skills for this purpose. She is a current Director, Townsville Mackay Medicare Local (TMML) and member of the National Technical Advisory Group for Health Workforce Australia.

Rachel Latimore

Rachel Latimore is a nutritionist who is passionate about improving the health of Australian youth and women. Rachel currently works at Diabetes Queensland as a health promotion officer where she teaches students the importance of healthy eating and lifelong cooking skills. Rachel believes in the true value that nutrition education and cooking skills provide in improving the health of our Australian population.

Nanette Laufik

Nanette Laufik is a physician assistant (PA) from Portland, Oregon, in the US. She is currently a permanent resident of Australia living and working in far-north Queensland.

She made a career change in the mid-1980s, having previously practiced as a registered nurse. She trained as a family practice PA at the University of Washington in Seattle, Washington. PA training is based on a medical model with emphasis on whole patient care and disease prevention.

Nanette came to Australia in 2009, hired by Queensland Health to pilot the PA concept in Cooktown, QLD. While in Cooktown she also worked at Wujal Wujal Aboriginal Health Service.

Nanette was hired by Mulungu Aboriginal Health Service in May 2011. She and Dr David Baker formed the first doctor-PA team in Queensland outside of a pilot project. They worked together with Aboriginal health workers and an Aboriginal social worker in the chronic disease clinic, managing patients with diabetes, hypertension, renal failure, rheumatic heart disease and other conditions within the Medicare framework.

Her employment experiences in the US included large suburban general practices, inner-city American health services, rural general practice and rural Indian health services. She volunteered in several overseas medical relief missions, including Albania, Afghanistan, Indonesia and Honduras and administered care to Hurricane Katrina victims in Mississippi. She participated as a coordinator in several medical education projects in Central and Eastern Europe.

She is currently employed at James Cook University–Cairns Campus in the School of Medicine where she is the Clinical Skills Coordinator for Year 4 medical students.

Louise Lawler

Louise Lawler is the Academic Leader for Indigenous Health with Wollongong University’s Graduate School of Medicine. Her role is to ensure the recruitment and retention of Indigenous medical students and that all medical students are introduced to the status of Indigenous health and the environments that maintain these inequitable situations.

Hailing from rural NSW, Louise has held clinical, educational and administrative positions in health and education throughout rural and remote Australia. She has been a remote area nurse and held positions as Director of the Aboriginal and Islander Health Worker Education Program in north Queensland, Director of the Remote and Rural Health Training Unit (Dubbo) and Head of the School of Health Sciences, Charles Sturt University in Dubbo NSW. More recently she conducted longitudinal research in Indigenous and community health as lecturer in the University of Sydney’s Rural Clinical School.

Louise holds an academic appointment as honorary research fellow with the Faculty of Medicine, University of Sydney, and is the Executive Officer of the Rowan Nicks Russell Drysdale Fellowship in Indigenous Health and Welfare.

During 2009/10 Louise was the Director of Future Workforce with Rural Health Workforce Australia which necessitated a close eye on rural and remote workforce issues and planning of ways to attract health students to the bush as practising clinicians. This presentation is a report on work undertaken via the National Rural Health Student Network, which surveyed over 1000 students and enquired of them what they thought were components of truly memorable clinical placements.

Helen Le Gresley

Helen Le Gresley is a team member from the Rural Adversity Mental Health Program of the University of Newcastle’s Centre for Rural and Remote Mental Health (CRRMH).

The Centre for Rural and Remote Mental Health is based in Orange and is a major rural initiative of the University of Newcastle, Faculty of Health, and the NSW Ministry of Health. CRRMH aims to bring quality education and research programs to all rural areas of NSW through effective partnerships. The Centre improves the mental health of rural and remote communities through academic leadership, collaboration and achievements in research, education, service development and information services.

The Rural Adversity Mental Health Program (RAMHP) is managed by the Centre and commenced in 2007. The key aim of the program is to build individual and community capacity that supports the mental health and wellbeing of rural and remote communities during periods of adversity. RAMHP emphasises building community resilience through partnerships with local services and agencies in alignment with the aims of the CRRMH.

Helen is a research associate with RAMHP, undertaking research projects that inform the program’s capacity to...
support the mental health and wellbeing of rural and remote communities during times of adversity.

With over 15 years’ experience as a community psychology practitioner, Helen has worked in both the UK and Australia in a number of sectors including not-for-profit, private equity, secondary and tertiary education, and local government. These roles have spanned a number of diverse areas including communications and web design, community cultural development, strategic planning and lecturing, and all have shared a focus on inclusive, strengths-based and participatory methods.

As an emerging researcher Helen favours the development of socially relevant, co-constructed knowledge which encourages shared and mutual learning and delivers authentic and meaningful outcomes for the participants and broader community. Her Masters thesis focused on the social construction of fatherhood, inspired by her time working with families at a family resource centre in Western Australia. In the near future Helen hopes to embark on a PhD exploring the facilitation of empowering community settings in the area of mental health and wellbeing.

She is a member of the Australian Psychological Society and the Society for Community Research in Action (Division 27 of the American Psychological Association).

Tanya Lehmann

Tanya Lehmann grew up on a small farm in Wagin, Western Australia. She trained as a dietitian at Curtin University, and in 1998 she ventured across the Nullabor to take up a new graduate position in the Riverland of South Australia. Stumbling across the best rural retention strategy known to the health system, Tanya met and married a local, and the rest, as they say is history. With their two children they live in a rammed earth house overlooking the Katarapko National Park, where they enjoy spectacular sunsets, falling asleep to the sounds of frogs and waking up to the morning chorus of kookaburras, pelicans and magpies.

Tanya has worked in the Riverland for most of her career, as a community dietitian, team leader, and manager of service development and community health. She also enjoyed a brief stint as a public health nutritionist in Carnarvon, WA, before the lure of the beautiful Murray River saw them return to the Riverland. Since 2008, Tanya has been the Principal Consultant Allied Health for Country Health SA Local Health Network (CHSALHN). In this capacity, she has managed a number of significant projects, including initiatives related to recruitment, retention, clinical governance, workforce redesign, clinical supervision and professional development. Tanya’s creativity, persistence, strategic thinking and partnership building skills enable her to find creative solutions to seemingly insurmountable problems.

Tanya joined the Services for Australian Rural and Remote Allied Health (SARRAH) family at the 2008 SARRAH Conference, became a Board member in 2009 and President in 2012. She has been SARRAH’s delegate to the Council of the National Rural Health Alliance (NRHA) since 2011. Tanya is a rurally-passionate, solutions-focused, bundle of energy, passionate about improving the lot of rural and remote allied health professionals and the communities they serve.

Hannah Licul

Hannah Licul is an active citizen of the Broken Hill community at 19 years old. She joined Active Broken Hill as a committee member at the beginning of her gap year in 2012 and then accepted the role of treasurer. Hannah strives to be a voice for the youth of Broken Hill through her involvement in the Australian Army Cadets, Broken Hill’s Lifeline Board of Governance and of course, Active Broken Hill. Hannah hopes to gain the most she can out of the opportunity that has been given to her to experience 2013’s National Rural Health Conference.

Melissa Lindeman

Melissa Lindeman is Associate Professor at the Centre for Remote Health, and a member of the Centre for Research Excellence in Rural and Remote Primary Health Care. She has a background in social welfare, public policy, research and education, in areas such as child protection, aged and disability care, community programs and health and human services more broadly. Recent projects have focused on assessment practice in Indigenous aged and community care, Indigenous dementia services, suicide prevention in Central Australia, remote youth programs, and the development of education programs in primary health care. Her higher education teaching experience has been in the areas of public health and health promotion, health/human service systems, ageing and community care.

Alexandra Little

Since graduating from the University of Newcastle in 2000, Alex Little has worked as a speech pathologist in rural settings across NSW and Victoria. Her experience covers both paediatric and adult clinical roles from acute care through to community-based services and everything in between. Alex is currently working for the University of Newcastle Department of Rural Health as a lecturer in speech pathology providing education and training support to undergraduate and practising nursing, medical and allied health professionals. She is also the Deputy Profession Director for Speech Pathology for the Hunter New England Local Health District. Together these roles enable her to support rural and remote health professionals, contribute to the training of the next generation of speech pathologists, and engage in her ongoing commitment to quality clinical education and improving access to services in rural communities.
Fiona Little

Fiona Little is a credentialled mental health nurse and authorised mental health nurse practitioner. She has 24 years’ experience in the area of acute mental health and consultation liaison mental health nursing within the public health care setting. More recently she has been working in primary health care focusing on the development of and access to perinatal mental health services within Tamworth and surrounding rural areas.

Fiona is currently employed at the University of Newcastle Department of Rural Health in Tamworth as a mental health academic. Her research interests include workforce development, promoting the role of the mental health nursing profession in rural practice, developing and evaluating service delivery models in primary health care and incorporating interprofessional approaches and education into clinical practice.

Karen Lock

Karen Lock BSW is a social worker and community development officer based in Millicent. Although growing up and educated in Adelaide she has spent all of her professional working life in rural South Australia. Currently she has a joint role working for Country Health and the Wattle Range Council giving an excellent balance between individual and community issues.

Karen has a passion for social justice and describes herself as a ‘specialist generalist’. Areas of interest include disability, feminism and health promotion. Some of the other projects Karen has worked on include a respite centre, supported accommodation and intertown transport. As well as working full time, she runs a beef farm with her partner and enjoys a round a golf when time permits.

Cate Lombard

Cate Lombard is Head of the Healthy Lifestyle Program and senior research fellow with the School of Public Health and Preventive Medicine, Monash University. Cate is also a highly experienced dietitian (APD) at the Victorian and national level. She has contributed to state-wide and national nutrition and physical activity policy and programs, including contribution to the development of Lifescripts (the national lifestyle program for GPs) and to preventive health policy and programs through senior positions with the Victorian Department of Health. A finalist in the 2012 Bupa Health Foundation Emerging Researcher of the Year award, Cate’s research focuses on preventive health particularly promoting healthy lifestyle behaviours, community-wide interventions and women’s health. A major achievement was the development of an innovative intervention to prevent weight gain for women (HeLP-her). The program has also been conducted in pregnant women and has support from the Victorian Department of Health.

Derrick Lopez

Derrick Lopez is a research assistant professor at the Combined Universities Centre for Rural Health (CUCRH) at the University of Western Australia. He has a background in longitudinal health studies and analysis of linked health data. He is currently working on the NHMRC-funded Bettering Aboriginal Heart Health in Western Australia (BAHHWA) project in collaboration with the Cardiovascular Research Group at the School of Population Health. His current work is focused on the treatment and management of Aboriginal cardiovascular patients using hospital morbidity data. Previously, he was involved with the Australian Longitudinal Study on Women’s Health and the Health in Men Study.

Andy Lovett

Andy Lovett is a Victorian regional paediatrician. He is Director of Paediatrics at Bendigo Health and also works in Shepparton and Echuca. He is Chair of the Victorian State Committee (Paediatrics) within the Royal Australasian College of Physicians and is a Director of Physician Education within that College. He has had a longstanding interest in Australia’s specialist regional paediatric workforce. He established the Victorian Rural Child Health Training Module—designed for advanced trainees in general paediatrics—in 2006, which very quickly became national. He has been an advanced paediatric life support instructor for 10 years and is proud to say that every course he has ever taught has been in rural and regional Australia. He sits on a number of state government advisory committees, where he seeks to be an active and thoughtful voice for the third of Victorians that don’t live in Melbourne or Geelong. He has a particular clinical and research interest in drugs, alcohol and addiction as they affect infants, children and adolescents.

Tracy Macfarlane

Tracy Macfarlane is a clinical psychologist registrar currently working for NSW Health at the Bathurst Community Health Centre, and at NSW Central West headspace. Her current interests include ADHD, behaviour management interventions, parent training, postnatal depression, disordered eating, and early intervention with adolescents. She is chair of the Western Region Branch (NSW) of the Australian Psychological Society, and is committed to strengthening relationships among psychologists within this large rural and regional area, and improving access to quality professional development opportunities.

Jenine Mackay

Jenine Mackay is a Victoria College of the Arts Drama School graduate and has extensive skills and experience in the performing arts and community arts and cultural development practice. Jenine’s background in the
performing arts includes as a dancer, actor, artistic director and performance skills mentor. Jenine has worked in the youth arts sector since 1991 managing and delivering circus, visual and performance programs and developed distinctive works of quality, innovation and collaboration with, by, and for young people in WA and the NT. Her work in WA includes developing intra and inter-regional arts projects and an international cultural exchange program with South African-based dance artists and youth mentoring programs.

Jenine has worked in the NT since 1999, together with her colleague Virginia Heydon, to develop both InCite Youth Arts and Arts Access Central Australia to ensure the deep roots and solid foundations of inclusive and accessible community arts practice not only endure but flourish prolifically in the central desert region.

Jenine is the Executive Director of InCite Youth Arts and has been in this role since 2005. She has been a board member of Arts Access Australia, the peak national arts and disability organisation, since 2008 and is currently the Chairperson.

Jenine has played an instrumental role in developing the partnership with the Mt Theo program to enable access to arts engagement by Warlpiri young people, women and their communities through the Red Sand Culture and the Southern Ngalia projects.

Fiona MacPhee

Fiona MacPhee is Program Manager, Ovens and King Community Health Service (OKCHS). Ms MacPhee has worked in community health-aged care sector in rural Victoria for the past 20 years, for 13 years running a small rural/remote district nursing practice in the King Valley. She has been the program manager of the Integrated Aged Care Assessment service since 2005. Her team is responsible for aged care assessments and a range of community-based nursing services across the Eastern Hume region of Victoria. She has lead several successful projects, most recently the 2010–2012 HACC Active Service Model seedling grant project Eating for Independence, and the 2011–2012 Workforce Innovations Grant Project introducing allied health assistants into community-based continence nursing and occupational therapy services. She is a member of the Hume region Integrated Aged Care Collaborative and Hume region dementia support working group, joint chair of the Hume region aged care packages providers/ACAS group and is the Rural ACAS representative on the Aged Care Planning Advisory Committee Victoria.

Robyn Main

Robyn Main is an optometrist who operates a mobile practice to aged care facilities in WA. She has also recently completed a MSc (Res) Optometry researching the topic 'Issues pertaining to the recruitment and retention of optometrists in rural and remote Australia'.

Recognising the need in remote WA for aged care and optometry services, she undertook a circuit of the Kimberleys in 2012 to the theoretically neediest people in Australia—those who live in remote Indigenous aged care facilities. Her results were surprising—a good news Indigenous (eye) health story.

Dan Manahan

Dr Dan Manahan is a graduate from The University of Queensland. He undertook his studies with the assistance of a Queensland Health Rural Scholarship and commenced clinical practice in Rockhampton where he completed his internship. He then moved to Emerald in Central Queensland where it was during this time he experienced the characters, practitioners, patients and friends that dramatically influenced his choosing of a career as a rural generalist.

After time in Goondiwindi, which further cemented his rural vocation, he relocated to Brisbane for advanced skills training where he obtained obstetrics, anaesthetics and surgical credentials and married Jacinta, a city slicker prepared to leap into rural life. Dan and Jacinta moved to Stanthorpe in 1996 and have settled there, raising four children.

In combination, Dan manages his current significant role as Medical Superintendent at Stanthorpe with his Rural Generalist Advisor role, while maintaining this continuing professional education, recently completing an external Diploma in Medical Sonography. Dan is passionate about both developing and facilitating medical education and training opportunities for medical officers across rural and remote Queensland.

Tania Marin

Tania Marin is a research associate at the University of Adelaide currently working in population research and outcome studies (PROS). Her research focuses are the social determinants of Aboriginal health, population surveying, quantitative analyses, and public health. Since 2010, Tania has been study coordinator for the South Australian Aboriginal Health Survey (SAAHS), which is a population survey of Aboriginal South Australian adults (15 years and over). She holds a Bachelor of Health Science degree and is currently studying for her Master of Public Health where she is exploring the associations between chronic conditions and health risk factor prevalence with the participation in custodial rights and Caring for Country activities on South Australian traditional lands.

Bianca Mark

Bianca Mark is a Ngarrindjeri woman, and has worked for SHine SA for the past two and a half years. In what started as a twelve-month traineeship, her position has expanded to include service delivery, and she has been provided with many opportunities to help present sexual health workshops to Aboriginal people, both within South Australia and interstate.
Priya Martin

Priya Martin graduated as an occupational therapist in 2003 from Christian Medical College, Vellore, India. She has been working as a full-time occupational therapist since, having worked in two countries; in acute and rehab settings; in clinical, non-clinical and teaching roles; and in the public and private sectors. Her special interests include neurological rehabilitation, geriatric rehabilitation, clinical education and interprofessional learning.

Priya is currently completing MPhil through the University of Queensland. As part of the MPhil degree she is completing a state-wide research project on clinical supervision. This project focuses on clinical supervision practices of occupational therapy clinicians working in Queensland Health. This conference presentation is part of the abovementioned research project.

Tarja Martin

Whilst Tarja Martin initially trained and practiced as a registered nurse, she has been working in preventative health for the last twenty years. Tarja started in preventative health as a project officer for skin cancer prevention for the Health Advancement Branch, Queensland Health, that then became a health promotion role with fledgling Health Promotion Unit that later became the Tropical Population Health Unit in Townsville. This role supported major state-driven initiatives in skin cancer prevention and cemented her love of health promotion.

Most of Tarja’s work has been in regional and rural positions. Tarja has worked on projects such as Health Promoting Schools, injury prevention, immunisation and in and in the last seven years she has been concentrating on chronic disease prevention attached to a primary health care team based in a small rural community of Ayr. This role also has required working closely with other small communities in the health service such as Bowen, Collinsville and Charters Towers. Tarja is one of the few health promotion officers working in this capacity in Queensland.

Being in this unique position has meant a great deal of coal face work as well as influencing strategic directions. This role has involved working across the health promotion continuum and working in strong partnerships with other agencies and service providers, government and non-government organisations and their communities. It has also allowed her to utilise some of her other skills, such as acting, to be embedded into her health promotion strategies.

Tarja has presented at a number of conferences over the years about the benefits of incorporating health promotion into a primary health team setting and on projects developed and undertaken in this rural area.

Lee Martinez

Lee Martinez has spent the majority of her life living and working in country SA, providing a lifelong experience and understanding of the needs of those residing in rural and remote areas.

Lee lives in Whyalla in country SA with her husband Louis and has two beautiful daughters who have both chosen city life—one in Adelaide and one in Sydney.

Lee currently holds a joint appointment with the University of SA University Centre for Regional Engagement Department of Rural Health and Country Health SA Local Health Network as mental health academic/knowledge broker and has held this position since mid-2011. The aim of the position is to build partnerships between the university/academia and the health sector to support research that is relevant to industry, academia and practice and enable translation of knowledge into practice. Prior to this, Lee held the position as Director Operations Mental Health Country Health SA Local Health Network since 2007.

Lee’s professional career has been in the rural health sector with a strong focus in community health, health management and health research. Her research interests are focused on building resources for mental health consumers in the community, enabling people to receive the services they require as close to where they live as possible and she has a commitment and passion to ensure equity of outcome for consumers of health services living in rural and remote communities.

Most recently in her current role Lee has worked with a small dynamic team to establish a Mental Health Research Observatory Unit for Country Health SA Local Health Network.

Kim Maurits

Commencing employment with SA Health in 2001, as a casual domestic cleaner with domiciliary care, Kim Maurits is proof that you don’t need a degree to carve a career in health, or to make a difference. Without finishing high school, or attending university, Kim has progressively studied and gained higher level employment within Country Health SA.

Throughout all her roles, Kim has focused on not only providing great service but also analysing data to show gaps, improvements, and suggested training requirements. Benchmarking with similar agencies, improving business outcomes, and seizing opportunities has given Kim an expert understanding of the perils and pitfalls of operating an intake referral service. Through leading teams, developing intake programs and tools, she knows that collecting great data makes a real difference, especially for clients.

With qualifications in business, training and project management, Kim has recently successfully implemented
stage 1 of the Country Referral Unit project, consolidating three teams across four programs into a single unit. Currently, she is managing the implementation of stage 2, which will see the expansion of Access2HomeCare across all of Country Health, providing streamlined access to services for the elderly. Kim’s major focus is how to make things easier—for staff, clients and the community care sector.

Combining her passions for writing, speaking and mentoring, Kim is always looking for opportunities to submit abstracts and share her knowledge with others. She frequently speaks at industry forums, sits on several project boards, shares her knowledge freely, and writes every chance she gets. Her next goal is to present at an international conference, preferably in Paris. She also has a monthly column in her local newsletter, and will shortly release her first ebook.

**Jenny May**

Jenny May is a practising rural GP and a rural GP academic from the University Newcastle Department of Rural Health based in Tamworth in northern NSW.

She is the Chair of the Female Doctors group of Rural Doctors Association of Australia and a member of the steering group for the project ‘Working safe in rural and remote Australia’. This multidisciplinary group has supported the project funded by the Department of Health and Ageing looking at occupational violence against rural professionals. She is the Immediate Past Chair of the National Rural Health Alliance, a member of the National Dental Advisory Council and is a member of the National Lead Clinicians Group.

Her passion is for the delivery of high quality health care for all rural Australians. She is a GP supervisor, an examiner for RACGP and ACRRM as well as a GP at Peel Health Care in Tamworth. She was the recipient of the Brian Williams award from the rural faculty of the RACGP in 2012. She supervises and teaches medical students, junior medical officers, GP registrars and support GP education.

Her doctoral studies examine the adequacy of medical workforce in regional centres which she sees as crucial to the delivery of medical care in rural Australia.

**Jodie May**

Jodie May is a clinical senior dietitian in Country Health South Australia (CHSA), based at Inner North Country Health Service. She completed a Bachelor of Nutrition and Dietetics at Flinders University, commencing work in CHSA in 2004. Initially based in Port Augusta and Port Pirie, Jodie gained experience working in rural and remote areas of South Australia. A move to the Barossa in 2009 resulted in links with the local paediatric team. An interest in feeding disorders developed, triggered by some complex clients and attendance at the Sequential Oral Motor Approach to Feeding course run by US psychologist Dr Kay Toomey. Jodie further increased her skills and confidence in paediatric dietetics through undertaking a four-month contract at the Women’s and Children’s Hospital in 2010. After moving into one of the newly formed clinical senior dietitian positions within CHSA, Jodie took on the paediatric portfolio with the goal of supporting the knowledge and competence of CHSA dietitians in paediatric dietetics.

**Tony McBride**

Tony McBride is a consultant in strategic planning and consumer/community engagement with wide experience in the Australian health and community sectors. He has worked with a wide range of organisations including the National Relay Service, several community-managed mental health and community service agencies in Melbourne, the Inner North West Melbourne Medicare Local, professional associations (including the Australian Physiotherapy Association), Health Consumers Queensland, Red Cross, Inner South Community Health Service, Arthritis Victoria, Mind Australia, La Trobe University, and government departments in Victoria and Tasmania. He is also currently Chair of the Australian Health Care Reform Alliance, an alliance of 30 national and state health professional and consumer peak bodies. Previously he was the CEO of the Health Issues Centre (consumer-focused policy, research and advocacy centre) and worked in consumer participation, research, community development, disability, primary health, local government, academia, and the health bureaucracy (Commonwealth).

He is also a member of the NHMRC’s Prevention and Community Health Committee, the National Standing Committee on Quality Care of RACGP, and the Victorian Branch of the Public Health Association of Australia. He was previously a member of the National Advisory Council on Dental Health, and was the Convener of the 2012 Population Health Congress.

**Ruth McConigley**

Dr Ruth McConigley is a senior lecturer in the School of Nursing and Midwifery at Curtin University. She has extensive experience in palliative care in a number of different roles. She has been a palliative care clinician in both community and inpatient settings in rural and urban Western Australia. She has 15 years’ experience in palliative care education, including as a staff development nurse providing post-registration education, an educator of nurses at TAFE, undergraduate and, postgraduate levels, and has also been involved in providing education to aged care workers in the Certificate 3 course. Ruth has also been involved in a number of palliative care research projects and has had a total of more than $1 million of research funding in the areas of rural palliative care and oncology nursing. Ruth is also the co-author of the Outline of Palliative Medicine, a how-to guide for clinicians that is made available to general practitioners Australia-wide via the Royal Australian College of General Practice website.
Tim McCrossin
Associate Professor Tim McCrossin has been a consultant paediatrician in Bathurst for over 15 years and Clinical Dean for UWS Bathurst Rural Clinical School since 2009. Whilst functioning primarily as a busy regional general paediatrician, interests have of necessity diversified to include service primarily as a busy general paediatrician, service and rural health issues. Research pursuits continue to include the broad scope of general paediatrics including a strong developmental and behavioural interest. This interest has been facilitated by collaboration with the Faculty of Psychology at CSU, Bathurst, which, for the past 10 years, has offered a multidisciplinary developmental assessment service within Bathurst.

Sharyn McGowan
Sharyn McGowan hasn’t moved far from her childhood home in regional Victoria. After graduating as an occupational therapist from La Trobe she worked in mental health in Ballarat’s Lakeside Hospital and then in Belfast, Northern Ireland. On her return to Australia, she moved to Bendigo working in outpatient rehabilitation, gaining experience in musculoskeletal, work rehabilitation and driving assessments.

For the past 15 years she has worked with cancer patients in the management of lymphoedema. As part of a multidisciplinary team she worked to further develop the regional lymphoedema service at Bendigo Health, creating an education-based program for those at risk of developing lymphoedema.

In 2010 she commenced a project officer position in cancer care coordination with the local Integrated Cancer Service and has now moved on to a dual position as the occupational therapist for the outpatient radiotherapy service run by Peter Mac at Bendigo Health, and as the occupational therapist within the community palliative care team.

Sharyn is passionate about the provision of multidisciplinary allied health services to cancer patients throughout the care continuum and is working to develop a stronger allied health presence within the oncology services.

Jennifer McInnes
Jennifer McInnes is currently completing her Bachelor of Midwifery at the University of South Australia, and has a background in sociology, completing her BA (Sociology) at Monash University in 2010. Her interests include health equity, and maternal and reproductive health. Recently accredited as a systematic reviewer by the Joanna Briggs Institute (University of Adelaide), she is currently investigating the implications for miscarriage and stillbirth rates of antenatal interventions to limit pregnancy weight gain amongst clinically obese women.

Jennifer has volunteered internationally in marine conservation in the Philippines, education in Nepal, the prevention of child prostitution in Mongolia, and providing basic midwifery skills to traditional birth attendants as part of the 2H Project’s Safe Arrivals team in Cambodia. She has also volunteered with the Australian Refugee Agency in Adelaide, and was the 2012 President of ROUSTAH—the students’ rural health club for the University of South Australia, an NRHSN-affiliated club.

Ellen McIntyre
Ellen McIntyre is Professor and Director with the Primary Health Care Research and Information Service (PHC RIS) at Flinders University in South Australia where she conducts applied research to enhance the sharing of knowledge and information among researchers, policy makers, practitioners, primary health care organisations and consumer representatives. She is also a researcher in breastfeeding. Ellen coordinated breastfeeding education programs for health professionals from 1989 until 2006. In 2005, Ellen received an OAM (Medal of the Order of Australia) for service to the community as a lactation consultant and counsellor, and through the development and delivery of information and education courses on breastfeeding. She is a past Director and Chair of the International Board of Lactation Consultant Examiners (IBLCE).

Carol McKinstry
Dr Carol McKinstry currently coordinates the occupational therapy course at the La Trobe Rural Health School in Bendigo, Victoria. Prior to coming to La Trobe University, Carol worked at Bendigo Health as a clinician and senior manager in quality and patient safety. At La Trobe Rural Health School, Carol coordinates all occupational therapy professional practice placements including service-learning and project placements. As well as leading the rural workforce research team at La Trobe Rural Health School, Carol’s research areas also include teaching and learning, interprofessional placements and oncology rehabilitation. Her Doctorate research was in workplace learning for early career occupational therapists.

Deirdre McLaughlin
Dr Deirdre McLaughlin is a senior research fellow with the Australian Longitudinal Study on Women’s Health (ALSWH), at the School of Population Health, University of Queensland. Deirdre was most recently the project manager for the Men, Women and Ageing study—a large longitudinal study which was funded by the NHMRC/ARC under their Ageing Well, Ageing Productively strategic award program. This project combined data from the Perth Health in Men Study with data from the 1921–1926 birth cohort of the ALSWH to compare gender differences in health and wellbeing in late adulthood. She is currently responsible for establishing and managing linkages among Commonwealth and state-based administrative datasets and data from the ALSWH. Deirdre is a registered
psychologist and is active in the Australian Psychological Society Ageing Interest Group. Her research interests centre around ageing, including rural and urban differences in mortality and morbidity, the impact of chronic conditions, gender differences associated with ageing issues and psychosocial factors associated with ageing well.

Marg McLeod
Dr Marg McLeod is currently Associate Professor and Associate Head of School in the School of Nursing, Midwifery and Indigenous Health at Charles Sturt University, working from the Wagga Wagga campus. Marg has recently returned to the rural environment after a number of years in the national capital. She worked in various senior roles while in Canberra, including: Deputy Head of School, Nursing, Midwifery and Paramedicine; Director of Research, Faculties, Education and National Activities at the Royal College of Nursing Australia (RCNA); and Executive Director of Australian Rural Nurses and Midwives (ARNM). In this capacity she operationalised the merger of ARNM and the establishment of RCNA’s first faculty. Marg continues her involvement with the Rural Nursing and Midwifery Faculty Advisory Committee, now a part of the Australian College of Nursing (ACN). Marg’s nursing career spans over forty years, having worked for thirty of these years in rural locations. She continues to lobby for health care equity and access in rural communities.

Faye McMillan
Faye McMillan is a Wiradjuri woman from Trangie, NSW. She has entered her second term as the Chairperson of Indigenous Allied Health Australia and is the Director of the Djirrawang Program (Bachelor of Health Science–Mental Health Program) at Charles Sturt University in Wagga Wagga. Prior to this, Faye worked at the University of Wollongong as course coordinator of the Postgraduate Indigenous Health Program.

Faye has a Master of Indigenous Health Studies and a Bachelor of Pharmacy. She was the first Aboriginal pharmacist in Australia, graduating in 2001. Her passion is the recruitment and retention of Aboriginal and Torres Strait Islander people into health professions as she sees the need for Aboriginal and Torres Strait Islander health professionals across all fields. She is also a strong advocate for improved teaching of Aboriginal and Torres Strait Islander health in tertiary health courses. Faye has an in-depth knowledge of the health and participation needs of Aboriginal and Torres Strait Islander peoples, particularly in relation to mental health and community pharmacy.

Kate McQueen
Kate McQueen graduated as a physiotherapist in 1997, and specialised in cystic fibrosis (CF), lung transplants and chronic conditions. Following overseas travel, Kate worked in Newcastle upon Tyne, England. Kate returned to Australia, and worked in community health settings, then rehabilitation for over nine years.

In 2002, Kate co-founded a CF charity, inspired by one of her best friends who died from CF. Using the funds, Kate initiated and delivered a new concept physiotherapy service to CF patients. She completed preliminary research and presented in Anaheim, USA, as well as at Australian and NZ Conferences. The service still runs today, helping CF adults breathe easier, providing hands-on massage and musculoskeletal treatment.

Kate loved being a generalist physiotherapist, as she got to spend quality time with her patients treating a mixed bag of illnesses/injuries. Combining her strong connection with the CF community with her love of rural health, Kate then ventured into project management.

The Rural and Regional Support Project at Cystic Fibrosis Victoria (CFV) was a brilliant opportunity to develop different skills and foster her interest in regional health and chronic illness, as the project focused on upskilling local health care professionals to create and maintain local health care and support. Concurrently, Kate commenced her Masters in Remote Health Practice in Alice Springs, NT. Kate is also passionate about Aboriginal health, and the Masters inspired Kate to pursue another dream—to get into medicine. A change of career was enticing, and she felt she could put her varied experience together with her love for the countryside to good use—as a GP.

In 2012 Kate, now a mother of one, commenced graduate entry medicine at Flinders University, Adelaide. Her goal is to become a country GP, focusing on family health in rural, regional and remote areas of Australia.

Leigh-Anne Metcalfe
Leigh-Anne Metcalfe is a primary health care program coordinator with Townsville Mackay Medicare Local. Leigh-Anne has over 25 years’ experience working as a practice manager, working with general practice, specialists and allied health.

Prior to the formation of Medicare Locals, Leigh-Anne was employed by a Division of General Practice to provide practice support to 17 rural practices in north Queensland and can relate to the problems encountered by practices situated in rural and remote areas. These practices extended from Cardwell in the north, Richmond in the west, and as far south as Bowen and Collinsville.

Jacqui Michalski
Jacqui Michalski is a student support officer for Flinders University’s Rural Clinical School’s IMMERSe (Integrated Multidisciplinary Model for Education in Rural Settings) program in Mt Gambier, South Australia, where health science students move to the region on longitudinal placements and learn in interprofessional
groups. Jacqui is also employed by the Greater Green Triangle University Department of Rural Health’s student support program.

Jacqui provides admin support and pastoral care to students involved in both programs which cover the Greater Green Triangle area of south-east SA and western Victoria. She has worked at the Rural Clinical School for five years, ensuring that students’ rural placements are positive experiences and encouraging students to consider a rural career in health after graduation.

Deborah Mills

From a diverse background in community and cultural development spanning 30 years, the last 20 at director/CEO level, Deborah Mills has a strong record in management and policy development in the public and not-for-profit sectors as well as commercial environments.

Deborah’s professional policy and research background spans cultural, social, health, social justice and environmental concerns. She has worked in federal, state and local government jurisdictions as well as for the not-for-profit and commercial sectors.

Deborah is a Master of Arts in Cultural and Media Policy, a company director, a fellow of the Institute of Company Directors (FAICD), an experienced facilitator and a qualified mediator (LEADR).

Deborah is the co-author (with Dr Paul Brown) of *Art and Wellbeing: a guide*, (Australia Council for the Arts, 2004) and has written extensively on cultural policy.

Deborah’s thirteen years at the Australia Council culminated in her Directorship of the Community Cultural Development Board (CCDB) for five years. This was followed by an executive appointment to local government and an appointment as CEO of a not-for-profit organisation.

For the last ten years Deborah has worked as a freelance consultant in policy, organisational and leadership development. For the last three years she has led the Arts and Health Foundation’s (AHF) campaign for a national arts and health policy. This work informed the decision of the Australian Government’s Standing Council on Health in November 2011 to develop a national arts and health framework; a draft of which was released for consultation in October 2012.

Deborah has facilitated the consultation process on the draft framework which has enabled individuals and organisations working in the arts and health sectors to participate effectively in its development. The National Rural Health Alliance has partnered the AHF during this process.

Jane Mills

Associate Professor Jane Mills is employed in the School of Nursing, Midwifery and Nutrition at James Cook University as the Director of Research and the Associate Dean Research in the Faculty of Medicine, Health and Molecular Sciences. Jane has a h-index of 10 (Scopus), an i10 index of 12, a total of four research reports, four books (one in press), 12 book chapters and two in press, 84 refereed journal articles with two in press, and four national and international keynote or invited conference addresses. Of these approximately 50% are publications or presentations with regard to rural nursing issues. Key papers with regard to the nursing workforce that have been published on the James Cook University ResearchOnline@JCU and ResearchGate have resulted in over 1500 full paper downloads in the past twelve months. Research work undertaken as team leader for the Queensland Health Office of the Chief Nurse has been used to drive nursing reform in Queensland in relation to rural and remote nursing.

Jane has held an NHMRC primary health care fellowship. Her NHMRC study investigated practice nurses’ access to and use of evidence for their work. She has been a CI on a number of research consultancies. She has also been the lead on several projects for organisations including Queensland Health, Royal College of Nursing Australia, General Practice Queensland and Australian General Practice Network. She is therefore an experienced team leader. In 2012 Jane was awarded an Australian Government Office of Teaching and Learning Citation for Outstanding Contributions to Student Learning. The title of the citation was ‘For inspiring student nurses and midwives to understand and use research findings, developing confident clinicians who integrate evidence into their everyday practice’.

Her primary areas of research have been in the areas of rural nursing and primary health care. She is also an experienced supervisor of early career researchers and research higher degree students.

Christopher Mitchell

Dr Christopher Mitchell is a general practitioner in Lennox Head, New South Wales, working for over 20 years as a rural GP where he has an appointment at the Ballina District Hospital.

Chris is the Immediate Past President of the Royal Australian College of General Practitioners and is a board member of the RACGP, the National Prescribing Service, the Therapeutic Guidelines Limited, North Coast GP Training, and the Northern Rivers GP Network.

Chris is a clinical professor with the University of Wollongong and holds a fellowship of the Australian Institute of Company Directors.

Mark Mitchell

Mark Mitchell comes from a nursing background. He worked in the acute care setting for 15 years before moving into a rural community health service as a health promotion officer. Between 1994 and 2009 Mark gained
project experience working on a variety of projects, many specifically with the North Coast Area Health Service (NSW) Aboriginal Health team. Mark joined the SmokeCheck team at Sydney University, (Sydney School of Public Health) in January 2010, where he managed a project to build the capacity of services to deliver brief interventions. In August 2012 Mark accepted a position with Queensland Aboriginal and Islander Health Council (QAIHC). The primary objective of the current project is to assist Aboriginal Community Controlled Health Services to better detect and manage otitis media, develop primary prevention strategies and build partnerships with other health care providers to ensure a strong focus on primary health care is maintained.

**Kirralee Moores**

Kirralee Moores is a speech pathologist with the Early Learning for Families (ELF) program at Southern Fleurieu Health Service in Victor Harbor, South Australia. The ELF program provides a multi and interdisciplinary service to children under five years of age and their families living on the Southern Fleurieu. Kirralee has worked in rural South Australia since she graduated in 2002 from Flinders University. Having grown up in country South Australia she is committed to providing responsive and high quality services to the local community. Kirralee is passionate about family-centred and multidisciplinary practice and has been involved in designing, implementing and evaluating a range of programs for children with developmental challenges.

**Lauren Moran**

Lauren Moran joined the Australian Bureau of Statistics as a graduate in 2012 after completing her psychology degree at the Queensland University of Technology. She currently works as a cause of death data analyst within the ABS Health and Vitals Unit, which is responsible for collecting, analysing and publishing national data on births and deaths, causes of death, perinatal deaths, marriages and divorces, private health establishments, and interstate trade.

Lauren recently presented a poster on ‘The value of multiple cause of death data in the mortality spectrum’ at the Australian Mortality Data Interest Group (AMDIG) conference.

**Anna Morse**

Anna Morse is project manager for the Aboriginal Vision Program of Brien Holden Vision Institute, Public Health Division (formerly ICEE). Anna’s first four years upon graduating (2005–2008) were as a clinical optometrist in Alice Springs, where she also worked with the outreach ophthalmology clinics in Central Australian and Barkly region communities one day per week. Since 2009, Anna’s work for the Institute has seen her based in Darwin where she is part of a team who facilitates optometry services to over 75 community health centres and Aboriginal Medical Services (AMSs) across all regions of the NT, predominantly in very remote areas.

The Institute partners with Regional Eye Health Coordinators (REHCs) and AMSs in both the NT and NSW to deliver eye care services that are effective, accessible and appropriate for Aboriginal and Torres Strait Islander Australians. An important aspect of the program is provision of appropriately designed training in eye health for REHCs, Aboriginal health workers and other primary health care staff (eg GPs and nurses). This intends to upskill the frontline health care staff in primary eye and vision care, to improve earlier detection and timely referrals for people in their communities.

As lead collaborator, the Institute is also involved in the Vision CRC research project ‘Models of vision care delivery for Aboriginal and Torres Strait Islander communities’. This project, spanning five years (2010–2015), aims to understand current practices and systems for eye care coordination and service delivery for Indigenous communities and work with health services to develop, implement, evaluate and refine a set of practical tools and systems to support and improve eye care outcomes for their patients.

**Daniel Mosler**

Dr Daniel Mosler trained in medicine at the University of Adelaide and began training in psychiatry at Flinders Medical Centre in 1999. He later developed an interest in rural psychiatry during a rotation with the Rural and Remote Mental Health Service in 2004. After securing a position as a staff specialist with Rural and Remote Mental Health Service in 2005, this has developed into an interest in telepsychiatry, integrating technology into mainstream clinical practice and developing local systems of care with regional country networks in South Australia. The service covers approximately 998 000 km² and a population of just under 475 000, with up to 2200 clinical telepsychiatry sessions each year.

Daniel’s clinical practice has centred on visiting clinic services to the South East Region, SA, in addition to the telepsychiatry service. He was granted a research award at the 2008 RANZCP National Congress for a research presentation relating to the development of telepsychiatry in South Australia. He was involved in a joint Commonwealth and state-funded substantial upgrade of existing network to a high-definition broadband-based network in 2011. He is currently working on a project involving a substantial improvement to the availability and quality of videoconferencing technology for mental health care, as well as establishing a Home Based Intermediate Care Service with seven available packages of care for South East Region residents, which should contribute to the enhancement of mental health care for the South East Region.
Lara Motta

Lara Motta is a research assistant at the Flinders University International Centre for Point-of-Care Testing. Lara is the point-of-care coordinator for the ACE (Analytical and Clinical Excellence) program, an international point-of-care testing (POCT) model for diabetes management which is now operating in 18 rural and remote Indigenous communities in seven countries. Lara is also the web manager for the Centre’s Graduate Certificate in Global Point-of-Care Testing, the first postgraduate academic qualification in the field of POCT.

Within Australia, Lara assists with training device operators and supervising quality testing for the largest national POCT program in Australia, QAAMS (Quality Assurance for Aboriginal and Torres Strait Islander Medical Services), which involves over 170 Aboriginal medical services, as well as the Northern Territory POCT program, and the Diabetes Management Along the Mallee Track program. Lara is also involved in TTANGO (Test, Treat and Go), a new NHMRC-funded trial investigating POCT for chlamydia and gonorrhoea in remote Australian Aboriginal communities.

Lara achieved First Class Honours in 2011 for her Honours thesis titled ‘Optimising point-of-care testing services for diabetes management in the Victorian Mallee Track’, and was awarded the Flinders University Medal in 2012 and the Neil Della Scholarship in 2011; both awards recognise her outstanding academic performance as an undergraduate student at Flinders.

Lara was as an invited speaker on POCT for HIV at the 28th Annual NRL Workshop in Canberra, and has presented posters at the 28th NRL Workshop and the 2012 Australian Institute of Medical Scientists (AIMS) National Scientific Meeting. Lara presents lectures in the Flinders University Bachelor of Medical Science POCT topic and has developed a video lecture on POCT for HIV in low resource settings in a collaboration with the University of Davis, California.

Mia Mulladad

Mia Mulladad is an Aboriginal family worker and community leader who has lived all her life in the remote Aboriginal community of Santa Teresa of 500 people, 80 km south-east of Alice Springs. Mia is a traditional healer who is involved in many local organisations including the Spirituality Centre which is a place of healing alongside various arts and crafts.

Emily Murphy

Emily Murphy is assistant project officer for healthTrack—Preventative Health Initiative and works as health promotion officer for Country Health SA Local Health Network Lower Eyre Peninsula Community Health Service, on the Eyre Peninsula. She graduated from Flinders University with a Bachelor of Health Science (Health Management)/Bachelor of Commerce (Accounting) in 2010. Emily is currently a member of the Australian Health Promotion Association and has recently completed their mentoring program.

Fiona Murray

Originally from the UK, Fiona Murray moved to South Australia and took up the post of Advanced Clinical Lead Podiatrist for Country Health South Australia (CHSA) on 1 February 2012.

Fiona qualified in the UK as a podiatrist in 1988; she has worked in many different clinical settings covering the whole scope of podiatry practice. From 2000 until her recent move, she was responsible for running the Diabetes Foot Service for Northumbria NHS Trust. Fiona has published a number of articles related to the diabetic foot and wound healing. She has presented at a number of national and international conferences on different aspects of the diabetic foot, wound healing and patient psychology.

Fiona has participated in a number of national guideline consultation groups for NICE, and was the founding Chairperson for FDUK (The Foot in Diabetes UK), a national interest group for the diabetic foot which has been responsible for producing a number of evidence-based national guidelines and care pathways.

Fiona is always keen to participate in research that adds to the evidence base of not only podiatry but allied health as a whole. She is in the final stages of completing her MSc in Podiatry.

Since her move to CHSA, Fiona has focused on establishing CHSA-wide standards for podiatry. Establishing a state-wide eligibility criteria is one of the first pieces of work CHSA Podiatry has completed.

Debra Myers

Deb Myers is an experienced arts manager and community cultural development worker, often working in regional or remote communities. She is currently the Creative Producer of the Yijala Yala Project based in Roebourne, WA, with the arts and social change organisation Big hART. Since 2006, she has been working full time in the not-for-profit arts sector with organisations such as the Adelaide Festival, Ananguku Arts and Culture Aboriginal Corporation, Ernabella Arts, Heart of Gold International Film Festival. Joining Big hART in mid-2010, Deb has lived and worked in Roebourne on the Yijala Yala Project since its inception, producing the project’s creative outputs such as an interactive comic for iPad, short films and the soon to tour major theatre work ‘Hipbone Sticking Out’.

Big hART is Australia’s highest-awarded, most innovative and high-impact social change arts company. Big hART brings artists and communities together on projects that empower positive change through the arts, working to produce quality art and effective social change at the same time. Established in 1992, the company works with...
individuals, communities and the nation, on projects that traverse three platforms—community development, art of excellence, and social policy. It has since expanded nationally, having worked in 43 communities, with 7500 individuals, producing 14 nationally and internationally touring theatre works and six feature length films. Big hART’s guiding motto is ‘it’s harder to hurt someone if you know their story’.

Enid Nangala Gallagher

Enid Nangala Gallagher was born in Yuendumu, NT, and attended schooling there and in Darwin and Alice Springs. Enid has trained for teaching primary grades, worked with Mt Theo as a cultural mentor, is a Mt Theo board member, holds a Waljja certificate in leadership and a Batchelor Institute of Indigenous Tertiary Education Graduate Interpreters Qualification. Enid currently works for NT Department of Children and Families, Remote Aboriginal Families and Children, working in a team to support families and clients in Yuendumu, Nyirrpi, Willowa and Yuelumu.

Enid joined the Mt Theo WYDAC (Warlpiri Youth Development Aboriginal Corporation) Committee in 2004 serving for periods as Chairperson and has attended several conferences on behalf of the program. Enid and her husband travelled to attend the Healing Our Spirits Worldwide conference in 2006 in Canada as a representative of the program.

Enid has been the Cultural Custodian of the Southern Ngalia Women’s Dance Project since its inception in 2010. In this role Enid is responsible to the Warlpiri communities of Yuendumu, Willowra and Nyirrpi and directly liaises with InCite Youth Arts, Mt Theo workers and senior Warlpiri women to support this cultural transmission program. Enid also acts as translator, provides transcriptions of project materials and reports to InCite and the Mt Theo Board (including Traditional Owners and Cultural Custodians/Elders).

Enid is a mother of four and grandmother of six. Enid says: ‘It’s a good thing that these camps and workshops keep going so the girls can learn. It helps them maintain their culture. The dance camps are good for the young people so they can learn both ways and keep on carrying it, so they can be strong leaders for their communities.’

Alexandra Newcombe

Alexandra Newcombe trained as a physiotherapist in the UK and worked in a large metropolitan hospital for five years before moving to a rural community GP practice. Alexandra moved to Queensland eight years ago and commenced as senior physiotherapist at Warwick Hospital. Alexandra has special interests in chronic pain, chronic disease management, musculoskeletal injury and stroke rehabilitation. Alexandra is currently working as project officer/clinician for a rural model of care project in the role of rural generalist allied health clinical leader working in the emergency department. Alexandra has a passion for rural practice and raising the profile of the scope and skill of allied health professionals.

Alexandra lives with her extended (four legged) family on an apple orchard outside Stanthorpe. Interests include competitive horse riding, rural life, classical ballet, pilates and growing English roses. Alexandra is also a qualified animal physiotherapist.

Jane Newman

Jane Newman is a Clinical Nurse Consultant Women’s Health, currently employed with Mid North Coast Local Health District. She has worked in a variety of nursing settings for over 30 years, including operating theatres, maternity services, cancer services, IVF, health promotion, project management and both nursing and health management. Jane has worked in women’s health in various clinical and management roles for the past 15 years.

Jane’s passion currently focuses on health promotion, intervention and early detection and empowering women in communities to take control of their health outcomes. This is achieved by education and support programs on a range of women’s health topics, across the lifespan from puberty to managing chronic illness and ageing well.

Jane provides women’s health clinics across several towns in the MNCLHD and offers several outreach clinics as required. She enjoys the opportunity to provide outreach services to isolated communities and also particularly enjoys developing programs to suit the needs of clients and the community. She regularly attends conferences, workshops and motivational groups to maintain the knowledge base and enthusiasm necessary to undertake a consultative role.

Jane lives in a beautiful rural coastal community and participates in many community events in the region. She has a passion for fine food and wine, long lunches with friends and is always planning her next holiday.

Brent Nielsen

Brent Nielsen has worked for the New Zealand Institute of Rural Health for nearly two years and is an experienced and organised senior manager in the health sector strongly focused on relationships, people, performance and results.

He has over ten years’ experience as a senior manager predominantly in the rural health sector, whilst leading complex business units effectively, in a non-government organisation and as project manager for the Transformation and Innovation Directorate of the national ambulance service provider.
Brent has a sound understanding of rural health issues and significant strategy development and implementation experience, complete with a Masters in Business Administration from Waikato University.

Brent resides in, and participates extensively with, the rural community of Cambridge, New Zealand, as well as governance roles for Cambridge Life Skills and Priory Chapter of St John in New Zealand.

**Shannon Nott**

An ambitious and passionate junior doctor, Dr Shannon Nott has proven himself to be an emerging leader in the field of health in Australia. As co-Chair of Future Health Leaders, a new organisation representing the 200 000 health professionals in training, Shannon works to improve health outcomes for all Australians and their neighbours in the Asia-Pacific region. Future Health Leaders aims to develop both innovative and sustainable solutions to current health issues in Australia through engagement with students and early-career health professionals across professions and sectors.

Shannon’s passion for creating a brighter future, particularly in the field of rural health, has seen him win numerous prestigious awards including Australian Medical Student of the Year in 2009 and being NSW Finalist for Young Australian of the Year in 2010. His leadership within the field of health has also seen him be the youngest member appointed to the Minister’s Men’s Health Reference Group advising Government on how to improve men’s health across the country.

Of Shannon’s many interests, rural health remains at the top of his list. Moving forward from his work as a medical student within the National Rural Health Students’ Network (co-Chair, 2008 and 2010) and the Australian Medical Students’ Association (Rural and Indigenous Officer, 2009), Shannon now works at Orange Health Service in central NSW. As a young advocate, Shannon has been invited to speak at many prestigious summits, chair multiple health organisations and has developed and run programs to develop a new generation of leaders across Australia.

**Maree O’Hara**

Maree O’Hara is a registered nurse and has been the Barkly Eye Health Coordinator for Anyinginyi Health Aboriginal Corporation in Tennant Creek, in the Northern Territory, for seven years. She is responsible for eye care for approximately 8000 people over 322 500 km² of the Barkly region.

Optometrist clinics are organised and attended by Maree and her assistant. She works with the ophthalmologist six times a year in Tennant Creek.

Maree has worked in Aboriginal affairs for 26 years including health, education, employment and the pastoral industry.

Originally from Sydney, Maree has worked not only in NSW, but Queensland and the Northern Territory.

Anyinginyi Health Aboriginal Corporation has allowed Maree to create a model of eye care that is sustainable for the future, if funding allows. The first year she started (under a different model) 90 people were seen. Last year there were 1200 people seen, the majority Aboriginal.

Maree is the only eye coordinator for the area, which allows her to put all patient information on Anyinginyi’s Communicare system. She also coordinates the surgical list. To achieve this, Maree has had continuous consultation with patients and continuous mentoring and advice given to her by Aboriginal colleagues. This has ensured a culturally appropriate, workable model.

However partnerships are crucial to this so that visiting services continue. They include Brien Holden Vision Institute, Fred Hollows Foundation, Tennant Creek Hospital, Alice Springs Hospital Eye Clinic, and RFDS.

The last major achievement was this year. A health promotion DVD was made by Fred Hollows Foundation based on Maree’s idea, using her as a consultant and filming at one of the Barkly Aboriginal communities.

**Lyn Olsen**

Lyn Olsen has been a nurse and midwife for over 34 years. Thirty-one of those years have been living and working in country South Australia.

She started her nursing career at her local hospital of Kimba and completed her enrolled nurse qualification at the Kimba Hospital in 1975. She then went to Adelaide and completed her qualifications as a registered nurse and then midwife in 1979 at The Queen Elizabeth Hospital.

Lyn returned to country South Australia, and worked as a nurse and midwife at the Streaky Bay Hospital. She was appointed as the Director of Nursing and Midwifery of Streaky Bay Hospital in 1984 until 1986.

In 1986, her family relocated to Port Augusta, and she then worked at the Port Augusta Hospital, in the roles of nurse, midwife, infection control nurse and deputy director of nursing.

Lyn completed her Diploma and Bachelor of Applied Science—Nursing in 1990 through Flinders University, Adelaide.

In 1994 the family moved to Quorn, in the Flinders Ranges of SA, where she managed the local aged care service for four years, overseeing the build of a new facility.

In 1998 Lyn returned to work at Port Augusta Hospital, as the Director of Nursing and Midwifery, a position she held for 10 years.

In 2009 she was awarded the South Australian Health Nurse Leadership Award.
In 2010 she was appointed as the inaugural Director of Nursing and Midwifery for Country Health in South Australia, when all 65 public hospitals in country SA combined under a single governance structure. This later transitioned to become the Country Health Local Health Network. She remains in this role today, and has led many changes for nurses and midwives across country South Australia, including the development of the clinical nurse role in improving safety and quality across the 65 hospitals.

**Peter O’Meara**

Dr Peter O’Meara is the Professor of Rural and Regional Paramedicine at La Trobe University in Bendigo, where a new course that focuses on the education and training of paramedics for rural and regional practice is being established. He was previously Professor of Paramedic Practice and Leadership at Charles Sturt University and one of the early staff members at Monash Rural Health. Prior to entering academia he worked in a wide range of operational and management positions for rural ambulance services in Victoria.

Peter is a member of numerous national and international colleges and associations, including the Paramedics Australasia, Australian College of Ambulance Professionals (New South Wales), Health Services Research Association of Australia and New Zealand, World Association of Disaster and Emergency Medicine, Paramedic Chiefs of Canada, Paramedics International and the International Roundtable on Community Paramedicine. Peter has undertaken extensive research related to rural health and ambulance services over the last 15 years. His current research is focusing on the development of conceptual and evaluation frameworks for the emerging role of community paramedics in rural Australia and North America.

**Kate Osborne**

Kate Osborne graduated from physiotherapy in 1998 and discovered her passion for rural and remote health in 2002 when she accepted a role in the beautiful Barossa Valley, where she continues to be based to this day.

She is in the Advanced Clinical Lead Physiotherapist for Country Health SA Local Health Network (CHSALHN), a role that enables her to connect with staff across all of rural and remote South Australia. Kate is well versed in the unique, and at times challenging, environments that confront allied health professionals in rural and remote settings. Since December 2012, Kate has been supporting significant operational health reform for CHSALHN as an acting regional operations manager for the Barossa Hills Fleurieu rural region. In her spare time Kate also dabbles in health reform at a national level, including through her role as board member for Services for Australian Rural and Remote Allied Health (SARRAH) since 2012.

Kate has extensive and practical knowledge of what works in this challenging environment and is committed to empowering allied health staff to bring about real change for the communities they serve. She has a holistic health focus and is committed to addressing the social determinants of health wherever possible to address inequities in health outcomes.

Kate lives in the Barossa and, when not working, she enjoys an active lifestyle with her many friends and family, including a commitment to the local sporting clubs.

**Katy Osborne**

Katy Osborne is a research fellow in the South Australian Community Health Research Unit at Flinders University in South Australia. She is a social scientist with a PhD in public health, and has an overriding research interest in examining the social determinants of health and health inequities. She works on research and evaluation projects relating to the social determinants of health, and has undertaken research in the areas of politics and public policy. Her research interests lay in the areas of gender and women’s health, neighbourhood and place as social determinants of health, and how participation in different life domains such as paid work, community volunteering, unpaid domestic work and leisure influence health in different ways. Katy applies both qualitative and quantitative methods in her research. She is experienced in multidisciplinary research, policy-relevant research and working with partners from outside the research sector.

**Althea Page-Carruth**

Dr Althea Page-Carruth has been living in Queensland for seven years only. Born in Tanzania and brought up in England since the age of five, she then moved to New Zealand to get married and raise a family. Fourteen years later she moved to Australia to follow her husband in his chosen line of work.

Originally she trained and worked as a podiatrist and, in her early career, worked as a senior podiatrist with responsibility for podiatry diabetic clinics in three London hospitals. Since then she has pursued a varied career in the UK as a clinician, then community health manager and then lecturer at Westminster University. In New Zealand (NZ) she led the NZ podiatry course but then worked as a private practitioner with a rural practice as this complemented family support roles. Later roles as a director of Central Otago Health Services, which ran the local rural hospital and community services, and as a member of the National Advisory Committee on Health and Disability in NZ, engendered a passion to ensure the equitable delivery of health care and a greater interest in broader public health issues.

Arriving in Australia, Althea decided to use the change of location and the dislocation from a full-time work as an opportunity to continue management studies and to contemplate health from the public’s perspective. She hoped that, by understanding the perspectives of rural
people in Queensland who experience firsthand what it means to live with diabetes, it would enable better rural service delivery solutions. Although involved in situations whereby health consumers had presented their opinions, there was often a gulf between their understanding and those of the clinicians with whom they spoke. Her studies have provided an opportunity to gain a deeper understanding of rural health consumers.

Georgia Panagiotopoulos

Georgia Panagiotopoulos (BPsychHons) is a third-generation Greek-Australian interested in conducting research with CALD communities who are routinely excluded from mainstream research. Born in the Riverland, she moved to Adelaide to pursue psychology at Flinders University. Her Honours thesis compared the wellbeing of older, widowed first-generation Greek and British-Australian migrant women. Her current PhD under Southgate Institute for Health, Society and Equity (Flinders) extends this research by exploring the widowhood experience and wellbeing of older Greek individuals in rural and urban SA. She is specifically interested in the social determinants of health and wellbeing, and gender differences. Georgia’s interest in this area was spurred by the experiences of her grandparents and parents. Her cultural background affords her the opportunity to conduct research solely in the Greek language before translating it to English for wider dissemination.

Annette Panzera

Annette Panzera is a part-time research officer in the James Cook University School of Medicine and presently working on the HWA-funded regional workforce planning project in north Queensland. She is also involved in expanding simulated learning capacity at the Cairns Clinical School and a liaison between JCU and QH for all medical education activities. In addition, she is presently engaged as part-time data manager on a clinical redesign service project for Queensland Health (located in Cairns and Hinterland Hospital and Health Service) examining how the hospital can improve ED waiting times to achieve the four-hour National Emergency Access Targets (NEAT).

Before returning to Australia in mid-2010, Annette spent 10 years working at the Organisation for Economic Cooperation and Development (OECD) headquarters in Paris, France, as a statistical policy analyst. Here she focused on producing quantitative health, education and family policy research. Some examples of OECD publications that she contributed to include: Health at a Glance, in particular the Health Quality and Care Indicators (HCQI); Child Health Indicators amongst others for the OECD Family database (2007-2010); Education at a Glance; and the Programme for International Student Assessment (PISA) (2004-2007). She was also one of the lead researchers on the Australian case study examining the importance of the role that private health insurance plays in OECD members’ health systems (2002-2004).

Annette has also worked as a consultant for the European Union, World Bank and the Unesco Institute for Statistics in developing quantitative indicators and databases on international health, family policy, pension and educational systems designed to support member countries’ policy reform initiatives in conjunction with work led by the OECD.

Jo-Anne Parker

Jo-Anne Parker has worked as a registered nurse since 1994 in a variety of roles. In 2008 Jo-Anne relocated with her family from Victoria to Western Australia. Jo-Anne is currently working as the Senior Public Health Nurse for WACHS—Goldfields and is based in Kalgoorlie, WA. This role is very diverse, ranging from disease control and prevention to health promotion.

Jo-Anne grew up in far-west NSW and, as a result, has a passion for services in rural and remote areas particularly those specific for Aboriginal people.

Jo-Anne is nearing completion of her Master of Public Health through Newcastle University and holds a Graduate Certificate in Management for Health Care Professionals from RMIT and Certificate in Sexual and Reproductive Health through FPWA.

Jo-Anne firmly believes that together we can make a difference.

Judi Parson

Dr Judi Parson is a paediatric qualified registered nurse, play therapist and postdoctoral research fellow at the University of Tasmania. She has experienced a clinically diverse nursing career which has taken her across a number of Australian states and to the United Kingdom. She has practiced in various specialty fields including aged care, transplant care, radiology, and paediatrics. She enjoyed being a nursing academic in Mackay, Queensland, prior to moving to Smithton, Tasmania, in 2004, where she completed her PhD. Her doctoral thesis was titled ‘Integration of procedural play for children undergoing cystic fibrosis treatment: A nursing perspective’. The results of Judi’s thesis then led her to investigate further play therapy techniques that would be appropriate for medical, nursing and allied health professionals to integrate specific skills for paediatric clients experiencing acute care services. She completed her MA Play Therapy (with Distinction), Roehampton University London, United Kingdom, to become a fully qualified play therapist and is actively involved in the development of play therapy in Australia.

Judi has presented in Australia, New Zealand, Oman, South Korea and United Kingdom, and comes to her current postdoctoral research fellowship post, based at the Rural Clinical School in Burnie, with research interests in
psychosocial health and specifically in developing play therapy across the lifespan. Judi is currently writing articles for publication on how play techniques can be integrated into health care services. Judi runs a small clinic at Play Therapy World in Ulverstone, and supervises play therapists as well as postgraduate research candidates in nursing and play therapy.

**Jodie Peace**

Jodie Peace is an accredited practising dietitian (APD) who has spent her working career providing services in rural communities within the Hunter New England Local Health District NSW, including Tamworth where she is currently based in the Tamworth/Nundle Community Health Service, Child and Family Allied Health team.

Jodie is dedicated to improving the health outcomes of children and families, and is passionate about developing and implementing community-focused health promotion and education strategies targeting preventative health risk factors in vulnerable groups.

Jodie has been involved in many successful and innovative multidisciplinary programs focusing on individual, workforce, and community capacity building to assist improving equity of services in rural areas.

**Jim Pearse**

Over the last 25 years Jim Pearse has been an active participant in health policy issues and research both within and outside of government. He established Health Policy Analysis Pty Ltd in 2003, a consulting firm focusing on health policy, analysis of health data for decision making, performance indicators, and health economics. Since 2003, Health Policy Analysis has undertaken a large number of consulting projects for the Commonwealth and state government, and non-government clients, including projecting demand for health services, costing, development of funding models and evaluation of health services. One of the more recent projects was a national evaluation of the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme.

Prior to establishing Health Policy Analysis, Jim spent 18 years working in various health and social policy areas within the public sector, most recently with the NSW Department of Health, and previously with the health and community services authority in the Northern Territory. In these roles Jim particularly focused on issues related to health service delivery, program evaluation, and funding for remote populations. Within NSW Health, Jim led work on the achievement of government equity objectives through resource allocation policies and models, the implementation of output-oriented funding approaches for hospital services, and Commonwealth/state relations.

Jim was a 2000–2001 Commonwealth Fund Harkness Fellow in Health Care Policy, and currently holds an honorary appointment as an associate professor with the Centre for Health Service Development at the University of Wollongong.

**Lesley Pearson**

Lesley Pearson is currently the Silver Chain Regional Manager of Country Primary Health, an area that covers over four state regions within WA. Lesley is responsible for leading and managing services to 12 Remote Health Centres from Shark Bay to Eucla, and four primary health hubs where Silver Chain provide nurse practitioners.

Lesley has taken leadership to the evolvement of the primary health services and nurse practitioner models to the communities within these regions. Lesley has 34 years of health experience in providing services to rural and remote communities, and is passionate and innovative about improving and challenging the inequity in health access to marginalised communities.

In 2007 Lesley was the executive producer (and film location nurse) of a small drama film *We Always Dress for Sunday Lunch*. This film confronts the issues for health services around individuals stories focusing on the impact and importance this has in person and community-centred care. In 2008 this short film won an AFI cinematography award.

Lesley was the recipient of the 2012 CRANAPlus Remote Health Management Award, nominated for her leadership in innovation, for her compassion and high degree of integrity in the delivery of health services to rural and remote Australian communities.

**Dianne Penberthy**

Dianne Penberthy’s home town is Bonny Hills on the mid-north coast of NSW where she lives with her husband and daughter. Dianne began her training as a nurse back in the 1970s in Newcastle as a mental retardation nurse at Stockton Hospital. She went on to complete her psychiatric and general nursing in the Sydney area. In 2004 Dianne completed an Advanced Diploma in Business Management through the University of New England.

Dianne is a registered nurse specialist and has worked for the NSW Health Service most of her career of 30 years. She has just completed the NSW Health Clinical Leadership Program—Leading For Better Patient Outcomes and is a strong advocate for this program.

Currently Dianne is the acting manager of Macksville and Bellingen Community Health teams and the Rural Primary Health Service. This is a team of over 60 allied health and nursing staff located in three different community health services.

Dianne’s previous position, for six years, was the Health Promotion Coordinator for the Rural Primary Health Service, working in communities of populations >5000 on the mid-north coast of NSW. Her role was to improve...
community access to quality primary health care services by working in partnership with communities and health professionals where she has undertaken many successful community projects. The Losing it in the Bush program is one of these successful programs with some fantastic outcomes. This program was a finalist in the local Health District Quality Awards 2012 and the winner of the Hastings Macleay Allied Health Awards for the Best Multidisciplinary Team Project 2012.

Joy Penman
Joy Penman teaches both science and nursing courses at the Nursing and Rural Health Unit, Centre for Regional Engagement, University of South Australia. She has over twenty years’ teaching experience locally and abroad. She recently completed her doctoral studies on spirituality in palliative care. Joy has extensive nursing, research and community service experience.

Jennifer Perino
Jennifer Perino is employed within the NSW Health services as Senior Health Clinician for the Dubbo Joint Investigation Response team. In this role she provides an interface between health services and the tri-agency partners of NSW Police Child Abuse Squad and Family and Community Services JIRT in the investigation response to child abuse and child sexual assault.

Jennifer’s background as a mental health clinician with specialist skills in trauma, abuse, and critical response have been particularly focused on children and assisting them to recover from the impacts of their experiences.

Jennifer established and managed a successful private practice for more than a decade in the rural remote towns of western New South Wales establishing services in numerous towns, providing training and support for service providers, clinical supervision for domestic violence workers, counsellors, Aboriginal health workers, and practical workplace assessments for counselling students.

Jennifer’s expertise in domestic violence, trauma and crisis counselling supported the presentation of domestic violence forums in ten towns from Broken Hill, Bourke and Cobar through Nyngan, Narrmorne and Dubbo to Walgett, Lightning Ridge, Coonabarabran and Coonamble.

After 4–5 years as Regional Coordinator of the Bila Muuij Social Emotional Wellbeing Initiative for a consortium of Aboriginal Health Services auspice by Bourke Aboriginal health service, Jennifer left NSW to work as mental health clinician for the Norfolk Island Hospital Enterprise. Utilising professional networks and excessive creativity Jennifer was instrumental in choosing, customising and implementing Norfolk Island child protection frameworks and developing links and partnerships to promote equity of access to health services.

David Perkins
Associate Professor David Perkins is Director of Research at the Broken Hill UDRH, University of Sydney. He has worked as an academic in five universities and senior health service manager in the UK NHS. He is Editor of the Australian Journal of Rural Health and a chief investigator in the Centre for Research Excellence Rural and Remote PHC. His research interests include the integration of mental and physical health care within rural settings, remote health service models, health service access and workforce development. David is a chief investigator on the Australian Rural Mental Health Study. He lives in Broken Hill, the accessible outback.

Robert Petchell
Robert Petchell is a freelance composer and music director who works with both professional and community-based musicians and groups. He is Music and Project Director of The Jam, The Mix, The Gig Inc. music and mental health project based in Adelaide, is Composer/Music Director for ‘Change & Adaptation’ a three-year arts, health and the environment project (2012–15) in the Southern Fleurieu region of SA; and he creates his own works such as the ‘Immersion’ CD for Soundscape and Saxophone.

Lisa Philip-Harbutt
Lisa Philip-Harbutt has spent over 30 years as an artist exploring the overlaps between visual, performing and community arts. Her passion is initiating cultural development and social change through arts practice. Lisa has been artist in residence on many projects. She has worked in rural and urban contexts, in schools, workplaces and community settings. She has designed sets and costumes, painted murals, made sculptures, puppets and temporary installations, created plays and short films, taken photos and edited videos. She uses the most appropriate artform for the concept of the project.

Lisa has been involved in the arts and health field of practice for over 20 years. During 1997–98 Lisa was the first Community Artist in Residence at the Flinders Medical Centre (FMC). FMC Arts in Health Program was the first program to be established in a hospital in South Australia and is recognised as the largest and most diverse program in Australia. Lisa also ran the Arts and Health stream of the National Rural Health Alliance Conference in Canberra in 2001.

Lisa has a BA in Visual Arts and Masters in Business (Research) in which she tackled decision making in the arts sector in South Australia. Her methodology was participatory action research. Situated in the International Graduate School of Management, her thesis was titled ‘Look out there is an artist in the business school doing research: A quest for an appropriate methodology’.
Lisa has been the Director of Community Arts Network of South Australia (CAN SA) for nine years. CAN SA is a small membership-based not-for-profit incorporated association. For over 30 years CAN SA has supported artists and communities in the development of their own arts and cultural practices.

Jennifer Pilcher
Jennifer Pilcher is studying for a PhD at the University of Sydney. Her main area of interest is in rural and remote health service planning. As a PhD student she is part of a team developing an index for planning maternity services in Australian rural and remote communities.

Jennifer has extensive clinical experience as a nurse and midwife in both the rural and metropolitan sectors and has worked interstate and overseas. She has held various clinical positions in the university, public and private sectors.

Jennifer currently works in the State-wide, Strategy and Planning team for Queensland’s Department of Health. She has managed health service planning projects including maternity and neonatal clinical plans; development of tools and frameworks; health service delivery in regional, rural and remote areas, including those areas impacted by resource industry growth; and the impact of infrastructure on contemporary health service delivery in rural and remote areas in Queensland.

Jennifer also managed the restructure, development and stakeholder consultation of the review of the Queensland Health Clinical Services Capability Framework v3.1.

Jennifer has been a member of a number of steering committees, investigating ways of improving access to health services in rural and remote areas. These include improving access to sustainable surgical services in rural and remote areas; infrastructure needs; solution finding for rural and remote specialist obstetric services; and implementation of maternity service review recommendations.

In 2008 Jennifer was awarded a scholarship to study a Graduate Certificate in Policy Analysis at Griffith University, which supported the work she was involved with in state-wide health service planning. She has also completed her Masters in Public Health in 2000 with a dissertation on 'Postnatal Depression and Health Service Use'.

Karen Piper
Karen Piper started with the Centre for Remote Health in 2003 and was part of the PHCRED NT program. She is currently part of the teaching program, and is the topic coordinator for remote primary health care. Karen facilitates primary health care workshops across Australia as well as being part of the Child Protection team, facilitating CP workshops across the NT. After graduating as a nurse and working in various clinical positions in Australia and internationally, Karen has for the last twenty years been working in community health in urban, rural and remote settings. This includes forensic nursing at Berrimah, as a midwifery educator, and as a child and maternal health nurse. She works collaboratively with a number of health service agencies in a range of primary health care activities. She has a Masters in Primary Health Care from Flinders University.

Her research interests include evidence-based practice, social marketing and health promotion, knowledge transfer, community development, quality and safety in primary health care and project evaluation, FASD and adolescent health.

Cara Polson
Cara Polson is a newly graduated accredited practising dietitian passionate about improving Indigenous health outcomes. Cara is currently working with Apunipima Cape York Health Council as a community nutritionist and highly values family-centred preventative health initiatives that focus on community strengths.

Rob Porter
Rob Porter has an Honours degree in Arts, with majors in philosophy and psychology. He has spent over 40 years travelling and working in rural and remote Australia in a variety of jobs, including as an ambulance officer and paramedic in rural Queensland, South Australia and the Northern Territory. Rob now lives in Peterborough in the mid-north of South Australia and is working with Flinders University’s Mid North Knowledge Partnership to develop new approaches to examining the age-old issue of recruitment and retention of rural and remote health professionals.

Sharyn Potts
Sharyn Potts is the Executive Officer of Yarredi Services. Based in Port Lincoln, Yarredi provides a regional domestic violence service and regional victim support service.

Sharyn has worked with victims of domestic violence (DV) since 1986, firstly with children, then with women escaping or affected by DV.

In 1998 Sharyn took on the role of Executive Officer and has been in that position ever since. She studied at Monash University through distance education, graduating with a double degree in 2002.

Over her time with Yarredi she has led the organisation through several major changes. The organisation has expanded substantially over the years in response to the needs of the community.

Sharyn’s career highlights include: being awarded life membership of Yarredi on her completion of 20 years of service; being awarded Victim Worker of the Year and Life Membership of VSS in 2006; being a ministerial
appointment on a state government forum for the prevention of domestic violence; receiving a Zonta Women of Achievement Award in 2009; and chairing the Coalition of Women’s Domestic Violence Services of South Australia.

She is a current member of the Coalition as well as the Port Lincoln Health Advisory Council and a board member of the Family Violence Legal Service Aboriginal Corporation which covers Port Augusta, Ceduna and Port Lincoln. She is also co-Chair of the Port Lincoln Domestic and Family Violence Action Group—a regional Violence Against Women Collaboration. Sharyn is also a member of the Women with Disabilities and DV Reference Group.

Her current hobbies include spending time with family and friends, swimming, travelling, doing puzzles and reading. She has recently begun learning to play guitar.

Sharyn was born and raised in Port Lincoln, and is married with three grown children and two grandchildren.

Pam Pratt

Pam Pratt commenced nursing many years ago and has worked in a variety of settings from country health services throughout South Australia, to large tertiary hospitals in metropolitan Adelaide. She is passionate about improving the country patient journey and the rights of country consumers to have the same access to health care as metropolitan clients. This has involved participating in the setting up of cardiac rehabilitation programs, sleep clinics, CPAP clinics and the Rural Burns Link Nurse Program in country South Australia, which all assist in providing services for country clients closer to home. Pam was awarded Honorary Life Membership of the Australian and New Zealand Burns Association for promoting burns awareness in rural areas. Currently she holds the positions of Patient Liaison Network Coordinator for Country Health SA Local Health Network and Patient Liaison Officer/Burns Link Nurse at Strathalbyn and District Health Service. The establishment of the Patient Liaison Network, comprising key patient liaison contacts in country health centres and rural liaison contacts in metropolitan hospitals, has improved communication and provided a vital network for country patients. Members of this network are actively seeking opportunities to improve the country patient journey and avoid hospital admissions, especially into metropolitan hospitals.

Linda Proietti-Wilson

Linda is a member of the Department of Health and Human Services (Tasmania) Rural Health and provides specialist expert advice on rural clinical policy development and implementation and reform of rural health service design and delivery. Linda has a background as a registered nurse and has previously worked in clinical and service management roles in urban and rural areas. Linda holds a Graduate Diploma in Business Management and a Masters in Clinical Nursing.

Rob Pulsford

Rob Pulsford has worked in the health industry for 26 years, originally completing hospital-based registered nurse training at the Royal Brisbane Hospital in 1989. Since then he has completed both midwifery and psychiatric nursing qualifications including a Bachelor of Nursing. Further postgraduate studies have been completed in project management, health economics, further education and training and a Master of Business Administration. Rob has worked extensively in rural, remote and regional settings across Australia and is currently Area Director Infrastructure for WA Country Health Service (WACHS). Particular areas of interest include the development of sustainable models of health care service delivery for rural and remote areas of Australia with an emphasis on the challenges presented in recruiting suitably qualified health practitioners.

Rachael Purcell

Rachael Purcell is a final year medical student at Monash University and a Master of Public Health student at the University of Queensland. In 2012 she was the Rural and Indigenous Officer on the AMSA National Executive. She has a strong interest in rural health and has completed extensive rural clinical school placements including a Bachelor of Medical Science (Honours) year based in rural NSW and a John Flynn Scholarship.

Christine Putland

Christine Putland is a consultant specialising in research and evaluation of arts and cultural initiatives designed to improve public health and wellbeing. She has a background spanning community arts, public and social policy, and public health fields. She graduated with an Honours degree from the Flinders University Drama Centre and a DipEd in Drama and English teaching from Sydney University in the 1970s. Christine then worked in community development and community services management in local government and non-government organisations within SA and NSW for more than a decade. After gaining a Masters degree from the Flinders Institute of Public Policy and Management, in 1994 she joined the Department of Public Health at Flinders University as manager of a research consultancy for the Commonwealth Government. After completing her PhD, Christine taught graduate programs in public health and primary health care, was an investigator on nationally competitive ARC and NHMRC research grants, and convened national training programs for health and arts practitioners in evaluation and research methods. She is currently undertaking research and writing projects for government agencies, foundations and community organisations around Australia. Christine is Chair of the Community Arts Network SA and holds academic status with the Southgate Institute for Health, Society and
Equity at Flinders University. She continues to publish for both academic and practitioner readers.

**Emma Quinn**

Emma Quinn is currently working with the Royal Flying Doctor Section South Eastern (RFDS SE) Section to investigate the provision of maternity care to women in remote communities. Emma has a keen interest in improving the provision of health care in rural and remote locations as she grew up in Broken Hill and remains committed to addressing health inequalities in the bush.

In Sydney Emma completed her BSc (Life Sciences) with first class honours in medical microbiology and immunology. Emma then worked for seven years in bowel and breast cancer research at the Garvan Institute in Sydney and the Department of Academic Biochemistry at the Royal Marsden Hospital in London respectively. Upon her return to Australia, Emma worked shortly at the National Prescribing Service before being accepted onto the NSW Public Health Officer’s training program. Emma completed her Masters in Public Health (with Distinction) from Kings College, London, which included a thesis on the health economics of breast cancer diagnosis and treatment. She is currently completing her Applied Professional Doctorate in Public Health (UNSW) with a focus on determining effective strategies that improve research translation in public health practice. Among other publications, Emma has recently first authored a chapter in the book Knowledge Translation in Health Care (2nd Ed), titled ‘Health Economics: an essential requirement in knowledge translation’ (in publication).

**Natalie Radomski**

Dr Natalie Radomski is the Manager of the North West Rural Medical Unit in the Monash School of Rural Health, Bendigo Regional Clinical School. Her role includes responsibilities for educational development, curriculum development, educational research and program evaluation across Monash rural health clinical placement sites in northern Victoria. Natalie is also the project manager for the Whole-of-System Student Clinical Placement project (WoSSP).

Natalie’s research interests are in the areas of workplace-based, health professional learning, interprofessional practice and community-based medical education. Her PhD investigated approaches to clinical decision making and health care teamwork in rural general practice settings.

**Kym Rae**

Dr Kym Rae completed her PhD in early 2007 looking at predicting the onset of labour in women, which provided a natural progression into her research passion that aims to reduce premature and low birth weight deliveries in Aboriginal communities. Kym has been the program coordinator and chief investigator of the Gomeroi gaaynggal research programs (NHMRC 569239 NHMRC APP1026733) since the early phases of consultation with the Aboriginal communities of the Hunter New England Area Health Service. She has been heavily involved in community consultation and developed community connections in each of the project locations and has developed a research plan that encompasses the needs and the priorities for health care for the local community.

Kym continues to be in close communication with the Aboriginal communities of Tamworth and Walgett particularly. Kym coordinates both the scientific research and ArtsHealth Gomeroi gaaynggal program. The ArtsHealth program was awarded the National Excellence award for an Indigenous ArtsHealth program in 2011 and has gained the Patronage of Her Excellency the Governor of NSW, Professor Marie Bashir. The ArtsHealth program has had a large number of exhibitions and participants have had a number of commissions and sales in 2012.

Kym continues to increase her publication output in Indigenous maternal and infant health, ArtsHealth and coordinate art exhibitions for the Gomeroi gaaynggal mothers. Her current work encompasses community liaison; research interests in prevention of premature and low birth deliveries, with a particular interest in early diagnosis of renal disease in Aboriginal women and their infants; mentoring and support for Aboriginal beginning researchers; and development and delivery of a pregnancy ArtsHealth program as requested by community members. Kym is passionate about working in partnership with communities to improve outcomes for Aboriginal communities.

**Robyn Ramsden**

Robyn Ramsden has had extensive experience in the area of student health and wellbeing with the Victorian Department of Education and Early Childhood Development where she led a team responsible for the development of health policy, programs and resources for students.

During that time she was also actively involved in significant research projects particularly in the areas of drug education and mental health promotion. She is a key research partner in the Australian Research Council-funded Drug Education in Victorian Schools Research Project which received the 2012 National Drug and Alcohol Award for Excellence in Community Education and Prevention.

Robyn undertook her Doctorate in Health and Social Sciences at Deakin University and is an honorary fellow at Deakin University in the School of Health and Social Development. Her special interests include health promotion and in particular the role of community and family in supporting the health of children, drug education and drug prevention and working with families from diverse cultural backgrounds.
She has published in the areas of drug prevention, drug education, and refugee issues.

**Fiona Reid**

Fiona Reid has worked at Womens Health and Family Services for over twelve years, and in her current role as special projects manager she is responsible for a variety of unique and innovative programs which reflect the integrated services provided by WHFS. Programs managed by Fiona include the Rural In Reach program; FIFO Family Enhancement service; staff and organisational capacity building (including development of Trauma Informed and CaLD resources) in the area of co-occurring and complex needs; and development and coordination of WHFS children and youth services. Fiona has been closely involved in the Rural In Reach program, from the development of the initial business case to the implementation and establishment of this unique service to meet the needs of women, their families and communities in rural and remote Western Australia.

A Masters qualified family therapist (MSoSc), Fiona has a wealth of professional, academic and community experience including: WHFS special projects manager (2011–current); City of South Perth Local Government Councillor (2011–current); member of the WA International Women’s Day collaboration (2011–current); Local Drug Action Groups Board Member (2012–current); Australian Institute of Company Directors affiliate member (Graduate candidate, 2012–current); Rotary Club of South Perth–Burswood President (2012–2014); Edith Cowan University sessional lecturer (2009–2011); WHFS alcohol and other drugs programs coordinator (2008–2011); Ministerial Advisory Committee on Blood Born Viruses and Sexually Transmittable Infections member (2009); and WHFS Addictions Counsellor (2001–2008). She has presented at international, national and local conferences on a range of health and wellbeing topics. Fiona is also a mother of two teenage children and in her spare time she enjoys travelling, reading and when possible being still.

**Janet Richards**

Janet Richards grew up in the Riverland of South Australia. She moved to Adelaide to attend university and has a Bachelor of Applied Science in Medical Laboratory Science. Janet has always had an interest in rural and remote health and in improving rural health services. She has worked as a medical scientist with the Red Cross Blood Transfusion Service (SA) and managed the Riverland branch of a private pathology laboratory. She returned to the Riverland when her children were young as she enjoys the country lifestyle.

Janet changed her career direction in 2009 when she joined the research staff at Flinders University Rural Clinical School in Renmark as a research assistant. Her research interests are medical education, workplace integrated learning in the clinical environment and interprofessional education. This research has resulted in her co-authoring several published papers and presenting at conferences in Australia and New Zealand.

Janet is currently studying part time toward an Honours degree in Health Science. Her research focus is mental wellbeing of medical students and explores the modelling of resilience by program administrators within the Parallel Rural Curriculum Program.

**Imelda Rivers**

Imelda Rivers is Manager—Arts and Cultural Development with Country Arts SA where she contributes to state initiatives, partnerships, and strategic directions.

She has worked for over thirty years within major arts organisations, festivals, community arts and cultural organisations and regional arts. Imelda originally trained in the performing arts and then developed experience in the facilitation of community cultural development with diverse cultures, communities, and art forms. Imelda’s passion is collaborating with communities, artists, and organisations to realise their creativity and address issues of importance. She believes the arts play a significant role in wellbeing and vibrant and sustainable communities.

During 2010–2012 Imelda was a peer advisor/assessor on the national Australia Council, Community Partnerships Advisory Committee. She has been involved in a wide range of organisations, boards, committees and projects while working in collaboration with arts and other sectors. Imelda is program manager for Country Arts SA, Arts and Health initiatives.

**Christine Roach**

Christine Roach is Manager, Medical Recruitment and Retention, NSW Rural Doctors Network. Christine has worked in rural and regional health for the past twenty years in disease prevention, patient support, consumer advocacy and more recently in the recruitment and retention of general practitioners in rural and remote NSW. She spent fifteen years with the NSW Cancer Council developing, implementing and evaluating programs in the Hunter and North West regions of New South Wales. With a team of twelve paid staff and up to 300 volunteers, she led the region collaborating and integrating community resources into improved cancer control strategies tailored to the individual community level. During her career she has trained, mentored and worked with volunteers at all levels of business and community, and has a great respect for those who volunteer to share their skills and expertise for the benefit of others. Her professional interest in community development extends to her own volunteer experiences, locally and overseas.

**Laura Robinson**

Laura Robinson is the Northern Territory and South Australian Hospital Program Manager for the Starlight Children’s Foundation. Her role is to coordinate and
manage Starlight’s NT/SA in-hospital and outreach programs with the aim of improving the wellbeing of children, young people and siblings by enhancing their primary health care experience through entertainment, play and distraction and by encouraging healthy living through using entertainment to deliver key health messages. Laura has worked for many years in child, youth and families services where her primary focus was on improving the psychosocial and physical wellbeing of disadvantaged and vulnerable youth in regional and remote Australia. She has extensive experience in working with multicultural and Indigenous youth and is the recipient of several industry awards. Laura is passionate about community collaborations and is a strong advocate of non-profit and government organisations working together to encourage ownership and sustainability of local community health and wellbeing programs. Laura has a good national perspective having lived and/or worked in most Australian states and territories including many regional and remote centres.

**Marian Robinson**

Dr Marian Robinson, whose qualifications include a PhD in business management, a Master of Business, a Graduate Diploma in Education, a Bachelor of Arts and a Graduate Diploma in Public Sector Management, is currently engaged in research projects for Bogong Regional Training Network. Marian is skilled in the conduct of empirical research projects for large and medium-sized organisations and in qualitative research, strategic planning, management decision making, organisational change and workplace reform.

Marian’s early career includes 12 years’ experience in metropolitan and regional TAFE colleges where she held various roles including those of senior teacher, staff development officer and industry consultant. Subsequently, she accepted a position as Manager, Staff Development and Training with the Australian Taxation Office. During that time and later, as Manager, Public Relations and Marketing, Marian worked on modernisation projects including organisational benchmarking, work-mapping and job redesign. She was a member of the ATO’s national benchmarking team and was involved in negotiations between the ATO and the Commonwealth and Public Sector Union when the ATO embarked on its first computerised human resource modelling exercise. Marian has also held managerial and advisory positions in occupational health and safety, workplace diversity, organisational restructure, recruitment, selections and performance management.

In recognition of Marian’s abilities in dealing with workplace reform and its impact on people, she was awarded an 18 month, fully-funded, ATO Commissioner’s postgraduate scholarship to conduct research into the quality of middle level managers’ decision making. The results of this major undertaking were provided to senior ATO personnel for integration into policy initiatives and development programs. During the last ten years Marian has developed a successful research consultancy business in strategic planning, organisational restructure and workforce planning. More recently Marian has held research contracts in the health industry. Projects include a needs analysis of general practitioner procedural practice in the Bogong region of Victoria and NSW, a longitudinal investigation into the career paths of former Bogong GP registrars and a study of sustainable GP obstetrics in a regional community. She has published several papers in Australian and overseas academic journals and holds positions on two research steering committees.

**Alison Rogers**

Alison Rogers has been working with The Fred Hollows Foundation for over five years as the senior program officer. She has a Bachelor of Health Science (Nutrition and Dietetics) and a Masters in Public Health (Health Promotion). Alison has been supporting remote Aboriginal communities in the Northern Territory with public health nutrition and community development programs for over a decade.

**Bernadette Rogerson**

Bernadette Rogerson is part of the Community-based Health Promotion and Prevention Studies group at James Cook University. Her previous work was in forensic settings delivering substance abuse and cognitive programs to inmates who predominately identified as Aboriginal and/or Torres Strait Islander. She has diverse qualifications in psychology, business and criminology and is a PhD candidate.

The projects Bernadette is involved in include:

- Leading implementation of NHMRC#1020514 (Chief Investigators: Alan Clough, Jan Copeland, Petra Buttnner and Yvonne Cadet-James) investigating cannabis withdrawal among Indigenous detainees and inmates
- Follow-up of the Queensland Police Service’s Return to Country project
- Evaluation of regional and remote Healthy Community Initiatives in rural and remote settings
- Validation of tools for appropriateness for use with Indigenous inmates and
- Devising better measures of cannabis use with consideration to frequency and quantity of use and potency levels.

**Margaret Rolfe**

Dr Margaret Rolfe is an experienced biostatistician who has lived and worked in the rural Northern Rivers area of NSW since 1985. Margaret’s current appointments include being a biostatistician at the University Centre for Rural Health—North Coast in Lismore NSW since April.
Stewart Roper

Stewart Roper was born in Scotland and immigrated to Australia with his parents when he was six years old, settling in Elizabeth to the north of Adelaide.

Stewart’s original tertiary studies were in zoology and biochemistry. After several years travel and work in a variety of areas he embarked on a nursing career, becoming a registered nurse at the Royal Adelaide Hospital (RAH) in 1984.

Following several years at the RAH, Stewart commenced work at Flinders University, Adelaide, in 1988 as a biology lecturer in the undergraduate and postgraduate nursing courses.

In early October, 1990, Stewart finished packing the back of the Valiant ute, pulled over the tarpaulin and farewelled family and friends. His destination was Amata in the remote north-west of South Australia, 1500 km away. He had never driven further north than Port Augusta, only 300 km from Adelaide.

Following orientation with Nganampa Health Council in Alice Springs, Stewart headed south for hundreds of kilometres on corrugated dirt roads to Amata, where the people were nearly all dark-skinned and spoke another language, yet he was in his home state of South Australia. Everyone he approached seemed indifferent to him when he introduced himself as the new nurse, but very interested in how much he wanted for the ute.

Stewart’s original intention was to stay for six months to a year. He eventually left after nine and a half years full time as a community health nurse. Stewart still works with Nganampa Health Council and returns regularly some twenty years after his arrival. He’s not completely sure how this happened, but somehow the character of the people and magic of the landscape overcame the challenges of living and working in such a remote location.

In addition to nursing duties, Stewart has also been involved with the health service and communities in interventions to reduce petrol sniffing and promote sexual health. He is currently employed as a projects officer with a wide variety of duties including entering and updating biographics, and assisting with child health and immunisation, ophthalmology, audiology and sexual health programs.

Louise Roufeil

Associate Professor Louise Roufeil is a health psychologist currently employed as the mental health academic at Mount Isa Centre for Rural and Remote Health, James Cook University. Louise has over twenty years’ experience as a clinician, service manager, researcher and consultant in rural and remote mental health. Her major areas of interest are workforce and the development, implementation and evaluation of innovative mental health service models to meet the needs of communities and health professionals in rural Australia.

Michel Ruest

With over 30 years of experience as a paramedic, training and clinical coordinator, ALS coordinator with the Regional Paramedic Program for Eastern Ontario where he assisted with quality assurance and continuing medical education to paramedics, Michel Ruest now is the Deputy Chief for the County of Renfrew Paramedic responsible for the Operations. Michel provides leadership and strategic direction in human resources, labour relations and the development and implementation of a rural ACP and PCP deployment system.

Over the past several years, Michel has contributed to the development of a Community Resilience Program. Recognising the ever-present pressures within the health care system and consistent increase in demand for assistance, Michel has assisted the Paramedic Service with responding to the needs through the creation of a Community Resilience Program. Ongoing community and industry partnerships continue to be developed and programs are being delivered, which will have a positive impact on morbidity and mortality rates. In consultation with a number of community stakeholders, the County of Renfrew Paramedic Service has developed a number of programs and services, such as an Ageing at Home Program, Wellness Clinics, a Heart Wise Program, AED/CPR Education Program, an ad hoc Home Visit Program, PACCT Program and the Community Paramedic Response Program.
In addition, Michel is a member of the Paramedic Chiefs of Canada Leadership Development Sub-Committee. Having recently received the Certified Municipal Manager, Level 3 (CMM III) EMS Executive from the Ontario Municipal Management Institute and the Emergency Medical Services Exemplary Service Medal, Michel is completing a public administration degree at Trent Rivers University in British Columbia, Canada.

Kylie Ryan

Born in Jamestown, SA, Kylie Ryan lived in Perth and Kalgoorlie, WA, before moving to Esperance, WA. Mother of five, Kylie enjoys gardening, walks along the beach, amateur theatre productions and arts activities and events. Kylie returned to study after having her fifth child and completed a Bachelor of Health Science. During her studies, Kylie participated in a remote placement at Jigalong in the Western Desert area of WA. Another placement was with mental health service, Bay of Iles Community Outreach Inc (BOICO) in Esperance. Kylie stayed at BOICO as a volunteer and then a paid staff member before gaining employment with the WA Country Health Service as project officer for the Act-Belong-Commit mental health campaign, a world first in promoting ways people could take care of their mental health. Kylie then became the WACHS Health Promotion team leader, managing portfolio areas including injury prevention, physical activity, nutrition, alcohol, other drugs and mental health. Kylie remained with WACHS for several years before taking on the role of Commonwealth Respite Coordinator for the South East Coastal Region. This role involved working with carers and care recipients to assist them with their needs, including arranging access to training, in-home support and direct respite. Kylie remained in the role until 2012 when she reconnected with BOICO in the capacity of service manager. Kylie’s passion is mental health and improving the lives of persons with mental illness, their carers’ and families. Working at BOICO provides opportunities to develop quality services that benefit people in the Esperance community and Goldfields region. Kylie believes in promoting how we are improving the lives of people living rurally by speaking at conferences to raise awareness and understanding of our challenges and successes. Kylie hopes to provide ideas to other services for implementing similar initiatives within their communities and regions.

Debra Sandford

Debra Sandford has lived with her three daughters and various pets in Victor Harbor for the past 10 years. Completing a Masters in Clinical Psychology at the University of South Australia in 2009, she has divided her time working with the Victor Harbor CAMHS team, ELF program and a small private practice since then. Debra is passionate about working with children and families. Her special areas of interest are paediatric sleep, attachment, the impacts of trauma on the developing child and wider family dynamic and building resiliency.

Debra enjoys the variability of working within a community health setting and values the opportunity to work closely with a talented and dedicated multidisciplinary team. She believes that good mental health care should be available to everyone regardless of race, gender or financial situation and is a strong advocate for changes to the current way mental health care is funded in order to make it more accessible to those who need it.

Phil Saunders

Phil Saunders has held the position of policy officer at Alzheimer’s Australia SA since late 2011.

He has over thirty years’ experience in the non-government community services sector. He began his career as part of a community development and cooperatives team in Christchurch, New Zealand. On returning to Adelaide, his work has involved consumer engagement, policy advocacy, project and campaign management, magazine editorial and micro-organisation set up and management in South Australia and New South Wales for state-based and national organisations.

His role at Alzheimer’s Australia SA follows ten years as policy project officer with Carers SA. Prior to that he worked across a range of disciplines, including unemployment, employment development, rural student accommodation, physical disability, mental health and volunteering.

The core to Phil’s work at Alzheimer’s Australia SA is consumer engagement as part of a three-step policy and advocacy strategic context across consumer engagement, organisational policy capacity and influencing change.

Phil has been responsible for policy submissions, papers and reports and undertaken presentations at state and national levels during his career. A ‘hobby’ is preparing book reviews for SACOSS News.

In his work Phil has taken a keen interest in the rural sector, regularly undertaking and reporting on consultations on the needs and views of people living in country regions. The Living with Dementia in Country SA project and associated Cost of Dementia questionnaire that Phil is reporting on in his presentation at this National Rural Health Conference is based on a similar exercise, Caring for Carers, undertaken from 2009 to 2011 for Carers SA.

Emily Saurman

Emily Saurman is a research officer and PhD candidate with the Broken Hill University Department of Rural Health, Centre for Remote Health Research. Her research interests include health service evaluation, access, and medical ethics.
Moya Sayer-Jones

Moya Sayer-Jones is a story activist. She believes in the power of people and the power of stories. Her mantra? Our stories keep us human.

Regarded as one of Australia’s leading narrative experts, Moya consults with business, government and non-profit organisations. She founded the story agency onlyhuman.com.au to help organisations understand the power of using real stories to communicate and connect with the people who matter most.

A graduate of Sydney University and the Australian Film and Television School, Moya’s idiosyncratic voice is seen and heard in many places. She’s a screenwriter, blogger, novelist and comedy columnnist, and is joyfully remembered for her creative problem-solving as the original Modern Guru in the SMH/The Age Good Weekend magazine. Follow her on Twitter @StoryDr.

Adrian Schoo

Adrian Schoo is Professor in Rural Allied Health Education at the Medical School of Flinders University. He is research active, reviews papers and grant applications, and has been involved in obtaining almost $3 million in external grants. Adrian has written more than 70 publications and his work informs policymakers and other decision makers, as well as educators and health professionals. Research interests include continuing education, allied workforce development and health service enhancement, particularly in the area of chronic (musculoskeletal) disease. Current interests include simulation in clinical education and continuing professional development.

Tarun Sen Gupta

Tarun Sen Gupta is Director of Medical Education and Professor of Health Professional Education at the James Cook University School of Medicine and Dentistry. He has worked in undergraduate and postgraduate medical education since 1993, with interests in rural medicine, small group teaching, community-based education and assessment. He is a co-Director of the Queensland Health Rural Generalist pathway and has previously worked in solo remote practice. He is a member of the Queensland Board of the Medical Board of Australia, a director of the Postgraduate Medical Council of Queensland, and a member of the Council of the Australian Medical Council. He has been involved in the national assessment committees of both the RACGP and ACRRM and currently chairs the ACRRM assessment committee.

He is married to Wendy; they enjoy the company of two thriving teenage children, a pair of disobedient golden retrievers and a neglected cat.

John Setchell

Dr John Setchell attended the Australian National University where he completed an Honours Science degree (1971) before completing a PhD in the neuroendocrinology of marsupials at the University of Adelaide in 1974.

Following a year as a postdoctoral fellow at the University of Adelaide he studied medicine at the Flinders University and began work as an intern at the Flinders Medical Centre in 1981.

Since then he worked as a general practitioner in Adelaide for five years before spending 18 months as the medical practitioner in the Ramu Valley of PNG. On his return, he was the Medical Director of the University of Adelaide Student Health and Counselling Service (1989–1998) and became the Health Services Manager at RFDS Central Operations in 1999.

During his time with the RFDS, John has been responsible for the provision of health services ranging from traditional clinics in remote areas to aeromedical evacuation services, and has overseen growth in the areas of primary care and health promotion/prevention programs. These programs include the Rural Women’s GP program and the more recent, privately-funded, Health Living Program.

John has taken an active role in the development of national RFDS health policies and programs such as the implementation of a national electronic medical record system and plays an active role in the RFDS National Health Advisory Committee.

Further interests of his have been the development of education programs for medical and nursing students and the provision of an emergency medicine training program for rural GPs in South Australia.

Jennifer Sheehan

Jennifer Sheehan is the Manager of the Rural Health Services and Capital Planning Unit (RHSCPU) within the Health System Planning and Investment Branch, NSW Ministry of Health; a position she has held for the last nine years. The Unit oversees the capital planning for rural health services in NSW, including the implementation and ongoing management of the Multipurpose Service (MPS) Program. Ms Sheehan has over 30 years’ experience in both clinical and planning areas of health, in fields as diverse as oral health, clinical services planning and capital planning.

Jennifer has a close working relationship with the Rural Local Health Districts and the Australian Government, having had significant success in the capital funding submissions as part of the Regional Priority, Health and Hospitals funding program for the development of Rural Cancer Centres, MPSs and a number of rural health services.

Jennifer is also a guest lecturer at the University of Technology, Sydney, as part of the Master of Health Services Planning program.
Craig Sinclair
Craig Sinclair is a health researcher based at the Rural Clinical School of WA. His training was in psychology, and after completing a PhD in 2009, he relocated to Albany, and has been working in postdoctoral positions on a range of rural health research projects.

Craig’s current research projects and interests include:

- Research with clinicians (psychologists and GPs) to explore perceptions towards the use of online mental health resources in the rural and remote setting.
- Community-based research exploring the perceptions of older rural adults towards advance care planning. This has included consultation with Noongar community members from across the region, as well as Dutch, Italian and Karen Burmese community members.
- Translating community-based advance care planning research into programs that can be implemented in regional hospitals. This will involve staff education packages and ongoing audits of end-of-life care using a clinical practice improvement framework.
- Consulting remote Aboriginal community members to evaluate the impact of the Western Desert Kidney Health Project (WDKHP). The WDKHP is an innovative outreach project, using an arts health approach to deliver primary health care and health promotion to ten communities in the Goldfields.

Evaluation work combined in-depth interviews with participatory film-making, to collect community perspectives on the impact of the Western Desert Kidney Health Project.

Tricia Slee
Tricia Slee is the Manager of Primary Health Care Programs with the RFDS in Western Australia, where she has worked for the past eight years as the RFDS on the Road Program Manager—a mobile health promotion initiative visiting people living in very remote locations across regional WA.

While Tricia was developing the model for delivery of the RFDS on the Road Program—the first PHC program to be funded by a corporate partner—she also formed strategic partnerships to provide free delivery of skin cancer screening for more than 10,000 residents of the Pilbara, Goldfields and Kimberley regions (over six years). More recently, Tricia has established a fee-for-service corporate skin screening service to remote mining sites.

Tricia has oversight of the newly developed Remote Area Dental Scheme (RADS), an initiative undertaken in partnership with Dental Health Services in WA. She is also involved in the establishment of a partnership with Karara Mining, which will enable RFDS to provide dental and broader primary health care services to residents of the mid-west region of WA from mid-2013.

Tricia has spent much of her life in rural Australia and is passionate about providing residents of regional Australia with better access to services and opportunities for health education that promotes better decisions about lifestyle and wellbeing.

Cathy Smith
Cathy Smith is working in a public sector regional area health service, as a nurse manager, providing strategic and project support to the Executive Director of Nursing and the Nursing Division of the Tasmanian Health Organisation—North West. In addition, she is a research fellow at the University of Tasmania in the Rural Clinical School.

Cathy has over 30 years’ experience in nursing and quality, accreditation, project, strategic support roles in regional hospitals. Her recent project work has included the primary health sector and improvement projects within community nursing.
Her professional interest areas include person-centred care, dignity and caring in the provision of nursing care, evidence-based nursing, along with emerging health care trends and the impact on primary health care for the future.

Deborah Smith
Deborah Smith is the Consumer Relationships Manager at the Consumers Health Forum of Australia, which is the national peak body representing the interests of Australian health care consumers. Debbie manages CHF’s Consumer Representative Program and the Our Health, Our Community Project, a major national initiative by CHF funded by the Australian Government to strengthen the consumer voice in health reform. This work provides leadership development for health consumer and community leaders in consumer and community engagement and provides avenues for everyday Australians to have their say in improving health care.

Janie Dade Smith
Janie Dade Smith is a health educationalist and project manager who has worked extensively in rural and remote health in Australia. Janie is currently Associate Professor (Medical Education) at Bond University.

Sharon Smith
Sharon Smith works as a rehabilitation coordinator (social worker) with the Acquired Brain Injury Outreach Service (ABIOS), a community-based rehabilitation and case management service for adults with acquired brain injury. Sharon has been an advocate within ABIOS for the development of culturally appropriate responses to working with Aboriginal and Torres Strait Islander people with brain injuries, their families and their communities. She was lead investigator (with her colleague, Susan Gauld) on the three-year research project working with remote Indigenous communities (2006–09) to develop the most suitable and culturally appropriate community-based service model for Aboriginal and Torres Strait Islander adults with acquired brain injury and their families. With colleagues, she has developed and implemented a training program on brain injury for health workers. She continues to work on advancing knowledge and skills to improve services and supports for people with brain injury and their families, with a special focus on partnering with Indigenous communities to develop culturally appropriate services and supports for Aboriginal and Torres Strait Islander People with brain injury, their families and their communities.

Vicki Sowry
Vicki Sowry is the Director at the Australian Network for Art and Technology (ANAT), a not-for-profit organisation that facilitates three-way partnerships between creative practitioners and host organisations. For the past two decades, Vicki has established and delivered professional programs for artists and filmmakers in partnership with industry. She has worked at Metro Screen, the Australian Film Commission, ABC Television and the Media Resource Centre. In 2007 she joined ANAT to manage the Art Science Program and, in 2012, was appointed Director.

Catherine Spiller
Catherine Spiller is a pharmacist currently working at the School of Pharmacy, University of Tasmania (UTAS) as a lecturer in clinical pharmacy and therapeutics. She is originally from the UK and has 16 years’ experience as a pharmacist in a wide variety of roles, having worked in hospital, community, primary care, senior management, training and education as well as academia. In the UK, she was heavily involved with the introduction of the new General Level Pharmacist Diploma and the Structured Training and Education Programme (STEP) for Pharmacists in South East London. With colleagues from Lewisham Primary Care Trust, South East London, she co-developed a competency-based training program for pharmacists-led anti-coagulant clinics in community pharmacy.

She moved from London to Hobart in 2010 and took up a position at the School of Pharmacy, UTAS. From mid-June 2011, she was seconded to a conjoint appointment as the Pharmacist Academic Clinical Leader with the Tasmanian Clinical Placement Partnership Project, a joint project between UTAS Faculty of Health Science and DHHS to optimise clinical placements for UTAS students in rural, remote and non-traditional settings. The project was a multidisciplinary project across the Faculty of Health Science and included leaders from medicine, nursing, physiotherapy, pharmacy and psychology. The work being presented is an overall summary of the achievements of this collaboration as an exemplar of clinical leadership.

Cathy Springall
Cathy Springall is a senior policy officer within the Rural Health Services and Capital Planning Unit, Health System Planning and Investment Branch, NSW Ministry of Health; a position she has held for the last six years.

Cathy has worked in the health sector for over 25 years in both private and public health facilities. The positions she has held have been quite diverse including health administration, occupational health and safety, human resource management, and policy work in various areas including aged care, cancer, risk management, government relations and rural health planning.

Prior to coming to Health System Planning and Investment Branch, Cathy worked in the Inter-Government and Funding Strategies Branch, NSW Health, where she first became involved in the funding and development of the Multi-Purpose Service (MPS) in NSW. She is a passionate advocate for rural health issues and a tireless advocate for MPSs and regularly promotes the benefits they bring to the local community in which they are situated.
Bella St Clair
Bella St Clair is a health sector project specialist with experience in operations, accreditation, compliance and quality improvement. She has run a number of projects for both health care organisations and accreditation bodies including the implementation of organisation-wide health service change management programs, accreditation program process mapping and redevelopment and business development of health programs. She is currently the Health Operations Manager for Royal Far West. Bella is also an experienced auditing and standards compliance assessor across a range of health care sectors.

Bella holds Masters degrees in quality improvement in health care and business operations. She is currently undertaking her Doctorate within the Australian Institute for Health Innovation at the University of New South Wales. Her research interests include funding and incentives systems in health care, and the role of accreditation in rural and remote health care facilities.

Julie Steffner
Julie Steffner is a social worker whose career has focused on child and family services with non-government organisations, and includes roles in case management, training and leadership. Julie has a Master of Child and Adolescent Welfare and is currently completing a Master of Social Work. Julie is currently with The Benevolent Society (TBS) as Family Referral Service Manager for the Hunter Central Coast and Lithgow. During her time with TBS Julie has been involved with the development and review of the FRS service model and practice standards.

Kylie Stothers
Kylie Stothers is a young mother of two children; she is a Jawoyn woman who was born and raised in Katherine, NT. Kylie comes from a large extended family with strong ties in Katherine and surrounding communities. Kylie is a social worker and has worked throughout the Northern Territory for over 15 years. Kylie currently works for the Centre for Remote Health and Flinders NT in the Katherine Campus. Her current role is as a lecturer and she (along with her colleagues) delivers training across the NT. Kylie is also involved in many local, regional and national committees and boards. She is the current Deputy Chairperson of Indigenous Allied Health Australia.

Kylie’s interest areas are in child and maternal health, working with families, health promotion and health workforce issues. Kylie is passionate about education and issues that relate to remote and rural Australia.

Jörg Strobel
Dr Jörg Strobel is currently Acting Clinical Director Country Health SA Mental Health Services. Born in Germany he trained as a psychiatrist and psychotherapist, and worked as a forensic psychiatrist before migrating to Australia in 1996. He has worked since in various settings in Metro Adelaide MHS and joined Country Health SA in July 2011.

His decision to specialise in psychiatry was based on a commitment to social justice and inclusion which also informs his interests outside of work. He has a strong belief in the human capacity to overcome adversity and is championing recovery-oriented work.

Areas of specific interest are population health, the impact of socioeconomic factors on health, health economics and sustainability of health service provision in times of tight budgets and an ageing population. Out of interest in the application of new technologies to enhance patient participation and empowerment, he became co-founder of a software company developing self-management tools that allow interaction between patient and therapist via a web portal accessible from any mobile device.

He serves on boards of mental health related NGOs and is an executive member of the Clinical Senate in SA.

Michele Summers
Michele Summers is the Administrative Officer for the Junior Doctor Program and Student Support Officer for Flinders University Year 4 students at the Flinders University Rural Clinical School in Mount Gambier. She has been responsible for providing support and administrative assistance to students and junior doctors on placements or employed at Mount Gambier and Districts Health Service since May 2006. On behalf of the Rural Clinical School, Michele has fostered effective relationships with students, junior doctors and other health professionals and provided administrative and social support to both educators and students to enable effective integration within the community.

Susannah Summons
Susannah Summons is an accredited practicing dietitian who has been working in the fields of urban, regional and remote Indigenous health for the last eight years. After working in St Kilda, spending time in the western Top End, and living in Ngukurr in Arnhem Land for around six months, she started visiting the Utopia region of the Northern Territory, which is located around 280 km north-east of Alice Springs. She is now entering her fifth year of working in that region.

The work in Utopia has evolved in response to the expressed needs of the community. Community members expressed concern about the cost of foods in the local store, the difficulty obtaining healthy food, and the subsequent desire to establish remote food gardens. Knowing nothing about gardening herself, Susannah embarked on a three-year food gardens project.

After completing a Certificate 3 in Permaculture and covering her entire lawn with food production gardens
Ann Sweeney has been the Southern Tasmanian Coordinator for Core of Life (COL) since July 2012. This two-year position (one day a fortnight) was formed in collaboration between Indigenous Early Childhood Development (IECD)—Population Health, Youth Health and YFER, to enable the provision of Core of Life in schools and flexible learning programs in southern Tasmania. Ann’s role involves supporting service providers in registering for training as facilitators and providing follow-up support in delivering COL education sessions. This role is complementary to her role as youth health nurse. Ann supports YFER to deliver training courses, one of which has already taken place in late 2012. Ann also established a COL trainers network for southern Tasmania. Having originally started COL training in 2006, Ann is a trained instructor and also enjoys co-facilitating COL youth education sessions to the youth of Tasmania (including her embarrassed adolescent sons). Ann has a background in mental health, midwifery and counselling, having worked as a birth centre midwife for 15 years. She continues to work in mental health and youth health and has recently completed further study.

Ann is enthusiastic about ensuring that young people get the message about the realities of pregnancy, birthing and parenting in an interactive and fun-filled way without feeling preached at, whilst supporting those working with young people in this program to have fun providing such important messages in an effective way. Ann is a registered general nurse, registered psychiatric nurse, registered midwife, and has a Master of Education I (Counselling) and Graduate Diploma in Nursing Speciality (Honours).

Kerry Taylor
Kerry Taylor is a Senior Research Fellow and Head of Health Education Research with the Poche Centre for Indigenous Tertiary Education. Kerry has extensive experience working in Central Australian remote communities with a range of organisations, including Batchelor Institute of Indigenous Tertiary Education and NT Department of Health. Kerry’s PhD thesis was a study of intercultural communications in health care in Indigenous language settings. Her main teaching and research interests include cultural safety, Indigenous health, health literacy and health workforce preparation.

David Templeman
David Templeman completed six years (2000–2006) as Director General of Emergency Management Australia (DGEMA), the Federal Government’s agency with responsibility for reducing the impact of natural, technological and human-caused disasters on the Australian community. As DGEMA, he was a member of the Australian Health Protection Committee, the Critical Infrastructure Advisory Council and the Australian Emergency Management Committee.
David played a central role in the whole-of-government response to many major emergencies in Australia and the region, including bushfires, extreme storms, cyclones, earthquakes and floods, including critical infrastructure failures. He also coordinated the Australian Government’s emergency management response to international crises such as the 9/11 terrorist attacks in the United States; the Bali, Madrid and Jakarta embassy bombings; Australia’s response to the 2004 tsunami in South East Asia and the London bombings in 2005. David contributed to national health emergency planning issues such as the severe acute respiratory syndrome epidemic in 2003, and avian flu pandemic arrangements.

David has been the Chief Executive of a national peak not-for-profit organisation in preventative health—The Alcohol and other Drugs Council of Australia—since 2007. He is a senior volunteer member of St John Ambulance Australia and the Chair of the ACT Alcohol and Drug Foundation (Karralika). In addition to these activities, David holds appointments on the boards of the International Federation of Non-Government Organisations and the International Council on Alcohol and Addictions. He is also a member of the National Leadership Group for the White Ribbon Foundation and a Board Director for a newly established NGO, the National Rural Law and Justice Alliance, a Board Director for Families Australia and a Friend of the National Rural Health Alliance.

Julie Thacker

Julie Thacker has a background in anatomy, psychology and education. She has taught and supervised research in hospitals and universities at undergraduate, postgraduate and fellowship levels and has written curricula for paramedic degree courses.

Andrea Thomas

Andrea Thomas was ‘born and bred’ in country South Australia. She took up her first job as a podiatrist in the Riverland (her home town) in 1989. Andrea was appointed to the senior podiatrist role at Riverland Community Health Services in 1992. She is responsible for ensuring the delivery of podiatry services for the Riverland region of South Australia, which has a population of around 38 000 people. Having worked in a rural area for all of her working life, Andrea is well aware of the challenges faced by rural clinicians.

Like other states, South Australian Rural Podiatry Services differ significantly across the many regional areas within the state. Things such as eligibility criteria, funding sources, case loads and staffing levels are not standardised across rural areas and the services people in the community receive is more often than not determined by their postcode rather than their clinical need. One of the first tasks undertaken by the newly appointed Clinical Lead Podiatrist was to address these inconsistencies and a number of working parties were formed to assist with this. Andrea was appointed as the lead for the ‘Eligibility Criteria and Priority of Access’ working party and as a small group of enthusiastic podiatrists, they were charged with developing standardised eligibility criteria for podiatry services across country South Australia.

Sally Thomas

Sally Thomas relocated in 2002 from south-west New South Wales to Port Hedland, Western Australia, with her husband and four young children. She undertook the portfolio of palliative care for both the hospital and the wider community of the Pilbara.

Moving to the Kimberley in 2005, she completed a Graduate Certificate in Diabetes Education and worked across the East Kimberley. As a home care nurse, Sally provided palliative care for clients from both the Ord Valley Aboriginal Health Service and Kununurra District Hospital.

In 2011 Sally was appointed as the community health nurse generalist/school health nurse for Wyndham, Kununurra and surrounding communities.

Sally commenced as the Coordinator for Palliative Care Services in the Kimberley in April 2012—this challenging but rewarding role is ever-expanding.

Sally and Sarah Davies have worked hard to align their chosen specialties and their strong working relationship has positively impacted service delivery and care for those living in the Kimberley.

Philip Tideman

Dr Philip Tideman is Deputy Director of Cardiology, Southern Adelaide Local Health Network; Director of Cardiology, Country Health South Australia Local Health Network; and the Clinical Director of Cardiology, Integrated Cardiovascular Clinical Network of Country Health South Australia (iCCnet CHSA).

His clinical interests include general and rural cardiology, invasive cardiac investigation, echocardiography and cardiac pacing.

He has had a major role in researching, developing, implementing and evaluating the role of Cardiovascular Clinical Networks in South Australia. His goal, both in research and clinical practice, has been to ensure that people living in non-metropolitan areas have the same level of access to cardiovascular care and equivalent clinical outcomes to their metropolitan counterparts.

His major research interests, including biochemical markers of myocardial necrosis, point-of-care pathology, medical information and communication technology, cardiovascular epidemiology, geographic variation in patterns of cardiovascular care and outcomes, clinical evidence implementation and continuous quality improvement in clinical practice, are seen as fundamental to achieving this goal.
Rosy Tirimacco
Rosy Tirimacco is the Operations and Research Manager of the Integrated Cardiovascular Clinical Network Country Health South Australia.

Rosy has extensive experience in implementing and running point-of-care testing (PoCT) in hospitals and general practice. She is heavily involved in PoCT education of rural doctors and nurses across South Australia. She is particularly interested in the integration of PoCT into clinical care pathways.

She is currently the chair of the Australasian Association of Clinical Biochemists Point of Care Testing Working Committee, chair of the International Federation of Clinical Chemistry and Laboratory Medicine (IFCC) PoCT Task Force, chair of the IFCC Glucose PoCT working group and project manager of the Australian Point of Care Practitioner’s Network.

Nicole Turner
Nicole Turner is a Kamilaroi woman and one of a handful of Aboriginal nutritionists in Australia; she is currently the health promotion manager of the Many Rivers Diabetes Prevention program which includes collaborations with Durri Aboriginal Corporation Medical Service in Kempsey, NSW, Biripi Aboriginal Corporation Medical Service in Taree, NSW, and Hunter Medical Research Institute at University of Newcastle, NSW. Nicole has worked on the Many Rivers project since it began, and now also co-manages the project. She obtained a Bachelor of Applied Science in Community Nutrition early this year and is also a Board Director at Durri Aboriginal Corporation Medical Service, Kempsey, NSW. Nicole sits on a large number of state and national committees, chiefly those on Indigenous chronic disease and nutrition and including Food Standards Australia and New Zealand. Nicole is very passionate about Aboriginal health and believes prevention is the answer to a lot of our health problems.

Madeleine Venables
Madeleine Venables is a fifth year medical student at the University of Western Australia, and originates from the southwest farming town of Harvey. Madeleine is the 2013 NRHSN Senior Medical Representative, and also holds a senior position on her Rural Health Club SPINRPHEX. She is highly dedicated to rural health and has a strong drive to improve health service delivery for country patients. A defining moment for Madeleine has been selected from a strong nationwide field of applicants for the 2012 Rural Health Workforce Award.

Through her national role on the medical portfolio, Madeleine advocates for students to many organisations including RAMUS and ACCRM, and has attended several conferences including the 11th National Rural Health Conference in Perth and Leadership Development Seminar in Adelaide. Madeleine continues to build upon her commitment as a member of the future rural health workforce, through ongoing rural placements with the John Flynn Scholarship Program in Shoalhaven, NSW, and through her university, and feels very strongly about being part of the multidisciplinary drive for rural health.

Aside from her involvement organising many local and national rural health and leadership events, Madeleine also enjoys travelling, fishing, camping and keeping physically active, and always loves getting back to the farm.

Melissa Vernon
Melissa Vernon is the Executive Director Primary Health and Engagement for the WA Country Health Services. She has an extensive background in health-related leadership positions in country WA with a mix of private, public and tertiary sector roles. These have included: tertiary education and academic posts in nursing, rural and public health; rural community and public health management; the implementation of telehealth in rural WA; and state-wide rural health development and policy.

She is particularly interested in: patient, family and community focused care as a journey across the health continuum; health service reform and development to integrate primary health services into interdisciplinary and intersector models of care that more flexibly meet the needs of rural communities; and increasing rural and remote people’s access to the services they need, to be informed and active participants in their health care.

In recent years she has received the Health Consumers Council Award for Excellent Service to Consumers and the Director General of Health Award for Community Engagement in Health. She has also worked in the Northern Territory with a focus on health improvement, prevention of illness, health and the arts and community involvement in health. She is Vice Chair of the Southern Edge Arts Board, and past Community Director of the Amity Health Board.

She is a keen sailor, isolated beach and wilderness recluse and mother of a fun-to-be-with 17 year old.

Heather Volk
Heather Volk is the Pharmacist Advisor with the National Aboriginal Community Controlled Health Organisation (NACCHO). NACCHO is the national authority in comprehensive Aboriginal primary health care and represents 150 Community Controlled Aboriginal Health Services.

Her work encompasses medicines policy for the Aboriginal and Torres Strait Islander sector as well as being an advisor on Quality Use of Medicines, Section 100 Supply, to rural and remote Aboriginal communities, Closing the Gap co-payment relief measure and program management of the QUMAX (Quality Use of Medicines Maximised in Aboriginal and Torres Strait Islander Peoples) program.
Heather represents the community controlled sector on the Fifth Community Pharmacy Agreement Programs Reference Group.

A pharmacist with 30 years’ experience, she has championed rural and remote pharmacy services. Heather was a former owner and manager of rural pharmacies and provided a travelling pharmacist service to rural and remote communities in Queensland and NSW before joining The University of Queensland’s School of Pharmacy as a lecturer in QUM and rural pharmacy. She was seconded from UQ to James Cook University’s Mount Isa Centre for Rural and Remote Health (MICRRH) as the Pharmacist Academic and has also worked with the Australian National University to develop new pathways into health degrees for undergraduate students.

Heather remains active as a community pharmacist working regular weekend shifts in a Canberra pharmacy as she enjoys community pharmacy and values the opportunity to interact directly with patients.

Heather Waite

Heather Waite has been working in the health industry for over twenty years in various roles and capacities. She has a background in natural therapies with a degree in naturopathy and a Diploma of Remedial Therapy, and has worked with both chiropractors and physiotherapists particularly in the area of remedial sports therapy.

Heather also has a Bachelor of Health Promotion degree and a Certificate IV in Frontline Management and, from 2006–2010, worked in Divisions of General Practice as a program coordinator and then clinical services manager of programs such as Better Outcomes in Mental Health (ATAPS), suicide prevention program, aged care, chronic disease management, after-hours GP clinics, and the Street Doctor Program.

Since mid-2010, Heather has worked at Rural Health West in the role of Professional Development Coordinator and manages programs such as the GP Obstetric Mentoring Program, the GP Anaesthetic Mentoring Program, the Additional Assistance Exam Support program for IMGs working towards fellowship of RACGP or ACRRM, and also coordinates supervised clinical attachments in tertiary hospitals for rural procedural GPs.

Whilst working at Rural Health West, Heather has also worked on several special projects such as the design and implementation of a comprehensive orientation program for IMGs new to Australia and rural WA, the initial stages of a new emergency medicine course for rural GPs, and a project on community-based DRANZCOG training to assist IMGs that want to gain their Australian qualifications.

Heather has gained a passion for rural health and a great understanding of the issues involved, particularly with the vast distances and isolation of some towns in WA.

John Wakerman

Professor John Wakerman is the Inaugural Director of the Centre for Remote Health, a Joint Centre of Flinders University and Charles Darwin University, in Alice Springs. He is a public health medicine specialist and remote general practitioner, with a long background in remote primary health care services as a medical practitioner, senior manager and researcher. He has specific academic interests in remote health services research and remote health workforce education and training. He also has a strong interest in utilising evidence for advocacy related to rural and remote health issues. He is a past Chair of the Central Australian Hospital Network Governing Council, Chair of the Central Australian Rural Practitioners Association (CARPA), a member of the NHMRC Health Care Committee, the Advisory Board of the Health and Hospitals Fund and of the Australian Therapeutic Goods Advisory Council.

Bruce Walker

Dr Bruce Walker FTSE has lived and worked in Central Australia for 33 years. As founding CEO of the Centre for Appropriate Technology Inc, the National Indigenous Science and Technology organisation, he has pioneered the development, application and delivery of technology to improve the livelihood of Australia’s remote Indigenous population.

Since stepping out of the CAT CEO role, Bruce has spent the past two years working as project director with the remoteFOCUS project convened by Desert Knowledge Australia. He is the lead author of the report titled ‘Fixing the Hole in Australia’s Heartland: How governments need to work in remote Australia’.

Bruce was one of the drivers of the Desert Knowledge movement. He is a fellow of the Australian Academy of Technological Sciences and Engineering; a life fellow of the Australian College of Educators; was awarded the 1999 ATSE Clunies Ross National Science and Technology Medal; is a Rotary International Paul Harris fellow; and was awarded a Centenary Medal for service to Indigenous population.

Anthony Wall

Anthony Wall is the Research Coordinator at Primary Health Planning Services, the planning and research arm of Rural Workforce Agency Victoria (RWAV).

Primary Health Planning Services, in conjunction with RWAV, provides high quality planning, stakeholder consultation, research and data analysis services to support Australia’s health workforce.
Anthony has 20 years’ social and market research experience—the past 15 years of which has been exclusively within the health care arena.

Anthony has managed projects at Millward Brown and Taylor Nelson Sofres global research agencies, and spent 10 years as Project Director at Health Marketing Solutions, a Melbourne-based agency dedicated to the pharmaceutical and health care market.

As Research Coordinator at Primary Health Planning Solutions, Anthony is responsible for the planning, management and reporting of all research components of our projects.

Anthony is a qualified practising market researcher and is a full member of the Australian Market and Social Research Society.

Chris Wallace

Chris Wallace is an Aboriginal Family Worker and community leader who has lived all his life in the remote Aboriginal community of Santa Teresa of 500 people, 80 km south-east of Alice Springs. Chris provides positive activities for the men and the community with horse treks, traditional dance, music, and song. He is also a member of a heavy metal band.

Diane Walsh

Diane Walsh is motivated by the desire for a safe and equitable health system that meets the real needs of real people—no matter where they live or who they are. She and her family have happily called Darwin home since 1997.

Diane is a member of Consumers Health Forum and has served in consumer health and governance roles such as the Medicare Australia Stakeholder Consultative Group and the Therapeutic Goods Committee for over 14 years. She chairs the NPS Better Choices, Better Health Consumer Advisory Group and is a community member of the Northern Territory Board of the Medical Board of Australia. She was Chair of the General Practice Network Northern Territory (GPNNT) Board from 2009 until its wind-up following the formation of the Northern Territory Medicare Local and is on the Governing Council of the Top End Hospital Network.

Alison Ward

Alison Ward, BSc (Uni of Melb), MND (Deakin), is an accredited practising dietitian with the Physical Activity and Community Nutrition Unit, Population Health, Department of Health and Human Services, Tasmania, for the past 15 years. She currently works in the area of food security.

Sue Ward

Sue Ward has been involved in the hearing-impaired/deaf sector for 34 years, being a parent of a deaf child, and also involved with the Wimmera Hearing Society Inc as a volunteer for 14 years.

Sue is currently the Manager of The Wimmera Hearing Society Inc based in Horsham, Victoria.

With a nursing background, Sue shifted direction and completed a noise management audiometry course, annual training with Australian Hearing/Wimmera Hearing Society, along with counselling training.

Because of Sue’s involvement with the hearing impaired for over 30 years, she has a great empathy of deafness and related issues. Sue has been managing the Wimmera Hearing Society Inc for 13 years and previous to that held an active role within the society for over 28 years.

Sue instigated and developed the current mobile testing unit and program, which travels and provides free hearing assessments in the western half of country Victoria. She also represents and supports many deaf service providers and groups within Victoria and Australia-wide. She is always keeping abreast with the latest information, along with providing advocacy for the deaf and hearing impaired people in rural communities.

Stuart Wark

Stuart Wark is a registered psychologist and has been working in the disability field since the early 1990s. He has been employed in both the government and non-government sectors covering areas of rural and remote New South Wales including Cobar, Nyngan, Bourke, Brewarrina, Narrabri, Moree, Inverell and Armidale. He completed his PhD in 2010 with the School of Rural Medicine at the University of New England, examining issues associated with the successful ageing of people with an intellectual disability. Stuart is currently working as a postdoctoral research fellow with the Collaborative Research Network based at the University of New England. He is also employed on a part-time basis as lead psychologist for The Ascent Group, a not-for-profit organisation that supports people with disabilities across rural areas of northern NSW. This role continues an ongoing employment relationship of 16 years, with Stuart previously undertaking positions with Ascent including Executive Manager of Clinical Services and Deputy CEO.

He is a founding member of Australasian Disability Professionals (ADP), a professional association for workers within the disability field. In 2012, Stuart was awarded a Churchill Fellowship to explore the palliative care and ageing issues for people with intellectual disabilities in the United States, Ireland and United Kingdom.

Kate Warren

Kate Warren is a Wiradjuri woman and registered nurse currently working as a research associate at the University of South Australia, Whyalla Campus UDRH.
Kate is a certified trainer of the Flinders Chronic Condition Management Program, both the generic and Close the Gap version. She is also a T-Trainer in the Stanford Chronic Disease Self-management, Chronic Pain Management and Diabetes Management Programs which means she can train trainers in all of these programs.

Kate conducts training for health professionals and consumers in Stanford and Flinders chronic disease self-management programs, and is involved in health research projects based on the management and prevention of chronic disease and population health. Kate co-facilitated the adaptation of the Stanford program for Indigenous Australians (the Living Improvements for Everyone or LIFE program) and has since developed the first train-the-trainer model of the adapted version.

Kate has also co-developed the lifestyle self-management program Shape Up For Life and has recently adapted it to be a peer education-based program. She is currently running a pilot of this program in Whyalla with a small Federal Healthy Communities Initiative grant.

Loretta Weatherall

Loretta is a Kamilaroi woman originally from Goodooga and Walgett. She grew up in these towns and eventually went to Sydney where she boarded and completed her HSC.

Loretta has been working for the University of Newcastle for the last seven years. She completed a Business Administration traineeship, her Indigenous Research Capacity Building Certificate IV and her pathology sample qualifications.

Loretta now works as the Indigenous Research Coordinator for the Gomeroi gaaynggal program and has become a mentor to young Aboriginal women along the way.

Gabrielle West

After graduating from Curtin University with a nursing degree, Gabrielle West began her nursing career at Royal Perth Hospital where she developed the passion for remote health through interaction with Indigenous patients from rural areas.

Working at Swan District Hospital, which was an outer-metro hospital (rural) at the time, consolidated the interest in rural health. To add to her toolbox of skills she completed her Postgraduate Diploma (Midwifery) and went on to apply this in a variety of primary health settings including school health, community liaison and industrial health.

Gabrielle has been working for Royal Flying Doctor Service since 2005, starting at the Port Hedland Base before taking the Flight Nursing Coordinator Position based out of Jandakot. In March 2010 she undertook the acting Director of Nursing and Primary Health Care role and was appointed to General Manager Nursing and Primary Health Care in October of 2012.

Working for RFDS Western Operations provides a perfect platform from which to develop new programs to meet the needs of people in Western Australia’s rural and remote areas, one of which is the dental program.

Pauline Wicks

Pauline Wicks is a Wiradjuri woman from Wellington, in central-west NSW. She has been involved in health for over 40 years. She completed her enrolled nurse training and took up a full-time position at Wellington Hospital, where she remained for almost 30 years. After leaving Wellington Hospital, Pauline transitioned to the Wellington Aboriginal Corporation Health Service and took on the role of clinic nurse. She remained in this position until 2005, when she changed roles within the organisation to become the Regional Eye Health Coordinator for the central-western area of NSW. This role involves coordinating eye clinics for more than 1000 Aboriginal clients in 20 communities across NSW. In 2009, Pauline received a Cert IV in Aboriginal and Torres Strait Primary Health at the Aboriginal College, Little Bay, Sydney. The eye skill set was an elective topic for this certificate and this training has assisted Pauline to be more effective in her current role. As the Regional Eye Health Coordinator, Pauline networks in partnership with the Brien Holden Vision Institute, Vision CRC, optometrists, ophthalmologists and Aboriginal health workers when conducting eye health clinics. She has also been a presenter at many conferences and education programs. A priority in Pauline’s role is to ensure her clients receive any follow-up care that they require once they’ve seen the ophthalmologist. By providing eye care services to the communities she services, Pauline believes this is her way of helping to close the gap.

Katrina Wilkop

Graduating in 1994 with a Bachelor of Applied Science in Physiotherapy, Katrina Wilkop has worked in metro and rural SA in the areas of rehabilitation, aged care, acute care and community health, in both private and public sectors. Following a move to the rural centre of Clare, SA, six years ago Katrina has been involved at the local health service providing physiotherapy services to the Lower North Community and is currently a member of the early intervention Healthy Families team. Her passion is coordinated and accessible provision of health care that considers the client and their families, in their capacity, at that moment. It incorporates the fluid integration of specialist intervention provided where possible in a transdisciplinary model of care. The rural setting provides the opportunity to explore and develop this passion as the challenges and complexities of the country context support creative and efficient models of health care delivery. Katrina was the winner of the SA Health, Allied and Scientific Health Excellence Award 2009, in the category of Evidence and Research Initiatives Informing Practice for her work on action maps.
Nick Williams

Nick Williams is the founder and Director of Value Added Marketing Pty Ltd, a health care marketing consultancy that provides a range of services from market analysis and strategic planning to positioning and campaign development. Clients include pharmaceutical and biotechnology companies, investors and health care industry suppliers.

Preclinical studies in medicine at St Thomas' Hospital in London contributed a perspective that kindled Nick's passion for therapeutic communication.

His expertise grew with more than 25 years of pharmaceutical marketing experience with research-based companies, leading and contributing to multidisciplinary teams across a range of therapeutic segments. He sustains ethical relationships with health care practitioners and opinion leaders in neuroscience, women’s health and rheumatology here in Australia and around the world.

Nick is particularly interested in analysis that informs the development of programs and tools that are designed to facilitate therapeutic concordance, and improve health care outcomes.

Nick consults with Roy Morgan Research to expand health care consumer insights for public and private sector clients.

Susan Williams

Dr Susan Williams is a research associate in the Discipline of Public Health, University of Adelaide, currently working on an ARC-funded project investigating the health impacts of climate change in rural South Australia. She has published papers on the relationships between high temperatures and adverse health outcomes for Adelaide and Perth, and provided evidence to SA Health in relation to the trigger temperatures to activate the SA Extreme Heat Arrangements. Previously she has worked in the Discipline of General Practice, University of Adelaide, on projects investigating cardiovascular risk assessment in general practice. Sue completed a Graduate Diploma in Public Health in 2008. Her original research training and PhD was in biochemistry and microbiology.

John Wilson

Dr John Wilson is currently the Aged Care and Social Services Program Manager with Nganampa Health Council, one of Australia’s premier Aboriginal Community Controlled Health Organisations. Over the past 20 years, John has been a health services manager and senior administrator with Nganampa Health Council on the Agangu Pitjantjatjara Yankunytjatjara Lands, Nindilingarri Cultural Health Services in Fitzroy Crossing and with the Northern Territory Department of Health and Families. He is an Associate Lecturer at the Flinders University and Charles Darwin University Centre for Remote Health in Alice Springs.

John is an author with Magabala Books, and has been co-editor of several foundation social work texts. His professional interests include health services management in remote Australia, child welfare policy and practice, and collaborative social work program design, development and implementation.

He has been a long time supporter of the International Women’s Development Agency, an organisation that funds and supports sustainable, grass roots development programs in the Asia Pacific region.

Heather Wilson

Heather Wilson has been a long-time local to Central Australia and Alice Springs for over 28 years. She is a mother of four children and started as a nurse in the 1970s at the Naracoorte Hospital then moved up and worked at the Alice Springs Hospital in the 1980s. She was a full-time mother for over 12 years and then returned to the workforce at Charles Darwin University in Children Services and lectured in this for seven years. She has worked in the trachoma program as an educator and training facilitator for three years and has now moved onto the remote allied health/eye health program.

Heather’s role as the Central Australian Coordinator in the Remote Eye Health Program is liaising with all 26 Central communities that receive Central Australia Aboriginal Congress Outreach Optometry Service.

Heather’s role is to provide personal administration, logistics, monitoring and evaluation, management, clinical activities and coordination of visiting eye health services to eye health patients, scheduling eye health specialist visits and liaison with clinics, hospitals and the communities that host the visiting services. She has developed an ongoing communication with major stakeholders including the Brien Holden Vision Institute, Alice Springs Hospital, Fred Hollows Foundation (FHF), and Centre for Disease Control (CDC) trachoma department.

Heather travels remotely with the visiting locum optometrists who travel up to the Territory from interstate, then travel usually on dirt roads to the remote communities; the distance on any given trip may cover over 1000 km in a week. The area she covers is of 1.2 million km². Heather works collaboratively with the Brien Holden Vision Institute enabling provisions of optometry service that are accessible, affordable and culturally appropriate.

Leigh Wilson

Dr Leigh Wilson is a lecturer in the Faculty of Health Sciences Ageing, Work and Health Research Group. With a Doctorate in Public Health, Leigh has a strong background in health and health system research, having worked in the NSW Health system as a health service manager and research study coordinator.
Leigh’s primary research interests are in evidence-based health care, environmental aspects of climate change (particularly heatwaves), aged care, public health, health policy, research methods, community health and behavioural health.

She has recently published papers on the effects of heatwaves in an elderly population, behavioural aspects of public health and community-based health care. Leigh is currently working as part of the Ageing, Work and Health Research Group to further investigate the effects of heatwaves in rural communities, and the results of the Ageing Baby Boomers in Australia (ABBA) study.

Leigh is a member of the National Climate Change Adaptation Research Facility’s Social Economic and Institutional Research Network and is a member of a collaborative teams undertaking research on novel statistical modelling of the impact of heat on illness in NSW; and the effects of extreme heat on culturally and linguistically diverse (CALD) populations in NSW, Queensland and South Australia.

Leigh is currently undertaking a PhD investigating heatwave knowledge and adaptive capacity of staff working in rural NSW aged care facilities.

Torres Woolley

Torres Woolley is the Evaluation Coordinator at the James Cook University School of Medicine and Dentistry, and an active researcher for over 15 years in both quantitative and qualitative methodologies. He has an interest in all things rural, remote and tropical, beginning a Masters in Public Health and Tropical Medicine in 1997, and a PhD in skin cancer epidemiology in 1999. Other interests include evaluation of complex interventions, research involving social network analysis, and visiting a new and exotic tropical island each year.
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ABC Rural Radio

ABC Rural is one of the largest groups of specialist primary industries on the world media scene, providing news and insights into the issues that matter to people, wherever they live across Australia. ABC Rural broadcasts a suite of radio programs on a daily basis on a number of radio networks, such as the Country Hour—Australia’s longest-running radio program. We also provide a comprehensive service online at abc.net.au/rural. Several programs will broadcast from the booth and reporters will file stories to stations across Australia during the conference.

General enquiries
GPO Box 9994
Melbourne VIC 3001

National Editor, Rural
Leigh Radford
08 8343 4383 [ph]
08 8343 4404 [fx]

ACRRM

ACRRM is the peak body for the rural medical profession in Australia, key partnerships and functional networks with other colleges, service providers and agencies. ACRRM’s main functions are centred on training and development for rural doctors, support for provision of services to rural communities and delivery of programs and services that fill national health needs and professional retention.

Australian College of Rural and Remote Medicine
GPO Box 2507
Brisbane Qld 4001
07 3105 8200 [ph]
07 3105 8299 [fx]
www.acrrm.org.au
acrrm@acrrm.org.au

Alcohol and other Drugs Council of Australia

The Alcohol and other Drugs Council of Australia (ADCA) is the peak, national, non-government organisation representing the interests of the Australian alcohol and other drugs sector, providing a national voice for people working to reduce the harm caused by alcohol and other drugs.

Alcohol and other Drugs Council of Australia
PO Box 269
Woden ACT 2606
02 6215 9809 or 6215 9800
www.adca.org.au

Andrology Australia

Andrology Australia (The Australian Centre of Excellence in Male Reproductive Health) provides information and education to the community and health professionals on disorders of the male reproductive health system and associated conditions.

Andrology Australia is funded by a grant from the Australian Government Department of Health and Ageing.

Dr Carol Holden
Chief Executive Officer
1300 303 878 (toll free)
info@andrologyaustralia.org
www.andrologyaustralia.org
Australian College of Nursing (ACN) believes that each and every nurse in Australia should have the opportunity to grow their career and further our profession. ACN provides nurses with tools to plan their career pathway, educational supports, opportunities to network and participate in professional forums and a range of benefits that stem from being part of a profession that is moving in the right direction.

Australian College of Nursing
Locked Bag 3030
Burwood NSW 1805
14 Railway Parade
Burwood NSW 2134
02 9745 7574 [ph]
02 9745 7502 [fx]
1800 26 55 34 [freecall]
www.acn.edu.au

Australian Indigenous HealthInfoNet
The Australian Indigenous HealthInfoNet is an extensive, free web resource helping to ‘close the gap’ in health between Indigenous and other Australians by making the evidence base accessible. Their translation research aims at providing the knowledge and information needed for health practitioners and policy makers to make informed decisions.

Australian Indigenous HealthInfoNet
ECU, 2 Bradford Street
Mt Lawley WA 6050
08 9370 6109
t.hoyne@ecu.edu.au
www.healthinfonet.ecu.edu.au

Australian Medical Placements (AMP) is one of Australia’s largest privately owned medical recruitment companies consistently chosen by the medical industry in providing short, long and permanent placements for over 30 years. AMP partners with over 900 health service clients in Australia and is a member of the Recruitment and Consulting Services Association.

Australian Medical Placements
Level 1, 84 North Terrace
Kent Town SA 5067
08 8333 5666 [ph]
08 8363 7657 [fx]
0450 009 392 [mb]
cathym@australianmedicalplacements.com.au
www.australianmedicalplacements.com.au

The Australian Primary Health Care Research Institute’s mission is to provide national leadership in improving the quality and effectiveness of primary health care through the conduct of high-quality, priority-driven research and the support and promotion of best practice.

Australian Primary Health Care Research Institute
Level 1, Ian Potter House
Cnr Gordon and Marcus Clarke Streets
Australian National University ACT 0200
02 6125 0766 [ph]
02 6230 0525 [fx]
aphcri@anu.edu.au
www.aphcri.anu.edu.au
The Australian Psychological Society (APS) is the largest professional organisation for psychologists in Australia, representing more than 20,000 members. The APS is committed to advancing psychology as a discipline and profession, spreading the message that psychologists make a difference to peoples’ lives, through improving scientific knowledge and community wellbeing.

The Australian Psychological Society Limited
Level 11, 257 Collins Street
Melbourne VIC 3000
03 8662 6638 [ph]
0435 896 444 [media mobile]
www.psychology.org.au
Twitter: @APS_Media

The Australasian Centre for Rural and Remote Mental Health leads the way in mental health awareness-raising, resilience-building and prevention strategies.

The Centre is highly regarded for the development and implementation of practical, innovative frontline programs, which address the mental health and emotional wellbeing of the three major population sectors in rural and remote Australia:

- those who live and work in the agricultural sector
- Aboriginal and Torres Strait Islanders
- those who live and work in the mining and resource sector.

Respected for its cost-efficiency, accountability and creativity the Australasian Centre for Rural and Remote Mental Health is ‘out there, making a difference …’

Australasian Centre for Rural and Remote Mental Health
PO Box 2362
Cairns Qld 4870
1300 515 951 [ph]
0400 104 322 [mb]
info@acrrmh.com.au
www.acrrmh.com.au

The Centre for Remote Health aims to contribute to the improved health outcomes of people in remote communities of the Northern Territory and Australia, through the provision of high-quality tertiary education, training and research focusing on the discipline of remote health.

Centre for Remote Health
a joint Centre of Flinders University and Charles Darwin University
PO Box 4066
Alice Springs NT 0871
08 8951 4701 [ph]
08 8951 4777 [fs]
www.crh.org.au

Charles Darwin University (CDU) and the Batchelor Institute of Indigenous Tertiary Education (BIITE) are working together to increase Indigenous educational opportunities within health sciences. We aim to provide students with a culturally safe academic environment that supports them to reach their potential and achieve academic excellence.

Faculty of Engineering, Health, Science and the Environment
Charles Darwin University
Darwin NT 0909
08 8946 7688 [ph]
08 8946 6151 [fs]
robyn.williams@cdu.edu.au
www.cdu.edu.au

Batchelor Institute of Indigenous Tertiary Education (BIITE)
Central Australian Campus
PO Box 9170
Alice Springs NT 0871
08 8951 8343 [ph]
08 8951 8311 [fs]
lynn.moloney@batchelor.edu.au
www.batchelor.edu.au
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. For more information, visit our website.

Continence Foundation of Australia
Level 1, 30–32 Sydney Road
Brunswick VIC 3056
03 9347 2522 [ph]
03 9380 1233 [fx]
info@continence.org.au
www.continence.org.au

CRANAPlus is the peak professional body for all remote health. We are the only member-based national health organisation with remote health as its sole focus. We educate, advocate and support those who live, work and play in remote Australia.

CRANAPlus
PMB 203
Alice Springs NT 0872
08 8959 1111 [ph]
08 8959 1199 [fx]
crana@crana.org.au
www.crana.org.au

Country Arts SA is one of South Australia’s largest arts organisations providing a range of programs and initiatives in partnership with health, environment, Indigenous and other community cultural organisations, the management of performing and visual arts venues and the provision of grant funding that supports the creative endeavours of communities and individuals.

Country Arts SA
2 McLaren Parade
Port Adelaide SA 5015
08 8444 0406 [ph]
08 8444 0499 [fx]
www.countryarts.org.au

DVA’s mission is to support those who serve or have served in defence of our nation and to commemorate their service and sacrifice. One way DVA provides support is by delivering a range of health care and rehabilitation services to eligible veterans and their families.

The DVA booth will showcase information to assist medical providers to access DVA services on behalf of the veteran community.

DVA has offices in each state and territory

DVA has offices in each state and territory
1300 550 457 (metro) [ph]
1800 550 457 (regional) [ph]
providerpartnering@dva.gov.au
www.dva.gov.au
Diabetes Australia

The National Diabetes Services Scheme (NDSS) is an initiative of the Australian Government administered by Diabetes Australia. The NDSS aims to help people with diabetes to understand and manage their life with diabetes, to reduce the impact of their diabetes and improve overall health outcomes.

NDSS/Diabetes Australia
GPO Box 3156
Canberra ACT 2601
1300 136 588 [ph]
admin@diabetesaustralia.com.au
www.ndss.com.au

Epilepsy Action Australia

Epilepsy Action Australia is a leading national service provider offering vital and often life-saving support and services to more than half a million Australians who will be affected by epilepsy in their lifetime. Epilepsy Action Australia provides a range of services including:

- training and education
- Epilepsy Action Online Academy
- online Myepilepsydiary
- residential events
- workshops and seminars
- individual programs.

Epilepsy Action Australia
GPO Box 9878
In your capital city
1300 374 537 [ph]
1300 886 894 [fx]
epilepsy@epilepsy.org.au
www.epilepsy.org.au

Dillons Bookshop

South Australia’s largest independent family-owned bookshop, Dillons, is well known for its massive range of fiction books, non-fiction reference books, music CDs, entertainment DVDs, gift ideas AND friendly knowledgeable staff to help you. The team pride themselves in sourcing the hardest titles! ABC Centre in store.

160–166 The Parade
Norwood SA 5067
Books 08 8333 1094 [ph]
Music 08 8331 9955 [ph]

Evomed

Evomed is focused on bringing new and innovative health care solutions to the Australian health care professional.

Accuvein—the latest in vein illumination technology, a new standard of care in venipuncture and IV access. Hand-held, portable and affordable.


Rob Gourlay
Director Sales and Marketing
Evomed
11 Heathcombe Crescent
Sandy Bay TAS 7005
0409 218 996 [mb]
03 62 25 2452 [fx]
robgourlay@evomed.com.au
www.evomed.com.au
www.accuvein.com
The General Practice Mental Health Standards Collaboration (GPMHSC) is a multidisciplinary body operating under the auspices of the RACGP, and includes representation from general practice, psychiatry, psychology and the community.

The GPMHSC strives to ensure optimal mental health for the Australian population through ensuing high-quality GP mental health education and training.

GPMHSC
100 Wellington Parade
East Melbourne VIC 3002
03 8699 0556 [ph]
03 8699 0570 [fx]
gpmhsc@racgp.org.au
www.gpmhsc.org.au

Healthdirect Australia manages telephone and online services providing Australians with access to health information and the right advice on the appropriate care for their health issue, when and where they need it. Services include: healthdirect Australia, after hours GP helpline, healthinsite, Pregnancy, Birth and Baby, mindhealthconnect, National Health Services Directory.

Healthdirect Australia
Suit 3, Level 19
133 Castlereagh Street
Sydney NSW 2000
02 9263 9037 [ph]
0438 214 142 [mb]
02 9263 9180 [fx]
info@healthdirect.org.au
www.healthdirect.org.au

Health Education and Training Institute — Rural and Remote Portfolio

Learn about our initiatives for health staff in rural NSW. Programs focus on building research skills, providing educational scholarships, training and mentoring rural generalist GPs and proceduralists, leadership development, videoconferencing for clinical review, education and support for staff working with Aboriginal mothers, babies and children.

Health Education and Training Institute
Locked Bag 5022
Gladesville NSW 1675
02 9844 6551 [ph]
02 9844 6544 [fx]
www.heti.nsw.gov.au

The Health Informatics Society of Australia is Australia’s premier member-based not-for-profit organisation supporting and representing Australia’s e-health and health informatics community over the past 21 years. HISA aims to improve health care through the use of technology and information, providing a national focus for e-health and health informatics. HISA is the national affiliate of the International Medical Informatics Association (IMIA).

Health Informatics Society of Australia (HISA)
1A/21 Vale Street
North Melbourne VIC 3051
03 9326 3311 [ph]
03 8610 0006 [fx]
0403 326 641 [mb]
amanda@hisa.org.au
www.hisa.org.au
Health Workforce Australia (HWA) is a Commonwealth statutory authority that delivers a national, coordinated approach to health workforce reform. It was set up by the Council of Australian Governments to address workforce shortages and growing demands for health care arising from an ageing population, growth in chronic disease and increased community expectations. HWA works in collaboration with governments and non-government organisations across health and education sectors to address critical priorities in the planning, training and reform of Australia’s health workforce.

Health Workforce Australia
GPO Box 2098
Adelaide SA 5001
1800 707 351 [ph]
08 3212 3841 [fs]
hwa@hwa.gov.au
www.hwa.gov.au

Healthy Living Network supports the Healthy Communities Initiative by listing the quality programs and service providers that have been assessed and registered against the Healthy Communities Quality Framework standards and criteria. The Healthy Living Network is a registration portal that provides a list of quality registered activities, programs and providers in your local area. All healthy living programs and services providers are invited to apply for registration and promotion.

Healthy Living Network
QMS
Suite 10, Level 1
104 Bathurst Street
SYDNEY NSW 2000
1300 456 000 [ph]
02 9283 7545 [fs]
info@healthylivingnetwork.com.au
www.healthylivingnetwork.com.au

For 25 years, HESTA has focused on helping those in the health and community services sector reach their retirement goals. We now have more than 750,000 members, 119,000 employers and more than $21 billion in assets.

HESTA’s size means we can offer many benefits to members and employers. These include: low fees, a fully portable account, easy administration, access to low-cost income protection and death insurance, limited financial advice (at no extra cost), super education sessions and transition to retirement options. We also provide access to great value health insurance, banking and financial planning. For more information visit hesta.com.au or free call 1800 813 327.

Issued by H.E.S.T.A. Australia Limited ABN 66 006 818 695 AFSL No. 235249/Trustee of Health Employees Superannuation Trust Australia (HESTA) ABN 64 971 749 321. For more information about HESTA, free call 1800 813 327 or visit hesta.com.au for a copy of a Product Disclosure Statement which should be considered when making a decision about HESTA products.

HESTA Super Fund
GPO Box 2913
Brisbane Qld 4001
07 3223 4900
07 3223 4955
hesta@hesta.com.au
www.hesta.com.au

Human Technologies are an Australian-owned, specialist organisation providing purpose-built product solutions for high-dependency personal hygiene—from the head to the feet.

We are committed to ensuring that all of our products are of the highest quality and integrity and are independently tested to ensure we are delivering the highest quality skin and body care.

Our aim is to make a positive difference to the care of the unwell, distressed and the aged in the community. We achieve this through developing high-dependency hygiene solutions that maximise care outcomes and time savings—savings that permit caregivers to deliver greater levels of overall high care!

Human Technologies
PO Box 14
Banyo QLD 4014
07 3630 4777 [ph]
07 3630 4711 [fs]
carla.menkens@humantechnologies.net.au
www.humantechnologies.net.au
IP Partners

IP Partners is a privately owned company with its head office in Thebarton, South Australia. The principal activities of IP Partners are to provide IT products and services to the health, corporate, SMB and education sectors.

IP Partners specialises in managed services, telehealth and supports platforms including Medical Director, Zedmed, Genie and Best Practice with the Health Sector.

IP Partners
85–91 South Road
Thebarton SA 5031
08 7200 6080 [ph]
08 7200 5524 [fx]
sales@ippartners.com.au
www.ippartners.com.au

Lifeline Australia

Lifeline is providing a series of Domestic Violence Response Training (DV-alert), which provides skills to recognise, respond and refer cases of domestic and family violence. DV-alert is a free, accredited training program conducted in all Australian states and territories for all health, allied health and frontline workers.

Lifeline is a charitable organisation that provides all Australian experiencing a personal crisis with crisis support and suicide prevention services. Lifeline relies on the generosity of the community to provide time and fund to support and sustain support services.

Lifeline Australia
24 Thesiger Court
Deakin ACT 2600
02 6215 9454 [ph]
02 6215 9418 [fx]
gia.chu@lifeline.org.au
www.dvalert.org.au/lifeline.org.au

JCU is a leader in providing health care professionals to rural, remote and Indigenous Australia. The School of Medicine and Dentistry’s, Physician Assistant (PA) course holds to that mission. JCU strongly believes in the potential of the PA prototype to enhance the Australian health care workforce.

The school offers a variety of postgraduate and undergraduate health-related courses.

PA Program
School of Medicine and Dentistry
James Cook University
Townsville QLD 4811
07 4781 6679 [ph]
07 47815780 [fx]
physicianassistant@jcu.edu.au
www.jcu.edu.au

MedicAlert® Foundation

MedicAlert Foundation is a non-profit membership-based organisation that provides a trusted 24/7 personal emergency medical information service for people with medical conditions, including allergies, special medications and/or advanced wishes.

To request membership forms or other resources, you can visit our Healthcare Professionals page on our website at www.medicalert.org.au or call Membership Services on FREECALL 1800 88 22 22.

MedicAlert Foundation
GPO Box 9963
Adelaide SA 5001
1800 88 22 22 [ph]
1800 64 32 59 [fx]
enquiry@medicalert.org.au
www.medicalert.org.au
Mercury Group of Companies provides leading HR support and solutions with cutting-edge technology, and are experts in executive recruitment, specialising within the rural health environment, non-profit and private organisations. First State Super is one of Australia’s largest industry funds. Members enjoy low fees and great value super and retirement fund benefits.

Mercury Group of Companies
Suite 303, 120 Bay Street
Port Melbourne VIC 3207
03 9645 5500 [ph]
03 9645 5504 [fx]
0405 971 977 [mb]
alix@mercury.com.au
www.mercury.com.au

Nursing and Allied Health Rural Locum Scheme
NAHRLS
NAHRLS is different. NAHRLS supports you.
The program is focused on supporting rural and remote health services by administering an uncomplicated start-to-finish locum placement service. This enables nurses, midwives and eligible allied health professionals take leave from their work for up to 14 days.

No fees or other hidden charges.

Jamie Smith
Marketing Manager
17T 2 King Street
Deakin ACT 2600
02 6203 9583 [ph]
02 6108 3510 [fx]
0432 202 284 [mb]
jamie@nahrls.com.au
www.nahrls.com.au

The National Relay Service is a government-sponsored phone service for people who are deaf or have a hearing or speech impairment. Relay calls reduce social isolation and allow users to have successful phone conversations with less misunderstanding. NRS users can ring anyone from anywhere in Australia, anytime.

National Relay Service
21A Elliott Street
Balmain NSW 2041
02 9555 4429 [ph]
02 9352 3443 [fx]
infosupport@relayservice.com.au
www.relayservice.com.au

The RACGP National Rural Faculty (NRF) provides education, support and advocacy for registrars and general practitioners living and working in rural and remote Australia. The NRF currently has over 8200 members, including more than 4750 GPs living and working in regional, rural and remote Australia.

RACGP National Rural Faculty
100 Wellington Parade
East Melbourne VIC 3002
03 8699 0407 [ph]
03 8699 0598 [fx]
0410 653 360 [mb]
rural@racgp.org.au
www.racgp.org.au/rural
The National Rural Health Alliance is Australia’s peak non-government organisation for rural and remote health. Its vision is good health and wellbeing in rural and remote Australia.

Member bodies representing health consumers, professionals, service providers and educators, work collaboratively in the Alliance towards achieving this goal.

Fundamental to the Alliance’s work is the belief that, wherever they live, all Australians should have the opportunity for equal health outcomes and equivalent access to comprehensive, high-quality and appropriate health services.

The Alliance has 34 Member Bodies and an office in Canberra.

National Rural Health Alliance
PO Box 280
Deakin West ACT 2600
02 62854660 [ph]
02 62854670 [fx]
nrha@ruralhealth.org.au
www.ruralhealth.org.au

The National E-Health Transition Authority was established in 2005 by the Council of Australian Governments (COAG) to help transform Australia’s health system by building the foundations for a national eHealth infrastructure.

NEHTA’s purpose is to lead the uptake of the eHealth systems of national significance and to coordinate the progression and accelerate the adoption of eHealth by delivering urgently needed infrastructure and standards for health information.

In the year ahead NEHTA, in collaboration with consumers, health care provider organisations, industry and governments, will continue to drive the national uptake of eHealth. In particular, building on the progress achieved to date with the 12 eHealth sites NEHTA will continue to focus on driving take-up and transitioning the sites to national adoption.

NEHTA will also further enable the improved continuity and coordination of care; medications management; the use of diagnostic information to enhance specifications and standards development.

In 2013 NEHTA will:

- continue to develop and rollout the national infrastructure and adoption support required for eHealth in Australia, as mandated and funded by COAG
- support the health sectors transition to the effective use of eHealth
- develop specifications and standards for other conforming health sector participants to connect the national eHealth records system.

The aim of this effort is to meet the national objectives for stakeholder adoption of NEHTA foundations and clinical solutions.

NEHTA
Level 25, 56 Pitt Street
Sydney NSW 2000
02 8298 2600 [ph]
02 8298 2666 [fx]
www.nehta.gov.au
Nursing and Midwifery Telehealth Consortia

The Nursing and Midwifery Telehealth Consortia consists of the Australian Practice Nurses Association, the Australian Nursing Federation, the Australian College of Midwives, the Australian College of Nurse Practitioners and CRANAplus.

The consortia project aims to provide more equitable access to specialist services for patients in regional, rural and remote areas by enabling nurses and midwives to facilitate and contribute effectively and set up high-quality telehealth consultations.

Nursing and Midwifery Telehealth Consortia
Level 2, 159 Dorcas Street
South Melbourne VIC 3205
03 9669 7450 [ph]
03 9669 7499 [fx]
0407 515 507 [mb]
kayebellis@apna.asn.au
www.apna.asn.au

On the Line

On the Line is Australia’s leading provider of professional remote counselling services.

Qualified professionals provide 24/7 support to people in need. Our professional services include MensLine Australia, the Suicide Call Back Service and SuicideLine (Victoria).

On the Line’s innovative telephone, online and video counselling services ensure people across Australia can access vital support.

Spencer Skey
Marketing and Events Officer
On the Line
PO Box 2335
Footscray Vic 3011
03 8398 8426 [ph]
SSkey@ontheline.org.au
ontheline.org.au

Optometrists Association of Australia

Optometrists Association Australia is the peak professional body for Australian optometrists. The Association is committed to assisting optometrists deliver quality eye and vision services and to ensuring optometry continues to evolve as a respected and satisfying profession. The Association represents members and their interests and provides a wide range of information and resources to support optometrists and to promote eye health to the Australian public. Visit our website for more information.

204 Drummond Street
Carlton Vic 3053
PO Box 185
Carlton South Vic 3053
03 9668 8500 [ph]
03 9663 7478 [fx]
aaanat@optometrists.asn.au
www.optometrists.asn.au

Point of Care Diagnostics

Point of Care Diagnostics—answers when you need them

The Point of Care Diagnostics team are specialists in patient-side medical diagnostics. POCD’s core business includes: diabetes, cardiovascular disease, respiratory disease, drug and alcohol screening, and patient self-monitoring, as well as other health screening solutions. POCD are happy to assist with any near-patient testing inquiry or advice on MBS rebates for PoCT, please visit us at booth #8 or online at www.pocd.com.au for further information.

Point of Care Diagnostics
PO Box 780
Artarmon NSW 1570
1800 640 075 [ph]
02 9437 1399 [fx]
pmerrilees@pocd.com.au
www.pocd.com.au
The Program of Experience in the Palliative Approach (PEPA) provides an opportunity for health, aged and community care professionals working in primary care settings to improve confidence and develop skills in working with people with palliative care needs. PEPA offers free workforce placements in palliative care specialist services and tailored workshops. Visit our website for more information.

Queensland University of Technology
60 Musk Avenue
Kelvin Grove QLD 4059
07 3138 6121 [ph]
07 3138 6030 [fx]
www.pepaeducation.com

GP Psych Support

GP Psych Support provides GPs with free patient management advice from psychiatrists within 24 hours. Enquiries can be submitted 365 days a year via phone, fax or secure website.

GP Psych Support psychiatrists provide comprehensive, evidence-based advice for children and adolescents, through to elderly patients.

This service is fully funded by the Department of Health and Ageing as part of its Better Outcomes in Mental Health Care Programs.

GP Psych Support
100 Wellington Parade
East Melbourne VIC 3002
03 8699 0308 [ph]
03 8699 0570 [fx]
gppyschsupport@racgp.org.au
www.psychsupport.com.au

Randstad’s Health and Community Care team has provided the best people in this industry for over 30 years. From large public and private hospitals to small remote and community care businesses, we have a strong understanding of what you really need from a recruitment partner—someone who understands your critical skills shortages and the complexity of legislation and regulations on your business.

We recruit and place nurses who care across all areas of your industry and our skilled and dedicated consulting teams always do more and go further to make sure every candidate who comes through your doors is the right match. So whether it’s a single role or hundreds of positions, we have the expertise, experience and resources to bring only the most caring people to your business. Working with Randstad will make your life easier.

Randstad Care
PO Box 2376
Cairns QLD 4870
Acute Rural 1300 658 899 [ph]
Acute Metropolitan 1300 132 190 [ph]
nurses@randstad.com.au
www.randstadcare.com.au
www.facebook.com/randstadcareaustralia
The Rural Health Continuing Education Sub-program (RHCE) Stream One, provides continuing professional development and multidisciplinary team-based opportunities for medical specialists in rural and remote areas of Australia.

It is an initiative of the Australian Government Department of Health and Ageing and is managed by the Committee of the Presidents of Medical Colleges.

RHCE Program Management Unit
145 Macquarie Street
Sydney NSW 2000

02 9546 5422 [ph]
02 9546 5419 [ph]
admin@ruralspecialist.org.au
www.ruralspecialist.org.au

The Royal Australasian College of Physicians trains, educates and advocates on behalf of more than 17,500 members. The Physicians Telehealth Support Project, funded by the Australian Government, supports physicians to integrate telehealth into their clinical routines through the provision of technical advice and resources. Visit our website for more information.

The Royal Australasian College of Physicians
145 Macquarie Street
Sydney NSW 2000

02 9256 5444 [ph]
02 9252 3310 [fs]
racp@racp.edu.au
www.racptelehealth.com.au

The Rural Health Education Foundation is an independent, non-profit organisation dedicated to delivering free health education to health care teams and communities in remote and rural Australia.

We deliver our programs via the Rural Health Channel on the national VAST satellite service as well as online and via DVD dissemination to provide accessible and relevant education.

Rural Health Education Foundation
38 Thesiger Court
Deakin ACT 2600

02 6232 5480 [ph]
02 6232 5484 [fs]
rhef@rhef.com.au
www.rhef.com.au
The Country Health SA Local Health Network, SA Health, provides rural public hospital and health services on behalf of the government of South Australia. We are committed to transforming health care and delivering health benefits so that rural and remote South Australians lead healthier lives.

Country Health SA—Adelaide Office
NAB Building
Level 2, 22 King William Street
Adelaide SA 5000
08 8226 6120 [ph]
08 8226 7170 [fx]
CHSA@health.sa.gov.au

Sybella Mentoring—rural and remote transition support
Sybella Mentoring delivers uniquely designed programs that support people taking on new employment opportunities in regional Australia.

Our programs build resilience and self-care skills, promote culturally safe practice, enhance emotional literacy in the workplace and help maintain employee motivation.

Sybella Mentoring
13 Endeavour Cct
Cannonvale QLD 4802
07 4946 1197 [ph]
07 4946 1197 [fx]
0414 908 472 [mb]
admin@sybellamentoring.com.au
www.sybellamentoring.com.au

Skilled Medical
Skilled Medical is a national medical recruitment placement and services company. We provide fully registered doctors to meet short- and long-term needs in general practices, hospitals, emergency departments, clinical units and health clinics across Australia, and deliver a range of specialist corporate medical solutions.

Skilled Medical
PO Box 1408
Carlton VIC 3053
1300 900 100 [ph]
09 8413 3030 [fx]
enquiries@skilledmedical.com
www.skilledmedical.com

Therapeutic Goods Administration
All Australians use therapeutic goods, some use medicines, biological products and/or devices on a daily basis. Therapeutic goods are regulated by the Therapeutic Goods Administration.

We are the part of the Department of Health and Ageing, responsible for safeguarding and enhancing the health of the Australian community through the effective and timely administration of the Therapeutic Goods Act 1989.

Therapeutic Goods Administration
PO Box 100
Woden ACT 2606
1800 020 653 [ph]
info@tga.gov.au
www.tga.gov.au
Tunstall Healthcare

Tunstall Healthcare is the world’s leading provider of telehealthcare solutions. Established in the UK in 1957, Tunstall now operates in 40 countries and supports more than 2.5 million people around the world. Our technology and services play a key role in helping older people and those with long-term health and care needs to stay out of hospital or residential care and enjoy a better quality of life.

Locked Bag 1
Kingsford Smith Drive
Eagle Farm QLD 4009
07 3637 2200 [ph]
07 3637 2255 [fx]
www.tunstallhealthcare.com.au

WorkCover SA

WorkCoverSA manages the South Australian Workers Rehabilitation and Compensation Scheme, which provides protection to workers and employers in the event of workplace injury.

WorkCover manages the Scheme on behalf of around 50 000 employers, including private and crown self-insured employers.

WorkCover aims to rehabilitate and compensate injured workers following a workplace injury, and return them to safe workplaces and the community. WorkCover supports injured workers by providing access to health and rehabilitation services to assist them to remain at work, or return to work following their injury.

WorkCover SA
400 King William Street
Adelaide SA 5000
08 8233 2026 [ph]
08 8238 5690 [fx]
dcaulfield@workcover.com
www.workcover.com

Western Desert Nganampa Walytja
Palyantjaku Tjutaku Aboriginal Corporation

The Purple House is primarily a dialysis centre for Western Desert patients and their families who have had to leave their country and relocate permanently for treatment in Alice Springs. The ‘Wellbeing’ Project generates employment, offers traineeships, and brings income back into the centre to assist with social support services.

WDNWPT
PO Box 5060
Alice Springs NT 0871
08 8953 6444 [ph]
08 8953 6222 [fx]
0416 851 131 [mb]
christy.vanderheyden@wdnwpt.com.au
www.westerndesertdialysis.com.au
Looking to publish important rural or remote health research?

The Australian Journal of Rural Health (AJRH)

- Thomson ISI impact factor 1.00
- Peer review
- Reader numbers increasing in Australia and globally
- Easy online manuscript submission
- Supported by the professional publishing services of Wiley Blackwell
- Free virtual issues on Disaster, Rural Workforce Research, Mental Health & Indigenous Health

Read online at nrha.ruralhealth.org.au/ajrh
Information

General information for delegates
The Adelaide Convention Centre is situated in North Terrace in Adelaide.

Telephone     08 8212 4099
Website         www.adelaidecc.com.au

Registration and information desk
The registration and information desk for the 12th National Rural Health Conference is located on the Plaza level of the Adelaide Convention Centre and will be open during the following hours:

Sunday 7 April 2013  8.00 am – 3.45 pm (closed during opening session)
Monday 8 April 2013   8.00 am – 5.00 pm
Tuesday 9 April 2013  8.00 am – 5.00 pm
Wednesday 10 April 2013  8.00 am – 3.00 pm

Registration materials including your name badge, dinner ticket, recommendations password, Conference satchel, handbook and program may be collected from the registration desk during the times listed above.

Alliance Council and staff are here to help. If you have any questions at all please don’t hesitate to ask one of the helpful staff in the orange shirts.

Your name badge is your entry to all Conference sessions. Please wear it at all times.

First Conference session
The Conference will begin with the Opening Ceremony at 4 pm on Sunday 7 April 2013 in Halls A, D and E on the Plaza level.

Conference sessions
All Conference sessions and associated events are being held at the Adelaide Convention Centre. A venue floor plan is provided in this handbook.

Exhibition Hall
The Exhibition Hall is located in Halls J and K. Morning tea, lunch and afternoon tea will be served in the Exhibition Hall each day.

Social functions
As a full delegate your Conference name badge is your automatic entry to all Conference sessions, including the Welcome Reception, Exhibition Happy Hour and Conference Dinner.

The Welcome Reception will be held on Sunday evening following the Opening Session in the Exhibition Hall.

The Exhibition Happy Hour will be held on Tuesday evening 9 April 2013—also in the Exhibition Hall.

Conference Bright Future Dinner and Awards Night
The Conference Dinner is being held at 7 pm on Monday evening 8 April 2013 in Halls F and G on the Plaza level of the Adelaide Convention Centre. Pre-dinner drinks will be served in Foyer F from 7 pm to 7.30 pm.

Entry to the dinner will be by the dinner ticket you received with your name tag. Please bring it along with you.

Speakers’ preparation room
The speakers’ preparation room is located on the Plaza level in Lounge C, just outside the main plenary hall. Staff at the registration desk will be happy to point speakers in the right direction. All speakers should report to the speakers’ preparation room with their presentation (preferably on a thumb drive) as soon as possible after their arrival.

Twitter
The National Rural Health Alliance Twitter account is @NRHAlliance and delegates are encouraged to use the hashtag #ruralhealthconf.

Messages
A notice board for messages is located beside the registration desk. Please check this each day for your personal messages and tell your colleagues if you see a message for them.

Mobile phone courtesy
For the comfort of others it is requested that delegates ensure their mobile phones are set to silent during all sessions.
**Internet access and wifi**

The Internet Café in the Exhibition Hall is sponsored by Australian Indigenous HealthInfoNet and will provide internet access for all delegates. There is also free wireless internet access (512kbps) throughout the Convention Centre. If you need access to a printer etc there is a Business Centre located in the foyer near the Exhibition Hall that is open daily for use during events (a small fee applies).

**Parking**

The Adelaide Convention Centre operates two convenient on-site car parks providing 1200 spaces with access to the Centre via elevator. The car park is under cover, security patrolled and has cash and credit card payment options. The Riverbank car park is accessible from Festival Drive and the North Terrace car park is accessible from North Terrace. A map showing the location of these car parks is in this handbook.

**Public transport**

There is an efficient public transport network of trams, trains and buses in Adelaide. The Adelaide CBD is also easy to walk around with wide, flat streets laid out in a simple grid pattern. The Adelaide Convention Centre is conveniently located in the heart of the city on the banks of the River Torrens and everything you need is only a few minutes’ walk:

- **Tram**—air-conditioned trams can pick you up right outside the Adelaide Convention Centre. Trips within the city centre are free. The route includes the Rundle Mall shopping precinct and the Central Market before continuing all the way to Glenelg. (The sunset at Glenelg can be spectacular!)

- **Rail**—the main railway station is right next door to the Adelaide Convention Centre and provides access to Adelaide’s major suburban centres.

- **Bus**—Adelaide’s City Free bus service is a complimentary service for people who want to get around the CBD quickly. A network of public buses connects the city to the Adelaide Hills, suburban beaches and shopping precincts.

- **Airport**—Adelaide’s international and domestic terminals are located 7 kilometres from the central business district, approximately a 15 minute drive.

- **Taxi**—there is a taxi rank in front of the Adelaide Casino on North Terrace. The trip to the airport takes around 15 minutes.

For further information about Adelaide’s public transport system visit: www.adelaidemetro.com.au

**Travel and accommodation**

If you have any last minute enquiries please feel free to contact Travel Makers for all your travel needs. Travel Makers can be contacted in Canberra by:

Phone: 1800 838 408

Email: anthony@travelmakers.com.au or phil@travelmakers.com.au

GET READY FOR THE
12TH CONFERENCE
BRIGHT FUTURE
DINNER

7pm for 7.30pm
Monday 8 April 2013
Halls F and G
Adelaide Convention Centre

Sponsored by HESTA: being there for others … it’s a choice.

Thank you to HESTA for again supporting this wonderful evening of dancing, celebrating, good food, and more dancing!

In recognition of those who are working for a brighter future in rural Australia, the night will also include a presentation ceremony for the winners of the Rural Health Research Award, the Friends Unsung Hero and the Des Murray Scholarship.

DRESS IN YOUR CHOICE OF BRIGHT COLOURS!

MUSIC BY ACOUSTIC JUICE

They’re back! Following their successful performance at the 5th National Rural Health Conference in Adelaide in 1999, Acoustic Juice has been invited to return to entertain delegates with a night of good music and lots of dancing.

Formed accidentally in 1996 by two local solo performers, Ian “Polly” Politis and Rohan Powell, Acoustic Juice are now South Australia’s number one corporate band and their reputation is unsurpassed in providing quality entertainment that is sure to keep the dance floor crowded all night!

Members of Acoustic Juice have, in various forms, performed around Australia and around the world. They have recorded in Nashville and Memphis alongside some of the industry’s greatest players, and they’ve graced the same stages as legendary performers such as Ray Charles, Carols Santana, Kenny Rogers and a host of the very best of Australian artists.

Musical ability aside, what makes this group special is the camaraderie within the group and the friendships they have formed over the years.

A truly unique bunch of good blokes with a strong commitment to a bright future.
Venue map
Venue car park

Adelaide Convention Centre Car Parking

The Adelaide Convention Centre operates both the Riverbank and North Terrace car parks, which are open 24 hours a day, 7 days a week. The Riverbank car park is accessed from Festival Drive and the North Terrace car park is accessed from North Terrace. A total of 1200 spaces are available and access to the Convention Centre is via lift.

As part of the Adelaide Convention Centre redevelopment, building activity is taking place in the vicinity of the entry to the North Terrace car park. The North Terrace car park will remain open, however entry will be restricted and payment will be required upon entry (with no EFTPOS facilities available). It is anticipated that this will result in delays in accessing this car park for the next several months if your event falls during this timeframe, we recommend that your guests be advised to park in the Riverbank Car Park to avoid any delays. Your guests should allow sufficient time to park and access the convention centre.

Video surveillance camera systems operate in both car parks and security officers patrol on a regular basis.

The following rates are applicable to each car park and all prices are inclusive of GST.

Early Bird $11.00
Available 7 days for entry between 5am and 9:30am and exit by 6:30pm. Beyond 6:30pm casual parking charges will apply as below to a maximum of $24.00 for 24 hours inclusive of early bird parking time.

Casual
0-1hr $4.00
1-2hrs $8.00
2-3hrs $12.00

Then an additional $1.00 per hour or part thereof to a maximum of $24.00 for each 24 hour period.

Trailers occupying a bay – same rates as above
Motor Bikes - $1.00 per hour or part thereof (must be parked in designated areas).

Monthly Parking
For monthly parking rates and availability, please contact the car park on 8212 4099 or acccarpark@adelaidecc.com.au

Conference and Exhibition Parking
The Adelaide Convention Centre understands the importance of having easy access to parking with attending or setting up for a conference, exhibition or function at the Adelaide Convention Centre. The convenience of being able to enter and exit when necessary is available through parking vouchers that allow multiple entries and exits for each 24 hour period. All bookings to be made no later than 5 working days prior to the event.

Parking Vouchers $18.00 per day
One car per ticket at any time (multiple entries per day). Prepaid parking only and no refunds for any unused parking.

Account Parking
We are pleased to offer two options as follows:

Parking Vouchers $18.00 per day
One car per ticket at any time (multiple entries per day). Prepaid parking only and no refunds for any unused parking.

Voucher – Pay as you use
By the hour/single entry and exit. Non-reserved parking. Parking is based on casual spaces available at the time of entry.

For further information regarding our car parking rates, conditions and services you may contact the car park on 8212 4099 or acccarpark@adelaidecc.com.au

Please note all prices quoted are inclusive of GST and correct as at July 2012, but may be subject to change.

Adelaide Convention Centre
North Terrace
Adelaide South Australia 5000
Ph + 61 8 8212 4099
Fax +61 8 8212 5101
www.adelaidecc.com.au
Pre-Conference events

Sunday, 7 April 2013, Adelaide Convention Centre

Rural Policy Forum, AHHA-NRHA-AML Alliance
Supporting rural Medicare Locals

9.45 am – 3.00 pm, Riverbank Room 2
This policy forum, Supporting rural Medicare Locals, will focus on some of the challenges faced by Medicare Locals that have a majority of their population in rural and remote areas.

Supported by the Australian Medicare Local Alliance (AMLA), the Australian Healthcare and Hospital Association (AHHA) and the National Rural Health Alliance (NRHA), this will be an opportunity for people directly involved with the 26 rural Medicare Locals to consider their common challenges in governance, funding and operation—including after-hours services.

Different perspectives will be presented, including those of rural Local Health or Hospital Networks, and MPSs. The program allows for interactive panel sessions as well as smaller workshop groups to distil the key issues to take forward.

Medicines in the Bush, Pharmaceutical Society of Australia

10.30 am – 3.30 pm, Riverbank Room 1
The effective management of medicines in rural and remote settings can be challenging for patients and health care professionals.

We invite you to a thought-provoking, informative pre-Conference workshop that will discuss use of medicines in palliative care and chronic disease, multidisciplinary teams and health professional prescribing. This session should be attended by all rural health professionals interested in medication management and prescribing, including doctors, pharmacists, Aboriginal health workers, nurses, and allied health professionals.

Dealing with depression: mental health skills training, Black Dog Institute

8.30 am – 3.45 pm, Meeting Room 1
Suitable for GPs, GP registrars, psychologists, social workers and mental health nurses.

Dealing with depression is a highly interactive program that aims to provide general practitioners and other professionals with a practical framework for diagnosing and managing depression. The program uses case-based learning to explore the key challenges for GPs caring for patients with depression and to devise effective strategies to address these.

RACGP—Using the eHealth record system to add value to clinical consultations

12.00 pm – 3.00 pm, Meeting Room 3

Seminar outline

- Are you ready for tomorrow’s clinical consultation when a patient asks you about their personally controlled electronic health (eHealth) record?
- Do you know what information you can find in an eHealth record?
- Do you understand the purpose, benefits and opportunities of the eHealth record system?

In this seminar you will learn from a GP about the basics of the eHealth record system, including:

- practical ways to include the eHealth records in your clinical workflow
- what and when to upload
- how to create and maintain a high-quality shared health summary.
Writing for publication workshop, Australian Journal of Rural Health

12.30 pm – 3.30 pm, Riverbank Room 2
Presenters: Editorial team of the Australian Journal of Rural Health

This workshop is designed for writers interested in publishing papers in a peer reviewed journal. The workshop focuses on strengthening writers’ skills to review and rework their own material to ensure that it meets the standards required for peer-reviewed publication.

ACHSM/FHL Rural Health Leadership Workshop: the difficult rural health leadership conversations we need to have

11.00 am – 3.00 pm, Meeting Room 2
This is a call to action to all rural health leaders, young and old, to join us in this session to engage in the difficult conversations we need to have in order to address the issues currently facing health leaders and managers working in rural and remote settings.

We know that there are discrepancies between managing and funding health services in major city environments and country areas. We also know that there is incredible energy and enthusiasm for change. What effect have the health reform efforts had over the last few years on wellbeing in rural and remote areas?

The Australasian College of Health Service Management has joined forces with Future Health Leaders to deliver this timely workshop on key aspects of rural health management. Led by various experts, we invite you to take part in these difficult conversations and help us to provide solutions to better health management in rural and remote settings.

Improving career pathways for Aboriginal and Torres Strait Islander Peoples in the health workforce: challenges and lessons learned in Australia and elsewhere
Flinders University and the Lowitja Institute
1.00 pm – 3.00 pm, Meeting Room 10

This workshop will provide an update on the 'Flexible pathways for an Aboriginal health workforce project' and allow participants to make a contribution to the next stages of the research. The project aims to develop strategies to provide more and more flexible health career pathways for Aboriginal and Torres Strait Islander people. The workshop will be interactive, initially focusing on what it means to be 'flexible', and then on uncovering innovative strategies from the health and other sectors in Australia and elsewhere, and finally on proposing new strategies that can be 'reality' tested during the remaining year of the project.

Presenter Kim O'Donnell will discuss her Doctorate of Public Health, which contributes in one specific area; the ways that governments and Aboriginal Community Controlled Health Organisations (ACCHOs) work with each other. It investigates relationships of (mis)trust between governments and ACCHOs and the impact these relationships have on accountability, problem solving and decision making in the delivery of comprehensive primary health care with and to Australia’s First Peoples.

This work aligns with The Lowitja Institute’s Research Program Three—to provide evidence for health system policy and administration reform and improve capacity to implement programs effectively.
Continuing Professional Development

The following organisations have accredited the 12th National Rural Health Conference for continuing professional development points/hours. Please let us know if you are affiliated with any of the listed organisations.

**Australian Association of Social Workers**
Attending AASW members should record the total hours of attendance towards achieving AASW CPD goals.

**Australian Nursing Federation**
Nurses and midwives attending the National Rural Health Conference can count their hours of attendance towards their mandatory annual Nursing and Midwifery Board of Australia (NMBA) requirement of 20 CPD hours. One hour of active learning equals one hour of CPD. Hours completed can be added to your ANF Professional Development Portfolio. ANF members in all states and territories are encouraged to attend this important conference event.

**Australian College of Rural and Remote Medicine**
Australian College of Rural and Remote Medicine are pleased to accredit the 12th National Rural Health Conference for 21 core points—ACRRM code E1301NRHA.

**Australian College of Midwives**
The 12th National Rural Health Conference has been endorsed by the Australian College of Midwives. An allocation of 6.5 MidPLUS points per day and 20 MidPLUS points for full attendance has been approved for midwives who complete this activity (equivalent to the number of actual activity hours).

**Australasian College of Health Service Managers**
This NRHA biennial conference (2013) is endorsed by the Australasian College of Health Service Management (ACHSM) according to approved criteria. Attendance attracts 21 continuous professional development (CPD) points as part of ACHSM’s CPD Program.
**User’s guide to concurrent sessions**

In your program, the concurrent sessions will appear in a format something like this:

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**LUNCH**

| Location |
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| First-time presenters | Top 20 abstracts | Refereed paper | Top ranking abstract |

On most occasions the concurrent sessions have nine streams. Each stream in each concurrent session usually consists of four 20-minute papers. A five-minute break is scheduled between each paper to enable delegates to move from one stream to another. People who have attended previous Rural Health Conferences will be familiar with this process, which allows delegates to take maximum advantage of the choices offered on the program.

Some streams have two 10-minute Soapbox papers in place of one 20-minute paper. Because of the standard five-minute break scheduled after the 20-minute concurrent session papers, delegates who attend one of the soapbox presentations are asked to consider staying for both of them to minimise disruption.

There will be three colloquia during the Conference and they do not have five-minute breaks between papers. A colloquium consists of four 15-minute presentations that run end-to-end without gaps, followed by a discussion between delegates and all four speakers. Because it will be (a) hard and (b) less desirable to try to break into or out of a colloquium, and because delegates who have heard the speakers will be encouraged to play an important role in the final discussion and formulation of outcomes, delegates are asked to consider staying for the full colloquium.

The majority of presentations in the Arts and Health stream will be 20-minute presentations with five-minute breaks between each, providing the same opportunity for delegates to change from one stream to another.

Hopefully this overview will assist your scanning of the concurrent sessions program and your decisions about what presentations you will attend.

And don’t forget that the concurrent session chairpersons and scribes are asked to work together to post one or two recommendations in the Sharing Shed via the laptop in each room before they depart the scene.
Awards, scholarships and competitions

**Louis Ariotti Memorial Award**
The Louis Ariotti Memorial Award is named in honour of the legendary Queensland bush practitioner who passed away in October 2008. Louis Ariotti contributed significantly to improved rural health both through his personal service and through great leadership in the sector.

The $10 000 award is provided by the Toowoomba Hospital Foundation to recognise innovation and excellence in rural and remote health in such areas as research, policy, leadership, workforce issues and service development.

**Toowoomba Hospital Foundation Research Grants Awards**
The Toowoomba Hospital Foundation (THF) Research Grants Awards are to promote and support research relevant to practice and policy in Australian rural and remote health.

The two THF Research Grants are valued at $10 000 each. Preference is given to applications from novice researchers who are new to the field. The grants program was established by the THF in conjunction with the Cunningham Centre. The Cunningham Centre is a Registered Training Organisation located at the Toowoomba and Darling Downs Health Service Campus.

**Des Murray Scholarship**
The Des Murray Scholarship enables one or more young person from a more remote area to attend and participate in the Conference.

The scholarship is in memory of a great friend to the rural and remote community.

**Friends Unsung Hero Award**
This award from Friends of the Alliance is to celebrate the extraordinary contribution of an unsung individual to the improvement of rural, remote and/or Indigenous health and wellbeing in their local area.

**Photography and Poetry Competition**
The Conference will feature some of the photographs and poems received in the Friends photographic and poetry competitions. Delegates can vote for their favourite entries in both categories and the winners will be announced in a plenary session at the Conference.

**The Gary Stewart Award for Excellence in Country Health Services**
The 12th Conference recognises the SA Health 2012 Gary Stewart Award for Excellence in Country Health Services, in honour and memory of Mr Gary Stewart’s significant contribution to rural and remote health. Awarded to Mr Andrew Lane, for his work and leadership as the EO/DON of Ceduna Hospital, this award helps us remember a great Friend of the Alliance, who attended many National Rural Health Conferences.
Arts and health

Close collaboration between arts and health practitioners has long been a cornerstone of National Rural Health Conference programs. This year we continue to blend a strong stream of papers focused on arts and health with vibrant performances and creative workshops that will challenge and extend your perceptions of arts and health!

Here are some of the highlights.

**Opening performance—Tutti choir**

Led by founder Pat Rix since 1996, Tutti’s mission is ‘unlocking creativity’ and discovering and building potential in people marginalised through disability, mental health problems and other illnesses. Over 60 per cent of people involved with Tutti identify with a disability.

The Tutti Arts Program, established in 2004, offers professional-level training, performances, and exhibitions in multiple artistic disciplines, for artists with a wide range of disabilities. Artists in the program have the potential to earn income through performances and sales of artwork at a range of exhibitions throughout the year.

In addition, Tutti has a community choir with over one hundred singers and musicians, including several fine soloists who identify with disability and mental health issues. Club Tutti, formed in May 2003, offers older people with intellectual disability the opportunity to enjoy choral singing and confidence building in a smaller social group. In 2006 Tutti kids began as an early intervention music and drama program for children with a disability and now offers six different age group programs for children aged 2–15.

Altogether, Tutti is an important cultural catalyst in the lives of around 230 South Australians aged 2 to 84, including 80 in regional SA who form the Big Country Choir.

As winner of the inaugural Music in Communities award 2008, and winner of the inaugural SALA Festival ‘Rip It Up’ Publishing Special Art Award 2010, Tutti is increasingly being internationally recognised as an outstanding model of artistic excellence, social inclusion and community cultural development. Fundamental to Tutti’s philosophy is the belief that education of both disadvantaged people and the wider community is essential to successful social inclusion.

**What makes your day worth it—The Australian Bureau of Worthiness**

The Australian Bureau of Worthiness has completed their census and the findings are out. We have randomly spoken with many of you and have collected your responses to the question ‘What makes your day worth it?’ The ABW have melded and sculptured your responses into a dynamic 30-minute storytelling event. What makes your days worth it 2013 Rural Health Conference? Come and hear the results.

**Emma Beech**

Emma started making shows for her mum in her bedroom when she was six. Since then, she has graduated from Flinders Drama Centre and gone on to become an actor and theatre maker who does stand-up documentaries. In the past seven years, Emma has performed and created new work in Denmark with Carte Blanche and Group 38. In Australia, she worked as an actor on screen with several local filmmakers, and hosted the television series Artshow with ABC and the Australia Network. For theatre, she has had the pleasure of creating and performing with Last Tuesday Society, Cab Sav, Real TV, Patch, Monkey Baa, Playwriting Australia. Emma collaborates regularly and vigorously with Sarah John and is a proud founding member of the Australian Bureau of Worthiness. Emma also plays Fatima alongside Stephen Sheehan in Dating the World.
James Dodd

James Dodd has exhibited widely across Australia in artist-run, publicly funded and commercial spaces. His work traverses the boundaries between visual street culture, alternative use of urban space and existing gallery conventions. He likes sunsets, palm trees and long walks on the beach. As a member of the Australian Bureau of Worthiness he brings his creative opinions, his social musings and his warm insights to an already overflowing pool of talent.

Tessa Leong

Tessa Leong wrote, directed and starred in her first show in year one assembly: it was about Martians. Directing highlights since graduation at Flinders Drama Centre as a directing student include Best We Forget (Adelaide Fringe Festival 2010, Tamarama Rock Surfers Season 2012, Under The Radar Brisbane Festival 2012) and Make Me Honest, Make Me Wedding Cake, which won the 2009 Adelaide Fringe inSPACE Development Award, both with isthisyours? Her work with Griffin Theatre Company, Sydney Theatre Company, Ontroerend Goed, Drop Bear Theatre, State Theatre Company of SA and Restless Dance Company has fed her love of new and challenging work. She has been involved in developments of new writing with Playwriting Australia, Vitalstatistix and Country Arts SA. Tessa has also tutored, directed and mentored at The University of Wollongong and Flinders University of SA on many creative projects. She is currently working on two new works with her company isthisyours?—Audio Commentary and That’s His Style. Her search for the worth in everyday occurs with Emma Beech and James Dodd as part of The Australian Bureau of Worthiness in which she has worked on I Met Port Road and I Met Goolwa. Tessa is a member of the Griffin Theatre Company Studio 2013.

The sound of many places—Robert Petchell

This is a new music work being developed specially for the National Rural Health Conference and inspired by the various locations that delegates come from and the experiences they bring.

Featuring collected sounds and recorded conversations combined with live performances by delegates, Adelaide composer/music director Robert Petchell will create a work that is a sonic tapestry of these rural lives and experiences.

Using current technologies such as smart phones and Skype, the work will be created and rehearsed leading up to the Conference, with the final three rehearsals to be held during the Conference itself.

The completed work will be performed in the closing session at the Conference.

Robert Petchell

Robert is a freelance composer and music director who works with both professional and community musicians and groups. He is Music and Project Director of The Jam, The Mix, The Gig Inc. music and mental health project based in Adelaide, is Composer/Music Director for ‘Change & Adaptation’, a three-year arts, health and the environment project (2012–15) in the Southern Fleurieu region of SA and creates his own works such as the ‘Immersions’ CD for Soundscape and Saxophone.

The power of dance as a tool for wellbeing—Move Through Life

Being part of a group of people who dance together offers much more for wellbeing than just the physical benefits. Dance offers people the chance to connect with others, release inhibitions, tap into creativity, enhance awareness of their own bodies, find a sense of belonging within a group, and embrace playfulness, to name a few. Together, these experiences can contribute to greater health, happiness and life satisfaction.

This workshop will introduce participants to Move Through Life’s philosophy that all adults should have the opportunity to dance so they are physically, creatively, mentally and socially active throughout their lives. It will draw on elements of composition, improvisation, small group ensemble work and informal performance to reveal how dance can be accessible to anyone, whether they have any dance experience or not.

By the end of the workshop, participants will have first-hand experience of the power of dance as a tool for connection with self and others, and leave with a clear idea of how dance can create change in people’s lives.

Jo McDonald

Jo McDonald is the founder and Artistic Director of Move Through Life, as well as the President of Ausdance SA and a member of the board of Ausdance National. She holds a Graduate Diploma in Creative Industries (Dance Teaching) from the Queensland University of Technology, as well as an Advanced II qualification in modern dance with the Imperial Society for Teachers of Dance (ISTD).
In addition to her work in dance, Jo has worked in regional arts for the last nine years, with both Regional Arts Australia and Country Arts SA. During this time she managed projects covering arts and health, arts and environment, digital culture and VET training. Prior to working in the arts sector, Jo worked as a project manager and researcher in the health and alcohol and other drugs sectors.

In addition to her dance qualifications, Jo holds a Bachelor of Science (psychology major), an Honours degree in psychology, a partially completed Master of Psychology (Organisational), and certificates in commercial music (performance) and workplace assessment and training.

**Juliette Griffin**

Juliette graduated from the Centre for Performing Arts in 1995 with an Associate Diploma in Dance. She worked as a professional dancer with Simone Clifford Dance Projects as well as an independent dance artist performing on stage and screen from 1995 to 2002. One of these projects included choreographing and dancing in *Music Is Our Culture*, a collaboration between Indigenous dancers and musicians with the Sydney Symphony orchestra performed in 1998 at the Adelaide festival.

After travelling the world and obtaining a science degree during 2002–2009, Juliette reinvented her practice and once again began studying, working and teaching in the fields of dance, physical theatre and circus. Juliette collaborated in *Just Add Water* 2012 and in *Under My Feet: Dance on Film* an Alexandrina Council initiative funded by Country Arts SA. She choreographed and performed in her debut physical theatre piece *Detectives* and *Sisters* for the Move Through Life’s 2012 ‘Illuminate’ season. In 2013 she will be performing with Playback Theatre, improvised theatre of the unexpected to expand on her love of physical theatre.

**Billie Cook**

Graduating from Edith Cowan University, Western Australian Academy of Performing Arts, with a Diploma of Performing Arts (Dance), Billie has been developing her practice professionally for over 15 years. Billie has performed with Kalika Dance Company, Fieldworks Performance Group and Buzz Dance Theatre, and appeared in *Emptiness* at the Adelaide Fringe Festival 2004, with *fling* and *Ignition* 5 with Australian Dance Theatre, and was the 2005 and 2008 recipient of the Enhancement Program at Australian Dance Theatre.

Billie has travelled with dance to Amsterdam, Spain, New York, South Africa, Dublin, Paris, Nepal, and Greece. She has shared dance with Ngarrindjeri dancers, Zulu dancers, Tibetan Buddhist dancers, worked in a classical Indian dance company, and danced Greek dances with her family.

Billie was Artistic Director for Restless Dance Company in 2006, working with artists with and without a disability. She directed *Within these lines* for the Australian Youth Dance Festival, Horsham. Billie currently teaches freelance classes at the Ausdance SA studio along with being a ‘Dancers in Schools’ tutor.

Billie is a mentor for Move Through Life choreographers, a member of MTL’s artistic advisory group, and often facilitates the weekly company technical class and choreographic development sessions. She is also a member of the Arts SA Arts Organisations Program assessment panel.

**Arts and health installation and workshops—Flinders Medical Centre**

**Installation**

*24 Hours* is a public art project implemented by Arts in Health at FMC, which reflects the continual activity of the hospital environment. The installation will be set up in the Exhibition Hall on Sunday 7 April and remain until the Conference closes at 5.00 pm on 10 April. The installation includes sounding, sound, movement, photography and film. It consists of four domestic-style felted panels with integrated digital screens showing eight short films.

**Felting workshop**

Felting is a popular activity with patients at FMC and can be done by people of all ages and abilities in a short space of time. A casual drop-in, hands-on felting activity with Helen Crawford where individual delegates can drop by and take part in the creation of a felted artwork is being held on Monday alongside the *24 Hours* installation.

**Sound therapy workshops**

These workshops will be with Bindi Blacher and Michelle Byrne. The ancient and pure sounds from singing bowls allow a gentle nurturing of the body, a calming of the mind and rejuvenation of the spirit. The *Sound for Relaxation* project operates at FMC one day a week, taking staff and patients into states of relaxation. Delegates will be able to take part in a relaxation workshop using meditation techniques and the healing sounds of Himalayan singing bowls.

**Art Trolley workshop**

The FMC Art Trolley is a mobile interactive art project that encourages patients, visitors and staff to engage in creative activities. The trolley is ‘driven’
through the FMC wards one day a week by community artist Helen Crawford, providing a creative outlet for patients, staff and volunteers. Participation in creative activities can offer a positive diversion for patients confined to bed or the wards. Delegates will be able to drop in to the FMC Art Trolley on Wednesday to create their own artworks and talk to Helen about her work at FMC.

Helen Crawford

Helen graduated with a bachelor of secondary art teaching in 1987. After four years of art teaching she pursued her own arts practice as a freelance artist, working predominantly in sculpture. Over the last decade Helen’s practice has focused on leading community arts projects, their development and management. She works with varied community groups and enjoys working with people of all ages and abilities. In 2011 she was shortlisted for the Ruby Awards in the category of innovation for a community road painting project in Bowden. Helen is an accredited member of Craft South and is a board member of Community Arts Network. Helen has worked on a variety of arts and health initiatives and as a project artist with Arts in Health at FMC. She currently runs the FMC Art Trolley.

Bindi Blacher

Bindi is an expressive arts therapist and a qualified art therapist (Ass Dip Transpersonal Art Therapy) with extensive experience as a teacher and performer of voice, drama and songwriting. She loves all things creative and holds a deep conviction about art as a powerful tool for healing.

Bindi currently works for ‘Life Without Boundaries’, a living arts program with clients from the homelessness, out-of-home care and disability areas. Bindi works with Arts in Health at FMC as an expressive arts therapist in ongoing programs with the acute care for the elderly unit and patients with eating disorders, as well as general patient referrals. At FMC she also facilitates meditation for staff and coordinates the weekly music program. Bindi has a private expressive arts therapy practice, Creativity Towards Wholeness, which she runs from Unfold Yoga and Wellbeing in Mount Barker.

Michelle Byrne

Michelle is a musician and sound therapist who uses Himalayan and crystal singing bowls, cosmic tone meditation drums, gong and gentle percussion to create a deeply nurturing environment for relaxation through sound. Sound is becoming more widely recognised as a tool for creating wellbeing on the emotional, mental and physical levels of being. Michelle holds a Diploma of Music and offers her ‘Shanti Sound’ courses and workshops throughout Australia, performs as a musician and singer in several well-respected musical outfits, and teaches choir in South Australian primary schools. www.shantisound.com.au

Circus performers and workshops—Circus Elements

Juggling workshop

Have you ever wanted to learn the art of juggling? According to scientists at Oxford University, tasks such as juggling can produce significant changes to your brain, so juggling increases brain power! In this workshop two tutors will guide you through all the necessary steps of juggling to using three balls. By the end of this workshop you will be juggling three balls or, if not, you will be sure to know at least how to get there!

Plate spinning workshop

Plate spinning is a nice skill to have under your ... plate! This workshop is designed to provide a relaxed-paced skill learning environment. You will have fun yet at the same time the workshop will certainly leave you determined to get it the way the professionals do!

Physical theatre workshop

This workshop is for those who wish to try something a little different and unleash their creative talent through improvised voice, storytelling and movement. The workshop is structured yet playful and bound to leave you smiling, laughing, and feeling a little freer!

Scott Griffin

Scott has over 10 years’ experience in circus performance and teaching in NSW with ‘POG’ circus performance company. Scott now resides in Adelaide running Circus Elements, as director, performer, administrator and teacher. His solo show The Great Griffini, a circus show combining juggling, audience participation and riding
atop a gargantuan unicycle while juggling fire continues to tour nationally.

Juliette Griffin
Juliette has an Ass. Dip. in dance performance and has worked as a professional dancer, as an independent dancer/choreographer and teacher and, more recently, as a circus performer/teacher and co-director of Circus Elements. Juliette now likes to focus on participating/leading physical theatre-based workshops. She is also a member of Playback improvised theatre.

Alessandro Gavello
Based in Adelaide since 2005, Alessandro has performed and taught circus and 'commedia dell’arte' to more than 10,000 audience members since then. Alessandro has been a regular lecturer in residency for the Italian University in Movement Science in subjects related to the performing arts, movement and body awareness. He continues to work and live doing what he likes the most: circus, physical theatre and teaching.

Ngarrindjeri weaving—Ellen Trevorrow
Led by Ellen Trevorrow, this workshop shares some insights into the Ngarrindjeri traditional weaving techniques. Delegates will enjoy the ambience created by a group working, weaving and talking together in a timeless fashion. Sitting, sharing, laughing and problem solving in this way has empowered communities generation after generation. Delegates will experience this traditional way of sharing stories and skills.

Ellen Trevorrow
Ellen Trevorrow, is a Ngarrindjeri weaver who was born at Point McLeay (Raukkan) in 1955 and raised near Tailem Bend SA. Ellen lives and works at Meningie, South Australia.

Ellen is a ‘cultural weaver’ with nearly 30 years’ experience making baskets, mats and fish scoops that the old people used for gathering food and for protection. Ellen acknowledges Auntie Dorrie Kartinyeri an Elder who taught her basket weaving. ‘Everything made by the old people served a purpose and it is an honour for me to be doing it today.’

Ellen’s works have been exhibited widely. She was a finalist in the Waterhouse Natural History Art Prize Award and The Watershed Art Prize Award. Her works are held in private and public collections locally, nationally and internationally, including USA, Germany and Japan, and many are held in South Australian Museum.

Images, messages, health and social media workshop—Moya Sayer-Jones
Moya Sayer-Jones has a special interest in health, welfare and the arts, including the challenges and opportunities new technology presents individuals and organisations. ‘A lot of people are stuck and even defeated by new communication channels, but the trick is to understand that online isn’t really about technology, it’s about people. And that’s good news. As health workers, we KNOW all about them!’

In this workshop Moya will share her own experiences working in the sector and her favourite best-practice story-based solutions from international organisations. Specific areas covered include:

- understanding how new media works ... and what doesn’t
- connecting with modern audiences using our personal strengths (storytelling, authenticity and purpose)
- finding your community
- using creative approaches to get users tuning in and sharing your content.
- the ‘too busy to blog/tweet/post/do one more thing’ guide
- Moya’s tools, apps and tricks.

Moya’s workshop is an inspiring and fun exploration of what’s possible when we take ourselves and our organisations ‘social’.

Moya Sayer-Jones
Moya Sayer-Jones is a story activist. She believes in the power of people and the power of stories. Her mantra? ‘Our stories keep us human.’

Regarded as one of Australia’s leading narrative experts, Moya consults with business, government and non-profit organisations. She founded the story agency onlyhuman.com.au to help organisations understand the power of using real stories to communicate and connect with the people who matter most.

A graduate of Sydney University and the Australian Film and Television School, Moya’s idiosyncratic voice is seen and heard in many places. She’s a screenwriter, blogger, novelist and comedy columnist and is joyfully remembered for her creative problem-solving as the original Modern Guru in the SMH/The Age Good Weekend magazine. Follow her on Twitter @StoryDr.
NRHA booth activities

One of the booths you will want to visit is the Alliance’s: 33/34. Please drop in to meet us.

At our booth you will be able to view and make recommendations online via the Sharing Shed, charge your mobile device, meet some of our members of Council and staff, or just sit down with us and knit a square.

We’re looking forward to meeting you.

You will also be able to learn about our advocacy and policy work. Perhaps you would like to tell us what are the key issues you would like us to work on? We are always interested to hear what is going on in rural and remote areas.

There will also be staff from the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme and the Rural Health Continuing Education (RHCE) Stream 2 in attendance.

Come and collect one or two of our publications, join Friends of the Alliance or sit down with us and knit another square …

Have your say!

At the Alliance booth you can access the Sharing Shed to make Conference recommendations, comments and suggestions to improve rural and remote health and wellbeing.

The Sharing Shed is on the internet and easily accessible. Alliance staff members are on hand if you need help. Maintain the tradition: ‘Vote early and vote often’—but you only have 12 votes each!

Join Friends of the Alliance and win an Apple iPad

Show your commitment to a bright future for rural and remote communities by joining Friends of the Alliance. Friends is a valued network of people who support the Alliance’s work.

On joining, you will receive a membership certificate, a Friends gift and go into the draw to win an Apple iPad. The winner will be drawn on the final day of the Conference.

Friends Hamper

We have asked all members of Friends to contribute ‘a modest something’ from their local community to the Friends Hamper. What better way to remember your Friends at the Conference and your love for rural and remote Australia than to have a basket of goodies from all over Australia to take home! The draw will be in the final plenary session.

Poetry and Photographic Competition

This competition provides opportunity to highlight life in rural and remote Australia through the art of photography and poetry.

Entries were open to members of the rural and remote health community and the top 20 entries are displayed in the Convention Centre foyer. All delegates are encouraged to vote for their favourite image and poem. The winners will be announced on the final day of the Conference. Winners in each category will receive $500, and second place $250.

The Knitting Nook

Knit and yarn with Friends at the Alliance booth. Relax and have a chat while knitting a square or even just a few rows for a worthy cause. The Knitting Nook will produce a blanket compiled of your handy work and donate it to a chosen charity after the Conference.

We at the Alliance all love to talk so please drop into our booth to say hello and have a chat. You don’t need to bring chocolate biscuits—that custom is reserved for visiting the Alliance’s office in Deakin.

See you there …
Gifts from the very heart

The 12th National Rural Health Conference is proud to be providing our keynote speakers with a gift of *At the Very Heart* by Storry Walton AM. The book celebrates the work begun by outback legend John Flynn with the Australian Inland Mission and its successor Frontier Services.

Weaving together memoirs and stunning images from generations of people who have walked alongside remote families and provided vital services for a century, *At the Very Heart* is a book to share with the whole family.

This special commemorative book features rare photos and stories from Frontier Service’s history.

Order your copy today by phoning the Frontier Services National Office on 1300 787 247 or download an order form at: http://www.frontierservices.org/frontier-shop/books.

2012 marked the centenary of the establishment of the Australian Inland Mission, which was the predecessor in the Uniting Church to the Frontier Services. This centenary publication recognises the people who have worked to provide these services over the last 100 years and, most importantly, celebrates the hope, spirit and resilience of the people of remote Australia.

The National Rural Health Alliance congratulates Frontier Services for their 100-year long commitment to a bright future.

Evaluating the 12th Conference

A formal evaluation of the Conference provides an opportunity for input from people who have committed considerable time and other resources to attending the event. It also helps the Conference organisers to assess the effectiveness of its various parts and to plan for the next one—to be held in 2015.

Evaluation of the 12th National Rural Health Conference will include analysis of feedback from the delegates as well as an internal assessment against the objectives set for the Conference. Delegates can provide feedback by:

- completing the post-Conference survey that will be emailed to you in the week following the Conference
- providing personal responses by email, phone or in person
- posting on Twitter and Facebook
- providing Conference reports for Partyline or other magazines and newsletters.

Delegates are encouraged to provide feedback on any aspect of the Conference on which they have a view.

**On-line post-Conference survey**

The major evaluation of the Conference will be conducted via an online post-Conference survey made available to all delegates in the days following the event through an email send. We hope you will be able to complete the questionnaire while your recollections and ideas are still fresh.

Delegates who complete the online post-Conference survey and who identify themselves in the response will go into the draw for a chance to win a fantastic prize.

**By email or phone**

Please feel free to contact us by email, Twitter or phone at any time to let us know what you think.

Email: conference@ruralhealth.org.au
Twitter: @NRHAlliance #ruralhealthconf
Phone: 02 6285 4660
Recommendations process

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 advocacy for them by national bodies like the NRHA. They play a key part in setting the Alliance’s agenda for subsequent years.

The recommendations process for this Conference should be particularly useful in this, a federal election year. The process is based on experience and feedback from previous conferences and the opportunities provided by new technologies.

The major innovation is the use of an internet-based recommendations system, which we have christened the Sharing Shed that will be available online at the Conference for the purpose of receiving recommendations. Access to the Sharing Shed is via http://nrha.org.au/12nrhc/about/recommendations-process/

The process is as open and inclusive as practicable. Delegates can access the Sharing Shed via their personal laptops, tablets and smart phones—or on a number of computers located at the Convention Centre—and are encouraged to submit recommendations for consideration at any time during the Conference. These computers will be located in the internet café, at the Conference registration desk, and in the NRHA exhibition booth where staff will be available to assist delegates with submitting their recommendation. All Conference delegates will have received individual log-in details for this purpose. Delegates who have lost their password may re-obtain it from staff.

Computers in the concurrent session rooms will also have access to the Sharing Shed to enable session chairs and scribes to enter recommendations that have been generated in their sessions. There are unique log-in details for each concurrent session. Also in the Sharing Shed Conference delegates are able to lodge up to 12 ‘votes’ to indicate support for their preferred recommendations. By these means it is possible to include all delegates in the process on an equal footing with paper-givers.

Note: The Sharing Shed is publicly accessible on the 12th Conference website. However only Conference delegates can submit recommendations.

As in previous years, a Conference Recommendations Group will review the recommendations received, take account of the level of support indicated by delegates, collate ideas spread across similar proposals, and present priority recommendations to a plenary session for the comments and approval of delegates.

The Conference Recommendations Group will be convened by Lesley Fitzpatrick and will include Gordon Gregory, Helen Hopkins and Lexia Smallwood.

Lesley Fitzpatrick will progressively inform delegates of key themes emerging from received recommendations and invite input from delegates on those that should be agreed as priorities. A recommendations roundtable will be held during the Conference at which the Recommendations Group will meet with interested delegates to further develop the priority recommendations. The process culminates in the plenary session on Wednesday when Lesley will involve delegates in a process of formally agreeing a selection of priority recommendations before they are presented to the Minister.

Everyone at the Conference is encouraged to make their views known and to propose recommendations for action at any level: for example for local, state or national governments, professional associations, universities and/or community groups. Media work at the Conference will reflect the tenor and content of the recommendations that emerge.

After the Conference, all organisations concerned with rural and remote health and wellbeing will be encouraged to act on and promote those recommendations that interest them. This can help assure the future for health and health services in rural and remote areas in five and ten years’ time.

Delegates will no doubt be providing feedback from the Conference via Twitter, Facebook and other social media forums. There will be a live Twitter feed on-site at the Conference, which will be monitored by the Conference Recommendations Group.
Recommendations—FAQs

Q. What happens to the recommendations?
A. They will be promoted through the media, through the Alliance’s Members and networks, and through targeted sends to organisations and individuals able to act on them. Agencies are encouraged to promote the recommendations that relate to their own area of interest. They will inform the Alliance’s future work program and other organisations are encouraged to include them in their planning and strategic directions.

Q. What has happened to the recommendations from previous conferences?
A. Some of them have been fully implemented, some have helped inform policy developments, and others have gone nowhere. Following conferences, the Alliance maintains a checklist to monitor the progress of recommendations. As a result of the recommendations from previous conferences there have been further developments on scholarships for allied health, a national inquiry into patients’ travel and accommodation, numerous inputs to the health reform process, various inputs to health workforce reports and considerations, continued pressure for a more strategic approach to rural and remote health research, a stronger focus in the Alliance on remote (cf rural) issues, and heightened awareness of the need to retain and increase the procedural skills of GPs.

Q. What makes a good recommendation?
A. A good recommendation is a proposal for action directed at a person or agency in a position to act on it, with some indication of how the costs will be met and what the timeline should be. It should accurately reflect responsibility for the issue of concern. When implemented, a good recommendation will lead to improved health outcomes.

Q. How are recommendations prioritised?
A. The Recommendations Group will audit all recommendations received and identify priority themes based on content, timeliness, urgency, achievability, cost-effectiveness and level of interest indicated by input and response, with due regard for a broad coverage of issues. Conference delegates contribute to prioritisation in plenary sessions.
**Review and selection process for concurrent papers**

The closing date for the receipt of abstracts for the 12th Conference was 1 October 2012. Over 500 abstracts were received for around 180 paper and workshop places in concurrent sessions.

All abstracts were then subject to a ‘blind’ selection process, which included ranking by an abstract selection committee. The purpose was to select abstracts on the basis of their potential value, their quality, their particular association with rural and remote (cf national or metropolitan) health, and their relevance to the selected Conference topics.

Our thanks to the members of the abstract selection committee: Rebekah Adams, Philip Anderton, Lisa Bourke, Peter Brown, Melissa Cameron, Tim Carey, Wendy Downs, Teena Downton, Craig Dukes, Pauline Glover, Penny Hanley, Desley Hegney, Helen Hopkins, Beth Johnston, Sharyn Kelleher, Tim Kelly, Tanya Lehmann, Shelagh Lowe, Susan Magnay, Geri Malone, Mary Martin, Lisa McInerney, Lachlan McIver, Deirdre McLaughlin, Jane Mills, Greg Mundy, Bradley Murphy, Shannon Nott, Nicole O’Reilly, Megan Passey, Andrew Phillips, Prasuna Reddy, Louise Roufeil, Bruce Simmons, Lexia Smallwood, Ruth Smiles and Susan Stratigos.

Authors of abstracts selected for a place on the Conference program were asked to prepare a full paper for inclusion in the Conference proceedings. Those who wanted their paper to be potentially eligible for inclusion in the Department of Innovation, Industry, Science and Research (DIISR) Higher Education Research Data Collection (HERDC), submitted their paper for a formal review process. Their papers were subject to ‘blind’ review by two independent expert referees. Successful authors were offered a general paper presentation or peer-reviewed paper presentation (20 minutes) or a soapbox presentation (10 minutes).

To be accepted as a peer-reviewed paper, the paper produced from the abstract needed to:

- be clearly expressed, using correct grammar and spelling
- show evidence of a literature search, including up-to-date materials, and reference the material appropriately (the Vancouver System being preferred)
- be analytical rather than only descriptive (eg of a program undertaken, a service developed etc)
- refer to the theoretical context or contextual framework in which the study was undertaken, and report on the work in the context of that framework
- show that the evidence related to the issue discussed had been considered
- present a coherent discussion of a topic that does not fracture into a number of issues thus clouding the intent of the paper
- demonstrate an emphasis on, and/or a relevance to, current health issues in rural and/or remote Australia.

The Conference Advisory Committee acknowledges the input of the following expert referees and thanks them for their time: Robyn Aitken, Philip Anderton, Brian Babington, Suresh Badami, Lesley Barclay, Brian Bowring, Tom Calma, Rob Curry, Craig Dukes, Lesley Fitzpatrick, Denis Ginnivan, Bruce Harris, Desley Hegney, Anthony Hogan, Helen Hopkins, Beth Johnston, Kathryn Kirkpatrick, Ann Larson, Louise Lawler, Anne Leversha, Yvonne Luxford, Sue McAlpin, Jo McCubbins, Mark McLeod, Susan Magnay, Julia Marley, Tim Metcalfe, Jane Mills, Dawn O’Neil, Gary Misan, Monica Persson, Andrew Phillips, Lyndon Seys, Bruce Simmons, Megan Stoyles, Susan Stratigos, Lindy Swain, David Templeman and Sue Wade

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**Refereed papers are highlighted in the Conference program by this symbol.**

**Papers from first-time presenters are marked with this symbol.**

**Papers for which the abstract was ranked in the top twenty are marked with this symbol.**

**The top ranking abstract is marked with this symbol.**
Friends of the Alliance is an organisation that supports the work of the National Rural Health Alliance!

What is Friends of the Alliance?
Friends of the Alliance (Friends) is a network of interested individuals and organisations that support the work of the National Rural Health Alliance. Friends provide the Alliance and its work with additional grassroots connections to the constantly changing rural and remote health landscape.

Friends has over 450 members across Australia.

Friends is established under the Constitution of the National Rural Health Alliance. The Chair of Friends has a seat on the Alliance Council.

Why join Friends?
Friends of the Alliance promotes and facilitates communication at all levels on rural and remote health issues between the NRHA, the wider community, people in the field and other relevant stakeholders including government agencies.

The aim of Friends is to ensure that all those interested in rural and remote health are kept informed of developments and assisted to promote and implement their strategies for improving health outcomes.

Friends receive discounted registration fees to the biennial National Rural Health Conferences and regular updates about Alliance movements and activities. Friends receive a membership certificate, Friends lanyard and lapel pin and a copy of the Alliance’s Rural and Remote Health Papers DVD which is a comprehensive collection of Conference and research papers on rural and remote health that have been published since 1991.

Friends are encouraged to raise local issues with their State Friends representative for reporting back to the Alliance.

Visit www.ruralhealth.org.au or see over page for details on how to join Friends of the Alliance.
Who can join?

Friends of the Alliance welcomes individual members, as well as small and large organisations interested in health issues in rural and remote Australia. There is a modest membership fee.

Friends Advisory Committee

With support from Alliance staff, the Friends Advisory Committee oversees and facilitates the activities of Friends and provides editorial support for the Alliance newsletter Partyline. The Choir of Friends is elected by the Friends Advisory Committee from within its membership.

For more information visit www.ruralhealth.org.au

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**Membership Application Form**

**MEMBERSHIP TYPE** (GST inclusive)

- [ ] Individual Membership $44
- [ ] Concession (not in paid workforce) $27.50
- [ ] Small Organisation (less than 50 staff) $165
- [ ] Large Organisation (more than 50 staff) $330

**AJRH Online Subscription (optional)**

- [ ] Individual $62.70

**PAYMENT**

- **Payment by Mastercard/Visa**
  
  Attach cheque/postal note payable to friends of the Alliance or fill in your credit card details:

  - Card type (please tick): [ ] Mastercard  [ ] Visa
  - Card Number: ____________
  - Expiry: ___ / ___
  - Card holder's Name: 
  - Amount: $  
  - Signature: ____________________________

- **Payment by Electronic Funds Transfer (EFT)**
  
  If you would like to make your payment by EFT please make a direct deposit to:

  - Account name: National Rural Health Alliance Inc.
  - BSB number: 032731
  - Account number: 114833
  - Reference: FRND[name] eg: FRNDMARY

  Once deposit has been made, please fax this form and your remittance advice to (02) 6285 4670

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**TAX INVOICE**

ABN 68 480 848 412

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National Rural Health Alliance A PO Box 280 Deakin West ACT 2600 P (02) 6285 4660 E nrha@ruralhealth.org.au W www.ruralhealth.org.au
Abstracts

Keynote abstracts

‘Health ready’ for all eventualities

Chris Baggoley

1Australian Government Chief Medical Officer

Rural and remote Australia is at the frontline of many challenges to the nation—environmental disasters such as floods and fires, risks of animal-borne infections, particular vulnerability to epidemics (including in remote areas and in some Aboriginal and Torres Strait Islander communities), industrial accidents (farming, mining) and work-related health challenges (FIFO, mental health).

These challenges are faced by a rural and remote health sector that may already be stretched—through distances and workforce shortages—but the resilience of rural communities in the face of adversity is well recognised. This resilience is one of the bases of successful innovation, but while it can be celebrated it should not be a reason for minimising access to mainstream health and other public services in such areas.

I will talk about systemic ways to ensure that rural communities are ‘health ready’ for all eventualities, including through innovative ways to overcome workforce shortages and through telehealth and the eHealth record.

I will also draw on past experience to talk about systemic approaches to safety and quality that can leave people in rural and remote communities feeling more at risk. Many rural services are concerned that setting the bar too high can result in service closure—and the risks associated with no local health care, including delays in receiving treatment, road and travel risks and family stresses.

What makes your day worth it?

Emma Beech

1Australian Bureau of Worthiness

The Australian Bureau of Worthiness has completed their census and the findings are out. We have randomly spoken with many of you and have collected your responses to the question ‘What makes your day worth it?’ The ABW have melded and sculptured your responses into a dynamic 30-minute storytelling event. What makes your days worth it 2013 Rural Health Conference? Come and hear the results.

Shining brightly: lessons from rural health time in the sun

Michael Bishop

1Rural Health and Aged Care, Darling Downs Hospital and Health Service, Qld

The presentation has two main components that highlight the sustained and sustainable impact being achieved in rural and remote health care as a result of resilient and creative partnerships between health workers and rural communities.

Examples from the Darling Downs and Surat Basin highlight the responses of the local communities to the unprecedented changes in health systems and health needs being experienced in these communities. Briefly, the examples showcase initiatives in cross border services delivery, community engagement and partnerships between public and private sectors.

A second theme demonstrates the significant impact that rural, remote and very remote allied health professional innovations have had and are having upon the health system, nationally and internationally through such organisations as SARRAH and the NRHA.

Supporting choices for older people: The Living Well and Dying Well program in aged care facilities

Robyn Brogan

1Tasmanian Health Organisation NW

In her presentation, Robyn will describe how a successful and sustainable program for promoting dignity in the last years of life has been developed and is operating in north-west Tasmanian residential aged care facilities. Key elements include a service model (Gold Standard Framework in care homes) initially developed overseas, which was adapted for use in regional Australia, plus a strong person-centred focus, and a team approach to advance care planning, supported by a growing eHealth capacity to document and share information. Exciting
developments in eHealth capability are beginning to support and extend the Primary Health Care Team’s capacity to align care with the older person’s dignity, their values, preferences, evolving priorities, advance directives, and negotiated goals of care.

Care is organised around a framework (7Cs: better communication, coordination and continuity of care, control of symptoms, care of the dying, care of all carers, and continued learning). This supports slow deep culture change with high value placed upon each team member’s quality relationships with residents and families. These relationships strengthen the team’s capacity to discover what may be the ‘right’ thing to do for this person (right care, right time, right place, and involving the right people).

The program enables the team to plan ahead, preparing everyone to be ‘on the same page’, with residents and families reassured and in agreement about the team’s duty of care when inevitable deteriorations occur. The program encourages safe ethical processes for activating pre-authorised Clinical Action Plans for the Dying Phase and for implementing a minimum protocol (End of Life Pathway) to guide care in those last days of life. Staff become more inspired and confident to offer and deliver supportive and palliative care, focusing on the person’s dignity and quality of living—especially in those last months, weeks, and days. The program is sustained through strong partnerships between Primary Health Care Community Teams, aged care providers, Tasmanian Health Organisation (NW), and State and Federal Governments.

Successful buy-in by Aboriginal and Torres Strait Islander communities to reduced tobacco use and mental health initiatives

**Tom Calma**

Tackling Indigenous Smoking

It is understood that a reduced rate of tobacco use among Aboriginal and Torres Strait Islander people would make a significant contribution to their improved health and wellbeing. The Australian Government has world’s best practice approaches to reducing smoking and this includes targeted approaches for Aboriginal and Torres Strait Islander peoples.

Some of the good news stories about reducing tobacco use among Aboriginal and Torres Strait Islander people will be described and illustrated through video presentations. The specific programs involved are providing benefits in their own right and demonstrating some of the principles more generally applicable to culturally appropriate, community empowerment health promotion.

The address will also cover some of the national developments with work on social and emotional wellbeing for Aboriginal and Torres Strait Islander people, some of which is now being led by an initiative that brings together government departments and mental health and suicide prevention interest groups. An understanding of these high-level national initiatives will provide a useful background for some of the more detailed presentations at the Conference in concurrent sessions relating to Indigenous mental health and wellbeing.

Tom will also describe the work of the Rural Health Education Foundation, which is a key provider of general health and wellbeing information (through Channel 600) to many thousands of health service centres and households in more remote areas, as well as of specific professional development material.

The successful strategic approaches and buy-in by Aboriginal and Torres Strait Islander communities and individuals to reduce tobacco use and take-up mental health initiatives need to be sustained for the longer term.

**Empowering rural communities through social media**

**Alison Fairleigh**

Mental Illness Fellowship of NQ Inc

People in rural and remote Australia are finding their voice and social media is responsible. The growth and popularity of social media over the past few years has transformed the way we communicate and has been instrumental in challenging rural stereotypes. Nationally, Facebook still dominates, with over 11.7 million users, but Twitter has also been a powerful tool, reaching over 2.2 million active users in Australia every month. Harnessing this power, people in rural and remote areas are creating online communities and orchestrating change. As such, social media presents an undeniable opportunity to help improve the health and wellbeing of people in rural and remote Australia.

Social media is an equaliser. The multi-directional nature of Web 2.0 technology enables rural people to interact and contribute content on social, environmental, political and economic conditions
that impact on their health. The traditional, top-down approach to information sharing has become irrelevant within the context of social media: people in remote settings now have the capacity to engage and participate. This undoubtedly can lead to more effective health promotion in rural and remote areas and ultimately, a more socially responsible health care system in which rural communities are given due consideration.

“Tell ‘er she’s dreamin’!”

James Fitzpatrick¹, Tanya Lehmann²

¹The George Institute for Global Health, ²Country Health SA

TL: ‘Do you remember when things turned around so well for rural health?’

JF: ‘No: remind me.’

‘It started at the National Rural Health Conference back in Adelaide. Do you remember that one?’

‘Of course I do: it’s where we met. And I knitted you some bright woolly socks.’

‘We were all determined to turn around that Medicare deficit of a billion dollars a year. And tackle that other billion in lack of access to allied health, the PBS, and oral health care ...’

‘Really? Was it that much?? Good gracious, we took on the world!’

‘And we built on some early runs with tackling Indigenous smoking to design illness prevention and health promotion for people outside the cities. We took the line that good mental health and having babies and living well and healthy ageing were all part of life in rural and remote communities, not something that could only happen in specialised centres in major cities.’

‘But that’s no big deal—just common sense!’

‘True. But there’s more. Telehealth was still in its infancy. People were inspired with what could be done—in the sessions and in the exhibition hall. Rural and remote health professionals and consumers signed up for the eHealth record and insisted that it was made to work for them. Country people joined up with their ‘Medicare Locals’ and Local Health Networks so that State Governments and Feds were working together on country services that worked. Good research in rural areas really took off and provided evidence on needs analysis and service design that gave attention to the social determinants of health in rural areas ...’

‘I certainly remember the energy and passion at that Conference. It was a real landmark in ensuring a bright future for rural health.’

‘Yep. And I still have those bright woolly socks.’

Overcoming barriers to full economic participation in more remote areas

Jan Ferguson¹

¹Ninti One Limited; Cooperative Research Centre for Remote Economic Participation

Jan Ferguson’s presentation will describe some of the work of the Cooperative Research Centre for Remote Economic Participation (CRC-REP) and evidence of the practicability of economic participation in more remote areas. CRC-REP began operations on 1 July 2010. It is focused on delivering solutions to the economic challenges that affect remote Australia and providing practical responses to the complex issues that can restrict full economic participation in such areas.

CRC-REP is a partnership of more than 50 bodies, including the Australian Government, four state and territory governments, non-government organisations, universities, private businesses and industries, including mining, pastoralism and tourism. Thirty per cent of its membership comes from Aboriginal organisations and communities.

The goals of CRC-REP are:

- to develop new ways to build resilience and strengthen regional communities and economies across remote Australia
- to build new enterprises and strengthen existing industries that provide jobs, livelihoods and incomes in remote areas
- to improve the education and training pathways in remote areas so that people have better opportunities to participate in the range of economies that exist.

Jan’s presentation will give some examples of entities whose approaches have successfully surmounted the barriers that exist and established robust, dynamic and viable enterprises that can serve as models and sources of inspiration to others.
A (rural) health system for the 21st century

Jane Hall
Centre for Health Economics Research and Evaluation, UTS

‘Health reform’ has been on the agenda for a number of years now, with Medicare Locals, Local Hospital or Health Networks and a new approach to activity-based funding for public hospitals being among the main results to date.

In her presentation, Jane will consider the extent to which Australia now has the health system it needs for the challenges of the 21st century, and what evidence we have to get us to a better place.

Jane will call on research evidence, including from the UTS Centre for Health Economics Research and Evaluation of which she is Director and from the work of the Centre for Research Excellence (CRE) in the economics and finance of primary health care in Australia. The CRE’s focus is on how primary health care policies affect the use and costs of health care, the quality of care, patients’ health outcomes and whether patients’ experiences are improved.

Access to a health system that works well, including for people who live in rural and remote areas, and which is economically efficient, is something in which all Australians have a stake. Health care can be seen as a human right—one that is available unevenly to populations with different characteristics. In addition, around 10 per cent of the nation’s GDP is spent on health, with Australians also paying around $800 per person in direct out-of-pocket health costs.

The provision of primary care in Australia needs well-considered reform, in order to achieve a stronger multidisciplinary and population-based approach and greater flexibility, including in relation to health workforce roles and mixed payment approaches.

Maximising lifetime opportunities through the NDIS

Dougie Herd
NDIS Launch Transition Agency

The National Disability Insurance Scheme (NDIS) has been described as a landmark reform, a once-in-a-generation opportunity and an idea whose time has come. But when the NDIS commences in July of this year in launched sites in the Hunter Area of New South Wales, South Australia, Tasmania and the Barwon Region of Victoria, what will it mean for individuals with disability, family members and carers? How will the service provider sector respond to the gradual transition from block-funded arrangements and program-related activity to individualised arrangements, personal budgets and new forms of self-direction and self-management of support plans in the future? How will the NDIS Launch Transition Agency operate during Stage 1 of the NDIS launch and how do we see the development of the NDIS over the next five years as we move from launch to the full scheme envisioned by the Council of Australian Governments’ NDIS agreement reached on 7 December 2012?

These are just some of the questions that drive and inform the development of the NDIS, the Launch Transition Agency and the many communities of interest who are watching, as well as contributing to, the preparations for launch of the NDIS on 2 July. Dougie Herd, one of the senior managers in the national office of the NDIS Launch Transition Agency, will give an update on preparations and arrangements for launch and consider some of the design and development challenges that will need to be addressed as the NDIS looks beyond launch towards the roll-out of the full scheme for more than 410 000 individuals with disability living in every community of Australia.

Of critical importance to the successful development of the NDIS will be its commitment to ensure that viable, sustainable and flexible support arrangements are within the reach of all eligible participants of the NDIS. That means choice and control over one’s ‘reasonable and necessary’ supports must be made real wherever people live in Australia. The question is ‘how’?

We know we can—because it’s in our own hands

Marie Lally
Farmer and health consumer

With Bob Wells and Jane Hall having provided the evidence for a fresh policy approach to rural health and the economic justification for the sort of health system we need to meet the challenges of the 21st century, Marie’s address will provide the inspiration and the explanation of how we can get there.

Marie’s experiences at national, state and local levels give her valuable insight into how an improved system can be achieved. National and state policies provide the frameworks for services, and those levels will be ignored by people on the ground at their...
peril. But the best hope and the best outcome will be obtained through local commitment, energy and accountability. Marie will encourage everyone with an interest in better rural health to use the magic of their own personal and family experiences—just as she has used hers—as the basis for a persistent and effective mix of advocacy and action.

For each of us separately and in our community groups, an evidence base for continued striving for a bright rural future is provided by the five senses: what we see around us; what we hear from our friends and our wider network; the people and agencies touched by our reports; and the sweet smell and the taste of success.

Accountability and system improvement

Sue Middleton

COAG Reform Council

Accurate, up-to-date and comparable performance data are invaluable tools for individuals and organisations seeking to influence systemic change and achieve improvements in real health outcomes.

Under the National Healthcare Agreement, Australia’s governments have committed to ensuring that our health care system provides all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live. These are lofty and admirable aspirations, though the distance from major cities still links closely to poorer health outcomes for many Australians.

The COAG Reform Council has been asked by Heads of Governments to report annually to them and to the public on whether progress is being made by our governments in achieving the health outcomes to which they have agreed to be accountable. This includes overcoming the great disparities in health outcomes between cities and rural/remote areas. This is a unique reporting role, which focuses on the performance of our governments, rather than of clinicians or individual hospitals.

This presentation will discuss:

- what the Council has learned in the first three years of its reporting about the disparity in health outcomes between cities and rural areas
- what data challenges are faced when trying to assess health outcomes in rural and remote Australia
- the importance of the Council’s performance reporting to informing advocacy and systemic change.

The state of rural and regional health—and its future

Rob Oakeshott MHR

Member for Lyne

In Australia there is a long-standing inequity where health funding is concerned between those who live in the major cities and those who live in rural and regional areas. Rebalancing this situation was one of the elements of the agreement signed between the two regional independents and the Prime Minister in 2010.

In his presentation, Rob will reflect on progress made since that time, and how people in rural and regional areas can be given a stronger voice on these matters. Further real progress will require firm and prudent national decisions on community services, welfare and potentially the tax system—especially at a time when significant expectations have been raised in areas such as disability services and education. It is significant that ABS figures show that the richest 20 per cent of Australians receive about half of all the wages paid but also get about 12 per cent of all government handouts.

Some of the work to improve equity in the funding of services for rural and remote areas can be led by parliamentary committee work and it must result in higher standards of accountability in the public sector, including effective oversight by bodies such as the Auditor-General. National leadership can also be exercised through upstream issues impacting on health and wellbeing, such as the Constitutional Recognition of Indigenous Peoples, and work to minimise violence against women and girls.

Rob views non-metropolitan disengagement in education as one of the key economic failures of Australia and he continues to work on turning this around. The availability of high-speed broadband to rural and regional communities and businesses is also a critical issue and one that impacts on health and wellbeing.

The Independents’ agreement with the Government has provided a number of funding ‘wins’ for rural health and hospitals, but much more needs to be done. The agreement included $1.8 billion for rural and regional health infrastructure. So far, more than
100 hospitals and health centres in rural and regional Australia are being rebuilt or upgraded as a result.

**Inter-state collaboration to enhance remote health care**

**Mick Reid**

1 Consultant

Mick Reid has been commissioned by the Health Departments of South Australia, Western Australia, the Northern Territory and Queensland to report on ways in which these jurisdictions might collaborate on initiatives to improve both the lot of health professionals in the remoter areas of those jurisdictions and the health of the people who live there.

The main task is to improve health services in more remote areas through a set of achievable initiatives to help attract and retain health professionals, maintain their skills and provide a range of appropriate services. The initiatives are to be quite specific and doable, not an overarching strategy for remote health service provision. The initiatives involve the collaboration of four autonomous jurisdictions and the strong interest of the Commonwealth.

The work is based around ten initiatives, grouped under five headings.

- **Recruitment and retention**
  - through HWA, work to devise a single brand for remote health employment to enable a collaborative approach to recruitment and portability of employment across jurisdictions
  - protect that brand for people who wish to work in remote locations.

- **Service planning**
  - develop a single service plan for local communities; the footprint of Medicare Locals is unsuited to develop and/or act on this plan
  - in developing the plan, identify common elements that should constitute core services—possibly based on the NT model
  - promote collaboration in development of the plan, including by private and public service providers.

- **Education and training**—‘how we maintain the skill base’
  - focus initially on initiatives relating to prevocational medical education and training—with nursing and allied health later. The aim is to facilitate a much better vocational training experience in rural and remote Australia
  - adapt Queensland Health’s Pathways to Rural and Remote Orientation and Training (PaRROT) as an eLearning program for all health personnel. It is based on early detection and early intervention in chronic disease and there are plans to roll it out as a national program
  - address the complexities relating to Aboriginal health workers whose work varies markedly from jurisdiction to jurisdiction. Implement national registration for all Aboriginal health workers (AHWs).

- **Telehealth services**
  - achieve more interaction across states and territories in provision of telehealth services.

- **Better returns from infrastructure investment**
  - look at how to provide better accommodation and infrastructure, including for service providers, and look at complexity of infrastructure grants.

**Palya**

**Stewart Roper**

1 Nganampa Health Council

Palya is a word used frequently in Pitjantjatjara/Yankunytjatjara and can have a variety of meanings, all essentially translating to ‘good’, as in ‘I am feeling good (well)’, or ‘That is good’. It is also used in greeting as in ‘Nyuntu playa’ (‘You well!’) with the reply ‘Uwa-na, playa’; (‘Yes, fine’).

Media coverage of only the most dire health and social problems sometimes afflicting Aboriginal communities risks generating disillusionment and fails to acknowledge the strength and resilience of the oldest continuous surviving culture on earth.

I have had the privilege of working and travelling with Agangu (the name by which the Pitjantjatjara/Yankunytjatjara refer to themselves) throughout their land for over twenty years. This has provided unique opportunities to photograph the
spectacular landscapes throughout years of extensive drought, broken finally by flooding rains and the accompanying explosion of wildlife. In addition, through increasing familiarity over the years, Anangu gradually became more at ease with my presence and having their photographs taken.

From several thousand transparencies, the images for this book were deliberately chosen to reflect the cultural resilience of Anangu and the beauty of their country. The detail in many of these same images, however, also hints at the underlying hardships of life.

Opening address

The Hon. Jack Snelling

South Australia is leading the way in innovative technologies to improve access to health professionals and support patients and staff. In particular, the Digital Tele-health Network is transforming the way we provide health care services for patients/clients living in rural and remote locations, particularly in the area of mental health. South Australia is also rolling out an Enterprise Patient Administration System, or EPAS—bedside computers in specific country hospitals that will enable patients and clinicians to use touch-screen computers for a variety of tasks.

The South Australian Government is committed to providing more health care services closer to home for its country residents. The South Australian Government has been systematically improving its country health infrastructure and enabling a greater range of services to be provided at the local level, particularly in the areas of renal dialysis, cancer care and mental health. These reforms are building the capacity and capability of rural health services.

Royalties for Regions partnerships: change, reform and service improvement in rural Western Australia

Paul Rosair

The Royalties for Regions program has six policy objectives, focused on building regional communities:

- improving services to regional communities
- attaining sustainability
- expanding opportunity
- growing prosperity.

Delivering community-based primary health care through comprehensive and integrated models of service is essential to address health issues for rural people, especially for the elderly, vulnerable groups, Aboriginal people, mental health, and parental and child health.

Addressing these health issues through collaborations that incorporate social determinants of health factors can significantly improve health gain for individuals and is expected to reduce the demand on hospital-based acute services.

The presentation will describe some of the legislative background to the RfR program and highlight some of the RfR partnerships. These will include partnerships with the Royal Flying Doctor Service, with the Pilbara Industry’s Community Council, and the Southern Inland Health Initiative. This last is a bold and innovative approach to bring about change, health reform and service improvement across a large part of Western Australia and provides a model that other rural health services could explore and implement.

The importance of prevention in rural health

Louise Sylvan

Australia is internationally recognised for its success in reducing smoking across the general population and for taking on the challenges of overweight and obesity and of harmful alcohol consumption—these three issues are the priorities of the new prevention Agency.

ANPHA is drawing on new and existing data to analyse the status and trend relating to these three key issues in rural and remote communities. Although the data is not as extensive as one would wish, it is clear that outcomes for rural and remote communities are not as positive on prevention measures as those in the cities—overweight and obesity is higher, smoking is higher, and although the harmful use of alcohol is a mixed report card, there is a lot of room for improvement here as well.

Louise will discuss the overall prevention ‘picture’ in each of the areas of priority, and talk about the
Agency’s work in developing new evidence and in designing and implementing health promotion strategies that recognise the strengths and needs of people who live in rural and remote communities. Peer support is a critical part of behavioural change in these areas of preventive health and some of the Agency’s innovative new approaches will be highlighted.

ANPHA recognises the strengths of rural and remote communities and the great things that can be achieved, and is exploring ways to work differently as well, rather than simply delivering ‘more of the same’ when it comes to health promotion.

**From evidence to action**

**Bob Wells**

1Australian Primary Health Care Research Institute, The Australian National University, ACT

Providing safe, effective and sustainable rural health services, particularly for smaller communities, has been an enduring problem in Australia. Particular problems have been identified in attracting and retaining an appropriate health workforce and in providing services that are both appropriate and safe. While there have been many programs, particularly in relation to health workforce and innovative service models (such as ‘fly-in/fly-out’) little seems to have changed.

Some new structural arrangements implemented through the National Health Reform Agenda, such as Medicare Locals and Local Health Districts/Networks have potential to facilitate more sustainable health services, but in isolation their impact could well be negligible. Research undertaken through the Australian Primary Health Care Research Institute and others suggests that real improvements are more likely to result from whole-of-system approaches that integrate economic, social and health initiatives.

A fresh policy approach is needed—one that provides consistent national policy, adequate funding and more local flexibility with improved accountability.
Concurrent abstracts

Aged Care Oral Health Outreach Program

Roshan Abraham¹
¹Mid North Coast Local Health District

Introduction: Improved dental health for older people has the potential to reduce avoidable hospitalisations, known to be much higher in rural areas than in major cities, as conditions such as cardiac disease and aspiration pneumonia are now known to have periodontal disease as an etiologic factor. However, dental workforce shortages in rural and remote areas preclude the very few dentists in these areas from providing on-site services to semi- and non-ambulatory residents in nursing homes or residential care facilities (RCF).

Aim: HM Oral Health planned and implemented a pilot program for a period of six months to develop a model to address the dental needs of residents in rural and remote RCF.

Approach: An oral health worker was sent to an RCF to educate staff on daily oral health care of residents, create individual care plans and start a pathway for comprehensive dental treatment. A borrowed dental van was driven into the RCF to perform comprehensive on-site dental treatment on non-ambulatory residents who would otherwise only access emergency dental services. The dental team then commenced treatment one day a month, getting each patient into the van and completing all the required dental treatment in one sitting.

Results: Of the 44 residents assessed and allocated individual care plans, 24 were assessed as requiring dental treatment and 10 were selected based on disability and severity of dental condition for on-site treatment.

The program created a pathway for comprehensive dental care, thus managing dental problems before they became emergencies.

Beyond our expectations, nursing staff and family members reported that the quality of life of these residents improved markedly following the dental treatment. While one resident started mingling more with other residents, another’s family started mingling with him more saying he smelt better; and a third stopped having UTIs.

A productivity analysis comparing the operator’s days at Booroongen and at Kempsey Public Clinic showed that despite time spent getting the van to Booroongen, setting up, getting patients on and dealing with equipment problems, the average values at Booroongen were only slightly lower than at the clinic, again unexpected. This suggests that the program’s productivity would be comparable to that of Kempsey clinic if a fully operational van is used.

Conclusion: The pilot program enabled funding to buy a new fully functional dental van and a major project is under way to expand the program to all RCF in the mid-north coast rural area.

Gender differences in recruitment, job satisfaction and retention of allied health professionals in Tasmania

Sharon Condon¹, Tony Barnett², Annabelle Bond²
¹Rural Clinical School, University of Tasmania, ²University Department of Rural Health, University of Tasmania

Background: Allied health professionals (AHPs) are integral to the provision of preventative, diagnostic and therapeutic health care in rural areas. However, there is a national shortage of AHPs, with recruitment and retention difficulties common in rural areas, including Tasmania. With the exception of some professions, women comprise the majority of the AHP workforce. Very little is known about career selection, job satisfaction and retention of male AHPs.

Aim: The study aimed to explore gender differences in recruitment, job satisfaction and retention of AHPs in Tasmania.

Methods: This 2012 research analysed data from the 2008 Tasmanian Rural Allied Health Workforce Study. The survey was posted to 2736 AHPs and an electronic version was posted online. Associations between gender and job selection, workplace characteristics, satisfaction and retention were analysed using univariate statistics and multivariate models controlling for age, years in profession and years in current position.

Results/relevance: A total of 1193 AHPs (44.8%) responded, although 11 were ineligible as the respondent was employed interstate. Mean age was 43.6 ± 12.0 years and 346 (29.3%) were men.
Pharmacy (n=162), physiotherapy (n=162), psychology (n=148), social work (n=85) and radiography (n=74) were the most common professions. Men had been in their profession longer (21.2±12.4 vs 17.3±12.2 years, p<0.0001) and current position longer than women (11.4±11.2 vs 7.3±7.6 years, p<0.0001). Men were more likely to report they were attracted to their current position for reasons of location (29.5% vs 22.2%, p=0.008), income level (34.4% vs 26.7%, p=0.008) and type of work (39.6% vs 52.4%, p<0.0001).

There was no difference in the proportion of men compared to women who felt ‘burnout’ (44.7% vs 39.0%, ns), dissatisfied with their job (10.8% vs 9.7%, ns) or intended to leave within two years (21.3% vs 23.8%, ns). However, male AHPs were nearly twice as likely to report locum backfill (RR 1.98, 95% CI 1.37–2.86), participation in clinical rotations (RR 1.38, 95% CI 1.15–1.65) and work flexible hours (RR 1.14, 95% CI 1.03–1.26). They were also less likely to work in chronically short-staffed workplaces (RR 0.85, 95% CI 0.75–0.96).

Conclusion: Salary considerations are important in recruiting male AHPs. However, job flexibility, variety and stable staffing levels appear more important within the context of current positions. This indicates that job flexibility is vitally important not only to female, but also to male, AHPs in rural areas.

**COMHeLP—a manual for audiological practice with Aboriginal and Torres Strait Islander Australians**

Amarjit Anand¹, Paul Hickey²

¹Audiology Australia/NT Department of Health, ²Audiology Australia

**Introduction:** Aboriginal and Torres Strait Islander Australians have the highest rates of hearing loss described in research literature, mostly due to conductive hearing loss secondary to otitis media.

The clinical management of conductive hearing loss in this population differs from that recommended for other populations because the underlying middle-ear disease is highly persistent and difficult to manage medically.

Consequently, audiological management is required concurrently with medical and educational management, often for extended periods. Special considerations and specific recommendations for providing audiological services to Aboriginal and Torres Strait Islander Australians are required to achieve better audiological practice and outcomes.

While Indigenous Australians are present in all parts of the country, in central and northern parts many reside in rural or remote locations. With increased distance from urban centres, health professionals must cooperate closely, learning skills from each other to enhance identification and management of their clients’ conditions. Hence much of the advice provided in these guidelines will apply equally to non-Indigenous and Indigenous Australian populations in rural and remote locations.

**Methods:** In 2001, Audiology Australia developed guidelines for audiological practice designed to inform and support audiologists who provide hearing services for Aboriginal and Torres Strait Islander populations in urban, rural and remote areas.

However, a need for revised guidelines became apparent and Audiology Australia developed ‘Chronic Otitis Media and Hearing Loss Practice (COMHeLP)—A Manual for Audiological Practice with Aboriginal and Torres Strait Islander Australians’.

These guidelines represent preferred practice patterns resulting from a synthesis of information derived from expert opinion and supported by the available literature as there have been no systematic reviews of the audiological literature in this specific area.

**Conclusion:** This paper will introduce COMHeLP, including an overview of otitis media and hearing loss in Aboriginal and Torres Strait Islander people, the purpose of the revised guidelines, implications for scope of audiological practice, and provide an overview of COMHeLP, including sections and appendices.

This manual has a very broad scope, therefore health and education professionals embarking on rural and remote work and Aboriginal health workers working with this population may benefit from an improved insight into this significant health challenge and find COMHeLP helpful in their own pursuit of better practice.
Motivations and concerns of younger optometrists choosing rural practice

Philip Anderton¹, Carina Trinh²
¹Manilla Health Service, Rural Optometry Group of OAA, ²Young Optometrists

Optometrists are relatively widely distributed in rural Australia. Each town or city of population 7000 or more can support one practice. They provide a local ophthalmic resource that works very effectively with GPs and nurses to provide ongoing care for persons at risk of refractive error, eye disease and reduced vision. Many rural optometrists are approaching retirement age, and there is no secure process of succession planning in place.

Forty-nine younger optometrists were identified in practices located in rural areas of NSW. They were invited to participate in an informal survey of factors that motivated them to choose rural practice, and whether there are any major issues that could be addressed by policy change. Nine responses were received (18% response rate).

Important themes were identified in their responses.

• Positive trends and motivating factors:
  - graduates of rural origin are more likely to choose rural practice
  - rural location is an opportunity to open an independent practice
  - all responders appreciate the opportunity for a broad interesting scope of practice and dealing with friendly appreciative patients
  - a positive rural clinical placement experience during undergraduate education has drawn some city-based graduates into rural practice
  - a significant number of graduates of metropolitan origin see rural practice as a temporary opportunity to gain experience for a few years, but their ultimate intention is to return to city practice. A number of these have changed their mind and decided to remain in rural practice.

• Deterring factors:
  - lack of social interaction with peers of similar age and interest
  - need to travel long distances to gain a social life and interact with relatives and friends, and to attend continuing professional education events
  - a perceived lack of quality high school education opportunities is seen as a major factor motivating return to more urban locations as children approach high school age
  - lack of available specialists to refer patients needing cataract surgery, and ophthalmologist care.

The need to secure a sustainable rural eye health workforce should be addressed by implementation of policy that attracts optometrists to rural regions and ensures positive experiences. Appropriate policy changes might include increased opportunities to support students of rural origin, continuation and expansion of rural clinical placement scholarships, and special program funding to state education authorities to establish high-quality selective schools in key regions.

Yarning On: making a difference to the health of young Aboriginal people

Susan Arwen¹, Bianca Mark¹
¹SHine SA

‘Aboriginal people having sexual and reproductive health outcomes that are equal to the best’ is the goal of Yarning On. Funded for three-and-a-half years through the National Indigenous Partnerships to develop and deliver ‘sexual health education programs targeting Aboriginal young people’ in 17 rural and remote Aboriginal communities in South Australia, the Yarning On model builds the capacity of schools and communities to deliver respectful relationship and sexual health education both within and outside of the school system.

There are two programs within Yarning On—the Aboriginal Focus Schools program and the Investing in Aboriginal Youth program. Both utilise workforce development training programs combined with local knowledge and solutions within the context of school-based curriculum and community education activities to address the issues of teenage pregnancy, sexually transmitted infections and low birth weight babies for teenage Aboriginal young people, which are significantly higher than for non-Aboriginal young people.
Central to the development of this unique program has been relationship building with Anangu and Aboriginal key community members, communities and agencies. This resulted in extensive consultation, collaboration and partnerships to ensure culturally and age-appropriate curriculum, resources and training programs. A literature review and program logic model underpins the programs development, implementation and evaluation. The complex issue of increasing the sexual health literacy of young Aboriginal people, especially in rural and remote communities, is a challenge and sits within the context of the community and access to services and resources many take for granted.

This paper explains the Yarning On model, learnings and the early evaluation findings.

This project is currently being evaluated by the South Australian Community Health Research Unit at Flinders University and through the SA Health evaluation of Close the Gap programs.

**GP referrals into the Stawell Health and Community Centre**

**Kate Astbury**

1Grampians Community Health

**Background:** Stawell is situated in the southern Wimmera (Victoria) and has a population of approximately 6100. The health and welfare needs of the community are predominantly met by three medical practices, Stawell Regional Health (SRH) and Grampians Community Health (GCH).

Traditionally GP referrals to the SRH allied health services were passed to the patient at the time of the consultation and the patient was responsible for making the appointment.

The services provided by GCH include: counselling; youth support; housing; programs for family violence, gambling, alcohol and other drug; psychiatric disability rehab support service (PDRSS); carer respite; and community support packages. GP referrals to these services were very rare and would number less than five for an average year.

The Stawell Health and Community Centre (SHaCC), a recommissioned technical school, was opened in 2010. This three-storey building became the home of GCH, SRH allied health services, Northern Grampians Shire HACC services, Intertwine Disability Services and the Patrick Street Family Practice, as well as several visiting services.

While the co-location of these services provided many opportunities for collaborative work between services, it also created some confusion with the local GPs. In response to a throw-away line made by one GP—we have no idea who is in that building and what they do—Grampians Medicare Local facilitated a meeting with the practice where the idea of a central point of referrals for services provided within the building emerged.

**Work to date:** Over the course of several months a referral template was developed by the group and embedded in the GP software by the Grampians Medicare Local. The template, which auto populates patient details, has a tick box list of all the services provided in the SHaCC, consumer consent and space for GP notes and comments. The referral is faxed by the practice to a fax machine located in a secure area, recorded and disseminated to the relevant organisation and/or program manager. The template has been adjusted in response to learnings from both the practices and the receiving organisations.

Over the past 12 months the group has developed and agreed on a formal referral protocol, including GP feedback.

A file audit is currently under way to measure the increase in the number of GP referrals received into each organisation, GP feedback and any alterations in the quality of referrals. It is anticipated the number of referrals to SRH may not have altered significantly, while GCH has had a significant increase of over 1000%.

Since recording began in June this year the following referrals have been received:

- June: 29
- July: 57
- August: 138
- September: 64
- to 4 October: 14

Since the development of this system it has been expanded to include the HACC services of Northern Grampians Shire. Further work will be done over the coming months to include Wimmera Uniting Care (child and family services) and the medical practice of Budja Budja Aboriginal Cooperative.

12th National Rural Health Conference
Food security and health risks facing vulnerable youth in north-west Tasmania

Stuart Auckland¹, Quynh Le¹, Hoang Boi Nguyen¹, Maree Gleeson²
¹University Department of Rural Health, Tas, ²Institute for Regional Development, Tas

Aims: Food security is determined by several interrelated factors—including food available, food access and food utilisation—all of which have a direct influence on health outcomes. The north-west coast of Tasmania has in recent years faced a number of socioeconomic challenges resulting from the loss of industry and infrastructure. Vulnerable and marginalised communities, including young unemployed people, have been significantly impacted by the economic downturn. The study examined the relationship between the socioeconomic environment, food security and the health status of vulnerable young people (18–25 year olds) on the north-west coastal areas of Tasmania.

Methods: An exploratory research design using a mixed-method approach was adopted to ensure the findings captured the breadth and depth of issues related to food security, socioeconomic conditions and related health problems associated with the target study group. A special feature of the project design was the use of a community-based participatory approach for the effective recruitment of participants. This approach complemented more traditional qualitative and quantitative approaches such as focus groups, interviews and on-line surveys distributed through social media networks.

Relevance: The study has direct relevance to the development of government policy frameworks associated with social inclusion, food security, community health and urban/regional planning.

Results: The study confirmed a close association between socioeconomic factors, health issues and food security amongst the target study group. The vulnerability of young people on the north-west coastal areas of Tasmania to food insecurity was determined by a number of interrelated factors that impacted on their individual level of food security. These factors included: influence of peer groups towards food choice; access and prevalence of cheaper food sources; personal attitudes toward food and diet, such as an acceptance of food insecurity as being the ‘norm’; lack of motivation and food preparation skills; lack of awareness of what constitutes a healthy diet; and the health implications of poor nutrition and access to transport.

Conclusion: Increased socioeconomic disadvantage has a direct correlation to increased levels of food insecurity and related health conditions. A whole-of-government approach in addressing the social determinants of food security that relate to food access, supply and utilisation has the potential to improve food security within vulnerable communities.

Organisational commitment for a bright community future

Carole Bain¹
¹Silver Chain, WA

Brookton is a small rural farming community of approximately 1500 people in the western wheatbelt region of WA. When the local hospital closed many years ago the local shire, with a volunteer board of management, decided that they would become the sole provider of the health and aged care services in the community. This model served the community very well, but as needs increased or changed, with increased governance and limited resources, it became an unsustainable model for the community. After much deliberation by the community it was decided, in March 2012, that all health and community services would be transferred to a well-established not-for-profit organisation.

After three months of working together the services were successfully transferred and no changes made, at this time. It was always the understanding, post-transfer, that there would be a program of community engagement and consultation to identify the service needs and gaps for now and into the future, specifically for the small community, before we would enter into any changes or growth in services. We wanted the services delivered to be what the community saw as being the need and the priority.

This presentation will discuss:

- the process that was used for community engagement
- how we identified needs and gaps in services and the changes required
- how we formulated a community advisory group and how they worked with us
- how we developed a local service plan
• how we developed measures around the plan and continually measured success
• how we ensured the plan was a living document, owned by the community and continued to be very visible to finally become part of ongoing community feedback.

In conclusion, I will discuss the outcomes for both the organisation and the community from the process that we went through, as well as the benefits and any learning that was obtained. Then, finally, how the commitment from both the community and the organisation resulted in a bright future for the health services in Brookton.

The implementation of nurse practitioners into the primary health care setting

Frances Barraclough¹, Lesley Barclay¹, Jo Longman¹, Gao Yu², Margaret Rolfe³
¹University Centre for Rural Health, North Coast

The nurse practitioner (NP) role has been established in Australia for the last twelve years. Yet despite its legal recognition, many health care professionals and much of the Australian public have little understanding of the role. Research conducted in Australia and internationally has confirmed that NPs are safe, competent and provide quality health care that is economical and valued. However current published research is predominantly focused on NPs providing care in acute settings in large metropolitan and regional areas; absent from the current literature is an in-depth study on the key components of how these roles are implemented and in particular how they are integrated in small rural communities. This project highlights the role of a NP in a primary health setting within NSW through an exploration of the perceptions of health care providers, including the NP. The NP described in this project provides mental health and drug and alcohol services.

The treatment and management of mental health disorders in rural areas can be complicated by physical isolation, distance, time, cost, lack of transport, lack of privacy and fear of stigma, and the availability of adequate services. Problems with service delivery are further compounded by staff shortages and the uneven geographic distribution of mental health professionals and facilities.

The project has demonstrated that clients were willing to access the NP service. There was a consistently high level of usage and around a third of clients were self-referred. The location of the service in a non-government organisation worked well and the NP was described as being integrated into the community. There was also evidence of improved integration between services. The service was described as taking the pressure off a number of other services. There was a reduction in ED admissions in the local hospital and a reduction of violence in the town.

The project provides substantial evidence that the NP service is more accessible than other mental health or drug and alcohol services due to the approach, location and availability of the NP.

There were no similar models in the literature on the dimensions of originating from the community, being led by a NP, or located in a non-health community organisation. However there is substantial literature based on the need for integration of mental health services, particularly in rural areas that suffer from fragmented services, difficulties with recruitment and retention, and lack of development of services and skills.

Virtually Intouch—an evaluation of desktop telehealth in rural and remote New South Wales

Elizabeth Barrett¹, Michael Edwards¹, Sharif Bagnulo¹, Shane Hatton¹, Rose Ellis¹
¹NSW Rural Doctors Network

Aim: To evaluate the effectiveness of simple, cost-effective telehealth solutions for rural and remote communities. The evaluation preceded and continued after the introduction of telehealth MBS items.

Method
• Identified specialties that were conducive to telehealth consultations.
• Identified communities unable to sustain a regular visiting service.
• Identified existing visiting services experiencing increasingly long waiting lists or where patients needed follow-up more frequently than the visiting specialist was able to provide.
• Validated potential trial locations based on the available infrastructure and technology capabilities.
Sourced doctors through an expression of interest.

Developed a set of indicators for measuring each telehealth consultation.

Developed evaluation forms based on the indicators to be completed by all telehealth participants.

Evaluated comparable outcomes of new desktop and existing dedicated video conferencing systems.

Evaluated comparable outcomes for Aboriginal and non-Aboriginal patients, supporting health workers and doctors.

**Relevance:** Documented experience of telehealth in Australia and overseas demonstrates that available technology can be used well, not only for group discussions and training but also for telehealth consultations.

We wanted to trial the image and sound qualities of simple desktop technologies that were easier for all parties and enabled specialists to participate from their own consulting rooms.

The specialties enrolled in the trial were oncology (medical oncology, radiation oncology and palliative care), clinical genetics, developmental paediatrics, endocrinology, psychiatry and cardiology.

**Result:** Evaluation data was collected through completed evaluation forms or structured phone interviews. The evaluation of desktop telehealth for rural, remote and Aboriginal patients has demonstrated overwhelming support for the service from patients and supporting health professionals and strong support from doctors.

The trial has identified the benefits and pitfalls. Lessons learnt can be embedded into practice easily to enhance the experience for patients, doctors and local health professionals.

**Conclusion:** Ultimately the trial has demonstrated that telehealth is an excellent way to support visiting health care providers to enhance patient care by improving access to services for rural, remote and Aboriginal communities.

The trial has provided a valuable experience and a number of resources, and has identified potential policy enhancements to improve telehealth consultations for regional and rural communities.

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**Humour and acute psychiatry—a world-first randomised controlled trial**

David Bell, JA Telfer, GS Malhi

1Northern Sydney Central Coast Area Health Service, NSW

**Aims:** This study aims to understand the role of humour in therapeutic engagement in an acute psychiatric setting.

**Methods:** Baseline data comprises a range of information from 80 patients on an acute psychiatric ward. This study has active and then passive exposure audio-taped components. In the active exposure arm, patients are blind and randomly assigned to a treatment and control group. The treatment consists of 15 minutes of a nurse or case worker using themes, with a humorous focus, to encourage the patient to reminisce on their childhood experiences. The control condition is identical but minus a humorous focus. During passive exposure, patients view two short humorous film clips of their choice.

**Results:** Outcome measures compare changes to therapeutic engagement, mood and expectations between the types of exposure. Quantitative and qualitative analysis was conducted to identify clinically pertinent correlations. Results demonstrated clinically significant improvements in therapeutic engagement with the use of humour for short-duration relationships on the ward, the preference of many patients for active humour over passive humour, the minimal risks of using humour in an acute psychiatric setting, and mismatches between negative or neutral expectations of staff and positive outcomes. As well, listening to short excerpts of a range of recordings of the reminiscences provides a rich experience of human interaction when there is a focus on humour in patients who are manic, psychotic, depressed, suicidal or distressed.

**Conclusion:** Results demonstrate the potential benefits of using humour in an acute psychiatric setting, with some interesting insights into the mind.

**Team sport as a catalyst for Yolngu girls’ participation in healthy behaviours**

Kevin Bird, Kay Coppa

1Miwatj Health Aboriginal Corporation

**Aim:** To build in positive healthy behaviour in all aspects of a Yolngu girl’s life, including education, self-care, self-discipline, respect for the law, and developing and realising goals and dreams.
Methods and relevance: Commencing in March 2012, a group of at-risk Yolngu girls aged between 12 and 16 from three East Arnhem communities participated in Miwatj Health’s Healthy Lifestyle Program. The program focused on a variety of activities, including a weekly drop-in centre, a healthy lifestyle clinic, regular high school attendance and engagement, and participation in the town netball competition.

Girls who achieved set criteria in these activities could qualify to attend a sporting and cultural trip to Sydney.

The criteria, which the communities endorsed, were chosen to ensure the girls developed a sense of endeavour and achievement. In short, they had to earn their place on the trip.

Significantly, this was the first time that girls from East Arnhem had taken part in a group excursion, compared with local boys who often travelled away on group sporting trips. The girls’ trip, which was part of a holistic healthy lifestyles program, differed from boys’ sporting trips, which focused almost solely on sport and competition.

Results: In September 2012, 15 teenage Yolngu girls travelled to Sydney for six days. The trip included netball workshops, tours of sporting facilities, visits to an inner-city high school and Bangarra Dance Theatre.

It was a busy and engaging trip that broadened the girls’ horizons and had a noticeable positive effect on their self-confidence.

At the time of writing, the girls had not long returned to their communities. They had been sharing stories of their trip and continuing to be involved in a range of health-promoting activities.

The presentation will discuss the impact of the program to date.

Conclusions: This program has shown the impact of positive participation to promote healthy behaviour and to broaden Yolngu girls’ horizons.

The challenge now is to work with the girls’ families and community to maintain and support these changes and aspirations.

From closure to world stage—a journey of rural commitment

Peter Birkett¹, Andrea Dunlop¹
¹Hesse Rural Health Service

When faced with extreme health care reform the small rural community can either accept an economic rationalist view of local health service provision or it can use the agenda as a catalyst to a new beginning and create exponentially better outcomes. Hesse Rural Health took the longer term strategic option, sought its destiny, raised the bar and is now a unique rural health care success story.

This is a presentation rich in both organisational and community learning. It begins with the community challenged by the need to sustain and be involved in local services. As the service mix changes and new robust structures emerge it will demonstrate the value of vision, wisdom and planning. The emphasis then shifts from viability to service enrichment through the creation of new programs specific to community need.

Hesse has developed from a rural hospital facing closure to a key integrated rural health service with multiple program layers. In the process the business of the health service has grown five-fold, with complementing growth in local employment and community participation.

Strategic planning, commitment to quality and creativity are integral to successful long-term rural organisational sustainability. Hesse is now going somewhere, driven by the ingenuity of its staff and the commitment of the community.

This paper will present other key outcomes overcoming health inequity for our rural community:

- the successful engagement of the Bendigo Community Bank to construct new health service infrastructure in a national demonstration project
- the commitment to improved farming generational health by targeting primary aged children
- and finally, the creation of an innovative and leading edge rural dementia environment resulting in Hesse being selected to be the Australian voice on an International collaborative to achieve electronic access to best practice rural dementia projects across the globe.
These key developments have placed our organisation before a much wider audience and helped keep country Australia on the map.

Our journey is one of resilience, vision and rural commitment.

Fostering nurse leadership in Australian rural hospitals: identification of underlying issues

Melanie Bish¹
¹Department of Rural Nursing and Midwifery, La Trobe Rural Health School

Nursing has been espoused as a profession central to continuing health care reform that is aimed at transforming health care systems to provide seamless, affordable, accessible quality care that leads to improved health outcomes (Fehr 2011). To demonstrate that nurses are industry leaders, capable of driving reform, nurses at all levels must be more assertive, vocal and visible (Barkers 2011). This stance reiterates the need for strong nursing leadership.

This study outlines the processes and outcomes of a participatory action research study undertaken to bring together rural nurse leaders to consider issues for nursing leadership in the rural context and identify underlying issues that may impact on strategies developed to foster nurse leadership in rural hospitals. Participatory action research is a process that aims to simultaneously bring about change in organisational practices and increase the understanding of social function through researchers and organisational members working as partners to change and reflect upon practice (Ragsdell 2009:568). The participatory action research group consisted of five directors of nursing from rural regions of Victoria, Australia. The group activities involved participants reflecting on their own practices, discussion and analysis of previous research, a review of current literature and critique of the activities of their organisation. The analysis of group activities resulted in the identification of five key themes: dispel the myths, adopt big-picture thinking, connect with colleagues, reflect on your own conduct, and create organisational buy-in. Discussion based on the identification of themes centred on improving the understanding of the way that rural nurses can do impact on the evolving health care system, increasing the level of inclusion of leadership into undergraduate programs to be more than a token gesture and to prioritise planning partnerships that are developed around the existing and projected issues in rural nursing.

The process has resulted in a cohort of knowledgeable, confident current nurse leaders, who as research-aware professionals have the capacity to influence and espouse the benefits of integrating research that involves critical reflection. This study has been an example of how industry and academic nursing professionals can work together to focus on improving rural nurse leadership in a manner that is informed by research findings.

Maximising the rural health benefits of a reformed health system: Medicare Locals

Mark Booth¹
¹Department of Health and Ageing

A total of 61 Medicare Locals are operating across all regions of Australia. Medicare Locals are independent primary health care organisations, established to coordinate primary health care delivery and address local health care needs and gaps.

Access and equity of access to services generally is a big issue for the country’s more rural and remote areas. While access to general practitioners is sometimes a problem, access to allied health practitioners (important players in the care chain/patient journey), specialist services and after-hours and post-hospital care are common issues for people living in rural and remote areas.

While individual practitioners are still responsible for a patients’ care, Medicare Locals play an important role in working collaboratively with general practitioners, other primary health care providers, local hospital networks, rural workforce agencies and communities to better integrate and coordinate the delivery of health care services.

From 1 July 2012, all Medicare Locals are being provided with flexible funding under the Regionally Tailored Primary Health Care Initiatives through Medicare Locals Fund. Medicare Locals largely have discretion to choose which activities will be funded to respond to local health priorities and address service gaps identified through a population health needs assessment process.

The soapbox presentation will focus on some of the smart approaches being adopted by Medicare Locals to address the unique health care challenges in rural and remote areas.
Perspectives of power in rural and remote health

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Aims: The study of rural and remote health has given little attention to the concept of power. Yet power is integral to why funding decisions are made, to the lack of status of rural practice, to why rural has become the second cousin to urban. Power is embedded in election outcomes, political responses, social relations and constructions of knowledge that impact upon rural and remote health outcomes. This paper discusses various ways in which power manifests in rural health and remote health, followed by the perspectives of rural and remote health professionals in Australia on this topic.

Methods: A discussion of power is presented that applies social theory, in particular the work of Anthony Giddens, to rural and remote health. This includes a discussion of political power, agency and leadership, social status, power in practice, power in communities, racism, the social determinants of health and the construction of knowledge in rural and remote health.

Following this, as part of a larger study exploring understandings of rural and remote health, interviews were conducted with 45 rural and remote health professionals. Interviewees were identified as those holding senior positions in four key areas, namely: policy, practice, academia or advocacy. Face-to-face interviews were conducted with each participant, including rural, remote and Aboriginal participants from every state and territory in Australia. During interviews, participants were asked to comment on a conceptual framework of rural and remote health, including a discussion of power. These responses have been analysed thematically.

Results: Most respondents considered the inclusion of power in a framework understanding rural health and remote health as important. However, the ways in which respondents referred to the concept of power was diverse, unclear and confused. Respondents differed in what power referred to, how power was understood and its utility in rural and remote health, but most commented it was ‘an important addition’ to understanding rural health and remote health.

Conclusions: While the topic of power has been unexplored in rural health and remote health, theoretical application suggests it plays a strong role in what happens in rural health and remote health. Further, most rural and remote health professionals agreed that it was an important element in understanding rural health and remote health. It is time to move beyond vague references to a detailed analysis of power. This will enable detailed assessment of rural health’s and remote health’s vulnerability, structural inequality and impacts of agency.

Deadly Mereny Noonak Ngyn Moort: good food for my people: mid-term evaluation

Claire Bowditch¹

¹Wheatbelt Public Health Unit

Background: In the wheatbelt region of Western Australia, multiple conditions exist that limit access and availability to healthy foods, putting many people at risk of food insecurity. The wheatbelt is classified as regional and remote and many people live on low incomes. The rate of obesity in the wheatbelt is higher than the West Australian average. Evidence suggests a strong correlation between food insecurity and obesity.

The wheatbelt also has an Aboriginal population of approximately 3025 people (4%). With links between nutrition and chronic disease, food insecurity contributes to the significant gap in life expectancy between Aboriginal and non-Aboriginal people in Australia. Subsequently, a three-year project has been funded with the aim to increase food security and thereby improve health outcomes among the wheatbelt Aboriginal communities.

Method: A comprehensive needs assessment has been conducted through surveys and meetings with community members and stakeholders. Findings from this needs assessment identified barriers and enablers to achieve food security in the region. Using a community development approach, and collaborating with Aboriginal and other community-level stakeholders, region-wide and town-specific strategies are being implemented to address gaps to the availability, access and utilisation of healthy food. Strategies include building the capacity of Aboriginal health workers in nutrition literacy to enable the effective delivery of an Aboriginal health program.
assessing the availability of food by surveying supermarkets; supporting schools in low socioeconomic areas to meet state policy standards; and supporting emergency food relief providers to provide nutritious food to those most vulnerable to food insecurity.

**Results:** This paper will discuss the findings from the mid-term evaluation of the Wheatbelt Aboriginal Food Security Project.

**Audit of medication lists for elderly patients admitted to a regional hospital**

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²Manning Rural Referral Hospital

**Aim:** To determine the type and number of discrepancies in the medication history information between general practitioners’ lists and the actual medication usage of patients aged 65 years or over prior to admission via the emergency department (ED) at a regional hospital in New South Wales, Australia.

**Method:** This clinical audit was conducted at a 166-bed rural referral hospital. A pharmacist identified patients who were 65 years or over and taking three or more medications prior to admission. Medication discrepancies were considered to be any variation between the medication history obtained by the pharmacist and the GP’s medication list. The clinical significance of the discrepancies was assessed in consultation with a general physician.

**Relevance:** In Australia, 30% of hospital admissions in the elderly population are related to adverse drug events. In rural and regional areas the problem can be exacerbated by the higher proportion of elderly patients and the distance patients travel to access services. Complete medication reconciliation is often difficult to achieve, particularly in the ED. Therefore, GP’s lists may be used as the basis for charting medications. Personally controlled electronic health records have been identified as a tool to improve the transfer of medical information at transitions of care. However, this is only useful if it contains accurate, up-to-date information.

**Results:** Forty-eight patients (mean age 82 years) were included in this clinical audit. The median number of prescribed, regular medications was eight (range: 3–16 medications). Seventy-five per cent (n=36) of patients had one or more discrepancy in their GP’s medication list, with the most common number of discrepancies being four. The pharmacist noted 164 discrepancies, with 45% related to non-current medications still being recorded on the GP medication list. The clinical significance of the discrepancies associated with the GP’s list was classified as either ‘minor’ or ‘minimum’; however, the potential clinical significance of the discrepancies in 19% of the patients was considered to be ‘moderate’ or ‘major’.

**Conclusion:** This exploratory clinical audit demonstrates that while a GP’s medication list is a useful tool in the medication reconciliation process in many cases, it is not a complete representation of what medications the patient is taking or using prior to admission. This audit affirms the role of the pharmacist in ensuring the accuracy of the medication history at hospital admission.

**Supporting high-risk maternity services in rural NSW**

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¹NSW Ministry of Health, ²Hunter New England Local Health District, ³Consultant Assisting NSW Ministry of Health with MSOAP

Flying from Williamstown to Moree in a six-seater chartered plane is an amazing experience. To be a clinician taking that plane to provide a high-risk maternity service in a small rural centre is even more significant. This presentation will describe the experiences of the staff from the John Hunter Hospital in Newcastle providing a high-risk maternity service’s outreach program 500 km away in Moree.

The outreach team of five, comprised of a maternal–fetal medicine specialist, area neonatal nurse consultant, social worker, high-risk clinical midwifery consultant and the Aboriginal Maternal and Infant Health Strategy Aboriginal Midwifery Manager, visit Moree 10 times a year to provide support and education for the local clinicians who are caring for pregnant women in and around Moree. Direct patient care and consultation is provided as required. The team is completed by local clinicians and includes the midwife and an ultrasound technician.

This innovative outreach high-risk maternity model, funded through the Medical Specialist Outreach Assistance Program (MSOAP), delivers high-quality, patient-centred care through collaboration between a tertiary centre and a rural health service. MSOAP is a successful Department of Health and Ageing initiative that supports health professionals to provide outreach services to rural and remote
communities, increasing the range of services offered locally by supporting visiting health professionals to effectively support women and their families through the antenatal and postnatal period; improving ongoing management and care; and increasing and maintaining the skills of health professionals in rural and remote areas in accordance with local need.

This presentation looks at the experiences of providers and users of the service, and identifies the positive impact on care, demonstrating this as a model for quality care in a rural environment.

**Pass the Parcel: a new approach for energy efficiency**

Joanne Brown

1Southern Grampians and Glenelg Primary Care Partnership

Health and climate change issues are lost in a haze of competing priorities, from finance to family. Research into the health impacts of climate change had largely focused on thermal stress, extreme weather events and infectious disease. At the time of commencement in this work, little work has been done on the indirect impacts resulting in social, economic and demographic changes. Evidence began to emerge about the population health impacts of climate change and the increasing demand for frameworks and tools to assist local communities develop and implement effective local responses to climate change adaptation. Between December 2007 and February 2008 Climate Change Adaptation: A Framework for Local Action was developed by the Southern Grampians and Glenelg Primary Care Partnership in response to demand from local agencies working with communities in health to support local planning for climate change. The framework identifies priority issues and actions, including household energy; household water use; transport; affordable food supply and community strength and resilience. A community development initiative in a small rural community informed the Pass the Parcel project.

The current standard of energy efficiency in community and public housing is very low; hence such households are highly vulnerable to increased energy pricing and climate change. The Pass the Parcel project aimed to engage 450 participants using a small temperature datalogger (an ibutton) to entice participation. The ibutton created personalised data for each participant, outlining the temperature inside their home compared with outside temperature. This data was then compared to the standard human comfort level and participants were encouraged to compare this temperature data with their own energy costs. Passing the ibutton around the community continued the conversation on energy and enhanced support networks. Participants were invited to a practical workshop and supported to make changes by participating in a range of community and government initiatives. PCP were able to advocate for increased access to support services for the community and increase capacity of partner agencies to respond. Although not due to be completed until December 2012, the project has now had over 400 households involved in the project, with positive results for both behaviour change and changes within the home relating to energy efficiency actions.

**Building the rural dietetics workforce: a bright future?**

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There is a lack of detailed dietetic workforce data, especially for rural and remote areas. Rural and remote areas are under-serviced and the workforce is unevenly distributed. Previous research has reported on the dietetics workforce across sites in rural New South Wales and as a small subset of allied health surveys. Census data has provided some form of benchmark for comparison across rural and metropolitan areas. Dietetic workforce data is complicated by a lack of consistent reporting of data, due to variable professional terminology and voluntary membership to an accredited practising dietitian program. This study aimed to determine the dietetic workforce changes across six rural sites in New South Wales between 1991 and 2012.

A multiple-case design study focused on six rural sites in the Hunter New England region of New South Wales. An analysis of human resource records from 1991 to 2006 was conducted. Positions in the health service, Divisions of General Practice (and more recently Medicare Locals) and private practice settings were included. Publicly available staffing data was reviewed in 2012 and findings compared with 2006 data. Dietetic staffing data was compared per 10 000 head of population. A review of census data from 2006 provided a comparison of case study data with national trends. Student placement numbers in each site are reported and compared with staffing increases.

In 2012 staffing numbers ranged from a minimum of 0.5 full-time equivalents (FTE) for a population of
8674, to a maximum of 12.2 FTE with population of 48 000 in 2012, equivalent to an average of 17.9 dietitians (range 10.8 to 25.4) per 100 000 population across the six sites. A growth of 8.5 FTE occurred across the six sites from 2006 to 2012. Australian census data on the number of dietitians or nutritionists in 2006, reported an average of 12.5 dietitians (range 7.3 to 23.3) per 100 000 population across states and territories. All three locations that had high dietetic student placement throughput between 2006 and 2012 experienced increases in staffing, mainly through non-traditional options such as the development of private practice and short-term project positions within the public health sector.

The uneven distribution and growth of dietetic staffing levels across rural sites remains. Growth in dietetic staffing is likely to remain ad hoc unless there is a strong commitment to the development of opportunities to meet the workforce shortage in rural areas and provide a bright future for the rural workforce.

Shhh: hearing in a farming environment

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Background: Around 60% of farmers have a hearing loss, compared to 22–27% of the general public. The impact of hearing loss is further exacerbated for farmers by lack of access to hearing specialities. Practising rural health professionals identify that hearing education and awareness is a gap in their skills. It is also noted that people with hearing loss often have three or more medical diagnoses and that the hearing loss exacerbates social confidence. The Shhh hearing project extended the outcomes from the successful Australian Sustainable Farm Families™ (SFF) program and the Canadian Montreal Hearing Help Program (MHHP). The SFF is successful in engaging with farming families and achieving behavioural changes, whilst the MHHP has been demonstrated as an effective intervention, assisting workers with hearing loss to overcome problems of reluctance and stigmatisation thereby improving their hearing and listening skills. The MHHP has not previously been used with farming populations, though with high levels of hearing loss, farmers are an obvious candidate group.

Aim: The Shhh hearing project tested the hypothesis that participation in early intervention hearing services would (a) contribute to significant reduction in the impact of hearing loss on farmers and (b) educate and empower farmers on their capacity to reduce their noise.

Method: Farmers from a variety of enterprises, including dairy, cropping and grazing, were invited to attend a workshop modelled on the MHHP and the SFF program. The subject cohort was a convenience sample drawn from the SFF™ program who had previously identified a hearing loss. The Shhh hearing workshop includes hearing screening, a physical health assessment and attending an educative and experiential session on hearing loss.

Results: This paper discusses the qualitative responses of fifty farmers and their partners on their attitudes to hearing and their level of acceptance and ability to cope with their hearing difficulties. Discussion will include coping and stigmatisation in their rural community. Pre- and post-analysis demonstrates changes to their practices to noise exposure on the farm, including the prevention of further hearing loss and changes to their daily social interactions.

Discussion: This is the first time the MHHP has been transferred into a farming population and provides an insight into combining the successful Australian SFF program and Canadian MHHP. Further, this project brings a multidisciplinary and rural/metropolitan team working together in farming communities.

Active in the outback

Steve Burton¹, Hannah Licul¹
¹Ministry of Health, Far West Local Health District

The Active Broken Hill Management Committee was formed and incorporated approximately three years ago, to combat declining participation in sport and active recreation and the associated public health issues.

The first Management Committee consisted of five community members and arranged face-to-face surveys with every known local sporting, physical activity and active recreation provider, in order to ascertain what local groups felt were endangering their growth and sustainability. Potential solutions were highlighted. 168 community members were also surveyed. The results were collated and the first Active Broken Hill Business Plan was developed.

Aim of the Business Plan: To retain and grow the range of sport, physical activity and active recreation
opportunities available in the city and to increase participation in health promoting activities by raising awareness across the community.

The website www.activebrokenhill.org.au was established early on. This incorporated the first ever free electronic database of all sport, physical activity and active recreation opportunities locally. It immediately increased access and provided dramatically improved communication and notification of events. Additional groups and associations are periodically added to the database.

A locally written fortnightly newspaper column, ‘Play your part’, commenced and is now two years old. It is widely read because of its local content and multiple-authorship. It covers a wide range of ‘preventative health’ topics and is written in an easy-to-read style.

New members are beginning to join some local clubs and associations as a direct result of this increased exposure. Local physical activity providers are experiencing their best-ever membership numbers. This is an area that would benefit from more formalised research. The Active Broken Hill link to Broken Hill City Council website is also receiving in excess of 250 direct visits per month.

Active Broken Hill is now working towards strategies that will ensure sustainability, such as scaled subscriptions from local sporting and physical activity groups, and corporate sponsorships.

The future: Improved community awareness via a high profile shopfront and part-time employee would greatly enhance uptake across the community. Active Broken Hill is addressing a vacuum that existed locally—the need for greater access to local sporting and physical activity providers and the need for a greater level of knowledge at a community level about the role of the individual in their own health and wellbeing. Given its increasing success, the Active Broken Hill model has the capacity to be replicated across larger rural centres in Australia.

‘Recovery’—the journey within three rural communities in New South Wales

Wendy Cabot1, Beth Cronin1
1The Benevolent Society

This presentation will highlight the unique difficulties and triumphs associated with the implementation of a community mental health program in a rural setting. It will identify the value of incorporating both peer support employment and consumer leadership. It will look at both qualitative and quantitative outcomes achieved by participants within the program, and the overall contribution the program is making to participants’ lives in both the New England and Central West areas of NSW.

The prevalence of mental health conditions in rural and remote Australia has been estimated as equivalent to levels in major cities. However, rural Australians face greater challenges as a result of such conditions, due to the difficulty of accessing the support needed for mental illness, and to the greater visibility and stigma that is often attached to mental health in a smaller community.

Over the past two decades there has not been any real increase in spending to ensure the availability of the range of support services, clinical and non-clinical, needed by people with a mental illness to live well in the community. As a result, many people with a mental illness struggle to find proper care. This problem is accentuated if you live in a rural area, which is likely to have fewer health professionals and a much smaller choice of health service providers.

It is within this context The Benevolent Society commenced its work in mental health, implementing the PHaMs program and developing a recovery-orientated service. The PHaMs program intrinsically values the wisdom of those with a lived experience of mental illness and distress. The employment of peer workers and involvement of consumers in shaping service developments are key components of our work.

The Australian Fourth National Mental Health Plan reflects the important shift in the field of mental health services, toward a recovery-orientated approach. Recovery is a unique and personal journey that includes a sense of hope, wellbeing and autonomy. Our work recognises and builds on people’s strengths and resilience, and capacity for self-determination.

The PHaMs service provides an opportunity for government and the non-government sector to work together to provide innovative assistance for people whose lives are affected by mental illness or distress. The aim of the PHaMs model is ‘to increase the opportunities for recovery for people whose lives are severely affected by mental illness’. This is underpinned by three secondary outcomes of increased access to appropriate support services at the right time; increased personal capacity and self-reliance; and increased community participation.
The Benevolent Society is Australia’s oldest not-for-profit organisation and has been working with vulnerable people and communities for nearly 200 years. In 2008 we were successful in securing the Australian Government’s Personal Helpers and Mentors program (PHaMs) Armidale and in 2009 Inverell and Mudgee.

**GP distribution in rural Australia—has the OTD moratorium worked?**

**Melissa Cameron**, **Sharon Kosmina**

*Rural Health Workforce*

**Aim:** To determine if the overseas-trained doctor (OTD) moratorium has been effective in increasing general practice (GP) workforce in rural and remote Australia.

The ‘Overseas Trained Doctor moratorium’ is the policy instrument utilised by the Australian Government to direct OTDs to work in ‘districts of workforce shortage’, and in particular rural and remote practice locations. Australia has experienced a rapid period of urbanisation and with this a maldistribution of GPs and primary health services. The OTD moratorium is part of a raft of regulatory and financial incentives, programs and policies that aim to address the supply and distribution of health workforce in rural and remote locations.

**Method:** Utilising the Australian Government Department of Health and Ageing, 2011 GP statistics we undertook an analysis of the overall numbers and full-time workload equivalent (FWE) GPs in Australia from 1984 to 2011.

**Results:** Between 1984–85 and the introduction of the OTD moratorium (January 1997) GP numbers (FWE) grew by 59% in major cities, compared with regional (42%) and remote (39%) areas. After the introduction of the OTD moratorium (1997 to 2011) GP growth in major cities slowed to 20%, whereas growth rates increased in regional (47%) and remote (52%) areas. Since the introduction of the moratorium (1997) the number (FWE) of Australian trained GPs, nationally has not changed, whereas the number of OTDs (FWE) has increased with greatest growth observed in inner (240%) and outer (156%) regional areas and remote (169%) locations.

**Conclusion:** Australia continues to support a number of policies focusing on international migration that aim to increase rural and remote GP workforce supply. The evidence reviewed for this study suggests that the OTD moratorium has been an effective policy driver in increasing the available supply of GP workforce in rural and remote Australia.

Over the past decade, the Australian Government has made a substantial investment to increase the numbers of Australian-trained health professionals, thereby reducing our reliance on OTDs. However, given the substantial lead times from medical training into workforce availability, we have yet to see an impact of these policies on rural and remote health workforce supply. For the foreseeable future the restriction of Medicare provider numbers associated with the OTD moratorium remains an important policy option for distributing GP workforce to rural and remote communities.

**New ways of delivering our business: for health practitioners and for artists**

**Anthony Peluso**, **Cath Cantlon**, **Imelda Rivers**, **Simone Gillam**

*Country Arts SA*

The intersection between arts and health is playing an important part in an environment of health promotion and prevention. As the discussion grows and the benefits of this area of practice are documented, focus is now being shifted to how practitioners from both the health and arts sides of the conversation deliver their business. In regional South Australia, two new programs are being rolled out that endeavour to contribute to this discussion. Artists are showing health practitioners new ways of engaging with their clients, creating more positive health outcomes, but also generating creative new ways of delivering health messages and practices. Concurrently, protocols and guidelines for artists working in mental health are also being developed that will better equip them for work in this arena. Both these initiatives will generate a more skilled workforce and employ more innovative models of delivery.

Contemporary community arts and cultural development practices are being used with health partners, their staff and community members who use their services to affect longer term integration in planning and resourcing their core business. This arts/health program promotes new models of practice that will have relevance beyond the immediate community. Some of these have been formulated specifically for local Indigenous groups, using comedy to tackle the topic of anti-smoking. Another works closely with Parkinson’s sufferers through the medium of dance, specifically learning to
tango. The results are being evaluated through an interdisciplinary evidence-based approach that critiques the partnerships between health and the arts to demonstrate that community arts and cultural development methods can work for health partners in delivering their strategic objectives.

Concurrently, a complimentary longstanding partnership between regional service agencies in the arts and mental health is now responding to the call for assistance for artists. One of the main aims of the partnership is to increase opportunities for social connection using arts and culture as an opportunity to improve wellbeing. The program is now extending from a local regional project to a state-wide strategic approach and one of the first outcomes is the development of a set of workable, respectful, ethical standards for artists working with people with mental illness. The resource will assist artists to demonstrate best practice when working with people with mental health issues and to encourage people to realise their creative potential.

Midwifery continuity of care for remote women: the central Australian experience

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¹Midwifery Group Practice, Alice Springs Hospital

International and national research, including a recent Cochrane review, has shown that midwife-led care is a model of maternity care that should be recommended for the majority of women as it associated with good outcomes for mother and baby. The ‘Midwifery Group Practice’ (MGP) is a midwife-led model of maternity care in Alice Springs. It commenced in March 2009 with the aim of achieving these outcomes as well as rebuilding maternity services in the bush. Changes have been implemented over the past three-and-a-half years to ensure its success and sustainability. The program is committed to working towards closing the gap in maternal health, especially in a rural and remote context. The MGP consists of eight midwives who work in conjunction with obstetric and medical staff at Alice Springs Hospital, Remote Health and Health Development. The MGP caters for approximately 280 women per year.

The presentation will commence with a detailed explanation of the MGP and how it works as part of a multidisciplinary Central Australian team. Forty per cent of the MGP clients are Aboriginal women from remote communities, many of whom have co-morbidities such as rheumatic heart disease, hypertension and diabetes. The MGP midwives work in consultation with: town and remote obstetricians; remote area nurses and midwives; remote outreach midwives; alcohol and other drugs officers; smoking cessation officers; diabetes educators; dieticians; social workers; preventative chronic disease nurses; women’s health educators; Aboriginal health workers and Aboriginal liaison officers. This multidisciplinary team works across Central Australia to provide each woman with the most comprehensive, safe and appropriate maternity care, regardless of their risk status. The challenge of coordinating and supporting such a wide team and often very complex women will be discussed.

Six hundred and fifty women have so far received care through the MGP. The outcomes of these women will be presented at the Conference. The presentation will also include a new initiative to commence a MGP in Tennant Creek with the aim of returning birth services to the area and eventually other large remote communities.

Midwifery continuity of care has been shown to have benefits in large trials. Our experience will add to the body of knowledge about this model in a specific context and community.

The attractiveness of Australia’s rural and remote spine for health professionals

Dean Carson¹, Rob Porter¹
¹Flinders University

The first decade of the 21st century represented a time of great change in rural and remote South Australia and the Northern Territory (Australia’s ‘spine’). There was a sustained drought in the south. There was a tremendous increase in resource extractive activity in the centre and north. The global financial crisis changed corporate, public and personal economies. There was a major focus on Indigenous health and wellbeing, particularly under the Northern Territory Emergency Response and the Working Futures policy. Economies were restructured, and the nature of rural and remote settlement changed dramatically. Into this context came a new health professional workforce drawn from the ranks of fresh university graduates, ‘reverse migrating’ urban practitioners, overseas-trained professionals, Indigenous communities, and ‘un-retired’ workers who found their superannuation arrangements suddenly inadequate for their needs.
This paper uses data from the 2001, 2006 and 2011 Census to examine who these new arrivals were, where they were attracted to, and how the spatial and occupational distributions of health professionals along Australia’s rural and remote spine changed over the decade.

Travel-related barriers to rural and remote patients accessing specialist care

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Aims: This study, to be undertaken by the Townsville–Mackay Medicare Local (TMML), aims to explore the outcomes when people are referred by their rural GP to a specialist in a larger regional centre—whether they attend, what it costs them, and the reasons they don’t attend. It will also gauge their acceptance of alternative approaches such as telemedicine. The study will be completed between November 2012 and March 2013—ethical approval has been sought from the James Cook University Human Research Ethics Committee.

Methods: Rural general practices will be recruited based on being located at least one hour by road from either Mackay or Townsville. They will compile a prospective list of patients referred for non-emergency diagnostic or specialist health care over a four-week period.

Two months later, the practice will send a semi-structured questionnaire to these people with questions about type of specialist, travel and accommodation, costs incurred, reasons for non-attendance, and their attitude to telemedicine. The proportion of referrals completed will be calculated from the returned questionnaires plus data supplied from the practices.

The questionnaires will be analysed using frequencies, relative risks and thematic analysis of comments, with stratification by location, age, type of specialist and working status.

Relevance: The data will enable TMML to address barriers to specialist access, and advocate for better travel support for rural and remote communities. It will also inform TMML’s telehealth initiative.

Results: Results will be presented at the 2013 National Rural Health Conference.

Conclusion: Medicare Locals are tasked with improving access to health care, and ensuring care is well integrated, equitable and efficient. Understanding the impact of specialist referrals on the consumer will assist with the re-design of services for rural and remote communities.

Pulmonary rehabilitation in country South Australia—a breath of fresh air

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\textsuperscript{1}Country Health SA Local Health Network

Introduction: Evidence has shown that participation in pulmonary rehabilitation enhances health-related quality of life and self-efficacy, improves exercise performance and mental health, reduces breathlessness, and reduces health utilisation (and associated costs). One of the greatest barriers to participation in pulmonary rehabilitation for country residents, was limited access to programs close to home.

To improve access to pulmonary rehabilitation and experience the benefits of participation, dedicated respiratory nursing roles and multidisciplinary teams providing pulmonary rehabilitation programs were established in 11 locations across country SA.

Method: Clients with history of high hospital utilisation for respiratory related admissions were identified upon presentation to emergency department or admission to hospital and referred to the respiratory nurse for further assessment, and encouraged to participate in pulmonary rehabilitation. Referrals were also received from local GPs.

A number of baseline indicators, including six-minute walk test, were recorded prior to commencement of the program and again at the end of the program to measure improvement. Clients also recorded their duration of exercise and appropriate clinical indicators at each session attended.

In addition to monitoring clinical indicators, pulmonary rehabilitation coordinators worked closely with clients to identify factors that were likely to increase risk of unplanned admissions and helped clients to develop strategies to reduce the likelihood of these risk factors impacting on their health. Examples include anxiety, social isolation, financial or transport issues, carer stress, learned behaviour, dependency on health service, stress, disease progression etc.
Outcome: During 2011–12, approximately 250 clients participated in a pulmonary rehabilitation group, with about one-third of these participants continuing to attend exercise maintenance groups. Data collected by group coordinators demonstrates improvements in fitness and clinical indicators, improved quality of life and a reduction in unplanned hospital presentations or admissions for this cohort of clients.

Conclusion: The employment of dedicated respiratory nursing roles and the establishment of multidisciplinary teams providing pulmonary rehabilitation at country health units have improved access to timely information, support and coordination of care for clients with chronic respiratory conditions. While client engagement in these programs has improved the health of many, resulting in reduced hospital admissions and/or length of stay, more significantly it has provided participants with opportunity to form friendships and networks, reduce social isolation, and support to regain their lives and independence, despite their chronic condition.

Medicare Locals—a long way in a short time

Kate Clarke1

1South West Health Alliance Ltd

Medicare Locals are regional primary health care organisations, set up by the Australian Government to better organise and manage local front-line health services. South West WA Medicare Local (SWWAML) was among the first group of Medicare Locals to be approved by the Australian Government.

The region covers an area surrounding the Perth metropolitan area to the south-east and north and comprises a land mass just under 200 000 square kilometres, with a population of just over 293 000 people.

The SWWAML is different to many other Medicare Locals, including:

- a large geographical area with three distinct areas each requiring a different approach
- while recognising the importance of medical practitioners in the delivery of primary health care, SWWAML is focused on all health practitioners operating in the primary health care setting

- SWWAML is undertaking a commissioning model and utilising service providers operating in the region to deliver services to communities on behalf of SWWAML.

The business model of commissioning of services presents a unique set of opportunities and challenges for the SWWAML. The opportunities include SWWAML being able to:

- focus on planning for health outcomes
- develop strategies that facilitate a range of service delivery models and allow SWWAML to play a pivotal role in the developing integrated service models
- purchase best-practice models, innovation and ensuring quality services
- develop the capacity of a small staff group to work in the areas of community engagement and clinical support and purchase services from the other service providers
- be responsive to community need.

The challenges include:

- ensuring a quality service is purchased that provides equity across the region
- establishing a robust evaluation methodology that ensures consistent and best-practice clinical governance
- ensuring that service providers promote the philosophy of SWWAML
- being able to promote the benefits of Medicare Local.

This presentation provides an overview of the model that SWWAML is developing that will provide a strong foundation for a regional approach to working across the health landscape to address health needs identified through a population health plan. There are multiple service providers, non-government organisations and all tiers of government involved in health, social services, justice and education.

Commissioning of services allows SWWAML the ability to work across sectors and contribute to the solutions needed for workforce development, capacity building for providers and assisting with the development of responsive models of care.
Disorders of swallowing are a common occurrence for people with acute and chronic diseases such as stroke, Parkinson’s disease, motor neurone disease and dementia.

Speech pathologists play a pivotal role in both the assessment of swallowing disorders and the design of individually tailored treatment programs for clients aimed at reducing risk of choking and chest infections as well as improving quality of life. Instrumental assessment of swallowing disorders such as with a modified barium swallow (MBS) is considered best practice to ensuring accurate treatment planning.

In rural communities, there is consistent evidence to indicate that health outcomes for people are poorer, partly due to reduced access to services and less specialism for allied health staff undertaking this assessment. In rural South Australia, access to MBS services by speech pathologists for clients has historically been poor for a number of reasons, including poor access to training opportunities, staff retention difficulties and reduced referrer awareness of the service. This is in contrast to speech pathology services in metropolitan areas where large hospital sites have well established weekly MBS services and good awareness of the service with referrers.

This presentation will identify issues and barriers related to access to and provision of safe and effective delivery of MBS services in rural South Australia using a systematic application of the following clinical governance principles:

- clinical audit—establishing a baseline of current and future practice, including staff survey
- developing a framework of education and training (both of staff and referrers)
- clinical effectiveness—evaluating effects on client management
- risk management.

Following this, there will be an exploration of how the PDSA (plan–do–study–act) cycle can be used to evaluate the impact of the clinical governance principles on specialised skill development for speech pathology workforce for the provision of MBS services (identified using clinical audits and stakeholder surveys). The PDSA tool is relatively simple to use for all health services, enabling a framework of continuous quality improvement to be embedded in the culture of a professional group or service.

Conclusions will be drawn from the audit and survey results for the baseline of current services and impact of a training and competency framework for the specialist skill development of speech pathology staff. Future PDSA cycles propose to evaluate changes in client access and clinical effectiveness for this service in rural South Australia.

**Neighbourhood cohesion among middle-aged women: the influence of psychosocial factors**

**Sue Conrad¹, Leigh Tooth¹, Annette Dobson¹**

¹School of Population Health, The University of Queensland

**Background:** Neighbourhood cohesion is positively associated with mental health and compared to city dwellers, regional residents experience higher levels of both. Neighbourhood disadvantage and individual demographic factors are also associated with both neighbourhood cohesion and mental health, and the interplay between them appears to affect women more so than men. The contribution of psychosocial factors such as social support, life satisfaction and stress to these relationships hasn’t been explored in the context of neighbourhood cohesion.

**Aims:** We determined whether there were differences in neighbourhood cohesion in middle-aged Australian women living in remote/very remote, outer regional, inner regional and major city locations, and the extent to which these differences were associated with psychosocial factors.

**Methods:** Cross-sectional data from 11 220 participants of the Australian Longitudinal Study on Women’s Health, aged 50–55 years were used. Women were randomly selected from the 1996 Medicare database, with oversampling of regional and remote residents. ARIA Plus was used to categorise geographic location of residence as remote/very remote, outer regional, inner regional and major city locations, and the extent to which these differences were associated with psychosocial factors.
neighbourhood cohesion (neighbourhood safety, connections and attachment and trust) were examined using multivariable regression models with adjustment for area disadvantage and individual demographics.

**Results:** Women living in remote/very remote, outer regional and inner regional locations reported better neighbourhood safety and connection compared to women living in major cities. Women living in outer regional and inner regional locations, but not remote/very remote areas, reported better neighbourhood attachment and trust compared to women living in major cities. Adding mental health, depression, life satisfaction, perceived control, stress and social support to the models did not greatly change the regression estimates, and the associations between geographic location and neighbourhood safety, connection and attachment and trust scores remained statistically significant.

**Conclusion:** These findings suggest that the differences in neighbourhood cohesion across geographic locations are not explained solely by demographic and psychosocial factors. Among middle-aged women, it appears that other factors, perhaps related to community resources or the physical environment make regional residents feel safer, more connected and experience greater neighbourhood attachment and trust than those residing in major cities.

**Mining towns—does the boom mean bust for health services?**

**Sarah Constantine¹, Kristine Battye²**

¹Health Workforce Queensland, ²Kristine Battye Consulting Pty Ltd

The Bowen Basin is one of Australia’s fastest growing mining regions and it is anticipated that there will be at least 10,000 new resident and non-residents by 2018 for the Isaac region alone. Resource towns benefit from this growth through the creation of more jobs and strengthened economies. The unprecedented level of mining activity combined with the fast-growing trend of non-resident worker operations in the region has triggered concerns on a range of issues and in particular the impact on the demand for health services.

The project was funded by local mining companies to determine the impact of the expanding resources sector on the health services in the town of Moranbah in Queensland and to identify strategies and new opportunities to ensure sustainability and to meet the health needs of this community.

The project was led by a community steering committee, including representatives from mining, and local and state government. There was extensive consultation with key stakeholders locally and regionally. In addition to consultation, a full-day workshop to discuss interim recommendations was held in Moranbah with key representatives attending.

Some of the key issues identified included:

- health services
  - significant demand by a non-resident population
  - lack of effective occupational medicine services
  - unmet community expectation for accessing health services
- health workforce
  - challenges in attracting and retaining health workforce due to lack of affordable housing and clinical space
- health planning
  - uncoordinated health services planning leading to a disconnected local health service.

Some of the key strategies identified to address these issues included:

- establishment of a Health Care Partnership Group to be a representative group ensuring a coordinated approach to planning to respond to the health needs and priorities of the community into the future
- engagement of a ‘driver’ to ensure the proposed strategies are progressed into actions
- harnessing existing local capacity to make the health services more sustainable
- attracting and retaining staff through provision of affordable housing and clinical infrastructure
- development of private/public service partnerships to meet health service needs, including occupational medicine.
The growth of the resident and non-resident population in Moranbah will continue with the expansion of mining. The project reflects that the ongoing sustainability of the health services will hinge upon the coordination and collaboration of Private Public Partnerships. Effective and timely engagement of the resources sector is also paramount to ensuring sustainable health service delivery and improving health outcomes in the region.

**Service delivery in pharmacy practice: what can be achieved in regional NSW**

**Carl Cooper**

1Charles Sturt University

In October 2011, I concluded a five-year project that involved transforming a small underperforming community pharmacy in Lockhart, NSW to a diversified and broad service offer to the small community. Although everything that I attempted may not have been successful, I will attempt to identify those lessons that I have learnt and focus on what other professionals can take away and use in their professional practice.

As a recent Charles Sturt University graduate, I was always interested in applying the skills and training that was part of a new cohort of students interested in pharmacy ownership—but this opportunity that presented itself meant that I could actually change pharmacy practice.

On 16 July 2007 I bought Lockhart Pharmacy and was responsible for the delivery of pharmacy services to an estimated population of 3618, with 25.3% of the population under 5 years old, 14.9% of the population aged 65 years and older, 42.1% with dependent children, an unemployment rate of 5.7%, an index of relative disadvantage of 1020 (high) and a 1.5% Indigenous population.

To meet the residents of Lockhart and establish rapport and confidence was my initial intent, however the challenges of computer systems that didn’t work, a dirty building, a leaking roof and a challenging relationship with the town ‘characters’ made for an interesting first few months in pharmacy ownership. The particular trait of the town locals to be called by a different Christian name than that they were known by Medicare Australia frustrated me initially, but only reinforced in me the special relationship that the residents had with themselves and the community.

As a direct consequence of developing the professional services at Lockhart, and first gaining accreditation through the ACCP, I was able to extend and develop the medication review services that I was already offering to Woodhaven (Lockhart) and Urana MPS. Consequent to that I was offered some additional review services into other MPS services at Hay, Henty, Culcairn, Leeton, Tumbarumba and Holbrook.

As a direct consequence of the 4th Pharmacy Agreement, the DMAS (Diabetes Management) and PAMS (Asthma Management) programs were initiated at Lockhart with specifically identified patients being enrolled and supported through these services. Unfortunately both these programs, although successful, were unable to attract further funding in the 5th Pharmacy Agreement. UTAS also initiated a warfarin monitoring program for four patients on long-term warfarin therapy. After education, patients were able to monitor their warfarin levels in their own homes, as well as continue to receive professional support from their general practitioner.

In 2008 I was offered another building for purchase with the Westpac sub-agency in it. As I was looking for a more suitable premises and this presented me with a much more substantial building, I redeveloped the building and opened this renovated and improved premises in early 2009. Banking services were separated from the pharmacy itself, although the banking staff were employed by the business.

In identifying the improvement to services in Lockhart, I need to note the contribution of many key local people in the community. The local GP, Dr Ken Mackey was extremely supportive of attempts to develop collaborative professional relationships—as he also was responsible for training of junior medical staff and improving clinical services in the community via the HMR model of review services. The Woodhaven manager (local nursing home), Lyn Hamson, helped to develop improved QUM services by facilitating a monthly MAC meeting.

In the space of five years, local support for the community pharmacy returned. I identified the improvement in local service delivery in the community pharmacy as the prime reason for this return of local support.
The impact of the National Broadband Network on rural patients and rural health practitioners

Kate Cornick¹
¹NBN Co

In April 2009 the Federal Government announced the formation of the National Broadband Network Company (NBN Co) to enable the delivery of high-speed broadband to Australians.

From conceptual beginnings in 2009, today the NBN is a very real prospect for all Australians. Construction is already under way in every Australian state and all three of our technologies—fibre, fixed wireless and satellite—have service available in first release sites.

NBN Co will give an overview of the project, its rollout and how Australia’s biggest infrastructure project will impact remote and rural medical services.

NBN Co’s presentation will have a special focus on our satellite and fixed wireless technologies being delivered to the most remote Australian communities.

Rheumatic fever and rheumatic heart disease know no boundaries

Jennifer Cottrell¹, Marea Fittock², M Nissen², M Russell², J Raupach¹
¹SA Department for Health and Ageing, ²NT Department of Health

Background: State and territory borders do not exist for Aboriginal and Torres Strait Islander people; boundaries are drawn according to birthplace and the relationship to those places. Programs working in Aboriginal and Torres Strait Islander communities need to acknowledge this and accommodate accordingly.

Despite it being a rare disease in industrialised countries, some of the highest rates of rheumatic fever (RF) and rheumatic heart disease (RHD) in the world are found in Aboriginal and Torres Strait Islander communities in central and northern Australia. RF and RHD affect young people in their most productive years and can have devastating effects. A prevalence study in SA in 2011 estimated almost 200 documented cases of RHD, with approximately 85 of these living in the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, with underreporting of cases likely.

Coordinated RHD control programs can assist in the prevention of RHD through identification of cases, improving clinical follow-up and encouraging adherence to secondary antibiotic prevention.

Method: The NT RHD control program has been running since 1997 and has successfully built up strong networks across the territory that facilitate the implementation of the control program. Since its commencement in 2012, the SA RHD control program has worked closely with the NT program. The two programs are working towards providing a service that is seamless for health services and patients in cross-border region of central Australia. This is achieved through close coordination of education and sharing the same electronic platform for the RHD Register, which records cases of ARF and RHD.

Benefits of working together have included the sharing of experiences, improved follow-up of patients, and improved awareness of the disease among health professionals in the region. Challenges of working across two jurisdictions have included negotiating the different practices and delivery of services within each health system, ensuring confidential sharing of patient information across jurisdictions and working within the time constraints of those involved.

Conclusion: Collaboration between and commitment from organisations is fundamental for the improvement of the health and wellbeing of individuals and communities. With the support of the NT, the SA RHD control program is laying the foundation for improved health outcomes for RHD patients across SA.

Integrating aged care assessment for older people of north-east Victoria

Sue Cowan¹, Fiona MacPhee²
¹John Richards Initiative, La Trobe University Albury Wodonga, ²Integrated Aged Care Assessment Service, Ovens and King Community Health Service

Current assessment processes for older people entering the aged care system are fragmented and challenging, as acknowledged in the new government report, Living Longer, Living Healthier (2012). Different agencies employ different assessment tools, service models and diverse approaches. This paper reports findings from a collaborative project designed to explore the challenges and opportunities associated with building common assessment processes across three diverse services in a rural centre in north-east
Victoria. By using a collaborative approach, the project team comprised three organisations—ACAS, HACC and Mental Health—in conjunction with a university research partner. The mixed methods design was conducted over three stages: (1) assessment of the policy context; (2) mapping of assessment processes across services; and (3) interviews across managers, practitioners as well as consumers and carers. Stage 2, which involved a comparative analysis of comprehensive assessment tools, revealed significant and key areas of data duplication, and commonalities and differences across the assessment and practice, and identified scope for developing compatible assessment processes. Building on this context, this presentation focuses on findings from Stage 3 of the project, which explored the experience of assessment processes and practices from the perspective of key stakeholders. The sample included the 'professional' cohort (n=25), including the direct line managers, CEOs and practitioners of the three agencies; and the older rural 'consumers and carers' cohort (n=16) who were current, or past recipients of the above services. The interviews were analysed for emergent themes. Findings highlighted the key challenges for assessment facilitation, implementation and engagement, as well as suggestions and innovations designed to improve the assessment experience. As widely understood, assessment informs the entrance and trajectory of care, it is has been therefore timely to consider the directives of the National Health Reforms (2011) and explore what is needed at the local level in order to develop a collaborative, integrated model of assessment to improve the gateway to the aged care system.

Aboriginal Child Well Health Checks—the benefits of a positive first experience

Libby Coy1, Catherine Sumner1
1Murray Mallee Community Health

For the past year (with federal funding) we have conducted an Aboriginal Child Well Health Checks program; providing a ‘positive first experience’ for young Aboriginal children and their families to access mainstream services in the Murray Bridge community. The mainstream services targeted were based on needs identified in the SA Aboriginal Health Care Plan 2010–2016.

Our experience has been one of success, particularly regarding dental health checks.

At this Conference we would like to present our journey over the past few years to establish and evolve our program, why we think we are on the right track, what we think will be essential for success in the future, and the challenges around developing cultural competency of mainstream services.

Sharing care the Kimberley way

Sarah Davies1, Sally Thomas1
1WA Northern and Remote Country Health Service

The Kimberley region of WA is vast, stretching from Broome in the west to Kununurra in the east. There are four towns and 200 Aboriginal communities in the region. Some communities are very remote and accessible only by airplane or four-wheel drive vehicles. Perth is the tertiary cancer centre, which is 2400 km from Broome and approximately 3500 km from Kununurra.

The population is estimated at 50,000, 42% of whom are Aboriginal. The population can double between May and October with the seasonal arrival of tourists to the region.

Rural cancer nurse coordinator and palliative care nurse coordinator positions were created as part of statewide initiatives, to improve outcomes for people diagnosed with cancer and to increase palliative care capacity in regional areas. Presently in the Kimberley the rural cancer coordinator is based in Broome and the palliative care coordinator is based in Kununurra. Care coordination relies on teamwork and communication between all health care providers. Teamwork promotes continuity of care and provides a smooth transition from diagnosis to treatment to palliation and survivorship as required.

We will present a unique model of care delivery involving both cancer and palliative care coordination across a remote region to a diverse population, demonstrating best practice service provision for our patients, enhancing not impinging on either service.

Two case studies will provide examples of care coordination and collaboration to demonstrate service provision to our patients in the Kimberley:

- The first case study will examine and discuss a 52-year-old Aboriginal lady with breast cancer who didn’t complete treatment.
- The second study will look at a 48-year-old lady from a very remote community with a late presentation of metastatic pancreatic cancer.
These case studies will explain the strategies the rural cancer nurse coordinator and the palliative care nurse coordinator use to overcome the complexities of access to cancer treatment and palliative care for patients who live in remote areas.

We will provide an insight into the management of remote and rural patients, highlight the obstacles and achievements and demonstrate a strong commitment to service delivery from all members of the multidisciplinary team regionally.

By developing practical interventions and identifying achievable outcomes the shared model of cancer and palliative care demonstrated in this presentation provides opportunities for the future delivery of a complex service in a remote region.

**Project to develop a telehealth model of care for people with diabetes**

Deborah Dean

We provide telehealth services to a population of approximately 270,000 over an area of 400,000 km², including many Aboriginal and Torres Strait Islanders. Our urban and remote communities are serviced essentially by various ‘fly-in/fly-out’ primary care medical teams meaning that health care provision is inequitable and disparate throughout these areas.

When this project was initially commenced, the naive belief was that identification of an evidence-based system of care and service delivery was all that was required and once everybody was made aware of the processes involved, all else would be straightforward.

Now in its third year, this project is now a shadow of its original conceptual image. In the first year there were 15 clinical contacts via videoconference unit, in the second year this figure climbed to 45 and last year we achieved 260.

The most powerful indicator was the recognition that each service had to be titrated to meet local need—this need being influenced by location, ethnicity and the attitude of the local service providers—and in so doing, each service became unique.

The common barriers were found to be:

- language
- culture
- reticence—the videoconference units were not installed with community consultation; this has created a lot of negativity
- unfamiliarity—people are not used to speaking into a television screen
- convenience—timing of the consultations need to coincide with the ‘fly-in’ team. (The primary care team become an extension to our multidisciplinary team)
- control—when a person sits in front of the screen, they may not know beforehand who will be present at the other site and what will be discussed
- a local champion—somebody, locally, has to be able to place the person in front of the screen at the appointed time and ensure they have been fully informed as to their rights
- immediacy—clinicians prefer to telephone the consultant for ‘on the spot’ advice. (We have had video consultations arranged within 5 minutes).

While it is acknowledged that face-to-face consultations are the gold standard, it cannot be assumed that all consultations provided this way do meet that standard. However, when all transmitting, quality, clinical criteria etc. are met, the ability to engage the client over the screen, share their results, X-rays, photos and together discuss the implication of proposed treatments—video must make for an acceptable silver standard.

**Pattern of utilisation of telepsychiatry services for geriatric consumers residing in rural and remote South Australia**

Pallavi Dham, Elaine Skinner, Jacob Alexander, Neeraj Gupta

Aim: Since the establishment of an independent Older Persons Mental Health Service (OPMHS) in 2010 within the Rural and Remote Mental Health Services (RRMHS) in South Australia, there has been a surge in the demand for telepsychiatry consultations. This study looks closely at the changes in patterns of utilisation over the years to better inform service growth and optimise service delivery.
Objective

- Compare utilisation patterns of telepsychiatry use by geriatric consumers (65 years and over) referred during two distinct years (2010 and 2011).
- Compare demographic details, co-morbid medical conditions, diagnosis and post-consult recommendations for the patient cohort.
- Postulate reasons for changes in utilisation with recommendations for the future development of a nascent service.

Methods and results: The study included a retrospective chart review of consecutive geriatric patients with mental health problems resident in rural and remote South Australia referred to OPMHS, Country Health SA for telepsychiatry assessment between January 2010 and December 2011.

Data comparisons were made for the following specific variables—socio-demographic details, participation of the family/local treating team, co-morbid medical conditions, diagnosis and recommendations made following assessment.

Discussion and conclusions: Interesting differences are observed in the profile of consumers referred to the OPMHS for telepsychiatry assessments with the evolution of the service. We hypothesise that these changes reflect the demand for such services in hitherto under-serviced areas. This has important implications for resource allocation and clinical outcomes for the elderly in rural areas. We discuss other hypotheses that might contribute to these changes.

Studies such as these have important relevance to services looking at either expanding existing resources or setting up new services for the elderly.

Trends in mental health service utilisation for Australian women

Xenia Dolja-Gore1, Julie Byles1, Deborah Loxton1
1Research Centre for Gender, Health and Ageing, University of Newcastle

Introduction: In 2006, new Medicare items were rolled out under the 'Better Access Scheme' (BAS) to improve access to mental health care. The Australian Longitudinal Study of Women’s Health (ALSWH) data provided an opportunity to examine factors associated with uptake of the BAS by women across three cohorts.

Methods: Participants from the ALSWH were eligible for the study if they had given consent for their survey data to be linked to Medicare data and had responded to the self-reported diagnosis questions on depression/anxiety. The women were aged between 28–33 years, 56–61 years and 79–84 years at the time the BAS was introduced. Participant data was grouped according to BAS use and diagnoses of anxiety/depression.

Results: Approximately 18% of women born 1973–78, 9% born 1945–51 and 2.4% born 1921–26 had used services provided under the BAS initiative. Approximately 20% of women self-reported a diagnosis of depression/anxiety and have not been treated under the BAS for all cohorts. Participants using the BAS initiative were more likely to be taking psychotropic medications, have regular GP consultations and to see a specialist, compared with women who self-reported a diagnosis of depression/anxiety and had not used the BAS, across all cohorts. Area and educational differences were noticed in the 1973–78 cohort, where women living in urban areas and those with higher educational qualifications were more likely to use the BAS services.

Conclusions: While there is a gradual uptake of the new BAS services, a large percentage of women who have self-reported a diagnosis of depression/anxiety have not been treated under the BAS. The data suggests that young women in urban areas have benefited from the services compared to other groups of women.

Key message: Inequity in the distribution of BAS services may still exist.

What the rural health indicators are indicating for New Zealand

Robin Steed1, Bernadette Doube1, Jan Cooper1, Brent Nielsen1
1New Zealand Institute of Rural Health

In 2010, the New Zealand Institute of Rural Health (NZIRH) commenced a three-stage research project to develop a national collection of rural health indicators related to the health status and health services for rural people in New Zealand compared to those people who live in urban centres under the three broad headings of health status, determinants of health and health system performance.
Health status of rural people has been of interest in recent years to researchers, industry groups, health service providers and health service funders. There have been many attempts to delineate rural health from urban and to drill down into further data for subsets of rural communities. Specific dimensions of health status are health conditions, human functions, wellbeing and deaths.

The development of the rural health indicator framework will enable high-level measurement, assessment and comparison of the health status of urban and rural New Zealanders and the measurement of disease and health trends of rural communities. Tatua Kahukura: the Maori Health Chart Book and the AIHW rural health indicator framework have been the sound footing for developing a set of rural health indicators for New Zealand.

The next two decades will bring growing numbers of older people in both rural and urban communities. Independent urban areas are projected to be home to an even larger proportion of older people aged 70 years and over (21 per cent) than highly rural/remote areas and rural areas with low urban influence (15 per cent). Age-related projections differ dramatically by ethnicity. The European population is facing a much greater increase in proportions of older people than are the Maori and Pacific populations, which will continue to have larger proportions of children. New Zealand is experiencing the unpredictable effects of a worldwide economic recession. This has affected, among other things, the country’s gross domestic product and levels of unemployment, which have the ability to influence the health status of New Zealanders.

The interrelationship between health status, determinants of health and health system performance is often questioned within and on behalf of rural communities; this piece of work offers a strong basis to compare relevant data and make national comparisons in this area.

This paper will briefly describe the development of the indicators and move on to a discussion of the key learning from this work and the future application of the data for health-sector planning.

What do we really know about best-practice allied health professional supervision?

Wendy Ducat
Queensland Health

Aims: The Allied Health Education and Training Department at the Cunningham Centre, Queensland Health sought to synthesise the best available evidence on the experiences and effects of professional supervision across the allied health disciplines (16 disciplines identified for the purposes of this review). Published and unpublished literature on the experience and effects of participating in supervision on allied health practitioner practice, service delivery and client outcomes is currently being reviewed, with a specific focus on geographically or professionally isolated practitioners.

Method: A multidisciplinary working group was formed in early 2011 to develop a focused research question and parameters for the review. In order to determine the current evidence on the experience and effects of professional supervision for allied health, a systematic review methodology, including both qualitative and quantitative literature, was chosen. A systematic review protocol was accepted for publication by the Joanna Briggs Institute in late 2011 with the comprehensive review due for completion in late 2012. A standardised keyword search of published and unpublished literature across 15 databases (including Medline, CINAHL, Psycinfo) as well as Dissertation Abstracts International and reference lists is currently underway. Once complete, standardised critical appraisal instruments from the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information package (JBI-SUMARI) will be used to assess methodological validity prior to inclusion in the review.

Results: The challenges and rewards of embarking on a systematic review will be shared during this presentation. Preliminary findings from the early stages of review completion will also be shared. Key findings include:

- a scarcity of high-quality supervision literature for allied health professionals, particularly in rural and remote settings
- an ever-increasing body of literature discussing the experiences and applicability of supervision across different disciplines
one rigorous randomised control trial (in a metropolitan setting) demonstrating a clinically significant effect of face-to-face supervision of psychologists on client outcomes

- controversy over the effectiveness of supervision across distance.

**Implications:** Potential implications for professional supervision in rural and remote allied health services based on current evidence will be discussed.

**Corporate and community: strengthening governance in the Aboriginal community controlled health sector**

*Donisha Duff*¹

¹National Aboriginal Community Controlled Health Organisation

**Introduction:** The first Aboriginal Community Controlled Health Service (ACCHS) was established over 40 years ago in response to the urgent need to provide appropriate, accessible primary health care services for Aboriginal and Torres Strait Islander people in Sydney.

Despite the various changes of government and levels of support, the number of ACCHSs has grown to over 150 located in urban, regional, rural and remote regions across Australia.

Many ACCHSs are now large million-dollar multi-service organisations that have adapted with the growing demands and external changes in the Australia health care system.

The current national health reform agenda and the regulatory reforms to the not-for-profit sector impact significantly on the governance structures and ways that ACCH services do business.

ACCHs are in the unique position of complying with stringent regulations and accountabilities (corporate governance), while also fulfilling community obligations imbedded in the NACCHO philosophy of 'Aboriginal community control' (community governance).

Opportunities to reform, coordinate and strengthen the ACCH sector are being presented, with the longer term vision of self-regulation having the political support of the current Minister for Indigenous Health, Warren Snowdon MP.

The NACCHO Governance and Member Support (GMS) Initiative was established in 2012 to extend the capacity and support for ACCH services to achieve and maintain good practice in governance.

A Sector Governance Network (SGN) was established, comprising representation from each state and territory affiliate. This ensures consultation, ownership and standards are culturally appropriate, driven by the members, and sustainable.

GMS support functions are administered by each state and territory affiliate, focusing on a strengths-based, preventative approach.

For the first time, the ACCH sector has endorsed a national sector standard for good governance. The NACCHO National Principles and Guidelines for Good Governance draws on existing corporate governance standards and includes elements for community governance. This is the benchmark on which the ACCH sector will measure, monitor and grow.

In addition, work is under way on sourcing:

- governance training and development programs
- preferred providers of business support services
- resources, tools and infrastructure that are compliant with the range of accreditation and reporting accountabilities of ACCHSs.

**Conclusion:** There is extensive international evidence that community control and governance has a beneficial effect on health. The opportunity costs of prevention and self-regulation outweigh the financial and social consequences of government intervention and administration. Investment in health also needs to focus on supporting reform of systems in changing environments.

**Where does a journey begin?**

*Trish Eerden*¹

¹Rural health consumer

Is it when your car is packed and you get up bright and early to head off to your destination? Or is it when you begin the research about all the places you could go and then narrow it down to where you will go? Or perhaps even earlier than that ... when you are on your way home from your last journey and start talking about where you’d like to go next?

Our journey to disability is a lot like that; it’s hard to say where it all began. Was it when our daughter was
10 months old and was assessed by an occupational therapist, speech pathologist and physiotherapist as being ‘developmentally delayed’? Or was it when she was six months old and we started to notice that things weren’t quite right? Or at three months when she spent a week in the Women’s and Children’s Hospital on oxygen for severe bronchiolitis? Or maybe even before that?

Of course I realise now that none of that really matters. We are left with the realisation that regardless of how it happened, our child is unquestionably unique. In the scheme of things labels like epilepsy, ataxia, cerebral palsy, asthma, intellectual disability matter not a bit, only that we learned to live with this unique child and that we developed the skills we needed to navigate the systems of support.

This session will take you on a bird’s-eye view of that journey, with brief stops along the way to explore some of the challenges of caring for a child with profound disability in rural South Australia. You will see that, even when the journey takes a detour to a dark and scary place, it is possible to find the way to a positive outcome. And perhaps you might learn along the way how profoundly and positively rural families can be affected by strong, dedicated and passionate service providers.

**Helping to empower regional multidisciplinary health teams to provide holistic palliative care**

**Bronwyn Ellis¹, Joy Penman¹**

¹University of South Australia

**Aims:** A two-year project funded by an Australian Government Department of Health and Ageing grant to our university aimed to: investigate the experience and perceptions of health professionals involved in providing palliative care in regional areas; identify continuing educational needs; and develop resources to enhance the skills of multidisciplinary palliative care teams, focusing on areas of pastoral care, counselling and support, which health professionals were often less confident to provide. This paper reports on the development of one of the resources and its evaluation.

**Methods:** A nine-person project reference group was formed with regional health partners and provided feedback on all stages of the project, including suggesting participants for interview. Data were collected through interviews as well as from a literature review. A ten-item questionnaire was used to evaluate the product.

**Relevance:** While palliative care clients may be of any age, the ageing of the Australian population increases the likelihood that people may develop a life-limiting condition or disease where end-of-life palliative care will be needed. Meeting the emotional and spiritual needs of clients and carers is important in providing holistic care.

**Results:** Eleven interviews were conducted with individuals experienced in working with palliative care clients and carers in or from regional areas. Themes emerging included the importance of: establishing trusting relationships, maintaining hope, providing emotional care, meeting the client’s needs, and awareness of cultural diversity and different meanings of spirituality.

A resource manual was produced. It included guidelines for individual and group use, definitions, an overview of relevant literature, psychosocial needs assessment tools, and reflective activities based on anonymised scenarios drawn from the interviews. Nine users provided formal feedback using the detachable evaluation form, while informal feedback was also received. Feedback on the resource manual has been very positive.

**Conclusion:** Busy health professionals can refer to this user-friendly guide to deepen their reflection on their practice. It can be a basis for multidisciplinary team professional development discussions, creating greater awareness of the emotional and spiritual needs of palliative care clients and caregivers, and presenting a range of responses to those needs. It also provides a useful educational framework for future health professionals. Hence it may contribute to brightening the future, however long or short that may be, for people with a life-limiting condition.

**Incorporating advance care plans into the new Personally Controlled Electronic Health Record**

**Isabelle Ellis¹, Catherine Smith², Linda Jaffray², Timothy Skinner²**

¹School of Nursing and Midwifery, University of Tasmania, ²Rural Clinical School, University of Tasmania

This presentation will report the results of a realist systematic review into models of electronic advance care planning.
Study aim: As life expectancy increases, so do the number of elderly people living with advanced life-limiting chronic illness. Advances in medical technology have greatly extended medicine’s ability to prolong life through artificial or mechanical means. There is also an increasing awareness and debate around people having the right to choose what health care, and in what environment, including the level of aggressiveness of treatment and care they receive when dying. Recent research indicates that for many, their individual preferences are at odds with the health care models available to them. Research has shown that this results in people dying in greater distress, increased carer distress, increased bereavement problems and increased health provider stress. A proposed approach to communicating these wishes has been to include them as an advance care plan (ACP) in the Personally Controlled Electronic Health Record (PCEHR). An ACP is completed by a person while legally competent to do so. It communicates their values, preferences and choices for treatment or life-sustaining interventions to be initiated, should their condition deteriorate such that death is imminent.

Method: A realist systematic review has been conducted into the models of advance care planning for elderly people with life-limiting chronic illness living in the community. Data sources include PUBMED, CINAHL, and PsycINFO. Articles were then added through a snowball approach; hand searching the reference lists of relevant research articles and grey literature reports. Articles were included in the review if they reported original studies, models of advance care planning, and were about elderly community-dwelling people. Both qualitative and quantitative studies were included.

Results: The authors reviewed 18 articles, 10 of which were qualitative studies and 8 were experimental or quasi-experimental. Only one article reported a model for developing an eACP. The authors found common themes, including the expectation of elderly people with chronic conditions that their primary care clinician would initiate conversations about end-of-life decision making. The most effective intervention was found to be patient-focused education rather than clinician reminders and education.

Relevance: As the PCEHR rolls out across Australia and is being generated by GPs and others working in rural and remote primary health, the proposed inclusion of the electronic advance care plan requires careful consideration.

‘Closing the Gap’—adult Indigenous oral health needs in small, remote Aboriginal communities

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1Kakarrara Wurrurrara Health Alliance, 2Tullawon Health Service

Aim: To understand and consider ‘Closing the Gap’ for Aboriginal adult oral health needs by measuring and describing these needs for three small remote Aboriginal communities and proposing the dental service requirements to meet these needs.

Method: The oral examinations from adult patients presenting for oral health care over two years are reviewed and provisional treatment planning to complete a ‘Course of Adult Oral Health Care’ for the three Aboriginal communities of the KWA have been developed. The treatment plans have identified dental procedures (fillings, extractions, scaling, construction of dentures etc) and estimated the time and number of required dental appointments to complete these oral health care plans. Indices of hours per adult patient, average number and time required for these treatment plan appointments and total weeks of oral health service delivery required are described.

Results: The assessment oral health status and measurement of oral disease often uses the measurements of dental caries experience (DMFT) and periodontal diseases (CPITN) to describe prevalence and extent of common oral diseases. This paper describes a methodology and the results of measuring the dental resources (time and money) required to treat oral disease within a primary oral care framework for populations with large unmet dental needs. Correlating these indices of DMFT and CPITN with the plans to complete the course of Adult Oral Health Care are discussed. These results are discussed within the context of policy development and aspiration to ‘Close the Gap’ of Indigenous oral health. This research proposes and describes a Primary Oral Care framework and Oral Health Care Plans and discusses these descriptions.

Recent announcements of a dental reform package and the closure of the Chronic Disease Dental Scheme will be reviewed in the context of this analysis of adult indigenous oral health needs and ‘Closing the Gap’.
Allied health assistant remote supervision workforce model

Carol Parker¹, Sharan Ermel¹
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Aim: Distance is frequently cited as a barrier that limits access to optimal delivery of health services in rural and remote areas. The aim of this project was to develop, trial and evaluate a remote supervision allied health assistant (AHA) model that could potentially be replicated in other rural health environments and thus reduce this barrier. The project aimed to improve the overall health outcomes for rural and regional communities through the increased training and utilisation of AHAs, under the remote supervision of allied health professionals (AHPs), to augment timely, and closer, access to some allied health services.

Method: The project was a collaborative arrangement where two rural hospitals, Inglewood and Districts Health Service (IDHS) and Boort District Health (BDH), partnered with Bendigo Health and Bendigo TAFE to develop and implement this AHA remote supervision model. IDHS and BDH nominated employees from their organisations to undertake training in Certificate IV in Allied Health Assistance (physiotherapy and occupational therapy streams) at Bendigo TAFE. In addition, the AHAs undertook a skills set in community rehabilitation that was contextualised to the AHA’s individual hospital setting. A peer-support framework was also initiated to enhance the employees’ knowledge and enable benchmarking with other AHAs. The remote supervision model commenced in June 2012, trialling a range of supervision and reporting methods including face to face, email, telephone and videoconferencing.

Results: By the time of the Conference this project will be fully implemented and evaluated. To date thematic analysis of the baseline interviews of management and allied health staff has identified issues with economics, great expectations, gaps in service, communication, sustainability, community acceptance and the need to work smarter. Practical tools that have been developed and introduced include supervision logs, internal and external referral pathways, a model of peer supervision, videoconferencing accounts and equipment, as well as marketing tools and materials.

Conclusion and relevance/practical application: Although the final results of the evaluation are pending, the benefits of this model of remote supervision are already being realised with the participating health services exploring the expansion of AHA roles across disciplines and divisions. Another local rural health service has also already looked at replicating this model to assist with improving health outcomes for their community.

Future of the GP procedural workforce in rural Victoria

Veronica Fil¹, Jenni Baker¹
¹Primary Health Planning Services

Rural communities have historically relied upon the general practitioner (GP) to provide emergency care services, deliver babies and perform surgical and anaesthetic procedure. Rural areas face limited health workforce supply, and the GP procedural model is recognised for the multiple roles they play in rural health practices. However, they are an ageing cohort, and the number providing these services is declining.

In recognition of this looming workforce shortage and to boost the number of the available GP procedural workforce, governments are currently developing and investing in training pathways to provide incentives and opportunities for rural procedural work. But while there is already a body of research into the supply of the GP procedural workforce, the demand side has been largely ignored. Once more procedural doctors are trained, will demand for them still exist? Given the range of infrastructure, regulatory and demographic changes that may take place by this time, the answer is not so simple.

To help answer this question, we have commenced a study to explore the contextual environment impacting the future GP procedural workforce in rural Victoria. The first phase of this study will obtain a snapshot of the current rural Victorian GP procedural workforce (anaesthetists, obstetricians and surgeons) and develop a cohort profile including age, where they practice, incentives and barriers to practice, future intentions and explore any succession planning activity. It will also explore potentially under-utilised segments of the workforce such as overseas-trained doctors (OTDs) who currently possess procedural qualifications obtained overseas, but that are not recognised by Australian standards.

Phase two of the study will involve a qualitative demand analysis to forecast the future need for GP proceduralists in rural Victoria in five years’ time. Factors to be considered include: population...
projections, government policy initiatives and changes to infrastructures, as well as consider alternative models of obstetrics health care delivery.

The methodology of this study will involve four steps:

1. **Desktop research** exploring current issues, research, policy, initiatives, training pathways, graduate projections, and alternative models of service delivery.

2. **Survey data** to collect information such as cohort characteristics, frequency of practice, location, future intentions, succession planning mechanisms and incentives/barriers to undertaking procedural work.

3. **Consultation** with individual GP proceduralists, OTDs and regional service providers to explore emergent themes.

4. **Quantitative demand analysis** based on expert opinion, population projections, expectations of future infrastructure, anticipated government policy changes, and survey results.

This presentation will deliver an outline of the study and its methodology (including the background issues surrounding the rural GP procedural workforce), as well as a discussion of the research findings.

**University rural health placements: building social capital in a local community**

**Ian Woodley¹, Karin Fisher¹**

¹University of Newcastle Department of Rural Health

**Background:** The challenges to deliver high-quality educational and lifestyle experiences for rural health students that maximise student exposure to local communities are problematic. A university in rural New South Wales has implemented a strategy for community engagement that immerses rural placement students in a diverse range of cultural settings and invests in building the social capital of the local community.

The university has aligned its resources as a community asset to build a network of partnerships, providing over thirty programs for rural health students to engage in during 2012. These programs provide substantial foundations for practice in student learning and benefits for the health and wellbeing of vulnerable groups in the rural community.

**Methods:** A review of data collected over the period January 2011 to December 2012 was undertaken. The key result areas of engagement with students, organisations and communities will be analysed using descriptive statistics from data maintained in a database and spreadsheet.

**Relevance:** The program operates in a context where the breakdown of family and social structure have contributed to challenges for health professionals engaging with and providing primary health care education to vulnerable groups. In addition, there is an inability, hesitation and unwillingness of groups over-represented in poor health outcomes to engage with health and welfare service providers. The partnerships have contributed to a multi-point intervention concentrating on child development and health education addressing generational patterns of early adoption of risk factors.

**Results:** Short-term positive outcomes have been seen in three areas. There have been significant increases in participation of health students and the number of negotiated outcomes between academics and partners. There is a willingness of partner organisations to embrace and mentor rural health students while accepting their clinical limitations. The third outcome shows enhanced community leadership from members of vulnerable groups who take responsibility for program implementation in their community.

**Conclusions:** This innovative model of student placement has shown positive short-term outcomes for three key result areas. These positive results suggest that a different approach to student placement not only informs their practice but also builds social capital by mobilising community members to take a leadership role. This innovative project demonstrates short-term successes in building social capital in rural communities while providing a bright future for students and vulnerable communities.
Healthy Tums, Healthy Gums: nutrition and oral health collaboration supporting vulnerable families

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Nutrition and oral health share a co-dependent relationship. It is estimated that 50% of children aged 5 to 6 years have experienced some form of tooth decay, which is 70% more common in vulnerable groups. The Intensive Family Preservation Program (IFPP) is an initiative of NSW Government Family and Community Services that seeks to support vulnerable families at imminent risk of having their children placed in out-of-home care. In Tamworth NSW, case workers within the IFPP identified poor oral health and nutrition as prevalent preventable health risk for program children. This resulted in a partnership between Oral Health and Tamworth Dietetic Services to investigate appropriate collaborative support strategies for this demographic.

Semi-structured interview protocols were conducted with key stakeholders, including IFPP families, to identify nutrition and oral health education and the learning needs. Consultations confirmed key education areas in childhood nutrition and dental hygiene. Subsequently a five session oral health dietetic education program ‘Healthy Tums, Healthy Gums’, with pictorial resources was developed. Lower health literacy resources were a reoccurring theme in interviews, with IFPP families identified as having a third-grade literacy level. Due to the lower literacy needs of the group, the program employed education methods to facilitate empowering families, including:

- how to versus why
- the teach-back or show-me approach
- demonstrations
- key messages
- limited syllable words
- pictures and illustrations
- utilisation of practical strategies to convey messages.

The initial pilot has been completed. Results indicate that collaborative messages had the greatest impact on improving knowledge. Baseline results indicate that prior to education participants lacked knowledge of the practical links between nutrition and oral health, and childhood management strategies that significantly improved post-education, e.g. integrated relationship between juice, decay and fussy eating; and how to encourage water consumption.

Sustainable partnerships have been formed with the IFPP to deliver the program three times per year to each new cycle. The collaborative program helps build capacity for individuals, as well as all associated organisations, by ensuring appropriate consistent and current information is disseminated to the community. The program supports partnership building between dietetic and oral health services, which in turn strengthens the delivery of coexisting preventative nutrition and dental health messages. While initially providing the opportunity to explore the education and learning needs of vulnerable families on these topics, success has allowed a current project to evolve that is exploring the potential applicability of program information for supporting the broader rural community setting.

Bridging difference: using leadership development to address challenges triggered by changes in land access and use in rural Australia

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¹Australian Rural Leadership Foundation

Conflict about land access and use has become a burning issue for communities and industries in rural, regional and remote Australia. Issues such as control over the environment, respect for cultural values, economic viability, the nature of community, and quality of life are central to the health of communities. A critical factor in addressing the challenges that resource extraction poses in rural Australia is to establish respect and trust and an understanding of the needs and aspirations of all those who live and work in the area.

In recognition of the need to work from the basis of respect and trust, Blackwood Corporation (BWD), a start-up coal exploration company operating in central and outback Queensland, decided that it wanted to provide a legacy for the areas in which it is active by investing in their future. BWD decided that one of the most effective ways of doing so was to develop leadership capacity in all areas of importance to the local communities—agriculture, mining, Indigenous development, community resilience and environmental stewardship—in which it operates.

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To progress this initiative, BWD partnered with the Australian Rural Leadership Foundation and provided resources to enable the Foundation to design and deliver a leadership development program (the Blackwood Corporation Leadership Capacity...
Building Program) for 15 local individuals from the Surat Basin and associated areas to enhance the level and quality of leadership on important issues. Participants were selected from agriculture, mining, Indigenous development, community resilience and environmental stewardship throughout Blackwood’s operational areas.

To ensure that the program had broad support and was working with the interests of all sectors, endorsements and letters of support were obtained from key groups including AgForce, the Queensland Resources Council, Association of Mining and Exploration companies, and from state-level Indigenous leader, Ron Weatherall, Deputy Director-General, Aboriginal and Torres Strait Islander Services.

This paper provides an overview of the Blackwood Leadership Legacy Program, which focused on personal development, industry and regional issues awareness and improving strategic thinking. It describes the participants, their interactions and their evaluation of the program and its outcomes. It assesses the success of the program against the key objectives, which were to assist participants to:

- deepen their understanding and appreciation of the respective importance of mining, agriculture, environment, Indigenous issues and community in, and for, rural Australia
- develop strong leadership and management skills, including persuasion and influence, negotiation, facilitation, media engagement, and project management
- develop greater self-awareness and adaptability in terms of leadership approach, behavioural responses, and interpersonal style
- provide practical solutions to ongoing regional land access and use
- foster ongoing relationships for peer support across sectors and regions.

The paper assesses the Blackwood Corporation Leadership Capacity Building Program model, its impact on participants, and its outcomes. It also addresses its potential for its use in other areas or future projects where the nurturing of collaborative relationships between stakeholders is central to a win-win future-focused outcome, that underpins the long-term future and resilience of the region.

Purpose fit or fit for purpose: development resources for rural allied health

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Introduction: Literature has demonstrated that allied health recruitment and retention for rural areas is challenging and that professional support, supervision and mentoring links to retention. Rural and remote AHPs have higher development and support needs due to the additional challenges of diverse caseloads, increased service management responsibilities, professional isolation and limited access to traditional forms of support and professional development (due to time and distance). In response to these identified needs two programs were implemented by the Cunningham Centre in mid-2012: Flying Start Queensland Health (FSQH) and the Allied Health Rural Development Pathway (AHRDP). The two programs complement professional supervision and mentoring arrangements for rural and remote AHPs by providing the resources to support development from new graduate to mid-career professional level.

Method: The FSQH initiative was designed to meet the needs of new graduate allied health professionals across the state. The intellectual property was purchased from NHS (Education for Scotland) as an existing and proven successful online training system and then contextualised for Queensland Health’s needs. FSQH could be described as ‘fit for purpose’, as the need was identified and then a product purchased to meet that need.

AHRDP was developed by Queensland Health as an adjunct to a progression process and is focused on rural and remote AHPs. Despite a vast array of individually useful materials there was no framework or cohesive product available that met the training needs of the target group. A framework with support modules and development resources was developed in-house specifically to address the needs of these clinicians. AHRDP was therefore created as a ‘purpose fit’ resource.

Results/discussion: The learning and development frameworks for each program will be presented with their corresponding development and evaluation processes. Factors that have impacted on each program will be discussed, including:
• dedicated time for supervision and support activities
• timing the release of support resources to align with new standards and policy
• recognition of the specific high support and development needs of early career rural and remote allied health professionals
• contextualising existing products and developing tailor-made resources.

A brief outline of further work on these programs and other strategies to address the development needs of rural and remote AHPs will also be discussed.

Interprofessional, student-assisted clinics: a solution for neurological rehab in remote Queensland?

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¹Mt Isa Centre for Rural and Remote Health, James Cook University, ²Central and North West Queensland Medicare Local

In north-west Queensland there are concomitant challenges surrounding access to rehabilitation for people with neurological or ageing conditions, service and staff capability and allied health student clinical placement opportunities. An innovative service response saw the birth of the North West Community Rehab project. The project utilises a service learning model to provide previously non-existent neurological rehabilitation services to people of outback north-west Queensland. It features authentic, high-quality, specialist clinical and context teaching and interprofessional learning, in a vertically integrated education model designed to build the capacity of both the current and future workforce.

Fifteen weeks of person-focused rehabilitation programs were delivered in 2012, utilising students, locally based allied health staff and specialist neurological clinicians, and comprising activities spanning prevention, early intervention, post-discharge and long-term follow-up for people with neurological and ageing conditions. Interprofessional student pairs, local clinicians and specialist staff were exposed to a range of disciplines and their contribution to rehabilitation in a remote context, developing a deeper understanding of roles and appreciation of the potential for recovery and quality of life in the north-west. Additional allied health disciplines were engaged for staff education and services.

Demand for services was high, exceeding capacity for most programs. Participant, student and service evaluations were positive with overall program ratings high. Students valued the multidisciplinary opportunity, small teams and getting to know their clients over time and in context. They felt as though they were making a difference. The model builds capacity, leaves a legacy and illustrates the feature of a successful clinical placement program. The interprofessional learning was highly valued by all and provoked an extension on the possibilities for additional disciplines to be included. The intermittent nature of the service generated challenges overcome by collaboration between organisations.

The NW Rehab project experience demonstrates that innovative service learning models can facilitate access to quality services, upskill existing rural and remote professionals and provide extended, authentic clinical teaching and life exposure to health students. It has broader applicability in a range of areas of previously non-existent services, poor access or shortages. The vertically integrated, interprofessional education model has allowed locally based clinicians to upskill in neurological rehab, specialist clinicians to gain understanding of rural/remote and Aboriginal health contexts and students to have a unique, authentic, extended specialist placement in a remote area and most importantly, people to access a vital service.

Emerging health professions: an opportunity for rural health

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Background: The changing landscape of rural health requires innovative and unique solutions to address challenges in providing a health workforce to meet the needs of rural and remote Australia. The move toward ‘rural generalists’ across many health disciplines is an exciting and encouraging development, and is welcomed by those future health professionals looking to train and work in rural Australia.

Aims: This presentation will outline the factors that future rural health professionals seek in a training pathway, and how the emergence of new generalist health professions impacts on this. It will also outline
the National Rural Health Students’ Network (NRHSN) position paper on the emerging training pathways for all health professionals, and examine how this can be integrated into future practice.

Key points:

- Rural and remote Australia needs health professionals suited to the unique style of practice in non-metropolitan Australia. This often means practitioners must have a broader and more multidisciplinary scope of practice/care.

- Training pathways for health professionals need to reflect this need and provide rural-specific training opportunities for health students. This is crucial to encouraging innovative future rural health workforce members, and ensuring the current gap in health service delivery is appropriately filled.

- New training pathways need to be well advertised and communicated for students to be able to engage with them, as there currently appears to be a lack of knowledge about this growing area of health care.

- Clear training pathways into rural generalist practice are an important way of encouraging tomorrow’s health professionals to consider a rural career.

- Novel health professionals are an opportunity to develop and implement exciting new models of practice.

- However, new models of practice still need to be considered within the context of current practice, in order to ensure the most effective changes are achieved.

- Appropriate supervision needs to be procured for any new training model, as this will allow for the highest quality model to be generated.

Conclusion: Emerging ‘generalist’ health professions, new models of training and innovative ways of practising are attractive opportunities for future workforce members when considering a rural or remote career pathway. However, it is crucial that these new ways of training and working are well articulated and developed in concert with current ways of practising, to ensure they achieve their goals of improving rural health service delivery and reach their maximal success.

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**Partnership outcome: brain injury training and support program for Aboriginal and Torres Strait Islander health workers**

**Susan Gauld**¹, **Sharon Smith**¹, **Melanie Butler**², **Linda Georgetown**², **Melissa Kendall**¹

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Nationally, acquired brain injury (ABI) is a significant health and disability issue. In Queensland, the prevalence rate is 2.5% compared with the national average of 1.8%. More than one in three (34%) people with ABI reported five or more health conditions, compared with about one in eight (13%) of all people with disability (Australian Institute of Health and Welfare, 2007). The rate of brain injury for Aboriginal Queenslanders is three times higher than for non-Indigenous people.

Previous research (2006–09) conducted by our service in partnership with two Aboriginal and Torres Strait Islander communities in Far North Queensland resulted in the development of a service model that is supported by key Aboriginal and Torres Strait Islander health and disability service providers in Queensland. The model identifies a local worker/s with brain injury knowledge as being the key link between communities and mainstream health services, and as being a key support within communities for people with brain injury and their families.

The Acquired Brain Injury Outreach Service has developed a pilot brain injury training program in partnership with colleagues from an Aboriginal community in southern Queensland. This program aims to deliver brain injury education in the context of a community based rehabilitation (CBR) model (WHO, 2004) to Aboriginal health workers, while establishing relationships and partnerships with and among program participants to facilitate ongoing support after training. The program aims to build capacity within communities by having a number of people trained, who become a link within the community for people with brain injury and their families.

This paper will discuss the partnership that has fostered the development of this training program, as well as the unique relationship that has evolved with this community to further develop a CBR model for people with ABI and their families. In addition, further training in Queensland will occur within
different communities over the next six months, and evaluation outcomes will be reported. Components of this culturally relevant and interactive training program will be presented.

**The Torres model of primary health care—the gap between reality and rhetoric**

Christine Giles

Portland District Health in South West Victoria

The Torres Strait Health District in Queensland encompasses the five northern most communities on Cape York and sixteen island communities in the Torres Straits, a population of 12 000 with two-thirds identifying as Indigenous.

Indigenous health care is on every government’s agenda with the latest strategy ‘Closing the Gap’ currently in place.

Introduced in 1996 the Torres Strait model of primary health care was a paradigm shift in the way Indigenous health care was organised and delivered in the district. Why then, in 2009, on closer review, is it not working: local community control, governments committing funding, better than recommended health care workers to head of population, chronic disease management systems—it ticks all the right boxes.

Since its introduction the population health data shows little or no improvement in the prevalence of chronic disease, sexually transmitted infections or rheumatic heart disease. The health service lost ACHS accreditation in 2000, clinician turnover rates are high, morale is low. What was happening within the model to cause this?

The fundamental principles of the model are sound; however, the implementation in the district was flawed. In 2009 these flawed elements within the model where evident. Taking the model back to first principles, five areas where identified and refined:

- Defining what is primary health care—over a decade, as new funding was available, the model became a jumble of programs within programs with gaps and overlaps in service provision. Acute care, mental health, public health, and primary health were defined.

- Role and responsibilities reconstructed into a four-framework matrix with ‘Professional’, ‘Management’, ‘Clinical’ and ‘Cultural’ reporting lines identified.

- Introduction of a new electronic clinical record system to replace the end-of-life chronic disease management system. Review and streamlining of other core systems, including supply chain, maintenance, travel and asset replacement.

- Development of a clinical governance framework across all service streams with accountabilities for outcome measures assigned.

- Review and restructure of staff education to a competency-based program with mandatory competencies for all clinical disciplines and training for managers.

In 2011 the health district, all 21 primary health clinics, the two hospitals, mental health and public health achieved accreditation with ACHS.

While the initial picture looks encouraging, further reform is needed particularly in the areas of managers versus clinician. This requires strong leadership, community engagement, vision and a passionate workforce to ensure a generational change in how the peoples of the Torres Strait view their health and wellbeing. Federal, state and local political point scoring and over-inflated egos have no place in this ongoing journey.

**Shaping the National Disability Insurance Scheme for rural areas**

Denis Ginnivan

National Rural Health Alliance

The National Disability Insurance Scheme will formally start with five ‘launch sites’ on 1 July 2013, and is proposed to roll out to a full national scheme within the ensuing four years. This major initiative, based on an ‘insurance’ approach, will bring significant changes to the way in which people with disability and their carers interact with service providers and funders.

The Alliance is conducting a project, funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), to consult with people in rural and remote Australia on the best ways to connect and deliver access to services for people with disabilities living in rural, regional and remote areas. The project will focus on practical solutions to the special challenges facing people in those areas, to ensure that the NDIS is effective for rural people living with a disability and their carers and communities.
This presentation will describe the design and progress of the project, and generate further discussion of the ways in which the NDIS can best deliver in the future.

Aspects to consider include a rights-based approach; the experiences of people in the health sector providing services for people with disabilities; the potential role for rural and remote health service providers in the delivery of the scheme; economic security and affordability; and the opportunities for interfacing with health reforms such as needs-based planning through Medicare Locals.

Health promotion in fly-in/fly-out contracted workforce: a case for a ‘Wellness Watch’ program

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1Minerals Industry Safety and Health Centre, The University of Queensland, 2Medical School, ANU College of Medicine, Biology and Environment, 3Thiess Pty Ltd, 4Traverse Drilling International

Fly-in/fly-out (FIFO) mining workforce practices are currently the subject of a House of Representatives Standing Committee inquiry, and at the forefront of social media attention. A recent review of key themes arising from the inquiry identified potential impacts to health services in host and source communities as a major source of concern (AusIMM 2012). However, little attention has been given to the merit of characterising individual and workforce health needs to better inform this debate.

This paper presents a case for a pilot ‘Wellness Watch’ health surveillance program for a remote mining location in South Australia. The health impacts of the FIFO lifestyle on individuals—and the potential impacts of worker health on mine safety performance, efficiency and workforce sustainability—are significant public health issues explored. Related health literature reviewed alongside occupational, safety and health surveillance data services scheduled under various State legislative requirements, collectively informs the conceptual framework behind the pilot program design.

Recommendations are offered on how health professionals might collaborate with mineral resources researchers, industry representatives and policy makers to create a step-change in workforce health status in the mining sector. A wider, ultimate objective for the pilot program is that the program might act as a catalyst for a national industry-wide initiative.

The Core of Life Program—Tasmania’s Indigenous Early Childhood Development Strategy Partnership

Christine Goonan1, Anne Sweeney2

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Core of Life (COL) program is now a national unique culturally inclusive life-education program designed for youth, focusing on the realities of pregnancy, birth, infant feeding and early parenting. Interwoven throughout the program is the exploration of strategies to support the ongoing strengthening of family relationships within local communities, and in 2012, YFER embarked on a partnership with Tasmania’s Population Health as part of the ‘Closing the Gap’ National Partnership Agreements Indigenous Early Childhood Development Strategy for activities throughout communities in Tasmania, Australia.

Tasmania has one of the highest rates of teenage pregnancy in Australia, second only to the Northern Territory. The Tasmanian rate of births for 15–19 year olds is 27.1 births per 1000, significantly higher than the national average of 16.1. Additionally, communities in southern Tasmania such as Derwent Valley, Brighton and Glenorchy, are recording rates significantly higher than the Tasmanian average. The proportion of students who had experienced sexual intercourse has increased between 2002 and 2008 surveys of Australian secondary students. In 2002, 35% of students reported having sexual intercourse, with this proportion increasing to 40% in 2008. The COL program is targeted at young people at a stage when they understand the relationship between actual and possible events and may be experiencing their first sexual encounter.

COL is a targeted early-intervention program aimed at youth in grades 9–10, involving both male and females, and is part of a multifaceted approach that has been integrated with local service provision, and involved other key players currently addressing teenage pregnancy in Tasmania.

This presentation will explore the role out of the COL training program to over 60 Tasmanians working with youth and the flow-on provision of youth education sessions to male and female youth all throughout communities of Tasmania. The strengths of the program will be explored, including...
the Indigenous components of the program and also the advantages of having funded a local central 'champion' at the regional level via a COL Coordinator role for ongoing mentoring and support.

Photographic imagery will be included in this presentation to enable participants to view the rich experiences the youth and local facilitators explore and share together in promoting healthy, strong and respectful relationships while aiming to support the decrease of teenage pregnancy amongst youth in Tasmania.

Making Blow Away the Smokes DVD for Indigenous smokers—the journey and lessons learnt

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Objective: To describe the process of making a smoking cessation DVD for rural and regional Aboriginal smokers on the north coast of NSW, from concept through to production and distribution.

Background: Indigenous smoking prevalence is high in northern NSW. Audiovisual messages are useful for Aboriginal health promotion. The aim of the Blow Away the Smokes DVD was to provide a culturally appropriate self-help resource to be viewed at home, or with an Aboriginal health worker.

Methods: Community consultation occurred through the No Smokes North Coast Steering Committee, and Arts/Media Subcommittee. A working party was formed with a smoking cessation expert, Aboriginal project officers and a media expert to develop a brief and tender process to find a suitable producer.

The content of the DVD was based on consultation with the local Aboriginal community and stakeholders as recommended by Brady’s report Vaccinating with Videos and evidence from previous research. Script development was a collaborative process between the producer and the medical director, with feedback from Aboriginal community representatives. Salient anti-tobacco and cessation messages were designed to be positive, re-enforcing and build efficacy. A range of trusted community members, Elders, Indigenous role models, ex-smoking mentors and experts presented the messages. Animated sections were included for visual impact: to entertain, educate and change the pace.

The narratives of people’s own stories and community dialogues were unscripted, allowing for spontaneity and a documentary feel. The DVD contains an extra feature for maternal smokers.

Filming occurred over a two-week period with strong input from Aboriginal community members across the mid-north coast. The DVD was pre-tested with a convenience sample of nineteen community and health professionals. The survey instrument was adapted from a questionnaire used to measure Indigenous responses to TV anti-smoking advertisements.

Results: The DVD was highly rated on scales measuring believability, acceptability, relevance, cultural suitability and effectiveness. The DVD was launched in December 2011 and distributed across the north coast of NSW through Aboriginal Medical Services and community organisations, and a dedicated website. The website received 300,000 hits in the first six months of it going live. The DVD has received favourable reviews from both professionals and community members across Australia.

Conclusion: Blow Away the Smokes is a unique and effective health promotion product, which has been developed cooperatively with the local Aboriginal community and is suitable for rural and regional smokers to educate, inform, inspire and support smokers to quit.

Talk and Tucker

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This standalone health service is located some 260 km round trip from the nearest regional centre, making many support services inaccessible due to distance. Due to 12 completed suicides in an 18-month period, there was an identified need in the community for an intervention program that addressed social isolation, mental illness and could be delivered on a limited budget. The implementation of the 'Talk and Tucker’ program addressed social isolation and mental illness by encouraging new friendships, redefining a sense of self and identity, and building confidence and self-esteem. The program looked at the critical perspective focusing on social inclusion and its ability to develop a sense of future. It involved participants in designing a menu, preparing the ingredients, cooking and dining together in a supportive environment.
The core vulnerable group had indicated a lived mental health experience and demonstrated high levels of depression and anxiety, and some had incompleted suicide. All participants lived alone with no indication of any social support networks and limited or no family contact. This program was delivered over a six-month period involving 12 participants and cost as little as $400 for ingredients. The program was delivered by the family support worker and supported by different staff and volunteers each time.

Participants were informed on what constituted healthy eating and meal planning on a budget. To minimise costs the preparation and cooking took place at the service with simple menus. Participants learnt how to prepare and cook a meal, then enjoyed sharing stories around the dinner table. Volumes of conversation flowed through each stage of the program with a lot of incidental teaching regarding healthy choices, both mentally and physically, and it was evident that friendships were flourishing. The last session involved organising a Christmas dinner for staff; participants were excited to present what they had cooked and waited excitedly for positive feedback. It was during this last session that some participants decided they would gather to share a Christmas dinner rather than being alone again. Words could not describe how proud these people were to be involved, share stories about their lives and feel included. To date, all stay in touch and socialise together. Many participants had previously lead extraordinary lives, yet became disconnected from life due to lived mental health experiences. To see participants build friendships and reengage with society was rewarding for both staff and participants.

A working group had a competition to devise anti-racist slogans or symbols that might appeal to a broad spectrum of health students and professionals. A focus group considered the efficacy of the entries. The slogan was selected as it was a common phrase akin to ‘Close the Gap’ and because its acronym, STAR, was optimistic and versatile. The yellow STAR represents hope and the entwined stethoscope is a multidisciplinary health tool.

STAR was launched in mid-September at the Australian Medical Students’ Association Global Health Conference. This included the production of badges, stickers, a webpage, and Facebook and Twitter. Since then it has been intensively marketed to health staff and students’ organisations.

Relevance: We continue to receive feedback from staff and students that racism remains common in health study and services. Using touch pads in a class of 190, 21% reported observing racism in study settings and 93% had observed racism in clinical settings. Less than 7% reported responding to racism at the time, while 74% said they felt they should respond, but did not. Of these, 93% said they would like to learn the skills to do this. Reasons for not responding were ‘Not having the skills’ (36%), ‘Fear of backlash’ (61%) or because ‘It was not their business’ (3%). The school has been trialling educating students about the nature of racism, the skills to respond effectively and building moral courage.

Results: There are early anecdotal findings of the benefits of teaching that racism makes people physically sick and inferring ‘We would not tolerate smoking in health services—so why racism?’

Initial responses to the STAR Project have been exactly as hoped for—people ask ‘What is that for’ and when told almost everyone says ‘Where can I get one?’

Conclusions: The fate of the STAR Project will be clearer at the NRHA Conference. The interaction between staff and students has been an excellent base for helping students develop organisational and advocacy skills and to develop greater understanding of racism.

The STAR Project—Standing Together Against Racism

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Aims: The STAR Project aims to encourage health students and staff to shift from being bystanders of racism to ‘taking it on’. Another aim was to contribute to the national anti-racism strategy ‘Racism: It stops with me’.

Methods: Reports about racism come from students, staff and from anonymous polling of whole classes of students using electronic touch pads, including in rural areas.
Impact of an Aboriginal community governed project: adiposity and food intake of rural children

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In 2007–08 and 2011–12 the Many Rivers Diabetes Prevention Project (MRDPP) conducted a repeat cross-sectional designed study of the impact of a culturally acceptable health promotion program on the BMI, waist circumference, food intake, physical activity participation and diabetes knowledge of rural NSW Aboriginal children aged 10 to 14 years. Total participant numbers were 1620 in 2007–08 (16% Aboriginal children) and 1230 in 2011–12 (24% Aboriginal children). Other aims of this study were to establish if a multi-component, culturally acceptable health promotion program directed towards improved physical activity and food habits could be developed for Aboriginal children, and then identify the barriers to implementation and sustainability of such a program.

The MRDPP is an Aboriginal community governed program of research and health promotion delivered by a team of Aboriginal project officers to all children in the two participating towns on the north coast of NSW.

All variables were examined by Indigenous status, geographical location, and school year (primary school compared with high school). Associations between factors were also examined. At the time of submitting this abstract data, analysis is nearing completion and preliminary data shows the following between 2007–08 and 2011–12:

- A culturally appropriate health promotion program can be established, meets few barriers and is sustainable when initiated and governed by the participating Aboriginal communities.
- No statistically significant change in the mean BMI, mean waist circumference and prevalence of obesity for Aboriginal children. This is a very encouraging result, although these factors continue to exist at higher levels than for non-Indigenous counterparts.
- An apparent increase in the mean waist circumference of non-Indigenous children.
- Decreased intakes of sugary drinks among the general population, and among high schools students in particular, however this is not apparent in Aboriginal children.
- Decreased vegetable intakes regardless of Indigenous status.

These and the final results, including associations between factors, will be described, and the implications of these findings for future health promotion programs will be discussed.

An evaluation of the impact of practice nurse initiatives on cervical screening in rural general practice

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Cervical cancer is one of the most preventable and curable of all cancers, particularly if women are screened for precancerous cervical cells. Since the implementation of the Australian National Cervical Cancer Screening Program in 1991, the incidence of cervical cancer declined, from a peak in 1993 of 11 per 100 000 women, to 5 per 100 000 women in 2009. Of Victorian women diagnosed with invasive cervical cancer during 2008, at least 81% had either never had a Pap test or were lapsed screeners prior to their cancer diagnosis.

Reforms to increase access to general practice preventive health services over the past decade included initiatives to ensure practice nurses had capacity to undertake preventive health activities including Pap testing. Despite these reforms, the most recent recorded rates of two yearly Pap test participation in the Grampians region ranged between 53.4–54.8%, almost 8% lower than the overall participation rate (60.7%) and about 16% lower than the highest recorded participation rate (69.2%) for Victorian women.

The Grampians region is a geographic area in western rural Victoria that has a history in agriculture that is evolving as primary industry and the composition of rural communities change over time. Preventive screening for cervical cancer is a primary care activity that not only supports health outcomes for females in their local communities, but also the health of their families. Costs associated with morbidity and mortality due to cervical cancer include personal, family and community losses that result in physical, emotional, social and financial burdens.
The research incorporated a mixed method evaluation. Qualitative data from key informant interviews was coded, analysed and scrutinised for repeating and emergent themes to detect for flawed assumptions and explain unintended outcomes. Factors such as: the general practice business case, practice nurse capacity—including workforce and access to education, infrastructure constraints, cultural and professional mores and indemnity issues—inhibit PN-Pap activity in the general practice arena.

There are large amounts of data available that depicts ‘what is happening’ in general practice. This research delivers an evaluation that illuminates the mechanisms influencing PN cervical screening, with a focus on what works, for whom, how and why. It incorporates into policy, a greater understanding of the complex contextual nuances of general practice, through the integration of evidence from GP stakeholders in the rural Grampians region of Victoria.

Simple, sustainable advance care planning processes in the MPS aged care setting

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There is increasing evidence to support the importance of advance care planning (ACP) for people with advanced chronic disease. Peel Cluster in Hunter New England Local Health District (HNELHLD) has implemented standardised, sustainable (ACP) processes into routine care delivery for aged care residents in Peel MPS facilities.

An annual point prevalent survey identified that ACP process was not well implemented within Peel MPSs. A survey tool was designed to gather data on ACP training undertaken, staff awareness and knowledge of ACP and attitudes towards ACP in their work environment. Results identified that staff were confused by the variety of resources and forms available for ACP use and would prefer a standardised, cluster endorsed suite of resources.

A working group was formed consisting of a MPS manager, nurse representative from each facility, Cluster Palliative Care CNC, ACAT representative and the Cluster Practice Development Officer. Very clear governance and reporting mechanisms were established. The survey results were used to identify gaps and develop strategies to embed ACP practices.

The working group identified ACP processes and resources most appropriate for the MPS environment. Tailored ACP process training packages were developed for the following MPS staff groups in addition to existing ACP online education:

- administration
- health service support
- nurses/allied health/VMOs.

The training included an overview of ACP, use of identified resources and specifically their role associated with ACP in their facility.

Working collaboratively with the Tamworth Base Hospital ACP Steering Committee, (chaired by Tamworth Rural Referral Hospital’s (TRRH) Director, Rural Critical Care and consisting of local RAFCs, Division of GPs, UDRH, practice nurse and TRRH nurses), lead to the development and wide promotion of a cluster endorsed, standardised user-friendly ACP form.

ACP working party delegates became ACP Champions at their local MPS facility. The ACP survey was repeated post Champion support. The survey demonstrated improved staff confidence; increased ACP discussion with residents/family/carers and increased documentation of ACP discussions. The majority of surveyed staff responded positively to recognising and responding to ACP documentation. The annual point prevalent ACP survey identified a 60% increase in ACP documentation and process improvement in the Peel Cluster MPS.

The project’s success was due to increasing staff awareness of ACP, their role in ACP and the introduction of simple resources and processes that were formally integrated into routine care.

Breast Cancer Network Australia’s ‘Seat at the Table’ program

Julie Hassard1
1Breast Cancer Network Australia

Breast Cancer Network Australia (BCNA) is the peak national organisation for Australians personally affected by breast cancer. We empower, inform, represent and link together people whose lives have been affected by breast cancer. BCNA represents more than 73 000 individual members and 308 member groups from across Australia. Eighteen per cent of our members are from rural and remote areas.
and 31% of our member groups are based in rural and remote areas.

Our ‘Seat at the Table’ program ensures decision makers in the national and state health systems are connected to the experience of consumers—women affected by breast cancer and their families. We invite, train, appoint and support women who have had breast cancer to become BCNA consumer representatives. Our consumer representatives participate on committees and research panels across the country, and internationally, and contribute informed views to benefit women affected by breast cancer.

The program currently has 75 trained consumer representatives, with 18 (24%) of these living in rural and regional areas.

This extensive representation is invaluable in driving change and improvement for rural women. Living in rural and remote Australia can bring additional challenges for women with breast cancer, especially around access to treatment and services. Our rural consumer representatives have the experience and knowledge to navigate an experience of cancer treatment on behalf of women living in rural areas.

BCNA’s Seat at the Table program is an internationally recognised program. BCNA consumer representatives have worked with scientists, researchers, clinicians, health service providers and planners since 2000 to improve the provision of treatment, services and care for those affected by breast cancer.

Some examples of projects rural consumer representatives have recently been involved in include:

- Cancer Australia’s Rural Health Professionals Advisory Network
- providing feedback on a patient experience survey, part of a major surgical/radiotherapy trial (TARGIT) in Western Australia
- Cancer Australia’s Breast Cancer Spaced Education Initiative Working Group

The most powerful way to bring about change is to hear directly from the women who have experienced breast cancer. BCNA’s rural consumer representatives understand the issues important to rural women with breast cancer and can powerfully advocate on their behalf.

**Learnings from the Santa Teresa social and emotional wellbeing program**

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**Aim:** The aim of this project was to investigate the experiences of people involved in the development and delivery of the Santa Teresa Social and Emotional Wellbeing Program. Santa Teresa is a remote Aboriginal community that is relatively resource poor with a high prevalence of mental health problems. The knowledge generated from this project would help to improve the program locally, as well as provide important lessons for policy makers and service managers more generally regarding culturally appropriate, fit for purpose, sustainable programs.

**Methods:** A total of 21 people with different involvement in the program—such as program operators, program participants, and program referrers—were interviewed for the study. Interpretative phenomenological analysis (IPA) was used to analyse the interview transcripts.

**Relevance:** Indigenous Australians are twice as likely as non-Indigenous Australians to report high or very high levels of psychological distress. It is important that attempts to address the social and emotional wellbeing of Indigenous Australians are relevant and appropriate to local contexts.

Santa Teresa is an Aboriginal community of more than 500 people that is located approximately 80 kilometres south-east of Alice Springs. In response to significant and serious events in the community, such as suicides and relationship violence, a social and emotional wellbeing program was developed. After the program had been running for four years, an independent evaluation was initiated to understand what people’s experience of the program in the community had been.

**Results:** Two major themes and nine sub-themes were developed from the interview transcripts. The first major theme was called ‘the big picture’ and it had the sub-themes: getting started; organisational factors; funding; the future; and operational problems. The second major theme was called ‘on the ground’ and it had the sub-themes: personal
struggles; program activities; measuring outcomes; and results. Generally, the program had been experienced positively in the community; however, important lessons emerged during the implementation of the program.

Conclusions: While the evaluation demonstrated that the STSEWBP had been experienced as an effective local response to serious problems, recommendations emerged that were more broadly applicable than the local context of Santa Teresa. The evaluation, therefore, as well as indicating that the STSEWBP was experienced positively by local people, also provided suggestions to be considered at a policy and organisational level to assist with a more widespread adoption of local and effective responses to community social and emotional wellbeing problems.

Pilbara Healthy Kids Initiative: a proactive response to primary health needs

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Northern and Remote Country Health Service

Background: The Pilbara Healthy Kids Initiative was developed late in 2008 by the Pilbara Population Health Newman team in response to the need to achieve better outcomes in Aboriginal health. The initiative was generated by a small team working remotely and expanded into a project that now covers a large section of the Pilbara, based on core primary health care principles such as: access, equity, early intervention, disease prevention and health promotion.

Research indicators and anecdotal/narrative information collected by staff had pointed to declining health standards among Aboriginal children in the Pilbara—across a range of health indicators such as weight, nutrition, skin, teeth, hair, eyes and hearing. The team determined that a combined health promotion and fun approach to these health issues would achieve more than individual/family consultations.

Project aims: The Healthy Kids Initiative aims, through delivery in remote Aboriginal communities and small towns, to:

- provide essential education to families to help promote healthy lifestyles for their children
- provide a platform to engage the local community on matters of health and demonstrate staff roles
- allow parents/caregivers to ask questions about the health of their child in a relaxed, non-threatening environment
- give the children an enjoyable, fun day
- build collaborative partnerships with Puntukurnu AMS, Wirraka Maya AMS, RFDS and with industry partners such as BHP Billiton.

Project outcomes: Project outcomes have included:

- increased recognition of services provided within communities
- informal yarning with family about staff roles and engaging community members and organisations
- messages through actions and modelling, less through words and language
- children experienced new play and learning through a variety of media and toys and demonstrated knowledge of healthy actions and lifestyles
- collaboration and partnership works effectively in remote areas, with services appropriately targeted to priority areas and delivered where people live
- upskilling staff to provide culturally safe and secure services.

Key learning: Four years of hard work by PPH teams has demonstrated that the Healthy Kids Initiative is a project that requires long-term commitment from staff to achieve long-term meaningful change in health behaviours as a means of reducing chronic disease.

Ongoing commitment (some staff have been involved since project inception); project evaluation and service review; and community engagement and capacity building are vital components in building bright health futures for Aboriginal families.
Heywood Rural Health and Winda-mara Aboriginal Corporation: better client outcomes through partnerships

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Introduction/background: In 2011, a small rural health service and its local Aboriginal Community Controlled Health Organisation (ACCHO), supported by the local Primary Care Partnership, took part in the Plan, Do, Study, Act (PDSA) Model for Improvement Project run by the Department of Health Victoria.

The two health providers are situated in the small town of Heywood, located 350 km west of Melbourne and with a population of approximately 1300. The town was originally a saw-milling area and is service centre for the local agricultural and pastoral industry. In the 2006 census, 5.0% of the Heywood population were Indigenous persons, compared with the national proportion of 2.3%.

The small rural public hospital and aged care facility, which provides a range of primary care and allied health services to the community. The ACCHO is also based in Heywood and provides services to approximately 600 Indigenous people across Heywood, Portland, Hamilton and surrounding areas. The overlap in clients serviced led to the need for the two health providers to work together more closely.

Methods: Recognising that for clients with chronic conditions, communication is pivotal to ensure quality outcomes, the original aims of the project were to enhance communication between the two services, and the GP, and to increase referral and uptake of service provision by the occupational therapist by the ACCHO.

Several challenges were met during the project time frame. Staff changes within all three organisations meant that continuity in the project team became an issue. There were continued challenges in finding face-to-face meeting opportunities with key stakeholders, due to part-time working, consultants, and geographical constraints. The PDSA methodology allowed us to reflect on changes that were taking place and respond to local needs. It became clear during the project that the development of a strong partnership was pivotal to the introduction of any other initiatives and this quickly became our focus.

Results: Key achievements of the project include:

- Service coordination policy and procedure in place: The policy was introduced and has been embedded at the small rural health service. This took time to embed, but was achieved through education, and by keeping the policy on the agenda at regular meetings.

- Robust feedback pathway: During a roundtable discussion, we identified a problem with the feedback forms returning to the GP at his main clinic, rather than at ACCHO. Once the problem was identified, we were able to fix it, by clearly identifying which requests were coming from the ACCHO and indicating that the results should return there.

- Stronger partnerships: Our greatest achievement from the PDSA project has been developing strong partnerships between the organisations. So far, this partnership has extended into other ways of working together, such as dietetics services, community-based work such as the local Men’s Shed, and walking across the bridge for NAIDOC week. CEOs of both organisations have formed a better relationship and are supportive of these initiatives.

Conclusions: This project serves to highlight the importance of developing strong partnerships prior to embarking on collaborative projects. While senior management support is important, engagement through all levels of staff develops trust and helps to build relationships that will enhance future working opportunities. By sharing resources and services, and encouraging collaboration, clients, particularly those with chronic conditions, will experience a more coordinated health service and better outcomes.

Mental health trajectories in three cohorts of women: are there urban/rural differences?

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Introduction: Evidence from a number of epidemiologic studies indicates that rates of
depression in women increase until about the age of 45, then decrease until they are in their mid-80s, at which time there is a small increase. Women in rural areas are more likely than urban women to experience depression across the lifespan. The aim of this paper is to compare the trajectories of depression in three cohorts of women to ascertain if there are any urban-rural differences.

**Methods:** Participants were drawn from the Australian Longitudinal Study on Women’s Health. Data from all surveys from the 1973–78, 1946–51 and 1921–26 birth cohorts were used. Measures of psychological distress were self-reported doctor-diagnosed depression (DDD) and the mental health (MH) subscale of the SF-36. An MH score of less than 52 was regarded as signifying psychological distress.

**Results:** Trajectories of doctor-diagnosed depression increased in the 1973–78 and 1946–51 cohorts over time, in contrast to the proportion with an MH score <52, which decreased over time in all cohorts. In the 1973–78 cohort DDD increased from 13% in survey 2 to 17% in survey 5, while MH <52 declined from 22 to 14%. The corresponding figures for the 1946–51 cohort were 10 to 13% and 15 to 12%. While for the 1921–26 cohort DDD remained constant at around 7% and MH<52 declined slightly from 10 to 9%. These trends were evident for urban, regional and remote women with no rural–urban differences apparent.

**Conclusions:** These results indicate that more women are being diagnosed with depression, which is apparently being successfully treated. The lack of difference between urban and rural women suggests that rural women are not disadvantaged in access to appropriate health services and treatment options.

**Securing the future: retention of older health care workers**

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The workforce shortages in the Australian health care system are well documented. These deficiencies are more evident in rural and remote areas of Australia and encompass most health care professions, including doctors, nurses, allied health professionals, and other health workers. In response to a rapidly ageing population, this shortage is likely to increase, placing pressure on the health system. However, while recruitment to rural areas has been a high priority in the past decade, the average tenure for these workers is low. Coupled with the shrinking supply of younger workers, retention of older health care workers will be significant in diverting an imminent rural health care crisis.

Utilising a sequential mixed-methods design, this study explored the factors that affect older employees’ decisions to work within the rural public health care system until traditional retirement age and beyond. The theoretical framework underpinning the research is the effort–reward imbalance (ERI) model, which postulates that strain results when employees perceive an imbalance between work expended and rewards received. In the first stage, survey data was collected from 299 women and men aged over 55 years working as nurses or allied health care professionals within the Hume region in north-east Victoria. Here the relationship between ERI and psychological strain was explored. In the second stage, interviews were undertaken with 18 health care workers from within the original survey cohort to further explore psychosocial factors that may affect retention.

Findings from the first stage confirm that those employees who experience high effort–reward imbalance also experience significantly lower levels of psychological wellbeing. Limited access to rewards associated with financial compensation, esteem and career opportunities were more important to this older cohort of workers. High efforts were also related to psychological strain. Further, qualitative interview data indicated that retention was negatively influenced by both increasing workload pressures and organisational constraints, and feeling valued by the organisation was a key factor in decisions to remain in a current position. Together, both sets of data provide a comprehensive analysis of factors that affect retention rate of older health care workers. These findings provide a basis for considering how governments and rural health care organisations can begin to address current and future rural workforce shortages at an organisational level.

**Our community taking our Health In Our Hands**

**Paul Holmes¹, Mary Holmes¹**
¹Health In Our Hands Information and Resource Centre Inc

Health In Our Hands is a community-owned health and information centre, managed, driven and manned entirely by volunteers. It provides the community with options for making lifestyle changes
and self-management of chronic disease. It has been operating within the community for ten years.

Chronic disease self-management and in particular the Stanford model is the driving force of all the centre’s activities. The centre holds a multi-licence for the Stanford model and has two T Trainers who have trained several hundred, including health professionals, leaders for these programs. Some peer leaders are also participating as facilitators for the online CCSMP program currently being offered in the USA. Using its peer leaders the centre is able to run programs such as the basic Stanford Chronic Disease Program, Stanford Pain Self Management Program and the Stanford Diabetes Self Management Program with other short health-related sessions also available. The centre works closely with local health services and the local campus of the University of South Australia by providing services, support and assistance in many projects.

Over the past ten years the centre has identified many opportunities to provide community members with the opportunity to take part in activities highlighted within the self-management programs; these include Tai Chi, simple exercises, relaxation, walking groups and other social but health-related activities. These programs are conducted by the volunteers who have undertaken many hours of training in order that programs are delivered correctly and safely.

Health promotion is a key role played by the centre; it has for nine years written and continues to write a fortnightly article for the local newspaper providing health-related information based on healthy living and lifestyle changes and promoting its services. Utilising the internet the centre runs its own website and has a presence in other social media outlets.

Volunteers work at the centre, which opens five days per week, in a room provided by the local hospital, and most of the services are conducted there but some services are now being run at other community locations to minimise client travel. Of the average sixteen volunteers, four have received ten-year service awards, with all but four having five-year awards.

Our presentation will demonstrate how a small group of determined community volunteers with very limited funding can, by working in partnership with other providers, contribute to major health outcomes both locally and nationally and indeed globally.

What soap is to the body, laughter is to good health

Mary-Jane Honner
Royal Flying Doctor Service Central Operations

Instead of becoming overwhelmed by something, laugh. A good giggle has a number of benefits, including reducing stress. It’s proven to be better than a bar of chocolate and a hearty belly laugh will produce a nice six pack, as a 100 smiles is equivalent to slogging away on the treadmill for 15 minutes!

RFDS decided to test the case that a laugh can create a new perspective to a problem and give a psychological distance that allows you to look at situations in a lighter and less threatening manner.

RFDS Central Operations provides primary health care to a number of rural Australians across both SA and NT.

The test, comedy HealthPlays—one about diabetes and the other depression. Both are serious health problems: diabetes is the fastest growing chronic disease in Australia and depression a silent stalker affecting so many.

The aim was to increase rural Australian’s knowledge of diabetes, depression and ways of preventing or managing these health issues.

The tour was successful in terms of the number of people attending and participation in the question-and-answer sessions post-play. Did the plays make people laugh? Yes. Can a good giggle be interpreted as an audience understanding the key health messages enough to seek a health check-up and/or make changes to their lifestyle?

The challenge was how to best evaluate the impact of the HealthPlays and ensure the results were meaningful for further service planning and ways to promote health messages in rural and remote areas where people are time poor.

An evaluation of which respite options work best for people with dementia and their carers living in rural NSW

Mary Hoodless
Greater Hume Aged and Community Services

Introduction: Carers of people with dementia are becoming increasingly dissatisfied with the quality, flexibility and availability of respite care. Lack of choice and failure to support consumer-directed or
person-centred respite services that are responsive to individual and carer needs are the main reasons for under use of many respite services.

Dementia, Australia’s ninth National Priority Area, is a serious chronic, usually progressive disease, often with complex physical co-morbidities as well as psychological and behavioural symptoms, requiring increasing demands on carers and family members. The literature has highlighted a gap in knowledge regarding effective and supportive community-based programs within a rural context. Moreover, current policy and program funding is based on traditional models of day activity programs and short breaks making it difficult for organisations to sustain innovative consumer directed programs. Greater Hume Aged and Community Services (GHACS) provides respite services across the Albury, Corowa and Greater Hume Shires in Southern New South Wales. GHACS responded to consumer choice providing innovative person and carer-centred recreational and artisan respite programs; however, funding criteria and policy are constraining their efforts. To address this they sought dementia services evaluation research funding from the Dementia Collaborative Research Centre—Assessment and Better Care (University of New South Wales) with the aim of informing policy and improving services for people with dementia, carers and families.

Methods: Theoretical propositions were drawn from Bamford’s (2009) study of methods to evaluate the effectiveness of respite services. The propositions were adapted to an Australian rural community providing a framework for ordering and analysing the data. Data was collected using guided interviews with people with dementia, focus groups with carers, and carer and service provider surveys. Data analysis was undertaken using an interpretivist approach interpreting the findings within the framework proposed.

Results: Collection of data is being undertaken from October to December 2012. The findings will be analysed and available from March 2013.

Involving people with dementia and their carers in all aspects of research is increasingly recognised as essential to inform services and care. Supporting participation in research will assist to overcome much of the stigma associated with dementia and also reflect their value within society and their equal right to participate in research.

Increasing community capacity building—the Dungog Eat Well Program and Community Kitchen Partnership

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The “Dungog Eat Well” (DEW) program was funded by the Commonwealth for three years to provide a dietetic service to the Dungog Shire located in rural New South Wales (population 8500). The program was established to provide individualised and group nutrition therapy to members of the community at risk of chronic disease. In addition to this, increasing community capacity building was considered an essential outcome of the program. Hence collaborating with pre-existing and trusted services was considered a high priority for community engagement and sustainability.

A partnership was formed with the service coordinator of the Dungog Shire Community Centre (DSCC), who identified a high proportion of families receiving food vouchers on a regular basis. A literature review identified a suitable program called Community Kitchens, which was initially developed in Frankston, Victoria in 2004 (communitykitchens.com). A planning meeting was held with DSCC coordinator, representatives and mentors and a program overview was developed. Recruitment initially focused on women from disadvantaged backgrounds, but also included general community members. Mentors were recruited from the local Anglican Church; Country Women’s Association (CWA) and included a retired home economics teacher. The local Anglican Church agreed to the use of their kitchen and cooking equipment.

Over a period of three months, eight sessions were facilitated by the DEW dietitian in conjunction with the mentors. Session topics included how to identify suitable healthy recipes, general healthy eating presentations and a supermarket tour. The participants also prepared, cooked, consumed and discussed meals in a group setting.

Findings from the pre- and post-program evaluation identified that the participants improved their skills, knowledge and confidence regarding healthy eating. The most notable and less expected outcome, however, was the positive shift in feelings of community involvement and socialisation. Mentors especially felt a bridge had been built between a generation gap and unexpected friendships formed.
To date, the Dungog Community Kitchen continues to be facilitated by the original mentors and members with minimal dietetic involvement. The program has further been adapted to suit the needs of the group to ensure ongoing sustainability. This has included babysitting by the local childcare centre, the establishment of a Facebook page and using fresh produce from the recently grown community garden.

Overall, the introduction of a community kitchen into the Shire of Dungog was a success and an alternative health model that increased the capacity of residents to improve their nutritional status with minimal input from dietetic services.

**Disengaged services and disempowered rural consumers: Implications for NDIS in the bush**

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**Aims:** The aim of this study is to assess key issues in service provision for families of children with developmental disabilities living in rural areas. A particular focus is on challenges of appropriateness and adequacy of support services in meeting the needs of rural clients.

**Methods:** The overall project used a multi-method research design, including postal surveys and in-depth qualitative interviews with parents of children with disabilities residing in northern rural NSW. This presentation focuses on findings from the qualitative component.

**Relevance:** Children with disabilities who live in rural Australia are doubly disadvantaged: first, by having a life-long disability; and second, by living in an Australian region that has limited services and opportunities. Given the debates around the implementation of the National Disability Insurance Scheme (NDIS), the findings from rural studies, of which there are very few, are useful in understanding the challenges associated with service provision from the consumer perspective.

**Results:** The overall parental perceptions were of fragmented and overly bureaucratic services, and disengaged service providers who were unsympathetic to the considerable needs and unique challenges of rural families. Some of the major themes included:

- **Lack of information**—Many rural parents were not made aware of types of services and eligibility criteria.
- **Bureaucratic barriers**—Parents reported a maze of bureaucratic processes to access even basic services. Often they had to provide the same information on multiple forms across different agencies.
- **Lack of training**—Health and other service providers, with a few notable exceptions, were perceived to have inadequate training and experience for their respective roles; and were reported to lack empathy for rural clients.
- **Fear of retribution**—Parents were ‘apprehensive’ of voicing their dissatisfaction with quality of services for fear of punitive action and withdrawal of few available rural services.

**Conclusions:** The study provides insights into consumer (parental) perceptions of inadequacy of support services and attitudinal issues of service providers. Policy makers need to focus on both increased availability and better integration of relevant support services, as well as commit to improvements in pre-service and ongoing staff training and professional development that is cognisant of perceptions and needs of consumers in rural areas. Implications of the present study for service provision for rural clients under the National Disability Insurance Scheme (NDIS) will be discussed.

**Analysis of roles and training needs for regional eye health coordinators**

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**Aims:** To define the key roles and training requirements for regional eye health coordinators (REHCs) and eye health workers (EHWs), and outline the process of recommending an ‘eye care skills set’ for national adoption and endorsement by the Community Services and Health Industry Skills Council (CCHSC).

**Methods:** A questionnaire was administered to all REHCs and associated personnel involved in eye care services to Aboriginal and Torres Strait Islander (Indigenous) communities across Australia.
survey determined REHCs’ typical job tasks, frequency of each task, priorities for training for new recruits to REHC positions.

Results guided the development of suitable competency units for a national REHC training package. This development process was undertaken collaboratively with a RTO for Aboriginal health workers (AHWs), and CSHISC.

Relevance: Despite widespread acknowledgment of the pivotal role of REHCs in delivery of effective and appropriate eye care for Indigenous communities, appropriate training has never been nationally endorsed for this cadre.

Hence, this represents vital work, by defining the core practice skills and establishing under the revised 2012 Health Training Package the eye care skill set for REHCs.

Findings have direct and tangible outcomes for REHCs, and therefore potential to contribute to improved vision care outcomes for Indigenous Australians.

Results: There were 35 respondents (17 REHC, 18 AHWs). The top roles, under three categories, rated by two-thirds of respondents as being very important for a new recruit to be trained in were:

- eye care knowledge/skills:
  - taking retinal photos (76%)
  - taking spectacle measurements and helping patients chose frames (69%)
  - interpreting retinal photos, measuring visual acuity and developing educational material (65%)
- organisational tasks:
  - referring patients with diabetes for a dilated fundus exam, organising diabetes screening and maintaining patient lists (79%)
  - scheduling dates for the visiting optometrist (69%)
- patient education:
  - explaining eye conditions (71%)
  - lifestyle and eye and explaining surgical procedures (65%).

By applying the detailed findings, an ‘eye care skills set’ was developed, with accredited units reviewed and improvements suggested to ensure the skills set package best aligns with the training needs of REHCs.

Conclusions: By understanding in detail the job tasks and training needs of current REHCs, an ‘eye care skills set’ training package has been recommended for national endorsement. Uptake of such training is likely to ensure a standard level of competency and confidence among REHCs, thereby contributing to improved job satisfaction, retention, and ultimately better capacity for regional eye care coordination.

Australian Medicare Local Alliance placing telehealth support officers

Janelle Jakowenko1

1Australian Medicare Local Alliance

The Australian Medicare Local Alliance, through funding from the Department of Health and Ageing has been able to place 13 telehealth support officers (TSOs) throughout Medicare Locals (MLs) around the country. A further six MLs independently obtained funding through the same tender. Since their placement, beginning July 2012 valuable lessons have been learnt about uptake of telehealth in rural general practice. These include using simple technology, developing a sustainable model by introducing regular telehealth clinics and when possible consulting with their usual specialists. Those who have championed the new method of clinical care have been young, old, techno-savvy and techno-phobic—the one thing they have in common is the willingness to enact change for the benefit of the patient. The use of videoconferencing in rural general practice goes far beyond clinical benefits. Clinicians can link up with colleagues, education providers and collaborative care teams, improving the retention of a rural workforce.

Make a mark: using art to educate youth about problem gambling

Stephanie Jelbart1

1Bendigo Loddon Primary Care Partnership

This paper will outline the process taken to develop, implement and evaluate a project for young people using art as a medium to address the social determinants of problem gambling. Data will be presented to demonstrate emerging statistics that warranted this project: the successful outcomes; the
evidence that highlights how resilience against problem gambling by young people can be built into school curricula; and how the arts can effectively be used as a tool for engaging, mentoring and educating young people about decisions that affect their health.

Bendigo Loddon Primary Care Partnership implemented an upstream integrated health promotion project in 2012 that addressed the social determinants of problem gambling—specifically the development of protective factors such as financial education, social connectedness and community engagement. The Bendigo Loddon Primary Care Partnership is a system of autonomous health and community service organisations and local governments in Greater Bendigo and Loddon, Victoria. This partnership of organisations came together in 2000 to improve the health and wellbeing of people in the area by working with one another, supported with funding and a policy framework of the Victorian Government. Our partnership covers a broad landscape of 9700 square kilometres of rural and regional Victoria. Our service system provides services to over 108 000 people within our catchment.

The project, funded by the Department of Justice, was in response to emerging evidence that young people, particularly young males, are engaging in internet gambling, with evidence stating that this can lead to problem gambling. Problem gambling affects individuals, families and the community. From relationship breakdown and financial crisis, to individual anger, anxiety and depression, the effects of problem gambling are vast and varied.

The project was a cross-curriculum approach, to educate students about the effects of problem gambling. It also aimed to enhance their social connectedness using the arts as a medium to provide an alternative to unhealthy financial activities and opportunities to think creatively. Participants were mentored, not only by a professional artist experienced working with young people, but also by a Gambler’s Help community educator, the class teacher, and mentors from a local youth group. The culminating outcome was an exhibition of the participant’s artwork—a reflection of their journey—displayed in a prominent position within the Bendigo Bank Central bank foyer, coinciding with Responsible Gambling Awareness Week in Victoria from 14–21 May 2012.

Results from participant surveys highlighted an increase in participants’ confidence in their ability to think creatively and to manage their money. Young people indicated they knew what to do if they or someone else was affected by problem gambling and felt more assured about making a positive mark on life. Further to the surveys, qualitative data collected from the participants indicated that this project had made a significant difference to their life.

To highlight the success of this project and commitment to this approach, the Bendigo Loddon PCP is creating a Resource Kit during 2012–13, which packages the project to enable transferability to other communities. Professional education will also be offered with this kit.

The Palliative Care Quality Improvement Project in regional WA

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Background: Palliative care across regional, rural and remote (RRR) Western Australia (WA) is varied and faces many challenges such as a declining and often transitory health workforce, a developing trend towards service centralisation, and the state’s unique geography.

To help address these concerns, the Palliative Care Outcomes Collaboration (PCOC) partnered with the WA Cancer and Palliative Care Network (WACPCN) to develop a quality improvement project that aims to assist health care services develop, improve and sustain quality palliative care delivery and patient outcomes throughout RRR WA, at minimal cost to the services.

The project involves improving the clinical skills of RRR health professionals who provide care for patients in the final phase of their lives and the development of a collaborative network of health professionals to ensure skill sharing and a coordinated approach to care.

Aim: We will provide an overview and evaluation of this regional palliative care quality improvement project.

Method: Regional palliative care managers (RPCMs) will facilitate the embedding of PCOC’s clinical assessment tools and the WACPCN’s WA Icp (Liverpool Care Pathway) into practice. RRR non-specialist palliative care providers will be trained in the use of the tools and pathway, and be supported to use them routinely when caring for people at the end of life.
The program is being rolled out throughout regional WA over an 18-month period in three phases: Phase One—Clinical tool education and integration; Phase Two—Data collection and extraction; and Phase Three—Data reporting and review.

Integral to the success of each phase is the ongoing review and evaluation of the project; active involvement of the RPCM; and continual support to the RPCMs by the project team.

Results: We will report on the progress of the rollout and the benefits and problems encountered in the implementation. We will report on the findings of case analyses used in the audit process and changes in practice reported by local health professionals.

Conclusion: This quality improvement project supports RRR health care providers to identify and assess their palliative patients’ needs and plan care in a more confident, timely and appropriate manner. Since rollout, the project has also engendered greater partnerships and capacity building of all health care professionals and services involved, which we envision, on a state level, will further support quality care provision and the seamless transition of patients between services.

The online intervention was designed to increase social inclusion, and enhance members’ sense of community and connection through participation in a range of activities, including online chat, blogs, community forums, video streaming, and games. The program has been evaluated with participants across a range of illnesses/disability, age, gender and socioeconomic status from metropolitan and regional areas of Australia utilising online surveys and focus groups, participant interviews, observations, and content analysis of transcripts and the website.

Focusing on the development and evaluation of a national online moderated social support program for AYAs (10–21 years) living with a serious illness, chronic condition or a disability the evaluation investigated: (1) the ways in which participation in the intervention impacted on members’ wellbeing, sense of identity and embodiment; (2) the role of moderators in supporting and maintaining a cohesive online community; and (3) ways for improving the delivery, member benefits, and longevity of the program. The results demonstrated that the intervention enhanced participants’ psychosocial outcomes, provided members with a strong support community, and encouraged greater acceptance and integration of members’ illness and/or disability with their identity. The results were stronger for those members experiencing higher levels of isolation from peer-based support communities. Based on the evaluation the program has recently undergone a series of changes, expanding its membership to include United States and Canadian AYAs living with a serious illness or disability.

The role of an online community in improving the wellbeing of geographically dispersed young people living with an illness or disability

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1Starlight Children’s Foundation

Online social support is a valuable resource for connecting, supporting and empowering young people who are living with an illness or disability and who are unable to access traditional means of peer-based support. In 2008 an online community was established to respond to the needs of adolescents and young adults (AYA) with a serious/chronic medical condition who were experiencing isolation from their peers and community. The issue of isolation was particularly evident for AYAs living in rural communities. An increasingly centralised model of specialised acute care meant that many AYAs were hospitalised away from their home community. Returning home was often challenging as it interrupted positive relationships developed in hospital with peers facing similar issues. Decreased energy, demands of care and time spent recuperating also impacted on their relationships at a time when these were crucial.

Community–Campus Partnerships and service learning: harnessing untapped potential for rural Australia

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1Broken Hill University Department of Rural Health, The University of Sydney, 2The University of Sydney, 3Broken Hill City Council

Introduction: Far western NSW experiences poorer outcomes across the social, economic and health determinants. Discreet health activity alone is not enough to address the complex inequities experienced across the region. Regional communities are becoming involved in critically appraising existing services and designing more sustainable ones.

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Aim: This paper aims to describe the evolution of Community–Campus Partnerships in far western NSW.

Method: The project used developmental evaluation to conceptualise the issue and applied an iterative process to generate options, test them and refine the innovation.

Relevance: Community–Campus Partnerships and service learning are well represented in the community engagement and higher education literature across many western countries. The approach draws on the educational pedagogy of service learning and value of place-based solutions. Partnerships seek to enhance regional development and sustainability while endeavouring to address the broader social and economic determinants of health and wellbeing.

These relationships provide fertile ground for student and academic learning, teaching and research while establishing an ethos of service and enhanced understanding of rural communities. Rural communities are empowered and actively engaged in providing leadership and direction of activity.

Results: The far west region, in collaboration with the University of Sydney, has established a Community–Campus Partnership to extend the current Broken Hill University Department of Rural Health engagement from health to non-health disciplines.

To date students and academics from across the disciplines of business (n=17), architecture (n=11), agscience (n=1) and education (n=12) have engaged in service learning activities within the region. Engagement has focused student and academic knowledge, skills and enthusiasm on ‘real world’ problems and opportunities for remote communities.

Participants have worked in partnership with local councils, businesses, health, Indigenous and community agencies, providing much needed human capital. Additional partnership programs are currently being negotiated in the areas of social justice, law and engineering.

Conclusion: There are potential workforce benefits in attracting new graduates from across multiple disciplines back to the region. In addition, there are benefits from participating academics providing support to existing professionals working in isolated communities. Community–Campus Partnerships bring with them great potential that can draw on the wealth of knowledge, skills, and human capital within academic facilities and integrate this with regional expertise, resilience, innovation and commitment.

Medical training and the point of conception of a rural doctor: a longitudinal study based on the MSOD project

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Background: The decision to become a rural doctor may be formed at one or more points during a doctor’s upbringing and training and may be revisited at any time during their subsequent career. It remains unknown at what point during their training medical students develop an interest in rural medicine and this knowledge may lead to insight into what aspect of training is most influential.

The aim of this study was to identify, on a national basis, changes in interest by medical students in rural practice during the course of medical training and to isolate the point that most strongly correlates with eventual attitude to rural medical practice.

Method: The Medical Schools Outcomes Database and Longitudinal Tracking (MSOD) Project currently follows all medical students in Australia and New Zealand from commencement of studies through to the first postgraduate year (PGY1), although further follow-up is currently under way. Preferred location of practice is asked on commencement, at completion of studies and in PGY1.

Results: 1459 graduates provided location preference data on entry, at completion and at the end of their first postgraduate year. Student who fail to meet the RUSC criteria for rural background consistently report a preference for urban practice with relatively minimal conversion (<10%) to rural preference between any two time points. In contrast, while students who meet the RUSC criteria are more likely to retain a preference for rural practice than those who do not there is a substantial conversion to urban preference (30–50%) between any two time points.

Three antecedent factors independently predicted rural preference in PGY1, in decreasing order of association: rural preference at end of degree (OR=27.78, 95% CI 18.90 to 40.82); rural preference at commencement of studies (OR=4.39, 95% CI 2.97 to 4.11); and being ‘ever married’ compared with never married (OR=2.57, 95% CI
Together these three antecedents provide good discrimination between rural and urban preference interns with an area under the receiver–operator characteristic curve 0.89 (95% CI 0.87 to 0.92).

Conclusions: Students’ attitude to rural practice at the end of their PGY1 year is more strongly influenced by their attitude at the end of medical training than their incoming attitude or rural background, confirming the crucial influence of the medical program in forming attitude to a rural medical career.

Cardiac rehabilitation in country South Australia—then, now and next

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Introduction: Cardiac rehabilitation in country South Australia to date has been provided in an ad hoc manner with minimal planning and little consideration to resources or standardisation. The South Australia Statewide Cardiac Clinical Network has developed a model of care for cardiac rehabilitation in South Australia. The model of care is premised on the standardisation of cardiac rehabilitation services through the use of clinical pathways and the introduction of a telephone-based phase 2 cardiac rehabilitation service to address the existence of barriers to patient attendance at these programs.

Aims: The aim of this project was to address the implementation of the model of care into country South Australia. The objective was to use this process to strengthen existing cardiac rehabilitation programs and improve access to secondary prevention of cardiovascular disease for all residents of country South Australia.

Methods: In April 2012, Country Health South Australia Local Health Network (CHSALHN) commissioned a five-month project to map existing country cardiac rehabilitation services and perform a gap analysis against the model of care. This project was completed in September 2012.

Relevance: Only 10–20% of eligible residents of country South Australians are currently accessing a cardiac rehabilitation program after experiencing an acute cardiac event. Barriers to access to cardiac rehabilitation are well documented and the provision of a telephone-based cardiac rehabilitation service is an evidence-based method of addressing these barriers.

Results: Service mapping revealed 17 existing community-based cardiac rehabilitation programs in country South Australia. These services were being provided in relative isolation compared to metropolitan equivalents and in the absence of strong clinical support and governance. Project recommendations resulted, designed to address three essential requirements for these programs: reduce isolation, increase clinical support and improve clinical governance.

In August 2012, a project report and its 27 broad recommendations were endorsed by the CHSALHN Clinical Cabinet.

Conclusion: In September 2012, implementation of the endorsed recommendations was commenced, entailing the execution of 39 achievement strategies and 172 individual actions. The implementation of these recommendations will ensure the provision of evidence-based standardised cardiac rehabilitation to residents of country South Australia. The implementation of a telephone-based program will greatly improve access to evidence-based standardised cardiac rehabilitation programs for residents of country South Australia who reside outside the larger rural centres with existing cardiac rehabilitation programs.

Psychological first aid for Aboriginal and Torres Strait Islander communities

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Psychological first aid (PFA) has emerged as the crisis intervention of choice in the wake of critical incidents such as trauma and mass disaster. The literature abounds with PFA definitions, its applicability and usefulness. However, little is known about the suitability of existing PFA approaches for Aboriginal and Torres Strait Islander communities.

This paper will outline plans to develop a PFA model considered acceptable to Aboriginal and Torres Strait Islander mental health professionals and communities in several rural and remote regions of New South Wales.

The paper will describe the traditional PFA approach; how PFA might be culturally adapted to
better suit the needs of Aboriginal and Torres Strait Islander people; and plans for a program aimed at understanding and developing culturally appropriate models of PFA interventions.

**Discharges against medical advice: relationship with rurality in ischaemic heart disease admissions**

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**Introduction and relevance:** Discharges against medical advice (DAMA) are associated with adverse outcomes for patients and service providers. We investigated risk factors for DAMA, including residential and hospital locality, in patients hospitalised with ischaemic heart disease (IHD) in Western Australia (WA) between 2000 and 2008.

**Methods:** All patients admitted to WA hospitals with a first-ever discharge principal diagnosis of IHD were identified in the linked WA Hospital Morbidity Data Collection. DAMA was identified from the discharge type variable. Demographics, accessibility-remoteness of residence, hospital type, age, sex, Aboriginality and area-level social disadvantage), as well as clinical variables (Charlson Comorbidity Index and a history of mental health or alcohol-related admissions based on five-year admission history; IHD type (myocardial infarction/unstable angina/other IHD) and admission type) were investigated as predictors for DAMA using multivariate logistic regression modelling.

**Results:** Of the 37,704 incident IHD cases identified, 21% were rural, 69% male, 4% were Aboriginal, and 0.6% (n=224) were DAMAs. Rural patients admitted to rural hospitals were more likely to DAMA (OR=1.51; 95% CI 1.04–2.18) whereas rural patients admitted to metropolitan public hospitals were less likely to DAMA (OR=0.46; 95% CI 0.28–0.77) compared with metropolitan patients admitted to metropolitan public hospitals after controlling for covariates. Patients admitted to private hospitals were unlikely to DAMA (OR 0.17; 95% CI 0.08–0.36). When stratified by Aboriginality, the increased ORs of DAMA among rural residents admitted to rural hospitals was non significant in both Aboriginal (OR 1.96; 95% CI 0.97–3.9) and non-Aboriginal patients (OR 1.39; 95% CI 0.89–2.19). Although both Aboriginal (OR 0.37) and non-Aboriginal (OR 0.55) rural residents admitted to metropolitan hospitals were less likely to DAMA than metropolitan residents, only the findings for Aboriginal patients reached significance. In a rural sub-analysis, rural patients were three times more likely to DAMA from district and regional hospitals than from metro teaching hospitals.

**Conclusion:** Although relatively uncommon, DAMA is often considered an indicator of the quality of hospital care. Rural residents admitted to rural WA hospitals for IHD have the highest risk of DAMA, even after adjustment for clinical and demographic factors. One explanation is that constraints in resources and expertise are adversely impacting on rural services. This suggests that the clinical and psychosocial management of IHD in rural WA hospitals requires review as part of a high-quality health system.

**Developing an evidence base to underpin rural workforce policy in allied health**

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**Aims:** To develop a theory underpinning rural workforce policy development in the allied health (AH) professions across public and private sectors.

**Methods:** The Rural Allied Health Workforce (RAHW) survey collected data in New South Wales (NSW) between 2008 and 2009, including demographic, employment, education, and recruitment and retention characteristics. Six follow-up focus groups held across regional centres in NSW were analysed thematically. Focus group results (which have been reported elsewhere) were triangulated with survey data using logistic regression modelling to predict intention to leave in RAHW public (n=833) and private sector (n=756) respondents.

**Relevance:** Policy initiatives to improve recruitment and retention of rural health professionals have relied primarily on evidence obtained from rural doctors, most of whom practice under a private business model. Much of the literature on the rural AH workforce focuses on the public sector, even though AH professionals work in a variety of public,
private and non-government organisations. Different policies and models may be appropriate for different health professions and sectors, and consideration should be given to this in recruitment and retention strategies.

Results: Private practitioners were older (mean age 47.0 years) than public workers (mean age 41.9 years) ($t_{1578}=8.55, p<0.001$) and were more likely to be male (69% private, 31% public) ($\chi^2=117.68, p<0.001$). In logistic regression modelling, high clinical demand predicted intention to leave in both the public ($p<0.001$, OR=1.40, CI=1.08–1.83) and private ($p=0.004$, OR=1.61, CI=1.15–2.25) cohorts, yet the ability to get away from work did not predict intention to leave in either group.

Compared with 40–50 year old respondents, 20–30 year olds in the public sector were 3.72 times more likely ($p=0.000$, CI=2.43–5.69) and private practitioners 3.38 times more likely to leave ($p=0.000$, CI=1.98–5.77). Respondents aged over 60 years were also more likely to intend leaving (public $p<0.001$, OR=35.41, CI=8.22–152.51 and private $p<0.001$, OR=7.38, CI=4.37–12.46). In the public cohort only, 30–40 year olds were significantly more likely to intend leaving ($p=0.002$, OR=1.88, CI=1.20–2.95). Professional isolation ($p=0.004$, OR=1.39, CI=1.11–1.75) and participation in community ($p=0.008$, OR=1.57, CI=1.13–2.19) also contributed significantly to the multivariate model only in the public cohort.

Conclusions: Evidence underpinning workforce planning in the rural AH professions is limited. This paper demonstrates differences between those working in public versus private sectors in the factors affecting intention to leave and supports policy development in alignment with public and private sector service funding models. Effectiveness of policies may be improved through better targeting.

‘But I’m an environmental scientist, not a mental health clinician’

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Despite clear links between the environment and health, natural resource management agencies and health services are not common collaborators. In a break with tradition, the Rural Adversity Mental Health Program (RAMHP), the Southern Rivers Catchment Management Authority (SRCMA) and the Centre for Health Equity Training, Research and Evaluation (CHETRE) observed potential health impacts of work being undertaken by farmers in the Southern River Catchment, prompting a health impact assessment to further analyse these health issues.

Initial findings of the health impact assessment indicated that promoting the health of the landscape was closely linked with promoting the health, and specifically the mental health, of farmers and vice versa. These findings led to a detailed report, containing a number of key recommendations surrounding health of farmers.

This presentation will focus on the role of RAMHP in supporting the CMA staff and management to implement many of the key recommendations pertaining to mental health and wellbeing. Twelve months down the track what do the evaluations tell us about working more creatively to address the mental health of farmers and farming communities and how are our environmental scientists now feeling? The success of the program and future directions will also be discussed.

Embedding telehealth in rural Victoria—choosing appropriate practice models

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Background: Telehealth is expected to play an increasingly important role in health reform with promises of improving access to specialist services in rural communities, potentially leading to better management of chronic conditions and health outcomes. Telehealth would support a model of care that integrates rural primary care and urban specialist services, reducing the time and financial cost of travel for country patients. However the perceived difficulty involved in soliciting telehealth services, organising telehealth appointments, booking facilities and coordinating staff, providers and patients has been identified as a deterrent to incorporating telehealth into the practice of private specialists.

Aims: To explore the practice models being used by private specialists providing telehealth services to rural Victoria and to identify the approaches that best facilitate the integration of telehealth into clinical practice.

Methods: A case study design was adopted to explore the practice models in use using a combination of survey (n=100 private specialists) and semi structured
interview with specialists providing outreach services to rural Victoria.

This paper reports on the administration of two practice models that aim to support the adoption of telehealth:

- teleclinics supporting particular patient populations in rural Victoria
- teleconsults supporting access to specialist services between face-to-face visits.

**Results:** Private specialists offer their services from a range of locations (various hospitals, private consulting rooms, home) to patients located in many different settings. Structured, well-communicated and replicable administrative practices are required to embed telehealth into practice. Despite the appeal of teleclinics to many private specialists, they cited the financial risk of fluctuating volume as a disincentive. There exists a level of discomfort among many private specialists with taking a proactive approach to promoting their telehealth services; many regarded it as ‘touting for business’. Strong support exists among the Victorian Outreach Assistance Service providers to offer video consults to rural patients; however, attitudes towards communicating this willingness to referring general practices and others remains a change management challenge.

**Conclusion:** There is little systematic and generalisable research on the most effective practice models to use for effective sustainable telehealth. This study in rural Victoria shows that structured administrative processes and agreed governance procedures can be integrated into practice to contribute to the confidence of specialists in using telehealth in situations where they regard it to be clinically appropriate. Research continues to be needed to identify the impact of various telehealth integration approaches on health outcomes.

**Creative Partnerships: collaborative art and science research to reduce stress and anxiety experienced by children undergoing painful, recurrent clinical procedures**

**George Khut**, **Vicki Sowry**

1Australian Network for Art and Technology

The result of an evolving three-way partnership facilitated by the Australian Network for Art and Technology (ANAT), with artist Dr George Khut and The Children’s Hospital at Westmead pediatrician Dr Angie Morrow, the BrightHeats project researched the ways the adaptation of biofeedback-based artworks can help manage pain and anxiety experienced by children undergoing painful medical procedures. The project designed, built and tested the use of a biofeedback-assisted relaxation training ‘app’, and its benefits above and beyond current iPad-based ‘distraction’ methods.

Through this creative partnership, artist Dr Khut was provided with insights into the workings of a hospital—where initial design concepts could evolve through observation of the experiences of children, their carers and health professionals. Together the partners explored the efficacy of multimedia interaction as a tool for managing painful procedure related anxiety.

The goal of the interactive artwork is to maintain a lowered heart rate—children are rewarded with sounds and visuals that respond to decreases in heart rate over different periods of time (i.e. changes that they can influence with their breathing, and longer term changes that require relaxation). The BrightHearts approach combines standard distraction methods with the principals of biofeedback relaxation training—focusing children’s attention away from the object of their anxiety and fear, and helping them to develop skills for observing and regulating their response during painful procedures.

Partnerships such as these increase recognition amongst artists, scientists, researchers and government agencies of the value of collaborative art and science research. The partnership between ANAT, Dr Khut and the Children’s Hospital at Westmead’s Dr Morrow, has provided a platform to develop creative arts practice in health care settings and ultimately to improve the experiences of children in hospital. This partnership was recognised as the national recipient of the Arts and Heath Foundation Award at the 2012 AbaF Awards.

**The certificate in gerontological nursing for rural and regional nurses**

**Tracy Kidd**, **Evan Stanyer**, **Judith Downie**

1Collaborative Health Education and Research Centre, Bendigo Health

**Aims:** To provide a hospital-run, university-accredited course designed to enhance knowledge base and advanced critical thinking skills of registered nurses working with older people in any health setting at a practical level.
Methods: The course is run over 22 weeks with a combination of face-to-face and online learning and also clinical placement. With a strong emphasis on current evidence-based practice, lectures are provided by a team of multidisciplinary experts in their field, peak body and industry representatives. Assessment tasks are aligned with current university expectations, including academic requirements, and learning outcomes.

Relevance: In Victoria, more than 46% of multi-day patient stays are for patients over the age of 70 years. Statistics released by the Department of Health in 2011 indicate that the Loddon Mallee region, which occupies more than a quarter of the area of the state, has a higher than average percentage of persons with need for assistance with core activities, and the highest percentage (among the geographical regions of Victoria) of people aged 75 or more living alone. Statistics of Australian hospitals show both the age and acuity of inpatients is increasing. Therefore the need to have a good understanding of the current issues and evidence-based practice related to nursing older people is vital. Concurrently, the need for nurses specifically trained in nursing older people is growing; however, there is a deficit of courses available to nurses with a focus on aged care and nursing older people in Victoria. Locally, there are currently no tertiary post-graduate aged care specific courses available.

Results: In the Loddon Mallee region there is increasing interest from local health services and individual registered nurses in undertaking the Certificate in Gerontological Nursing, with expressions of interest and subsequent student cohorts trending upward every year for the last five years. Student cohorts are made up of nurses working in a variety of regional and rural settings. Our data indicates an increasing interest of applicants to pursue further university study following completing this course, with more than half of the current cohort of students indicating this intention.

Conclusions: This course is going some way toward fulfilling a dire need for aged care specific training within the nursing workforce in rural and regional Victoria. Evaluation data indicates students find the course invaluable to their clinical practice.

Challenges facing rural populations seeking orthopaedic paediatric services in western NSW

Peter Kilby

Aims: To look at the distance travelled by patients requiring paediatric orthopaedic care in a major rural centre in western NSW.

Methods: We performed an epidemiological review of all the admissions to the paediatric department under the care of the orthopaedic team over a three-month period. The inclusion criteria allowed for patients up to 18 years of age, with a minimum of one night stay. All patients were recorded by postcode, age, type of injury and distance travelled for follow-up appointments. This included fracture clinic for removal of casts, wound checks and post-operative checkups. Type of injury included upper limb, lower limb, infection or spinal injury.

Relevance: Dubbo Base Hospital is the major orthopaedic centre servicing western NSW patients. It is located approximately 410 km north-west of Sydney. It has a population of 41 000, but services over 120 000 population in the catchment area. It services north to the Queensland border and west as far as Cobar and Bourke. Recent challenges with retention of full-time local anaesthetic and orthopaedic staff result in many situations of fly-in/fly-out on-call services. If the local service was to be closed down or amalgamated with the next largest centre (Orange Base Hospital 151 km away) this would pose even greater burden on rural patients in accessing orthopaedic care.

Results: Over a three-month period (September, October, November 2010), 104 patients were admitted to the paediatric ward under the care of orthopaedics. This included 72 upper limb injuries, 21 lower limb injuries, ten infections and one spinal injury. The average age of patients was 10.72 years (1–18 years). The average distance travelled was 99.50 km.

Conclusions: It is well known that rural populations often have to travel great distances to seek specialist care. This study found that the average distance travelled by patients seeking paediatric orthopaedic care was 99.50 km one way. If we break down the results, 35 of the 104 patients were Dubbo residents. The remaining 99 patients were from surrounding rural townships. The average distance travelled by this group of patients was 142 km. This in fact meant
that a round trip to the fracture clinic for follow-up was approximately 284 km, posing significant logistical, financial as well as time commitments due to the distance imposed on these families. If the services were lost in this location the average distance for this population would now become 215 km (a total 430 km round trip) for follow-up.

**Complex post-traumatic stress disorder—breaking the silence of the fringe dweller**

*Jacqueline King*

1Jacqueline King Contemporary Glass Art

This presentation is a personal narrative of my own journey with complex post-traumatic stress disorder (PTSD), from diagnosis to management.

Commencing with a broad outline of my own professional background, the story will reveal the crippling effects of complex post-traumatic stress disorder, it’s symptomology and the difficulties encountered when dealing with government bodies, institutions, communities and day-to-day living through the darkened filter of this illness.

This poorly understood illness does not yet appear in the DSM, but is expected in the next release (Diagnostic and Statistical Manual of Mental Illness). By observation it is often resistant to the usual PTSD treatments and lifelong. It also misses out on disability support payment from Centrelink, as does PTSD, despite its crippling nature, which ensures the struggle of those trying to navigate through a life trying to manage it is all the greater.

From a regional perspective, I will discuss the disadvantages and advantages I’ve experienced in the management of complex PTSD in regional Australia, plus the immeasurable benefits of an arts practice in coping with this illness.

I will also covers its effects on an emerging arts practice and an anecdotal account of how its impacts have shaped my own arts practice, including the difficulty in submission of grants, proposals and arts opportunities whilst in the grip of the illness that by nature comes and goes.

**Supporting medical students on rural clinical placements**

*Katherine King1, Rachel Purcell1, Catherine Pendrey1*

1Australian Medical Students’ Association

There is an immediate and ongoing need to analyse the effectiveness of rural clinical placements in increasing rural career uptake and thus decreasing critical shortages in the rural workforce. Rural clinical placements provide valuable training and learning opportunities for medical students and it has been postulated that rural exposure is associated with an increased likelihood of working rurally in the future. Australian medical students are now required to complete four weeks of rural clinical school experience under the Rural Clinical Training and Support (RTSC) Program.

The Australian Medical Students’ Association (AMSA) recognises that rural clinical schools (RCS) provide a diverse range of incentives and supports to students undertaking rural clinical placements. The aim of this study was to ascertain the importance of incentives and supports for students undertaking rural placements, and to analyse the impact of student supports on intentions to work rurally. Through this analysis, we aimed to determine whether students who felt well supported during their rural placements were more likely to work rurally than students who did not.

As part of the 2012 FRAME survey, which students completing placements within rural clinical schools are invited to complete annually, additional questions have been integrated to investigate student opinion of the incentives and support they receive and how well supported they feel during their rural placements. Australian RCS students will be invited to complete a 20-minute online or paper-based survey between September 2012 and January 2013. The survey will also seek to identify associations between student demographics, career intent and student perceptions of support from their RCS.

It is expected that this study will make a valuable contribution to the literature assessing the impact of support and incentives on student experience of rural placements and intentions to practice rurally. It is hoped that the results of this study, which will be available in early 2013, will facilitate the enhancement of support and incentive strategies for students during RCS placements. This research is likely to generate discussion regarding how well-supported medical students feel while on rural
placements and the impact of this on their intentions to work rurally. It will also provide an opportunity for strengths and weaknesses of current strategies to be identified and reflected upon. The outcomes of this research may indicate that continued assessment and analysis of the impact of supports and incentives on student experience of rural placements is warranted.

Building community through storytelling

Gail Kovatseff

1Media Resource Centre

Digital storytelling is an empowering experience: it brings the individual’s story to the fore and also gives them a strong sense of accomplishment because individuals are given the skills to make their own stories. The Media Resource Centre now not only runs digital storytelling workshops but uses them as the foundation for wider digital engagement strategies. The aim of these strategies, which often involve partnerships with other NGOs and organisations, is to help overcome social isolation and build connectivity within communities. Gail will discuss some of the thinking behind their digital engagement strategies, particularly Aged Care, Digital Lifestyles and Mindshare.

Starting with the end in mind

Sarah Larkins1, Annette Panzer2, Richard Murray1, Neil Beaton3, Jane Mills2, Ruth Stewart1

1School of Medicine and Dentistry, JCU, 2School of Nursing, JCU, 3Queensland Health

Aim: Health workforce planning is often done reactively, assuming continuation of patterns of health care utilisation and adjusting for demographic projections. This HWA-funded research involves partnerships in a geographically bounded area including a regional centre (Cairns) and two small rural communities in north Queensland (Mareeba and Yarrabah) to develop a demonstration model of health workforce planning. The focus is on creating a flexible and sustainable rural health workforce plan that responds to community needs.

Methods: An action research methodology, involves key stakeholders in four cyclical stages of health workforce planning, with continuous process evaluation:

- Stage 1: Develop an essential health services plan (basket-of services) for each of the planning areas.
- Stage 2: Remodel and build appropriate health service models that deliver the agreed upon priority health services.
- Stage 3: Assess the skills-sets required and from there configure the desired workforce needed to appropriately deliver these health service models.
- Stage 4: Develop a workforce and training plan that details and costs the training of an appropriate health workforce to serve rural population needs.

Results: The project is in progress, but by Conference time we will be able to present:

- Integrated health service models that deliver the agreed-upon priority health services for the two target areas (including strengthening existing local and outreach models of service provision and balancing this with appropriate regional service location). Likely innovations include increased use of telehealth and innovations in public-private funding.
- Analysis of skills-sets required and configuration of the desired workforce to best deliver these health services. The focus for this workforce planning is on ensuring that available health workers have a wide range of general skills, in line with evidence showing that health professionals with more ‘generalist’ skills provide better outcomes at lower cost in rural areas.
- A workforce training and education plan outlining the training of an appropriate health workforce for these communities. This considers adequate support mechanisms (including professional development) for the rural health workforce, local training and providing alternative pathways that allow similar progression and development to urban counterparts.

Conclusions: This project demonstrates that participatory health workforce planning is possible, based on strong and respectful partnerships between stakeholders. Although complications often arise due to differences in funding models, employment conditions and inflexible information technology systems between service providers, these can be overcome where there is a shared vision to innovate and a commitment to that process from all stakeholders.
A physician assistant working in Aboriginal health—a new approach for Australia

Nanette Laufik1,2
1Mulungu Aboriginal Corporation Health Centre, 2School of Medicine, James Cook University

Aim: To describe the role and contributions of a physician assistant (PA) currently working in an Aboriginal Community Controlled Health Service, and share recommendations and insights for expanded implementation of the role.

Relevance: With the recent report by Health Workforce Australia endorsing the relevance of physician assistants in rural Australia, it is timely to describe the experience of a PA currently working in a rural Aboriginal Community Controlled Health Service. This role, which is new to rural Australia, also serves as a model for potential career advancement for Aboriginal health workers.

Results: The classic role of the physician assistant as an extension of the supervising doctor has enabled this doctor–PA team to increase access to care planning for people with chronic disease to manage conditions such as diabetes, hypertension and rheumatic heart disease. Under the supervision of the senior medical officer, the physician assistant sees patients in the chronic disease clinic, briefs the doctor on her findings, and together they formulate the treatment plan. The efficiency of this model has resulted in improved financial performance, enabling the chronic disease clinic to be self-sufficient for medical staff. Because the physician assistant handles a large portion of the clinical commitments it has enabled the supervising doctor to devote more time to more complex cases, managerial duties and the training of medical students and junior doctors. Furthermore, the PA helps to support the system of screening of patients by Aboriginal health workers and offers direction as required. The PA also participates in the interdisciplinary teaching of both medical students and Aboriginal health workers.

Conclusions: The physician assistant is a true force multiplier, readily fitting into the rural health scheme, working closely with the senior medical officer and improving the efficiency, productivity, financial returns of this chronic disease clinic.

This experience of the physician assistant in Aboriginal care could serve as a model for other communities in bringing long-term stability and relationship building to community care, whilst improving the quality and efficiency of clinic management. It will also lead to increased and improved training opportunities for health workers, medical students and junior doctors.

What ‘makes’ a placement

Louise Lawler1, Shannon Nott1
1Orange Base Hospital

One of the most effective strategies for recruiting health professionals to rural and remote practice is through early positive experience. To this end most students of the health sciences now have an array of placements and clinical experiences that can be undertaken in rural and remote settings throughout Australia. Just being in the setting, however, does not always ensure the experience is positive for the student of the host agency.

In order to ascertain just what ‘makes’ a positive placement experience from the student’s perspective, one thousand and forty health science and medical students were surveyed to determine what were the important clinical and social aspects of a placement that made it positively memorable enough that they would be keen to pursue postgraduate positions in rural and/or remote positions.

The aim of the study was to garner the issues, activities and ingredients that students felt made for a positive learning and social interchange as well as highlighting aspects of placements that they considered detracted from the overall experience. Armed with this information the study proposed to develop a guide for rural and remote host health facilities outlining tangible strategies that can be adopted to ensure positive experiences from all students’ placements, thereby enabling the attraction of enthusiastic and positive postgraduate practitioners in greater number.

The survey was disseminated via the National Rural Health Students Network national database to senior undergraduate and postgraduate students of nursing, allied and Aboriginal health and medicine. The response rate was above twenty five per cent.

Utilising both qualitative and quantitative data analysis methodology, results indicate interesting issues regarding different types of placements, clinical, experiential, selectives and electives, extending to the nomenclature describing placements in different disciplines. There seems to be widely understood descriptions of different placements types among nursing and allied health students and much
more varied understandings among medical students, which dictate the expectations of the placement. Generally allied health students appear more focused on clinical experiences and less concerned about social aspects of placements. There is, however, general consensus regarding the types of activities that makes placements positive or detract from them.

The conclusions present a set of guidelines for conducting remote and rural clinical placements that are more in tune with students’ expectations and more likely to provide a very positive experience, which will hopefully result in greater numbers of students selecting rural and remote practice post graduation.

**New South Wales rural and remote communities’ perception of health telephone support services**

**Helen Le Gresley**¹, **Carlie Lawrence**¹, **Prasuna Reddy**¹

¹The Centre for Rural and Remote Mental Health, University of Newcastle

It has long been recognised that there are inequalities in the use of mental health services across Australia and specifically in rural versus urban communities. Numerous factors have been identified as contributing to this in equity, including physical access to appropriate mental health care services; social stigma; agrarian values; and affordability.

In an attempt to address some of these barriers, a number of telehealth and e-mental health services have been introduced such as telephone support/triage, and internet based e-mental health resources and service delivery. While there is some research regarding the efficacy of these services, there appears to be limited exploration of community perception of these types of support. Such research would be useful, as recent evidence suggests the growing number and types of these services available may be confusing to community members and creating difficulties for service providers in establishing an authoritative presence.

The following paper outlines a research project exploring the perception of health—including mental health telephone support services—available to rural and remote communities in NSW. Surveys and interview data obtained from residents and service providers are reported, including knowledge and awareness of support types and availability, in addition to perceptions of need for such services. Knowledge, awareness and likelihood of using mental health telephone support services versus other health support services, are also explored alongside usage data from the Rural Mental Health Support Line.

The research provides an evidence base for marketing, provision and development of mental health focused telephone support services for rural and remote communities in NSW. Targeting service delivery at the perceptions and aspirations of community members and service providers will encourage more relevant, useful and widely accessed mental health telephone support services in the future.

**Embedding clinical supervision in rural and remote contexts—is it worth the effort?**

**Tanya Lehmann**¹, **Kate Osborne**¹, **Saravana Kumar**²

¹Country Health SA Local Health Network, ²University of South Australia, International Centre for Allied Health Evidence

Clinical supervision is defined as ‘a working alliance between practitioners in which they aim to enhance clinical practice, fulfil the goals of the employing organisation and the profession and meet ethical, professional and best practice standards of the organisation and the profession, while providing personal support and encouragement in relation to professional practice’ (Kavanagh et al. 2002).

Clinical supervision (CS) is attributed with the ability to reduce burnout, improve job satisfaction and retention of clinicians, to safeguard professional values and standards, and to support quality clinical practice.

An Allied Health Professional (AHP) Clinical Support Framework and Policy were developed and endorsed by Country Health SA Local Health Network (CHSALHN) Executive in 2009, and the requirement for clinical supervision was then written into all AHP job descriptions. These structural changes were not sufficient to bring about the cultural and practice changes necessary to embed CS. Clinical leadership roles with designated responsibility and quarantined time for CS, plus training, were also needed. A significant investment by CHSALHN saw the implementation of these roles and an extensive training program during 2011–12.

Informed by the literature, the CS model was designed in consultation with key stakeholders to accommodate the unique challenges of the context,
including dispersed workforce and predominance of ‘rural generalist’ roles. It fosters reflective practice, is profession specific but not content rich, delivered within a matrix structure (separate line manager and clinical supervisor roles) and the majority occurs remotely (via telephone).

An iterative, realist evaluation of the CS structures, processes and outcomes was undertaken in 2012–13, including a combination of qualitative and quantitative methodologies.

The authors will assert that embedding effective CS in rural and remote contexts requires resource investment, strong and persistent leadership, and extensive stakeholder engagement, to enable development and sustainable implementation of ‘fit for context’ structures and processes.

Evaluation results will be presented, and drawn on to answer the questions, ‘Is clinical supervision really worth the effort?’ and ‘Could clinical supervision be one of the keys to a bright future for rural and remote health services?’

Towards systematic data collection and referral pathways for Indigenous youth suicide attempts

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Suicide is now a significant contributor towards Indigenous premature mortality in Australia. There have also been an increasing number of anecdotal reports of child and youth suicides and suicide attempts across Central Australia. However, no systematic protocol or database exists to collect information on attempted suicides in the region. As a result, suicide attempt data are collected in an ad hoc manner and methods and classifications vary between organisations. Suicide and other suicidal behaviour among Aboriginal peoples is often the outcome of complex and multilayered factors, and suicide responses have often focused on crisis response or post-vention activities. It is essential that evidence-based approaches to Aboriginal youth suicide are developed. Capturing accurate data on suicide and suicide attempts will provide a better understanding of the issue and enable the development of targeted interventions.

The aims of this project were to develop a systematic data collection system for Indigenous youth suicide and suicide attempts, and suggest appropriate referral pathways between agencies in Central Australia when a young person is assessed at risk of suicide. The latter aim was to achieve a more systematic approach to the provision of preventative interventions to individuals and their families. This project has been undertaken with the support of an Aboriginal Advisory Group, and ethics approval from two ethics committees. Twenty-two in-depth interviews were conducted with a range of practitioners from related areas (such as primary health, community support, youth services). Data were analysed using cross-case and thematic methods involving four researchers.

In this paper we report on the issues raised by individuals in achieving the stated aims, including:

- diversity of client data systems across agencies and within government departments; and inconsistent definitions of ‘Indigenous’, ‘youth’ and ‘suicide’
- confidentiality; and fear of labelling clients
- difficulties in identifying young people at risk; and a perception of an inability to provide support for those individuals
- problematic criteria for access to services
- lack of confidence of staff to respond and recognise at risk clients
- cultural issues confronted by practitioners.

Possible ways of managing these issues are also proposed. In similar settings overseas, such as Canada, data collection systems have been developed, which has required working through many similar issues. In reporting the themes raised by practitioners in Central Australia, we provide a basis for progressing the aims of the project locally and potentially further afield.

Shifting the wait: meeting the demands for paediatric speech pathology services

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As consumer demand for paediatric speech pathology continues to outstrip capacity, it is critical that traditional service delivery adapts to keep pace to
maximise the spread of clinical resources, avoid waiting list blow-outs and continue to meet the needs of the community. Capacity to do this at Tamworth Community Health Service has been compromised due to difficulties in recruitment and retention of junior and senior staff in the speech pathology department. Challenging times called for creative thinking, so based on its success elsewhere, a model governing overall service delivery was implemented (and evaluated) with the goal of delivering positive, sustainable caseload management change. Now branded as ESSENce, the model operates around family-centred practice, with block periods of assessment bookings, followed immediately by intensive therapy and then ongoing follow-up initiated by caregivers. Careful adaptation of the model was undertaken to align it with requirements of the health service and the needs of the local community, and the model was subsequently utilised with all new outpatient referrals entering the system over a twelve-month period. The experience of implementing such a radical service model and the subsequent data outcomes will be discussed in this paper.

One year on, and with the entire department set to transfer over to the new service method, the model has proven an efficient way of managing the demands of a busy, complex caseload. Processes are also in place to ensure the effectiveness of the model is carefully evaluated. After 12 months, a 16-month backlog of referrals has been cleared and wait times for initial assessment and therapy have been considerably reduced, even though referral numbers remain the same.

In turning the service around, the journey has not been without its challenges, encountering the expected and the unpredictable in the trialling of ESSENce. Comprehensive planning and strong management support have been critical to the success of the trial, as well as clear and regular communication with key stakeholders.

The capacity to sustain this change in the long term is possible, but only time will tell and the proof will be in clinical and service outcomes. Models like this are new to the delivery of allied health services and still considered controversial by many. However, operating within models that can flex with service demand and yield to fluctuating staff capacity is undoubtedly the recipe for a bright future for clinicians and consumers in an ever-changing health environment.

The experiences of youth peer educators sharing health information

Karen Lock1, Leesa Walker2, Megan Cain2, Lucie Walters2

1Wattle Range Council, South Australia, 2Flinders University Rural Clinical School

Background: There are limited rural health and wellbeing services that specifically target young people in the Limestone Coast region of South Australia. In particular youth-friendly drug and alcohol, sexual health, and mental health services can be challenging for young people to access. These challenges are found in many rural regions where low population density necessitates generic health services to meet the needs of culturally and demographically diverse population groups.

Intervention: A collaborative project was developed by Wattle Range Council, Community Health Services, Child and Adolescent Mental Health Services, Shine SA, and Blue Light Outdoor Adventure with grant funding from Focus in Youth and the Innovative Community Action Network in 2011.

High-school student and youth volunteers were recruited to participate in an Information Peer on Peer program known as iPOP. This program involved attending a three-day peer educator workshop where information was provided about drugs and alcohol, sexual health, mental health issues affecting young people and services provided by local and state-based health providers. The volunteer peer educators were then encouraged to share their knowledge with their peers on an ad hoc and formal basis, and participate in monthly support and training meetings.

Methods: In late 2011, at the end of the first year of the iPOP program, peer educators and their parents and guardians were invited to participate in separate focus groups or interviews to describe their experience of the program. Interviews were recorded and transcribed and analysed for themes using an iterative process.

Results: Themes included: shaping career intent; anticipated disquiet; new knowledge; self-care strategies; moral dissonance; emotional load; and undefined boundaries. Together these themes tell a story of the strengths and risks of the iPOP program.

Discussion: This research sought to ensure that the iPOP program first did no harm to the volunteer peer educators. As a consequence of the themes identified, recommendations have been made to
strengthen this community-based peer-to-peer health promotion program, including: changing the education program slightly to improve the safety of the learning environment; ensuring active participation of peer educators in the planning, implementation and evaluation of future years of the program; and provided a defined end-point with certificate of recognition for students’ contribution at the end of their commitment.

**Conclusion:** Engaging youth in peer-on-peer education can be a successful way of spreading important messages; however, it is a complex process to ensure the safety of those who volunteer as peer educators. This community collaborative project begins to develop strategies to ensure these youth thrive in this challenging and important role.

**Phase one of a cluster randomised trial to prevent weight gain in women living in rural communities**

*Cate Lombard*1, *Cheryce Harrison*1, *Samantha Kozica*1, *Nicole Ng*1, *Helena Teede*1

1Women’s Public Health Research, Monash University

Halting weight gain in those who are currently normal weight as well as those who are overweight or obese is one of the most critical public health priorities currently facing Australia. Women are at greater risk of obesity than men, and rural women represent a particularly high-risk group, gaining greater weight than their urban counterparts. Despite the recognised need, few weight gain prevention interventions in adults have been reported. Our group has previously developed a weight gain prevention intervention for women living in a metropolitan area (HeLP-her), which showed a significant difference between the intervention and control groups (adjusted -1.13 kg, CI -2.03 to -0.24) at one year. We have now adapted this evidence-based program for delivery to women in rural communities.

The primary aim of this HeLP-her rural project is to determine if a one-year behavioural intervention plus one year observation prevents weight gain and improves health-related behaviours in women living in small rural communities in Australia.

Between September 2011 and March 2012 we aim to recruit 840 women aged between 18 and 50 years living in 42 small rural towns and deliver phase one of the project. In this cluster randomised trial the item of randomisation (or cluster) is the town, with data analysed at the individual level. Primary endpoints are measured weight change and secondary end-points are diet and physical activity behaviours, self-management behaviours and quality of life measured at baseline, one year and two years. Community prevention interventions in real-life settings are complex and challenging to deliver. We have successfully engaged multiple sectors within the 42 target communities, including local government, health and education. The recruitment is occurring as planned and we will discuss program delivery and baseline data. To our knowledge this is the largest lifestyle-based randomised controlled trial to prevent weight gain in adults in Australia and the learnings from this project will impact on population weight gain prevention strategies nationally.

**Disparities in ischaemic heart disease care for rural Aboriginal people**


1Combined Universities Centre for Rural Health, University of Western Australia, 2School of Population Health, University of Western Australia

**Background/relevance:** Aboriginal people are three times more likely to have an ischaemic heart disease (IHD) event compared with other Australians but have lower rates of coronary artery procedures. This may be partly explained by the location of the hospital where Aboriginal people present for treatment, availability of such services, personal preferences and subtle in-hospital discrimination. This study aims to compare transfers to metropolitan hospitals and receipt of coronary artery procedures by Aboriginal and non-Aboriginal people admitted to rural hospitals in Western Australia for IHD.

**Methods:** Linked data were extracted from the WA Hospital Morbidity Data Collection for acute admissions to rural hospitals between 2005 and 2009 with a principal discharge diagnosis of IHD (ICD 10: I20–I25). Admissions were stratified by age group (25–54 and 55–84 years), Aboriginality and IHD type (myocardial infarction, unstable angina, all IHD). Outcomes within 28 days included all-cause death, transfer to a metropolitan hospital and coronary angiography. Crude proportions of patients with the outcomes and times to coronary angiography by age group are presented.

**Results:** Aboriginal people were younger (52 versus 66yrs, p<0.01) and more lived in remote than regional areas (60% versus 18%, p<0.01) compared to non-Aboriginal people. Proportions transferred to metro hospitals were similar regardless of diagnosis.
and age, but fewer Aboriginal people in the 25–54 year age group with MI were transferred to metropolitan hospitals by the second day than in non-Aboriginal people (70% versus 83%, p<0.001). Fewer Aboriginal people in the 55–84 year group received an angiogram than the same group of non-Aboriginal people (51% versus 64%, p<0.01). Among the 25–54 year group, fewer Aboriginal people had a coronary angiogram by the second day compared to non-Aboriginal people (23% versus 39%, p<0.001).

Conclusions: Similar proportions of rural Aboriginal and non-Aboriginal people were transferred to metropolitan hospitals following acute admission for IHD. However, among MI patients, fewer Aboriginal people received coronary angiography and many faced delays in receiving this procedure. These results highlight potential disparities in current practices and signal the need for a change in policy, resourcing and practice to improve the provision of cardiovascular services to rural Aboriginal people.

The Australian Rural Child Health Training Module

Andy Lovett

The Rural Child Health Training Module has existed in various forms for the last six years. It has taken aspects of the general practice training paradigm for rural locations and modified it for specialist training. It is offered to advanced trainees in general paediatrics (RACP) undertaking their mandated six-month rural rotation.

The module consists of a three-day face-to-face meeting, commencing twice yearly and follows with 18 videoconference seminars at weekly intervals. Seminars are of 90 minutes duration, with half being dedicated to a didactic session presented by an ‘expert’ in a given field—such as ‘What’s new in gastroenterology?’, ‘Managing the dying baby’ or ‘What is a business case and why should I care?’

The other 45 minutes is clinical case discussion generated and lead by the trainees. Feedback indicates that this more open and discursive format is most valued by trainees.

The cohorts are closed and limited to a maximum of 16 per group.

The module has been evaluated independently by the University of Melbourne and found to be very effective in supporting the excellent clinical training material available in rural and regional Australia.

There has been impressive buy-in on the part of trainees, supervisors, hospitals, the College of Physicians and the government.

An outline of the module and learnings will be presented.

Arts engagement programs with Warlpiri communities sharing traditions and stories

Jenine Mackay, Enid Nangala Gallagher

InCite’s partner, the Mt Theo Program is nationally recognised for prevention, aftercare and support for petrol sniffers and is repeatedly cited as ‘the success story’ in petrol sniffing intervention.

Strong trust relationships exist between Warlpiri communities, InCite and Mt Theo as a result of the long-term investment and use of skilled community artists. Without this trust it’s impossible to achieve this engagement. The collaboration involves two programs of delivery: the ‘Red Sand Culture’ and the ‘Southern Ngalia’. Both initiatives support re-engagement with culture, family, education, numeracy, literacy, and other health and wellbeing outcomes, all integral to the personal and professional development of young Warlpiri individuals.

Since 2007 ‘Red Sand Culture’ has been steadily developing with the delivery of hip hop music and dance skills workshops, starting in Yuendumu and expanding to include Willowra, Nyirrpi and Lajamanu. Participation numbers have far exceeded expectations. The repeat visits by artists/mentors has proven vital to establish trust relationships and have been a key to the increased participation and quality of the work engaged with and produced by the young people.

‘Red Sand Culture’ is now ready to take new steps in achieving sustainable outcomes for Warlpiri youth, including tailor-made professional development and mentoring for identified individuals and young leaders in each community.

The concept of ‘Southern Ngalia’ began in 2007 with discussions with senior Yuendumu Warlpiri women over their disappointment that younger generations did not seem interested in engaging with traditional
dance and opportunities to do so were diminishing. In 2009 the Mt Theo Program supported three days of consultation meetings as the basis for the 2010–11 successful pilot stages of the project.

Southern Ngalia is a three-way intergenerational collaboration between Mt Theo, senior Warlpiri women and InCite. Built on trust relationships it responds to senior women’s requests to build this platform for opportunity to collectively explore, share, record and the transmission of Warlpiri culture. It is a program of women’s dance camps and presentations.

Mt Theo has identified the need to target young teenage girls who are on the verge of dropping out of secondary school for participation to increase re-engagement with Warlpiri culture as a successful strategy for building self-esteem and curbing anti-social behaviour.

Southern Ngalia focuses on achieving: stronger links with traditional song and dance; creating new generations fluent in the ceremonial and cultural knowledge of their parents/grandparents; strengthening of Warlpiri culture; showcasing within and beyond the region.

Remote Indigenous aged care facilities of the Kimberleys—an eye health audit

Robyn Main

Aim: An outreach circuit of Indigenous aged care facilities (ACFs) was conducted in July 2012 providing optometry services to those unable to attend regular clinics. Examining the eye health of the residents and therefore establishing if their eye sight was adequate for their needs, or if not, referral pathways to local services were investigated.

Method: Liaising with the ACF staff, visiting ophthalmologists and local optometrists to organise the circuit was imperative and included emails and phone calls from six months before the visit took place. Administrative requirements included lists of residents at each ACF, their personal details including medical records and Medicare names and numbers were required. Equipment suited to mobile optometry was required. Residents were examined in a consultation room at each ACF on the designated day. Results were recorded in a computerised record system. Referral to visiting ophthalmologists was implemented when necessary.

Relevance: Service provision to remote areas is a recognised issue that needs to be highlighted if the health gap is to be closed. ACFs are the ‘final chapter’ for health care and, therefore, the gaps endured in earlier years can be revealed more clearly. In eye health, optimum care results in good vision and therefore improved quality of life, especially in the latter years of a person’s life. An audit of eye health indicates the wellbeing in this important area—eye sight.

Results: Six ACFs were visited over eleven days. A total of 109 residents were examined. Of these, 107 were Indigenous people ranging from 63–101 years of age. The majority had good eye health, with nine requiring referral for ophthalmological examination, mainly cataract extraction.

Conclusion: The low incidence of ophthalmological referral required and the excellent findings of good vision and eye health in the ACF populations of the Kimberleys is a ‘good news story’ that should be celebrated by all who have worked so hard in the past to enable these legends to enjoy seeing the sunsets of their final years.

Culturally appropriate engagement strategies for collecting quality data in an Aboriginal population

Tania Marin, Ivan Tiwu Copley

Background: South Australian Aboriginal and Torres Strait Islanders (respectfully referred to here as Aboriginal persons) comprise 1.7% of the SA population and live in all areas of the state. The process of identifying a representative Aboriginal population group for the purpose of research is therefore a complex task and challenges the researchers’ methodology. Working in Aboriginal communities poses questions and considerations for the researchers and the participants on cultural safety and appropriateness.

Method: Methodological rigour is essential for achieving quality data in population surveys, and methods need to be flexible to provide cultural appropriateness for all involved. Communities have a right to expect that if they agree to be involved in research, it will be of sufficiently high-quality and rigour to generate meaningful results, as well as the process being respectful of their culture and historical contexts.
The SA Aboriginal Health Survey (SAAHS) is a representative population survey of 399 randomly selected Aboriginal adults, aged 15 years and over, living in South Australia. Data were collected over a 12-month period with trained Aboriginal interviewers using a face-to-face questionnaire. Dwellings were selected from a sample of collector districts by screening for Aboriginal residents and asking for their consent to participate in the survey. Respondents provided self-report information on a number of issues, including socio-demographics; chronic illness; health risk factors; cultural activities; and health service usage.

To obtain this unique and robust data it was important that we addressed the needs of the communities we visited. Foremost, we:

- abandoned a ‘one-size-fits-all’ approach
- engaged communities through collaborative partnerships
- showed passion for the project, and how the participants would benefit; if not directly, then for their communities
- employed only Aboriginal interviewers and engaged local members of a community where possible
- provided gender choice for the interview
- listened to local knowledge and incorporated that into the data collection process
- always used inclusive language.

Conclusion: These data have been collected in a culturally responsible and respectful manner while adhering to strong methodological principles for quality data collection. We are confident that by using respectful and culturally appropriate methods for the SAAHS, it has provided a high-quality data source of information that will be used to inform government policy and practice, with minimum negative impact on participants and their communities.

Clinical supervision for rural Queensland occupational therapists—is the future looking bright?

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Introduction: Clinical supervision provides an opportunity to engage in guided reflection on current practice in ways designed to develop and enhance future practice, within the context of an ongoing professional relationship.

The quality of clinical supervision received by occupational therapists is fundamental to professional development, professional competence and the safety of occupational therapists and clients. Clinical supervision has also been linked to staff retention and patient outcomes by a number of disciplines. It has been acknowledged in the literature that the quality and effectiveness of clinical supervision received by occupational therapists has not been addressed sufficiently.

Aims

- To determine the effectiveness of clinical supervision received by regional, rural and remote supervisee occupational therapists in Queensland.
- To explore the barriers and facilitators of clinical supervision received by regional, rural and remote occupational therapy supervisees.

Methods: A survey regarding clinical supervision practices and the Manchester Clinical Supervision Scale (measuring the quality and effectiveness of clinical supervision) were completed by 88 regional, rural and remote Queensland Health occupational therapists. Opportunity was also provided to the participants to comment on their current supervision arrangement.

Relevance: In Australia, allied health professionals in rural settings have identified a lack of clinical supervision opportunities from colleagues in close proximity as an impediment to clinical practice (The Superguide—A handbook for supervising AH professionals, April 2012). The effectiveness of different modes of delivery of clinical supervision has been inadequately examined as a means of addressing this issue. The results of this study provide a unique perspective on clinical supervision in rural Queensland.
Results: Occupational therapists who completed the survey were predominantly female (93%). Most occupational therapists in regional, rural and remote areas find their clinical supervision to be effective and of good quality (mean 75, SD 13.95). The MCSS scores can range from 0 to 104, with a score of 72.8 or more indicative of effective and good-quality clinical supervision. The barriers and facilitators of clinical supervision faced by regional and rural practitioners will be presented along with the characteristics of occupational therapists who consider their supervision to be most effective.

Conclusions: The findings will be of interest to managers and supervisors in regional, rural and remote areas, especially in those areas where retention of staff has been an issue. There is potential for this research to be expanded across other allied health disciplines.

Promoting health—using your arts ‘skill set’ in a rural health promotion

Tarja Martin

The health promotion role requires an ability to work across the health promotion continuum, using frameworks such as the Ottawa Charter and working in effective partnerships. However, in a rural setting it is often the coalface community-based activities that create the platform for the behavioural change required to improve wellbeing.

A skill set such as acting can be the secret weapon in your health promotion armoury. It became apparent that using performance skills could be used to effectively and memorably sell important health messages to the community. Once immersed into whatever character is required humour is more than often the other important message/educational driver.

In the health promotion role one can create the concept/event, write the plans, secure funding and partnerships, design evaluation and marketing tools, everything in between, run the event and then at some point ‘frock up’ to MC or do a ‘set’ and use the character to value add to the health-based activity.

In this rural community ‘The Dame’ for example is incredibly popular with the very young, the very old and everything in between. She is extremely versatile and promotes healthy eating (Go for 2 & 5), literacy, active ageing, falls prevention, sexual health (men’s and women’s), Aboriginal and Islander health and more. When events such as the Stay on Your Feet Expos are evaluated, for example, it is the Dame and her messages that are recalled and motivate change and a desire to attend other events. She is quite the drawcard. The Dame has been engaged by other health services to support their events and even opened a health promotion conference.

Many in the communities still do not know the Dame’s real identity (and she likes it that way). Others believe the Dame is her full-time job! Sadly the Dame is not a ‘triple threat’ and can only imagine how much more effective she could be if she could sing and dance.

‘Arts in health’ has a proven track record. So don’t keep your arts skill set for outside your work, if you see an opportunity to combine health and your skill set at least try it as it may well become your secret health promoting weapon in your rural community, just like hiding the vegies in children’s meals. Good for them and they don’t know it.

Community-based intermediate mental health care in the country South Australia context

Lee Martinez

Purpose: In 2011 the Country Health SA Local Health Network (CHSALHN) established a number of mental health intermediate care services (ICS) whose aim is to support the transition of mental health consumers of services from acute care to a range of sub-acute health service options. The ICS provide sub-acute care options in community settings, including intensive bio psychosocial care in a person’s home, in collaboration with community mental health centres, local health professionals, medical and other specialists, non-government organisations, and supported accommodation services. This study reports the findings of a review of the operational outcomes of the four early adopter ICS sites in Port Augusta/Whyalla, Port Lincoln, Mt Gambier and Kangaroo Island.

Method: A mixed-method approach was used involving document review, key informant and carer interviews, and a consumer survey to assess broad stakeholder perceptions of the ICS service. The choice of approach was influenced by its capacity to enhance the generalisability of findings and to improve the utility of the evaluation in terms of informing future policy development. The project was guided by a project reference group comprising a
representative from each service as well as key clinicians, carer representation and CHSALHN managers. The study received ethical approval from SA Department of Health.

Findings: Three different service models have been developed influenced by mainly local contexts. Eligibility criteria for the services are as service outcomes. Consumers and carers describe a number of benefits resulting from their contacts with ICS services. Service enablers include an assertive team approach, interprofessional collaboration, psychosocial support as an integral component of service provision, a community-based facility, interagency collaboration, simple referral systems and a single point of contact for consumers and other stakeholders. Barriers include difficulties recruiting suitably experienced staff, lack of ICS or indeed designated mental health beds in some regional hospitals, problems with data systems, uncertainty of resource allocation, limited promotion of ICS services as well as lack of clarity regarding contractual arrangements with external agencies.

Maximising client outcomes through improved service delivery and data reporting

Kim Maurits¹
¹Country Health SA

In July 2012 the Country Referral Unit assumed operational responsibility for the Country Home Link program, which facilitates the discharge of country clients from metropolitan hospitals.

An opportunity existed to redesign the service response to these referrals, in order to facilitate the patient journey for rural and remote clients. This is particularly important for Indigenous clients who need to return to country to help their own healing process. The process needs to work equally well for a client returning to the remote APY lands, or returning to Mt Gambier. Having current service information means timely discharges to save bed days, and monitoring occupancy levels means not over-committing country resources.

Our aim is to look at the existing processes, to streamline and automate as much data capture as possible. Service availability needs to be accurate so we can provide rapid referral confirmation to facilitate the discharge of country patients.

Streamlined reporting and entry and exit processes are just part of the client journey chain. By strengthening clinical handover practices we seek to reduce risk and improve information flow. We have to know what services are available, and get a commitment from the local health unit to deliver these services. This includes drafting an escalation process to be used if the requested service is not available. For the patient to experience a seamless transition from hospital to home, all the pieces need to fall into place.

To date we have developed data quality audits that allow the monitoring of outstanding discharge summaries. This assists in maximising the revenue for country generated by the packages. Progressing to extracting our data directly has improved our ability to meet reporting obligations. We will develop a robust seven-day service model, which will include intake officers working closely with clinical support staff to ensure referrals are responded to within the two-hour timeframe. This is critical to avoid delaying client discharges.

Other improvements have included increasing the Country Home Link package occupancy by 12%, redesigning the service contact information database, improved crystal reporting to track data errors, and documentation to support improved data collection at local site level.

With the further roll out of the Country Referral Unit in 2013, there will be one unit coordinating metro to country referrals, utilising a ‘no wrong door’ approach. By working together, we can make a real difference in helping our country clients get home.

Keys to retention: the importance of ‘Working safe in rural and remote Australia’

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Background: This paper will report the outcomes of the first stage of the ‘Working safe in rural and remote Australia’ project. This project is the result of collaboration between the Rural Doctors Association of Australia (RDAA), Australian College of Rural and Remote Medicine (ACRRM), Australian Nursing Federation (ANF), Police Federation of Australia (PFA), Queensland Teacher’s Union (QTU) and Council of Remote Area Nurses Australia Plus (CRANAPlus).
The key aims of this project were to understand, identify and, investigate the safety of workplaces in rural and remote Australia.

**Method:** The first stage of the project was to learn more about workplace violence in rural and remote Australia through an online survey and a review of grey and black literature. This included reports, electronic databases, and a stakeholder survey.

**Results:** Evidence from the survey of 600 workers suggests that perception of risk of violence was key to participants’ decision making around retention. The literature examined offered information on the incidence, prevalence and impact of the violence experienced by professionals delivering key services in rural and remote workplaces, as well as the perceived and actual risks, causes of violence, levels of cooperation across the three sectors, and barriers to cooperation.

Risk factors were identified that appeared unique to the rural and remote setting.

**Conclusions:** The incidence and prevalence estimates appeared unreliable without uniform data collection standards. This was compounded by an under-reporting of violence in the workplace and ambiguity surrounding definitions of workplace violence. Violence prevention strategies must be multifaceted and consider individual, organisational and situational factors to be effective.

**Relevance to practice:** As a result of this research, an online portal has been developed for employers and professionals working in rural and remote Australia that is a ‘one-stop shop’ for information, case studies of cross sector cooperation and links on workplace violence.

Accessing strategies and stories of other communities and employers’ approaches to workplace violence is both enabling and important. Minimising and mitigating the risk of occupational violence in rural communities remains core business for communities, employers and professionals in the rural and remote sector. It will support greater retention of an experienced and sustainable workforce in rural and remote areas and, involve heightened community awareness of violence as a public health issue.

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**Multidisciplinary therapy services for children with feeding disorders in country South Australia**

**Jodie May**¹, **Larissa Ashton**¹, **Tara Brook**¹

¹Country Health SA

This project aimed to map the patterns of service delivery and quality of therapy services provided to children with feeding disorders across country South Australia, and make recommendations around training needs and service models for clinicians working with this group.

The results will be particularly relevant to rural multidisciplinary paediatric therapy teams working with children with feeding disorders, including fussy eating, complex feeding disorders, tube-fed clients and infant feeding disorders.

Rural health services can have limited access to specialist services and experienced staff. Country Health SA allied health workers identified this as a factor impacting on services to increasing numbers of children referred with complex feeding disorders. This can be a high-risk group of clients, requiring specialist skills and time-intensive input. A study into this issue was driven by the Country Health SA clinical senior speech pathologist, dietitian and occupational therapist with a defined ‘portfolio’ in paediatric feeding, appointed under the evolving Allied Health Professional Clinical Governance Structure.

A survey was developed aiming to collect quantitative and qualitative data on a range of factors relating to services provided to paediatric feeding clients in country South Australia. This was delivered by email across Country Health SA to occupational therapists, speech pathologists, dietitians, physiotherapists, social workers and allied health assistants, with a particular focus on those with a paediatric workload.

The survey—the first of its kind conducted in rural settings in South Australia—provides a unique insight into factors relating to services provided to paediatric feeding clients, including:

- the frequency and types of services provided to clients with different types of feeding issues (fussy eating, complex feeding disorders, tube-fed clients and infant feeding disorders)

- trends affecting service delivery by discipline, location and clinician experience
• the extent of multidisciplinary collaboration, evidence base, and evaluation of feeding services
• training completed in the area of paediatric feeding
• the confidence of clinicians in providing support for a range of feeding issues
• self-identified needs to improve worker confidence and competence.

We will present conclusions drawn from survey results around the strengths and gaps in services currently provided to complex paediatric feeding clients in country South Australia. Recommendations will be shared around training, competency and resource needs for allied health clinicians and consistent service models for working with children with feeding disorders, with a focus on improving quality of services and subsequently reducing clinical risk.

Can you hear me? Raising hearing loss awareness through rural Medicare Locals

Tony McBride¹
¹National Relay Service

Hearing impairment (full or partial hearing loss) is a relatively hidden condition in rural Australia, where farmers in particular have high rates of impairment due to unprotected use of farming machinery and other occupationally related causes. People who lose hearing capacity as they age tend to neither see themselves as disabled nor to link into support services. But although it is a significant issue for about five per cent of the population, it is not a health issue that features high on health service or government agendas.

This presentation will describe the strategies used in a 2012 project to increase awareness among rural health professionals through joint action with rural Medicare Locals (MLs). The findings will have relevance to organisations seeking to implement change in other important health areas via the new vehicles that are Medicare Locals.

The National Relay Service (NRS) is an Australian Government program that provides a phone service for people with hearing and speech impairments to have effective social, business and health care phone calls via third-party relay officers. It is a valuable tool for reducing social isolation among older people affected by hearing impairment. Health professionals in primary health care are influential in fostering use of the NRS among older people, but the NRS is conscious that knowledge about hearing impairment and relay calls among these providers is typically low.

The project systematically liaised with all MLs in operation for more than six months. MLs were typically open to discussions on the issue and a diverse range of strategies was jointly developed to raise awareness within the sector. In rural Australia, these varied from distributing regular brief communication items (via e-newsletters etc), to educational sessions for practice nurses to running booths at agricultural shows to developing an innovative online learning module. The NRS also commissioned data from the ABS to feed into the ML’s population health planning.

This presentation will share the findings of the work and the lessons learnt, and assess the potential of rural Medicare Locals to collaborate on such projects. The presentation will conclude with both practical and policy recommendations.

Assessing the effectiveness of ADHD treatment—a collaborative regional approach

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Aim: To measure the performance of children recently diagnosed with ADHD, both on and off medication, using a wide range of commonly available neuropsychological tests.

Methods: Children recently diagnosed with ADHD (paediatrician diagnosis according to DSM-IV-TR criteria, APA, 2000) were referred to the Bathurst Child Developmental Unit. The Bathurst Child Developmental Unit has been operational since 2002 as a joint collaboration between the Department of Paediatrics at Bathurst Base Hospital and the School of Psychology at Charles Sturt University (CSU) Bathurst.

Twenty children (17 boys, 3 girls, age 7 to 12) from the Central Tablelands of NSW were recruited between June 2009 and November 2010. All children had commenced medication within the previous 6 months.
Children within the study were administered a range of psychological tests looking at executive functioning, academic performance and behavioural measures both on and off medication. Children completed the test battery twice, in two approximately 90-minute sessions at least one month apart. Testing occurred in a quiet room, free of distraction, at CSU Bathurst. The children were assessed by the same registered psychologist as part of a Masters of Clinical Psychology.

Tests administered included the Connor’s Parent Rating Scale—revised (CPRS-R:L); Wide Range achievement Test—3rd edition (WRAT-3); Connor’s Continuous Performance Test—2nd edition (CPT II); the Trail Making Test (TMT); Test of Everyday Attention in Children (TEA-Ch); Digit Span and Similarities Subtests of the Weschler Intelligence Scale for Children, Fourth edition (WISC-IV); Complex Figure of Rey (CFR); Rey Auditory Verbal Learning Test (RAVLT) and the Cancellation test.

A series of paired sample t-tests were used to examine the impact of medication on participant’s scores. Participants were provided with feedback about the assessment through a report of the results provided by the researcher to the paediatrician.

Results: Despite the small sample size, significant improvement was noted on several measures from the CPT-II (suggesting improvement in attention) and on the Digit Span Subtest of the WISC-IV (suggesting improvement in working memory capacity). Significant decreases in problem behaviours were also observed on the CPRS-R:L. Furthermore, non-statistically significant improvements were noted across a number of other measurements, providing some clinical utility. These results will be presented and discussed using the tables and descriptive statistics that were made available to the treating paediatrician.

Relevance: ADHD is the most commonly diagnosed biological behaviour of childhood, occurring in 6 to 9% of school-aged children. ADHD remains a clinical diagnosis with ongoing controversies regarding over-diagnosis and over-treatment frequently cited in the media. Within a regional setting, assessment of medication efficacy generally requires both formal and informal parent and teacher feedback. This study looks at a novel multidisciplinary approach to assessment of medication efficacy within a regional setting.

Resilience: a model for allied health service provision in an oncology setting

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1Bendigo Health Care Group. 2Loddon Mallee Integrated Cancer Service

In its Cancer Action Plan 2008–2011, the Victorian Government identified four action areas to address over that time period. Of significance for the provision of allied health services was the identification of supportive care as a key priority area, recognising the need for early detection of supportive care needs through screening, and intervention to support patient and carer. Follow-up care and survivorship issues were identified as an under-developed but important field of cancer service provision.

This paper will be presenting a model developed with the aim of providing allied health services to an oncology population based in a regional health service. Historically, allied health services within the local medical oncology unit have been limited to dietetics and social work. External to the unit, most breast cancer patients are eligible for specialist multidisciplinary outpatient services, however there is no single, specialised rehabilitation service for other diagnostic groups. This results in a disparity of service provision dependent upon diagnosis. The aim of the resilience program was to provide an evidence-based, sustainable, patient-centred program addressing cancer risk factors, side-effects of surgical and adjuvant treatments and supportive care needs in a bio-psychosocial framework. It also aimed to promote awareness of the role of allied health in this patient population.

With funding provided by the local Integrated Cancer Service, this demonstration project was developed and conducted over the period of a year. Allied health staff experienced in oncology facilitated a group-based program that combined exercise, multidisciplinary education and relaxation training. Content was based upon current evidence and upon the needs of the individual participants as identified at initial assessment. Participants completed evaluations at the completion of each session and were also involved in interviews at the completion of the program. The outcome of these quantitative evaluations will be discussed along with the insights gleaned from qualitative interviews.
Specific insights into the process of formulating such a program will be presented with the aim of encouraging the engagement of allied health staff in this developing service area. This will highlight the opportunities and challenges that were identified during the planning, implementation and evaluation periods of the program. It will also present avenues for further consideration.

Changes to eligible midwifery status—new possibilities for rural maternity care

Jennifer McInnes¹
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Eligible midwifery status presents a tremendous opportunity for expanding rural access to maternity care. Recent changes to the Standing Council on Health’s determination on collaborative arrangements, which allow for collaboration with health services instead of a named obstetrician, are particularly relevant. Eligible midwives in rural settings have the potential to reduce the financial and emotional burden of extensive travel for antenatal care, and more importantly, the risks women will not access care due to prohibitive time and cost requirements. This is also relevant to Indigenous women, for whom birthing on their own land has additional significance.

Rural and remote consumers have highly limited access to antenatal care, local birthing services, and postnatal care that most Australian women take for granted. Closure or downgrading of rural maternity services transfers the economic, logistical and emotional burden of care from governments to families, and presents additional risks in terms of late or no access to antenatal care. The resultant deskilling of local health professionals presents serious difficulties if and when emergencies present.

The National Rural Health Alliance puts forward excellent recommendations for improving and expanding access to rural maternity care, but thus far neglects the opportunity presented by eligible midwifery. To support rural maternity care, significant research is required on the recruitment, retention and impact of eligible midwives in rural areas. This presentation will discuss policy guidelines and incentives to utilise eligible midwives in rebuilding rural maternity care. This includes policy requirements for rural hospitals to negotiate in good faith to establish collaborative relationships; funding for rural midwives to achieve the additional qualifications to become eligible midwives; and thoughtful retention of new direct-entry midwifery graduates, within appropriate models of care. This paper will also discuss international research and successes in rural maternity care, and the implications for policy development in Australia.

Cochlear implant management through the use of teleaudiology

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Objectives: Clinical service delivery for cochlear implant recipients is rapidly evolving due to exponential growth of the CI population and technological advances. Expanding selection criteria, bilateral cochlear implantation and a broadening of the age ranges considered for cochlear implantation have been a strong impetus for the growth in the population of CI recipients. As a result, Cochlear implant clinics must reconsider their traditional service models to ensure that they meet the needs of their ever growing client base, while preserving a high standard of service delivery.

The aim of this current study was to develop generic guidelines for the application of teleaudiology in cochlear implant mapping. Further, identification of incidental applications of teleaudiology in cochlear implant management was captured to develop models of management for cochlear implant recipients with limited access to centralised services.

Study design: Remote mapping was conducted using commercially available products readily accessed in most cochlear implant clinics with a total of 70 cochlear implant ears. Recipients were aged from 12 months to 85 years, some with additional needs, and were at various intervals of their post-operative management, including initial activation (or ‘switch on’).

Areas evaluated included time taken to complete a session, as well as clinician and recipient satisfaction as measured by questionnaires.

Results: Remote mapping sessions were completed on 82% of occasions. Incomplete sessions were due to poor internet connectivity. Most adult recipients and parents of paediatric clients were pleased with the outcome of their remote mapping or could see the value in developing this procedure for future implementation.
The time taken and outcomes from the remote mapping was on average the same as that taken for face-to-face sessions.

Incidentally, teleaudiology was used to evaluate the integrity of the cochlear implant, troubleshoot external equipment, and to provide auditory training to maximise the integration of the signal provided by the cochlear implant.

**Conclusion:** While remote mapping was effective with a range of cochlear implant recipients and devices, modifications at the remote site and at the local end were required to accommodate the needs of certain clients, such as children with additional needs, and when using interpreters.

A series of use cases and guidelines has been developed to assist other clinics in the implementation of remote technology when managing cochlear implants recipients.

**Developing professional competencies for rural health students through service-learning placements**

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¹La Trobe University

**Aims:** This paper aims to highlight an alternative model of professional practice education that enables students to develop generic skills and competencies that all rural health professional students require, such as cultural awareness, enhanced communication skills, teamwork, problem solving and understanding of social determinants.

**Methods:** Second-year occupational therapy students undertake a 13-week, part-time, service-learning placement situated in two local regional secondary colleges. In pairs, occupational therapy students spend two hours per week working with secondary school students who have a variety of issues such as mental health, school disengagement, learning disabilities, autism spectrum disorder or limited English. A significant number of these students are also from a refugee background. At university, preparation and ongoing workshops provide occupational therapy students with support and knowledge relating to learning and teaching, communication, professional behaviours and cultural competence. Students keep a reflective journal throughout the placement and give formal presentations on their placement experiences to academic staff and college welfare and teaching staff.

**Relevance:** To adequately prepare for the complexity of rural practice, undergraduate students require professional practice placements in a range of diverse settings including non-clinical services.

**Results:** Service-learning has provided students with the opportunity to develop generic professional skills such as communication, rapport building with clients, time management, and skills in organising, negotiation and conflict resolution. Students gain an appreciation of how socioeconomic, education, cultural and psychosocial factors impact on secondary students. Occupational therapy students also have a significant impact on the students they work with, providing them with one-to-one support, a positive role model, and lifting aspirations of rural students who have lowered self-belief and educational goals. Feedback from host organisations has been overwhelmingly positive, with requests to expand these placements.

**Conclusion:** Gaining essential generic professional self-management and communication skills can be achieved from service-learning placements, outside of the traditional health or human service setting. Although service-learning is well established in the US and in some parts of Europe, it is under-utilised in Australia. It is recommended that health professions view professional practice placements more broadly, particularly to acquire generic professional skills and consider innovative placements outside of the traditional settings for early year students. Service-learning placements provide universities with a vehicle for authentic community engagement to increase higher education participation for rural and regional secondary students who often lack positive roles where there are benefits for all partners involved in these placements.

**Mental health in older rural Australian women**

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**Introduction:** Although older adults generally report lower rates of depression than younger adults, there are conflicting findings regarding urban–rural differences in psychological distress in older adults. Previous research has shown that older women are more likely to be widowed and to have limitations in
physical functioning; older rural women may also experience difficulties accessing appropriate health and social support. Older rural women could therefore be more vulnerable to psychological distress.

Methods: Participants were drawn from the 1921–1926 birth cohort of the Australian Longitudinal Study on Women’s Health (n=12 432) who were aged 70–75 when recruited in 1996. The main variables used were: psychological distress as measured by the Mental Health Index (MHI) of the SF-36 scoring less than 52; area of residence classified as major cities, inner regional, outer regional and remote/very remote; sociodemographics; physical functioning; and social support. General estimating equation models were used to estimate the independent effects of each of the variables on the proportion with MH <52 over the course of the study (15 years).

Results: After adjustment for other factors older women residing in inner regional, outer regional, and remote/very remote areas were found to have significantly better mental health compared to women in major cities as measured by MHI <52 (ORs 0.90[0.82–0.99], 0.85[0.77–0.99], 0.66[0.46–0.95]).

Conclusions: Older women living outside major cities have significantly better mental health. This advantage is greater in the remote/very remote areas. They may be a more resilient group.

Enhancing computer literacy and information retrieval skills: a rural and remote nursing and midwifery workforce study

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1James Cook University, 2Australian Catholic University, 3Charles Sturt University, 4Hashemite University Zarqa-Jordan

Nurses and midwives, collectively, represent the largest workforce category in rural and remote areas of Australia. Maintaining currency of practice and attaining annual licensure with the Australian Health Practitioners Regulatory Authority (AHPRA) present challenges for individual nurses and midwives and for their health service managers. Engagement with information and communication technology, in order for geographically isolated clinicians to access ongoing education and training, is considered a useful strategy to address such challenges.

This paper presents a pre- and post-test study design, which examines the impact of an online continuing professional development (CPD) program on rural nurses and midwives. The aims of the program were to increase basic skill acquisition in the utilisation of common computer software, the use of the Internet, and the enhancement of email communication.

Findings from the study demonstrate that participants who complete a relevant CPD program gain confidence in the use of information and communication technology. Further, increased confidence leads to increased access to contemporary, reliable and important health care information on the Internet, in addition to clinicians adopting email as a regular method of communication.

Health care employers commonly assume employees are skilled users of information and communication technology. However, findings from this study contradict such assumptions. It is argued in the recommendations that health care employees should be given regular access to CPD programs designed to introduce them to information and communication technology. Developing knowledge and skills in this area has the potential to improve staff productivity, raise health care standards and improve patient outcomes.

The National Arts and Health Policy Project

Deborah Mills1
1Arts and Health Foundation

On 11 November 2011 an arts in health paper, developed with the assistance of the Arts and Health Foundation (AHF) and calling for the development of a national arts in health policy, was passed through the Australian Government’s Standing Council on Health. This decision was supported at the meeting of arts and cultural ministers in March 2012.

These decisions were a response to the AHF’s campaign for a national policy for arts and health driven by the desire to enable improvements in the health and wellbeing of individuals and communities through a more cohesive approach to knowledge sharing and sector development for contemporary research and practice in arts and health.

Australia’s first arts and health policy will have been developed by March 2013, so the 12th National Rural Health Conference will provide a timely opportunity to review the policy and provide an analysis of its strengths and weaknesses against:
• the opportunities and challenges presented by attempts to develop cross-sectoral and multidisciplinary policy

• the scope of the policy and its ability to embrace a focus on wellbeing rather than ill health

• its alignment to the values and principles driving arts and health practice in Australia

• the expectations of the arts and health sectors on what a national policy framework should deliver

• the opportunities and constraints provided by the current policy environment in both the arts and health sectors.

This analysis will be supported by a brief overview of AHF’s activities to develop and inform a national policy including:

• three years of quantitative research and consultation with the arts and health sectors in Australia

• the development of strategic partnerships with key organisations, including the Victorian Health Foundation (VicHealth), the National Rural Health Alliance, Arts in Health at Flinders Medical Centre and Disability in the Arts, Disadvantage in the Arts WA (DADAA WA)

• establishment of two online platforms to support the Australian arts and health community

• a submission in response to the National Cultural Policy Discussion Paper demonstrating the role that an arts and health policy could play in the Arts Minister’s whole-of-government approach to arts policy

• convening a national arts and health policy forum in Parliament House, Canberra, in June 2012

• facilitating the consultation process to provide input to the draft Arts and Health Framework developed for the Standing Council on Health.

The process of evacuating a regional hospital prior to a pending natural disaster

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On 3 February 2011 tropical cyclone (TC) Yasi struck the coastline of north Queensland, Australia. This study explored the process of a pre-emptive evacuation of a 330-bed regional hospital prior to the cyclone. A range of health care professionals and middle management staff (n=15) were interviewed about their experience of the hospital evacuation. Patient care and safety was the overarching priority for everyone involved in the hospital evacuation, but communication issues challenged the effective management of the evacuation process. Four hierarchical levels of leadership were identified. Communication breakdowns between each level, and the lack of an evacuation plan, led to confusion about roles, responsibilities and processes, contributed to lengthy delays for patients waiting to be evacuated, and resulted in less than optimal patient care. Given the unpredictability of natural disasters, a comprehensive disaster evacuation plan focusing on communication, pre-planning and leadership, is essential for hospitals in vulnerable locations.

eHealth: supporting adoption in rural communities

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Introduction: The personally controlled electronic health system (eHealth record system) commenced operation in July 2012 and has the potential to significantly improve the way health care is delivered in rural communities. This paper will give an overview of the national eHealth record system and the potential benefits, as well as describing the support available for consumers and health care professionals in rural communities. It will also include a demonstration of the system, showing how the various components of eHealth technology are used together.

Rural health and eHealth: People living in rural communities face unique challenges in gaining access to health care. They are likely to have to travel in order to access specialist (and even generalist) health
care services, often resulting in fragmented health records.

The national eHealth record system is a critical component of Australia’s eHealth strategy, and has the potential to significantly improve the way health care is delivered in rural communities. It is a secure, electronic record of a consumer’s health information, stored in a network of connected systems. The eHealth record system will bring key health information from a number of different systems together and present it in a single view.

Rural communities are a key target group for the national eHealth record system, with the benefits of participation centred on improved personal control over health information, improved continuity of care (thereby enabling improved management of chronic disease), improved coordination and follow-up post of acute episodes, and reduced adverse drug events.

Supporting adoption of eHealth: A range of initiatives is in place in order to support the adoption of eHealth in rural communities, both for consumers and health care providers. Consumers will be able to register for an eHealth record in a number of different ways, including online, by phone, and by mail. Once registered, consumers will be able to access their record via an online consumer portal. For health care providers, the system is being promoted through a broad range of rural health organisations. Additionally, the Practice Incentives Program (PIP) eHealth Incentive offers incentives for practices to set up the infrastructure required for eHealth.

Conclusion: Broad adoption of eHealth is critical to its success, and the more widely it is adopted the greater the benefits for Australians living in rural and remote communities will be. It is therefore important to continue to measure and report on uptake, and to evaluate the outcomes.

Listening—the first step to developing a state-wide hearing health plan

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Queensland Aboriginal and Islander Health Council (QAIHC) supports twenty-seven community-controlled health services. An important role is to build organisational capacity and assist in planning, development and delivery of comprehensive primary health care to their communities; as well as assessing health needs of Aboriginal and Torres Strait Islander individuals and families.

It is widely recognised that otitis media is a significant health problem in Aboriginal and Torres Strait Islander communities. Otitis media can significantly impact language development, education, social interactions and psychological health, which lead to poor employment opportunities, greater likelihood of substance use (including tobacco and alcohol) and in turn lay down the foundation for other chronic illnesses/diseases. It would be impossible to ‘Close the Gap’ on education and health if Aboriginal and Torres Strait Islander children’s hearing is impaired by this largely preventable condition.

The Commonwealth Government’s Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes measures expand these health services for Indigenous Australians. Funds have provided the first steps for QAIHC to investigate strategies that determine an implementation plan for our health sector that will enhance prevention, early identification and early treatment of appropriate ear and hearing health programs towards Indigenous communities.

These steps include the importance of consultation amongst Aboriginal and Islander Community Controlled Health Services; as well as the importance of negotiations amongst key organisations involved in Hearing and Ear Health Plans across the state.

This paper will report on the key findings of this process and the recommendations to be included into a state-wide Hearing Health Plan for the Aboriginal Community Controlled Health sector in Queensland.

Helping families overcome eating difficulties through play picnics

Kirralee Moores\textsuperscript{1}, Debra Sandford\textsuperscript{1}, Erin Croft\textsuperscript{1}
\textsuperscript{1}Southern Fleurieu Health Service

For many children eating is a pleasurable and social experience that also provides the nutrients needed to maintain health. Conversely, for many families in our community, supporting their child to eat is extremely challenging.

Aims: Play picnics (PP) provide a positive food experience in a supportive and social setting for children and their families where the child has an identified difficulty around their oral intake or
comfort around food and mealtimes. Children involved in the PP are encouraged to explore food and food utensils in their own way; they are not expected to eat.

Methods: Adapted from the Early Autonomy Training (EAT) Program developed by the Graz Hospital for Sick Children in Austria, PP were facilitated by a multidisciplinary team (speech pathologist and occupational therapist) in the Early Learning for Families (ELF) team at Southern Fleurieu Health Service with support from a therapy assistant. Additional support from the ELF physiotherapist and psychologist was also provided as required. PP were held for one hour once a week over a four-week period, with an expectation that parents would provide play picnics at home. Parents/carers were interviewed using a semi-structured interview pre- and post-program (at program end and 6 weeks post). Using qualitative methods the pre- and post-program interviews were themed into the following categories: food intake (FI), food variety (FV), food exploration (FE) and parents perceived stress around meal times (PSMT).

Relevance: There is increasing demand on regional health services to support children with complex eating issues following discharge from metropolitan hospitals, thus assisting to avoid traumatic and costly re-admissions.

Results: Under the FI theme parents reported an increase in their child’s general willingness to consume food at meal times and an increase in the amounts of food their children ate at mealtimes. Parents reported an increase in the types and variety of food their child was willing to attempt (FV). Parents also reported that they felt less stressed and anxious and felt more confident to follow their child’s cues around meal times (PSMT). In addition, they also reported that their child appeared more relaxed and happy and showed more pleasure and willingness to explore new foods during the eating experience (FE) after completing the PP program.

Conclusions: This model has provided successful and long-lasting results. It can be easily replicated and has been manualised. Further it can be facilitated by a variety of multidisciplinary combinations. Programs such as PP reduce the demand on services provided by metropolitan acute settings.

What’s fair in vision care? Potential approaches for equitable access to spectacles

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Aims

• To understand the benefits and disadvantages of existing spectacle schemes, particularly access to them by Aboriginal and Torres Strait Islander (Indigenous) Australians.

• To gauge optometrists’ support for the concept of a ‘national spectacle scheme’ (NSS) for Indigenous Australians.

• Using these findings, to recommend potential approaches for improved access to affordable spectacles for Indigenous Australians, to ensure more equitable vision care.

Methods: A survey questionnaire was administered to Australian optometrists and associated personnel (Oct 2011 and Sep 2012), to provide a scoping analysis of existing spectacle schemes in each state/territory of Australia, understand benefits, barriers, and optometrists’ insights about access to the schemes by Indigenous Australians, and gauge the level of support for the concept of a NSS for Indigenous Australians.

Relevance

• There are significantly higher rates of vision impairment amongst Indigenous Australians, half of which is due to uncorrected refractive error (URE).

• State and territory government subsidised spectacle schemes are available to Indigenous Australians meeting pensioner/concession criteria. Yet, higher rates of URE in this population suggest that such schemes may be under-utilised.

• One potential approach to overcoming correcting refractive error (i.e. cost) is a National Spectacle Scheme (NSS), proposed in concept by a range of stakeholders in the Indigenous eye care sector. Such a targeted approach may align with similar ‘close the gap’ measures to overcome
the distinct disparity in visual health experienced by Indigenous Australians.

Results

- Survey respondents indicated majority support for the concept of a NSS, and indicated they would likely use this scheme, given some considerations regarding defining eligibility criteria, promoting availability of the schemes to the target population, and logistical and administrative concerns relating to the introduction of an additional scheme.

- Based on the survey findings, and broader lessons learnt and discussions with other service providers and government representatives, a concept/position paper was developed, proposing some possible approaches:
  - introduce a standardised NSS, specifically for Indigenous Australians
  - introduce a NSS, but with broader eligibility criteria to (all economically disadvantaged people)
  - advocate to state/territory governments to conform their pensioner spectacle schemes to a set of common criteria to ensure equal opportunity to access affordable vision correction for all people.

Conclusions

- A ‘position paper’ regarding spectacle provision for Indigenous Australians has been prepared, ready for submission to government and other relevant stakeholders.

- This survey primarily uncovered practitioner perspectives; the ultimate decision and policy should be developed in consideration of other factors.

Rural intermediate care in South Australia: a perspective on the first 12 months

Daniel Mosler1, Scott Clark1
1Country Health SA

Intermediate care has become an established mechanism in South Australia for providing sub-acute levels of psychiatric care to clients during the transition from hospital to community settings, as well as providing an alternative to hospitalisation for clients who prefer home-based care or non-hospital treatment. Facility-based intermediate care services have been operational in metropolitan Adelaide for approximately two years, but a further challenge arises when considering such a service in rural and remote locations. In particular, funding restrictions and a sparsely spread rural population have not allowed for facility-based services. The teams were established in the context of a state-wide rural population of approximately 475 000, managing with only one resident psychiatrist (0.2 FTE) currently practising in rural South Australia. The current model relies on visiting psychiatric clinics and a videoconferencing network of 106 sites, providing a consultation-liaison model of care to the rural population.

The Rural and Remote Mental Health Service in South Australia has aimed to meet this need via the development of five regionally based intermediate care teams with a model similar to that of existing metropolitan hospital-at-home services. The first of the five teams was established in Mt Gambier, in the south-eastern region, with a population of 24 000, but servicing a region of 65 100. The larger regional centres—Mt Gambier, Whyalla, Port Lincoln, Berri and Kangaroo Island—have been allocated funding to provide a total of 30 packages of care for clients appropriate for intermediate care. Capital works are currently in process to add approximately 14 facility-based intermediate care beds, attached to four of the major regional hospitals in this state.

The success of this service, in terms of providing an improved level of capacity for the mental health service, as well as achieving its goal of reducing the need for inpatient admissions, has been underpinned by a number of examples of positive feedback via clients and mental health staff alike. This paper aims to give a qualitative description of the experience of the team involved in establishing the service in Mt Gambier during its first 12 months and to give a perspective of its place in the wider network of mental health care across rural South Australia.

What the world needs now is Love
Punks: using digital media for positive change

Debra Myers1, Elspeth Blunt1, David Palmer1
1Big HART

The YijalaYala Project is a long-term, multi-platform arts project based in Roebourne, WA focused on telling the story of the community in a range of
media. Through arts and digital media skill development and content creation, it explores the inter-connection between past, present and future, young people and older generations, and ancient and modern culture, while engaging young people at risk of offending, substance abuse or leaving education in activities that may assist them to make positive life choices as they grow into adulthood.

Roebourne has long been viewed as one of Australia’s most socially dysfunctional towns, with a long history of trauma that plays out in behaviours such as substance abuse, crime, domestic violence, unemployment and truancy. While many programs and projects introduced into the community focus on the problems, the YijalaYala Project wanted to find a way to change the narrative into something more positive. The focus on new media came about in an unexpected way in 2011 when a group of Roebourne’s young people got together with Big hART’s mentors to make a zombie satire film about how youthful energy can bring about change to situations that are stuck, and is essential in keeping individuals and communities healthy and strong. The film has adults as zombies, trapped by bad habits and repetitive tasks, meeting the young, trickster Love Punks who ‘doctor them up’ with a bit of fun and Burt Bacharach. The film was a huge success both in and outside of the community and it left the kids wanting to do more ‘Love Punk’ stuff. Big hART’s mentors saw how keen on computer games and mobile devices young people in the community were and introduced workshops in digital media and literacy that led to the making of an online game starring themselves, followed by an interactive comic for iPad that combines animation, music, voice-overs, live action films and text that tell stories of their world, culture and country.

The workshops and the products that have been created have brought the stories of this previously troubled community into the public sphere and generated much-needed positive media attention for a community that the media and outside public love to fear. This presentation will introduce you to the power of combining digital media, positive role-modelling, life-skill building and the energy of youth to bring about positive health consequences and social and emotional wellbeing in a Western Australian Aboriginal community.

Engaging Australia’s rural future health leaders: the role of social media

Shannon Nott
Future Health Leaders, NSW Health

Background: Social media is a tool that has been recently given the ‘approach with caution’ tag by the Australian Health Practitioner Regulation Agency. The recent release of AHPRA’s preliminary consultation paper on social media policy has caused a significant uproar within the health care ranks with little recognition of the huge benefits that social media can bring. Future Health Leaders is a new organisation in the health advocacy arena in Australia representing health students and early career health professionals (within five years of graduation). One of its key goals is to provide high-level as well as grass-roots facilitation of individuals and organisations to comment on health issues in Australia, as well as promote health programs. This paper will share the lessons learnt from this organisation through its engagement platform with Gen X and Gen Y as well as health organisations across Australia and the world.

Objective: This paper will specifically look at how the rural health care community can utilise social media to its full in engaging our next generation of health leaders in rural and remote Australia. Through this analysis, the paper will showcase best-practice models in the utilisation of social media, particularly in inspiring a new generation of health professionals, as well as engaging with our youth population of patients. The paper will look at the evolving AHPRA social media policy and contrast this with the benefits of social media, especially within the rural context. It will also highlight some pitfalls of social media and ways in which we can upskill graduate professionals in the appropriate use of social media.

Key messages
- Social media is a tool that can be utilised to engage rural Australia future leaders.
- Social media can narrow the professional/patient health information gap, benefiting communities especially in regards to primary prevention of disease.
- Strong and appropriate use of social media can promote rural health to students at university.
- Social media has its pitfalls; however, these are preventable.
Conclusion: This paper will explore how social media can play a significant role in rural health practice as well as how we can use it to engage the next generation of health leaders in rural and remote communities.

'I can see clearly now'—an Aboriginal success story

Maree O’Hara
Anyinginyi Health Aboriginal Corporation

This paper will present an overview of an eye health program that has been running for the last six years in a remote region of the Northern Territory. The service covers an area of 322,500 sq km. In 2006, the eye health program serviced 250 clients—fast forward to 2011, and 1200 people were seen, and the program continues to grow.

As well as the number of clients growing, knowledge and perception of eye health is slowly changing for people in one of the largest regions. Previously many people did not expect to be able to see as they got older, and thought loss of sight was normal, and that nothing could be done. Now the community are more aware of the services available to care for their eyes.

The journey has been long but highly exciting! The eye health service has been re-created under the guidance of many Aboriginal health professionals and the community members so that the service continues to be flexible to the clients, creating a more accessible service. Barriers such as transport to eye health services, access to affordable glasses, and flexibility of appointment times have been addressed, and are reviewed on an ongoing basis. The intense sunlight of our region, and sensitivity to it after some eye examinations was a concern, so we sought funding to offer free, fashionable sunglasses to all clients who wanted them.

Fear of eye surgery was and is of great concern, so an Aboriginal interpreter, a local person, was employed to be at every appointment and in surgical theatre. The eye team was there at every eye appointment also, so friendly faces were always available. The local Aboriginal Health Corporation has supported this program so that two people are now employed to maintain the level of care. Aboriginal people have advised and supported this program from the beginning to make it one they can proudly own. The clinics are run in very flexible ways so Aboriginal lifestyles and preferences were taken into account every time, knowing that one size does not fit all.

Confidence in our service by other organisations has been shown in many ways, the latest being that a DVD is being made on eye health in one or our own communities with the eye coordinator as consultant and gopher! This may soon be viewed nationally on TV and available for all health centres.

Seeing used to be a luxury, but it is now a right that all can and do demand.

Adaptation of the clinical nurse role for improved safety in SA rural hospitals

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Country Health SA Local Health Network

Aim: Utilise the RN2 clinical nurse role to implement quality and safety priorities across the Country Health SA Local Health Network (CHSALHN).

Problem: A number of quality and safety initiatives needed to be coordinated and applied consistently across CHSALHN, but communication and standardisation across 65 sites was challenging due to geographical distance and diversity in resources.

Method: In the 2007 Nurses and Midwives Career Structure Review, a clinical nurse role was introduced that could undertake portfolio responsibility. In 2011, the work completed by these experienced nurses was aligned and structured by:

- identifying five key quality and safety priorities
  - deteriorating patient
  - medication safety
  - fall and fall injury prevention
  - infection prevention and control
  - blood safe

- adopting a tiered model spread evenly across CHSALHN sites
  - Tier 1 was a project lead
  - Tier 2 was a Portfolio RN2 (nominated by each group of hospitals/site)
  - each portfolio was supported by a DON lead

- clinical nurses were supported with a training workshop
all staff undertaking the project/program were encouraged to undertake the SA Health Clinical Practice Improvement Program.

Relevance: A new staffing resource was organised to efficiently address significant risk areas within CHSALHN and implement systems in accordance with National Health Service Standards.

Results: The organised distribution of clinical RN2s facilitated:

- two-way communication between project team and local staff
- communication across multidisciplinary teams (someone able to participate at local forums)
- site-based decisions within standardised systems and tools
- increased buy-in from local staff; combated change fatigue
- networking within clusters and across all of CHSALHN
- a support network between clinical RN2s
- early identification of problems
- ownership of project/program improved work flow; someone driving targets
- the rapid establishment of local experts and champions
- improved outcomes in key quality and safety programs.

Conclusion: A successful adaptation and utilisation of the clinical nurse role assisted in overcoming the barriers of distance and diversity to begin the process of embedding key safety and quality priorities.

Active ageing, employment and rural SA: a Health in All Policies project

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Aims and relevance: The South Australian Health in All Policies (HiAP) initiative provides a framework and mandate for intersectoral policy work on the social determinants of health. Participation in decent and meaningful employment is a social determinant of health, and is also an important strategy to promote ‘active ageing’ in the population. This paper reports on an intersectoral project undertaken by both the SA HiAP Unit and Country Health SA Local Health Network (CHSA LHN) that focused on promoting employment participation (both retaining existing workers, and enabling older individuals to re-enter the workforce) as a strategy to support active ageing in rural South Australia.

Methods: The project included a number of activities. The initial phase comprised a literature review to identify existing evidence on factors associated with employment participation among older workers (age 45+), and workshops in four areas of regional South Australia with CHSA LHN employees. At these workshops, participants provided information on the local context impacting upon employment participation. Following these initial steps, a desktop analysis was conducted to identify policy opportunities in each region to promote employment retention and re-entry. CHSA LHN staff were actively involved and supported by the HiAP Unit to engage with local non-health stakeholder organisations to identify and implement policy opportunities to enhance older rural residents’ employment participation.

Results: This paper presents preliminary findings from each of these aspects of the project. Two major models were combined to categorise the identified literature: the Social Determinants of Health Framework and the Active Ageing Framework (both developed by the World Health Organization). These suggested four levels of potential policy influence on workforce retention and re-entry:

- cultural/policy climate
- work and non-work context of daily life
- work and non-work social/community relationships
- individual behaviour.

Non-work contextual factors identified by workshop participants included housing and transport. The findings suggest that the involvement and capacity building of CHSA LHN staff offered benefits for their organisation and for the local stakeholders in the non-health sector, and ultimately improved employment opportunities for older rural workers in South Australia. However, this approach also presented a range of challenges and complexities.
Conclusion: We conclude with a discussion of policy implications for using a Health in All Policies approach to build capacity within and outside the health sector to promote active ageing through employment in rural areas.

Survival stories: wellbeing of older widowed Greek migrants in rural South Australia

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Worldwide, the experience of widowhood affects many older adults and can be associated with diminished mental health and wellbeing. This presentation draws on PhD research exploring the social and economic dimensions of wellbeing in widowhood for older Greek widows and widowers in South Australia’s Riverland region, including factors of ethnicity, residential location, gender, socioeconomic status and social support. Australia’s ageing population (individuals aged 65+) includes 55,000 first-generation Greek migrants who arrived mainly in the 1950s and 1960s, and who have aged ‘in place’ in a ‘foreign land’.

Aims: The work presented in this paper aims to fill a gap in existing knowledge about the widowhood experiences among rural older Australians from a culturally and linguistically diverse background, and the implications of this knowledge for service delivery and policy. This group is particularly likely to experience multiple disadvantages, and has lower service use than the mainstream Anglo population.

Methods: A qualitative study has been designed to capture the distinct and nuanced ‘voices’ of older Greek widows and widowers from rural areas in their native language by a researcher who shares their cultural and linguistic background. A mutual understanding and consideration of relevant socio-historic, cultural and contextual information enables a deeper understanding of the widowhood experience and wellbeing for this cultural group. In-depth interviews are used to uncover the lived experience of widowhood and factors relating to wellbeing, as presented by individuals who are routinely excluded from mainstream research due to linguistic difficulties and rural locale.

Results: Findings from in-depth interviews with 20 widows and widowers will be presented, and will focus on the following aspects of widowhood: participants’ perceptions of their health and wellbeing; the lived and cultural experience of widowhood in a rural area; gender differences in bereavement/widowhood ‘roles’; and the impact of socioeconomic status and social support (including the importance of family) in daily life. The paper will draw on Bourdieu’s conceptions of four types of capital (social, cultural, symbolic and economic) to explore the factors shaping experiences of widowhood. Implications for policy and service provision for this group will also be highlighted.

Conclusion: Cultural background shapes the way individuals experience ageing and widowhood. This paper presents the voices of some older rural migrants, appreciating that experiences vary both across and within groups. Only by depicting the lived reality of older rural Greek-Australians from their subjective vantage point may we truly begin to inform policy and service diverse populations.

Goldfields SHAK Facebook—a new approach to providing sexual health advice

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Background: The Goldfields is located in the south-eastern corner of Western Australia and is the largest region in WA. The area is more than three times the size of Victoria and covers almost a third of WA’s total land mass.

The permanent regional population of the Goldfields is around 59,000, boosted by a significant number of workers who fly in from Perth to work on remote mining sites. Just over half the population lives in Kalgoorlie-Boulder (approx 32,000) and another quarter live in the Shire of Esperance (approx 13,000). It is estimated that 8% of the region’s population is of Aboriginal descent, compared to 3% for Western Australia as a whole. There are 17 Aboriginal communities within the Goldfields.

The concept of using social media and the establishment of a Sexual Health Facebook page was born in response to increasing rates of chlamydia in the Goldfields. Chlamydia is the most commonly notified sexually transmitted infection (STI) in Western Australia and is endemic in the Goldfields with males and females aged 15 to 24 years found to have the highest rates. Traditional methods of health education have limited success with this difficult-to
reach target group. But young adults in this age-group are very IT savvy— a talent worth utilising.

The Northern and Remote Country Health Service Public Health team have successfully established the first Facebook page in use within WA Department of Health (breaking new ground for others to follow).

**Aim:** To increase communication on sexual health matters to the target group of people aged 15–30 years, thus improving knowledge of sexual health and increasing the uptake of use of services in the region.

**Background research:** Current forms of social media were reviewed; with the conclusion being that social media can be an effective tool in reaching the target audience. A survey of local youth was conducted and the results showed 85% of those surveyed used Facebook on a daily basis; and furthermore 82% would use Facebook to access information on sexual health.

**Results:** Goldfields SHAK was launched in February 2012, 12 months after the original proposal was submitted. This innovative initiative has been highly successful, especially within the hard-to-reach population many of whom are Aboriginal. Continuity is important; staff turnover can be a challenge within the region and Facebook allowed for this. The process of establishing the Facebook page, the running of the program (including safety, quality and risk) and the results to date (successes) will be shared in the presentation.

**The art of integrating play into rural paediatrics**

**Judi Parson**

1University of Tasmania

Research has shown that children who require acute health services may experience anxiety, distress or psychological trauma. Vicariously, family members and health care professionals may also experience similar responses. One way to alleviate the impact of distress is by integrating play therapy skills and techniques into rural paediatrics.

Play has been identified as a children’s nursing competency yet it has been given little attention throughout Australia. Play is represented in the literature as the child’s way of communicating. Thus, it is through this medium that adults must use developmentally appropriate language for the child to understand and comprehend their health care service. It is not appropriate for the child to be expected to communicate at an adult level.

As a paediatric qualified registered nurse and play therapist, I plan to share my experience and demonstrate to health care professionals working in rural areas some practical skills and techniques that could be integrated. For example, when a child is required to have a peripheral venous cannulation, offering ‘the magic glove’ technique may help the child cope with the fear of, and in doing so minimise, pain associated with the procedure. Additionally, when a child is required to undergo a specific procedure, personalising a calico doll may be used as an age-appropriate educational opportunity. Sensory play can be used as an expressive play technique to facilitate relaxation when a child may be distressed. These play experiences may include textures such as clay, play doh, slime, squishy squishy toys, paint, sand, and water to experience tactile sensations and could be made available for integration into the health care experience. Projective symbolic play can give health care professionals insights into the child’s thoughts and feelings about their present emotional state.

Play is a state, a mindset that is fun, creative and imaginative. You can integrate the art of play into rural paediatrics by maintaining an attitude of playfulness.

**The impact of the Medical Specialist Outreach Assistance Program on improved access to specialist services for regional and remote Australia**

**Jim Pearse**

1Health Policy Analysis Pty Ltd, 2Australian Health Services Research Institute

People living in rural and remote populations tend to have poorer health care status, and thus have higher health care needs. However, they have less access to health care services, including specialist medical care and optometry. The Medical Specialist Outreach Assistance Program (MSOAP) and the Visiting Optometrists Scheme (VOS) were established to address these issues. This paper reports on the results of a national evaluation of MSOAP and VOS undertaken in 2011, with a specific focus on estimates of the impact of MSOAP on access to specialist care.

The national evaluation had a broader set of aims including to assess effectiveness, efficiency and equity impacts of the programs, identify opportunities for
improving coordination and streamlining of administration, and examine the potential impact of health reform for both programs.

Evidence for the evaluation was gathered through:

- reviewing of program documentation and literature
- analysis of program and other data
- interviews with stakeholders across Australia
- reviews of written submissions from stakeholders
- a survey of clinical service providers supported through MSOAP or VOS
- case studies of eight localities across Australia.

The evaluation concluded that MSOAP is having a material impact on access to specialist services for rural and remote Australia. Overall, it is estimated that MSOAP has reduced the gap in access to specialist service between major cities and rural and remote Australia by 0.4–0.7 percentage points for inner regional areas, 1.9–2.9 percentage points for outer regional, 2.0–2.9 percentage points for remote and 9.0–13.8 percentage points for very remote. In addition to improving access, the program has other benefits, such as maintaining continuity of care and promoting shared care between primary and specialist providers.

Conceptually, alternatives to outreach care include patient-assisted travel, telemedicine and ‘primary care only’ care. In practice these modalities are not direct substitutes, and there is a mix of approaches for improving access is feasible. It was concluded that, in general, outreach specialist care represented a cost effective alternative to patient-assisted travel. The impact of the program on health status could not be assessed.

‘Losing it—in the bush’: a partnership to support rural communities

Dianne Penberthy1, Jane Newman1
1Mid North Coast Local Health District

‘Losing it—in the bush’ (LIITB) empowers small and isolated rural communities populations (<5000 people) to take action to improve their own health in partnership with their community. LIITB is a locally developed program empowering rural people living in the Port Macquarie Hastings Local Government Area to make healthy lifestyle changes to reduce their risk of acquiring and the complications from chronic disease. A partnership between nine rural communities, Port Macquarie Community Health (PMCH), Port Macquarie Hastings Council and At My Pace Specialist Rehabilitation, the program operates out of seven rural halls. Funding for this program was through the NSW Health Healthy Community Council Grants 2010-11. Each venue received exercise equipment, which is theirs to keep. The Rural Primary Health Service developed a twelve-week program that runs in each venue. Sessions are two hours per week, including an exercise component and a presentation on healthy lifestyle by PMCH professionals. Professionals include: dietician, health promotion, women’s health, mental health and occupational therapy. The program promotes existing national health programs; Measure Up, Get Healthy Telephone Line, Swap It Don’t Stop It, and the Heart Foundation Walking Groups Program. The Rural Adversity Mental Health Program has built capacity into this program by providing education and funding health days on mental health and wellbeing. This is a preventative and interventional model to tackle health issues associated with inactivity and poor nutrition. Participants lost weight, gained strength and flexibility, lost centimetres off their waist and increased their cardio fitness as a result of the program. Feedback from participants showed overwhelmingly the sense of fun they had as a group. Most communities continue to do some group exercise following completion of the program.

All participants (n=149) achieved increases in flexibility (89% and 80%); agility (20%); strength (14% and 20%) and cardiovascular fitness (19%). A combined loss of 2.5 metres in waist measurements is astounding.

This program is sustained through the establishment of local walking groups and the equipment is left in each hall for the community to use.

Take home message:

- ‘You don’t have to do a lot of exercise to feel so much better and more energetic.’
- How vital to good health is having fun, making new friends and enjoyed the sense of community.
A brave new world

Jennifer Perino1, Vicky Jack2
1Australian Counselling Association, College of Clinical Counsellors, 2Minister for Social Services

With a struggling economy as the backdrop Norfolk Island Government bravely entered a new world. An outside world that was rapidly encroaching on a lifestyle and a culture that holds its independence tenaciously, as a self-governed external territory of Australia.

Norfolk Island is a small (8 km by 5 km) sub-tropical island off the eastern coast of Australia, isolated not only in its geography but also by a combination of diverse cultures and unique social structure.

Without a history of child protection services, the Child Welfare Act 2009 was enacted as legislation recognising a need for child protection strategies enforced by law. An implementation plan was needed and subsequently the model chosen was the tri-agency model of New South Wales’s Joint Investigation Response Team (JIRT), with some significant differences.

Norfolk Island’s new framework included the newly appointed Child Welfare Officer (accountable to the court registrar); Australia Federal Police Officer-in-Charge on Norfolk and the Mental Health Clinician employed by Norfolk Island Hospital Enterprise. The spirit of this partnership was underpinned by a core principle of providing supportive interventions for children and their family. Hence the Norfolk Island tri-agency model was named ‘Joint INTERVENTION Response Team’.

For the first time in its history mandatory reporting became legislation and the first child welfare officer position was established. Six categories of mandatory reporters were identified and training needed to be provided to framework this. Similarly the pathways for reporting and templates for two levels of report: mandatory reports congruent with the legislation; and voluntary reports (a ‘referral of concern’), which provided the opportunity to identify risks to a child or young person.

The legislation identified only two offences under the Child Welfare Act: ‘Intentional physical injury’ and ‘Sexual assault’. A number of challenges were a natural consequence of this legislation. This community of 1700 people was unfamiliar with these new initiatives to protect children and young people. Establishing a child welfare framework in a small rural remote community isolated in time and space, and believed to be idyllic, was a challenge to mindset as well as established practice, policy and custom.

While modelled on the principles of a New South Wales ‘JIRT’ structure, the strengths of Norfolk Island’s model is the implementation and practical application of those principles. The partnerships implicit in this initiative heralded a broader network of partnerships set to enhance the access of Norfolk islanders to other allied health services.

The Australian Rural Mental Health Cohort Study: Implications for policy and practice

David Perkins1,2
1The ARMHS Research Team, 2Broken Hill UDRH, University of Sydney

Aims: To summarise the findings to date regarding rural and remote mental health from the ARMHS cohort and to discuss the implications for rural health policy and practice.

Methods: A community-based cohort of rural and remote residents are part of a unique study that examines the experience and determinants of mental health problems and mental disorder at individual, household, community and regional levels and identifies the implications for policy and practice in places with workforce shortages and service gaps.

Relevance: Most mental health studies are cross-sectional and based in urban settings. Few address the individual in the context of their social and geographic setting. The major policy developments of recent years have been focused on regional and metropolitan communities. This study provides unique knowledge of an under-researched rural population that comprises 30% of the population but receives few services.

Results: The study identifies groups that have high distress but are largely invisible, such as the rural disabled and unemployed. It finds that rural environmental adversity (eg, drought impact) is associated with significant psychological distress but social and community level factors may mediate this effect. Findings about suicidal ideation and suicide attempts points to particular at-risk groups, the key role of social integration and support, and to the effect of disease pathways other than clinical depression. Most importantly this study suggests that up to half of those who may have a serious mental health disorder did not speak to a health professional about this problem in the last 12 months.
Conclusions: The national and state mental health commissions are about to report on mental health and wellbeing and most data is derived from metropolitan studies. Studies like this can inform policy and practice, particularly when the investigators are drawn from universities, state and local health services.

The Jam, The Mix, The Gig—music and mental health project. A creative arts project for survivors of mental illness

Robert Petchell1
1The Jam, The Mix, The Gig

In coming to terms with the effects of mental illness, people have used a range of approaches—and one of these is involvement in creative arts projects, which encourage self-expression, social interaction through being part of a group activity and a sense of achievement through personal skills development and working as part of a team.

The Jam, The Mix, The Gig (The JMG) is a community-based music and mental health project that offers options to participants to:

- just enjoy playing music with others, whatever your ability
- develop your skills and/or song writing further
- perform to the public as part of the The JMG Band.

‘THE JAM’ is a music jam session where you can share your music skills with others, try out some ideas, write some songs, or just ‘have a go’ and enjoy being part of having a good time with music.

‘THE MIX’ is a music skills development session and a chance to present your songs, poetry etc to the group, and to get help in developing your confidence and skills.

‘THE GIG’ is a performance event to a general public audience that will give you the opportunity to perform your work to the best of your abilities, and to receive recognition for this.

The JMG is currently funded by Arts SA, the SA Government’s Arts funding agency, and SA Mental Health Service and is managed by a nine-member board made up of participants, carers/parents and mental health workers.

Apart from an overview of The Jam, The Mix, The Gig Inc. music and mental health project, I will also be focusing on our partnership approach with non-arts funding agencies and organisations to extend the work and benefits of The JMG into new areas, such as:

- partnership with Common Ground Pty Ltd, an integrated homeless housing project in the centre of Adelaide
- partnership with The Hub Community Mental Health in Port Pirie, SA for a workshop and performance program from March to December 2013, funded by the Regional Arts Fund through Country Arts SA.

Reflecting on the growth of arts and health

Lisa Philip-Harbut1
1Community Arts Network SA

After 35 years as an artist, 20 years of work in arts and health and 10 years as the Director of Community Arts Network SA, I am in a reflective mode. It would be great to share some of the stories from regional communities that have undertaken projects in which art was a tool for change and health was the context or the concept.

I was introduced to the work of the NRHA in 2000 when the conference was in my home town, Adelaide. I was lucky enough to be the coordinator of NRHA’s arts and health stream at the 2001 conference in Canberra and I was also a speaker at the following year’s conference in Tasmania.

Since that time the practice has developed and evaluation methods have evolved. I am now asking myself what have been the significant changes over the years and where are we going now in the practice?

This presentation will use spoken word and large screen abstract video projection. It was a hate of PowerPoint that first led me to explore alternative modes of presentation. And the trainer in me was interested in ways of opening up audiences’ minds to explore their own connections to new ideas. But it was the artist in me that has pursued this format for the last 15 years, both in Australia and overseas.
A partnership approach to delivering health education programs in remote Indigenous communities

Cara Polson1, Rachel Latimore1, Margaret Ross-Kelly1, Mary Hannan-Jones1, Judith Aliakbari1
1Apunipima Cape York Health Council

Introduction: Need for Feed is an innovative healthy cooking and nutrition program for Queensland high school students in grades seven to ten. The program is being rolled out by Diabetes Queensland to 120 schools across Queensland between 2011 and 2015.

To ensure the program reaches Aboriginal and Torres Strait Islander communities, a partnership was formed between Apunipima, Diabetes Queensland and Cape York Hospital and Health Service to facilitate the implementation of culturally appropriate Need for Feed programs across the Cape.

Program aims: The Cape York Need for Feed program aims to:
• improve student confidence and skills to prepare and cook healthy meals
• increase local capacity at a community level to support future nutrition/cooking programs
• strengthen partnerships between health providers, including Diabetes Queensland, Apunipima, Queensland Health, community-based schools and The Queensland University of Technology.

Method: Program implementation is guided by consultation and engagement with community members, including elders, health action teams, health workers, school teachers and other local service providers. Where possible, programs are run with assistance from local community members to develop community capacity for ongoing nutrition programs. Programs are facilitated by a community dietitian (or nutritionist), advanced health worker—nutrition (or health promotion officer) in cooperation with school health nurses (Queensland Health) and where possible, Queensland University of Technology students. On the ground staff provide continuous feedback of learnings to Diabetes Queensland.

Cape York Need for Feed program evaluations are being undertaken through process (reflection logs and program feedback) and impact evaluations (pictorial food belief and behaviour questionnaires both pre- and post-program).

Results: Initial trials in the Cape highlighted the necessity of being flexible and adaptable with program structure, content and materials to suit the diverse needs among Indigenous communities. Partnerships among organisations have been strengthened with the aligned focus to deliver programs that are culturally appropriate and suitable to the needs of individual communities. Evaluations from each trial guide the modification of program materials such as recipes, educational activities and evaluation tools used for each successive program.

Conclusion: This partnership approach to delivering health education programs in remote Indigenous communities demonstrates how organisations can work together using a translational research framework where learnings from practical applications of programs are shared with researchers to inform continuous improvement to current processes.

Engaging people with disabilities in the prevention of violence against women

Sharyn Potts1
1Yarredi Services—Port Lincoln Regional Domestic Violence Service

As the incidence of violence against women with disabilities is much higher than for the general population, a local project concept was developed to not only address this problem, but also to involve the target group in the development of a practical resource.

Further to this, young people with disabilities were identified as being a cohort where it was believed the most inroads could be made in the prevention of this abhorrent social issue.

A 10-minute DVD workshop resource entitled ‘Stop ~ Don’t Cross the Line ~ violence is everybody’s business’ was developed as a collaborative effort by incorporating community development principles across the entire process. Focus groups, consultation and workshops were undertaken with somewhat surprising benefits.

Most importantly, this project successfully involved the participation of young people with disabilities, plus their families and carers, in the planning, design, art work and even acting in the final stages of development and production of the end product.

The complexities of working in a smaller rural location also needed to be negotiated.
In particular, workshops conducted with groups of young people, both female and male, with disabilities, including cognitive, learning, physical and mobility, aided the development of scenarios for the DVD.

Some of the positive outcomes to date have been improved collaboration at a local level, improved information and skills imparted to the target cohort, and the distribution of the resource to many disability-focused organisations across the state. One of the strengths has been that the life of the project goes beyond the actual development process.

In November 2012 the workshop is to be presented to members of one of the original focus groups made up of young people with a disability, the primary target group. It is expected that results of this will be reported on in the final paper.

**Patient Liaison Network—improving the journey for country patients having to travel to access health care**

**Pam Pratt¹, Karen Dixon¹, Lyn Olsen¹**

¹Country Health SA Local Health Network

The patient liaison nurse (PLN) role, across areas of country South Australia, formally began in 2007. It was recognised there was a need for a key contact in country health services to better manage patient journey issues.

The formalisation of the PLN role in country health services along with the rural liaison nurse role in metropolitan-based health services has enabled the network to form with a common purpose to improve the patient journey for country people. ‘Aboriginal patient pathway officers’ were put into practice to specifically target patient journey issues for Aboriginal and Torres Strait Islander people.

Liaison nurses are the central contact for country clients and they:

- become the link person for communications between country and metro
- promote the access of care options closer to home
- create awareness of the issues faced by country clients accessing health services outside their area
- advocate to support a return home from metro hospitals
- become the resource person for services available to assist the patient journey
- ensure discharge planning processes occur in a timely manner.

The Patient Liaison Network coordinator’s role was introduced in 2010 to provide essential support for patient liaison nurses and other health professionals, to develop and disseminate information supporting positive patient journeys and ensure that the Patient Liaison Network continued to have active engagement in coordination of patient journeys.

Advocacy about patient journey issues, and a stronger patient-centred-care focus, has resulted in significant improvements across country and metropolitan health services for individual patients.

This paper will present the progress so far, documented benefits and key achievements.

**A brighter future—measuring how we are tracking with the National Strategic Framework**

**Linda Proietti-Wilson¹, Kim Atkins¹,²**

¹Department of Health and Human Services, ²University of Tasmania

**Aim:** We have been tasked by the Rural Health Standing Committee to develop key indicators for use by the Commonwealth, states and Northern Territory to monitor performance against and progress toward the five outcome areas of the National Strategic Framework for Rural and Remote Health. Importantly, the reporting must not impose a significant burden on rural services nor duplicate existing reporting processes.

**Relevance:** The National Strategic Framework for Rural and Remote Health was developed collaboratively by the Commonwealth, states and Northern Territory as a national policy that aimed to influence high-level decision makers to redress the inequities in service delivery and health outcomes currently experienced by Australians living in rural and remote areas. In the absence of a system of reporting against the framework there is no way of telling how its aims are being met.

**Method:** We are working with jurisdictional representatives to develop:

- an agreed set of principles to underpin the indicators
• an agreed road map towards achievement of the framework’s objectives

• an appropriate set of quantitative and qualitative measures underpinned by reporting criteria.

We began by reviewing the current literature on conceptual frameworks for health performance reporting in order to identify the potential strengths and limitations of various approaches and to develop a rural and remote-appropriate theoretical framework to guide the development of reporting indicators.

We are going to use the theoretical framework to analyse the broader literature on performance reporting and actual reporting frameworks in use in Australia and elsewhere, in order to identify a potential set of indicators for performance and progress reporting that were suitable for use in rural and remote areas. At the same time we will collect information about existing reporting items and processes from the Commonwealth, states and Northern Territory.

Throughout, we are consulting the jurisdictions and the National Rural Health Alliance to determine the applicability of the draft set of indicators, and to take advice about gaps, needs, duplication and reporting burden.

Result: The result will be a flexible toolkit of resources that can be selected to suit local circumstances, but which, in each case, report on progress in the five outcome areas of the NSF. The reporting items are backed up by evaluative criteria that determine progress (or lack of).

We will also produce a theoretical approach to health service performance that is specific to rural and remote contexts, and could be used to reliably inform service agreements and service planning in rural and remote areas.

Aligning a $1.5 billion infrastructure program to meet expectations and consistently deliver critical outcomes across country Western Australia

Rob Pulsford

WA Country Health Service

WA Country Health Service (WACHS) delivers health services across all of rural WA, an area of 2.55 million square kilometres with a total population of over 470,000 people. Health services are delivered from a variety of settings ranging from 70 hospitals to remote area nursing posts and community health centres.

WACHS is currently delivering a $1.5 billion infrastructure program across country WA. This level of government investment in health infrastructure is unprecedented and has resulted directly from WA’s fortunate financial circumstances arising from the mining resource boom, as well as the State Government’s Royalty for Regions Initiative where 25% of mining royalties is directed into rural and regional WA.

Not only is the scale of the overall health infrastructure investment impressive, so too is the breathtaking diversity and complexity of the many infrastructure projects being planned and delivered at the one time.

For instance in the southern part of the state the Southern Inland Health Initiative, which at its core comprises $325 million in infrastructure upgrades, includes $147 million to redevelop six major district hospitals with another tranche of investment focusing on redeveloping 31 small hospital/nursing posts with an investment of $108 million. Also located in the south of the state is the $170 million Albany Health Campus project, which will result in the inclusion of state-of-the-art ICT infrastructure, which will act as a pilot and forerunner to the $2 billion Fiona Stanley Hospital, to drive the delivery of service reform and significant change in how health services are delivered.

In the north of the state there is the $207 million Karratha Health Campus, which represents the biggest single hospital construction investment ever in country WA. There is also the $50 million East Kimberley Project, which includes a $20 million Integrated Primary Health Care Centre, adjoining the Kununurra hospital, as well as eight other individual projects ranging from the construction of new remote health clinics to the delivery of dedicated staff housing.

The sheer scale and breadth of WACHS’s capital works program brings many opportunities and many challenges. The opportunities are provided to staff who have the once-in-career opportunity to be part of major capital projects—many seeing projects through from the very beginning of planning and business case development until practical completion.

Opportunities also exist in terms of reform, improved patient safety, and increased functionality to support contemporary and more effective models.
of care. The provision of new ICT infrastructure leads to quantum changes to the way patient care is delivered and recorded, i.e. electronic medical records.

At the heart of these opportunities is the joy and satisfaction experienced by health care staff, and members of rural and regional communities, who are part of projects which are often regarded as most important and integral to the health and wellbeing of rural communities.

However with the opportunism there are challenges. Across WACHS the need for well-documented, articulated and understood governance structures is paramount in ensuring that projects are managed in line with the available budget, scope and program. The expectations on WACHS to deliver effectively on the $1.5 billion capital program is immense.

To achieve this, strong project leadership, both project and program level accountability, and clear well-articulated and well-documented project process have been developed and are continually evolved to ensure that this significant government investment maximises outcomes in terms of the design and construction of contemporary health care facilities, as well as supporting service reform and the delivery of new models of care.

A strong focus is also made on stakeholder and community engagement to ensure that communication regarding ongoing project development is clear and transparent, and that stakeholder expectations are effectively managed.

**Art, health and the evidence debates: practical insights from field research**

**Christine Putland**

1Southgate Institute for Health, Society and Equity, Flinders University

This paper concerns the proliferation of art and cultural programs designed to improve individual and community health and wellbeing at the local level, and the challenge to provide evidence for their effectiveness. Arts and health initiatives in rural and remote communities around Australia involve a wide range of ages, cultures and art forms, addressing the full spectrum of health determinants in health promotion, clinical and community settings. The sheer scope and diversity of practice is testimony to their perceived benefits by health professionals, artists and communities alike. With the increasing up-take of the arts in health fields internationally, however, comes the expectation of evidence-based practice and rigorous evaluation of their effects. While each context presents particular research challenges, debates about evidence in relation to broad social and economic determinants—what counts, which methods are appropriate—are perhaps most controversial. It is no coincidence that this is also the part of the field where the interdisciplinary nature of practice is most apparent.

The practical implications of these debates will be explored, drawing on the experience of evaluating several major community-based initiatives in South Australia, with particular reference to the Regional Centre of Culture program in 2010 and 2012. An initiative of the SA Government, this program is distinguished by the arts and culture playing a leading role in extensive, region-wide, intersectoral partnerships to ‘(re)vitalise’ communities. By offering diverse opportunities to engage creatively, such approaches aim to enhance quality of life and promote individual health and wellbeing, while building the conditions for creative and more resourceful communities in the longer term. Evaluation findings consistently suggest there are compelling reasons for the growing interest expressed by rural and remote health services in collaborative arts-based approaches. The capacity for arts practice to draw out and extend multiple personal and social strengths within individuals and communities makes them particularly well suited to addressing complex social and economic determinants of health and wellbeing. These same qualities also present a range of challenges in demonstrating the observed effects, however. The paper will discuss these issues taking into account the multiple perspectives on health, art, and evidence that inform such ‘upstream’ health interventions. Experience shows that just as complex problems call for genuinely multidisciplinary interventions, their evaluation requires that these be matched by multidimensional research methods.

**Evaluation of evidence-based maternity care in remote communities of far west New South Wales**

**Emma Quinn**1,2, Jacqueline Noble3, Holly Seale2, Mike Hill1, Jeanette Ward3

1NSW Public Health Officer Training Program, NSW Ministry of Health, 2School of Public Health and Community Medicine, University of New South Wales, 3The Royal Flying Doctor Service South Eastern Section, Broken Hill, NSW

**Introduction:** Over the last decade, there has been continuing concern about the need to address the
inequity about the number and availability of birthing services and the sustainability of the maternity workforce in rural and remote areas of Australia. In Far West NSW, there is anecdotal evidence to suggest that not all women receive continuity of care across organisational partnerships and that clinicians find it difficult to consistently implement evidence-based care due to challenging organisational, economic and workforce factors, outside the control of single organisations in a shared care model. With the 2009 announcement from the Australian government about the maternity care reforms and the increasing evidence of the safety and effectiveness of non-medical models of care; perhaps it is time for real change?

Aim: The project aims to identify any issues in providing evidence-based care in Far West NSW and identifying facilitators that will potentially enable midwifery-led models of care to be provided as an option in our rural and remote context.

Methods: A purposive sample of key clinicians who provide maternity care in Far West NSW (n=~20–30) will be invited to participate in a semi-structured interview. The interviews will collect information on: the current gaps in delivering evidence-based maternity care; and potential barriers and enablers to delivering midwifery-led models of care and other evidence-based services in Far West NSW. Ethical approval for the project has been obtained from the UNSW HREA panel. Interviews will be conducted in November and December this year. The interview data will be recorded, cleaned and coded in Excel and imported into SAS for further statistical analysis. Frequencies and descriptive statistics will be calculated and multiple regression analysis performed on selected outcomes.

Results and conclusions: These results will be used by the Royal Flying Doctor Service South Eastern section to inform further policy and service development with local partners in Far West NSW.

Designing whole-of-system placements for undergraduate medical, nursing and allied health students in rural settings

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Background: Funded by the Victorian Department of Health, the ‘Whole-of-System’ Student Clinical Placement Project (WoSSP) focuses on the challenges and needs of smaller rural health services when teaching health professional students in community-based placements. The WoSSP model has a unique focus on broadening student understandings of patient-centred care, health service complexity and interprofessional practice. Our intention is to encourage a deeper understanding of the bio-psycho-social dimensions of health care within a geographically defined health system. Project partners include the local rural hospital and the two major university health education providers in the region. Community and health service representatives are involved as project steering group/advisory group members.

Project deliverables include strategies for cross-disciplinary curriculum customisation and WoS placement coordination. A core goal is to enable students to gain a deeper appreciation of patient care journeys (including the contributions of other health professionals and barriers to health service access).

Methods: This paper reports on the features of the evolving WoSSP model and presents preliminary program evaluation data that maps how a workable interprofessional clinical placement strategy was developed. A written questionnaire and semi-structured interviews with student, health service and teaching staff participants were used to inform WoSSP program implementation across two action research pilots during 2012. We were particularly interested in investigating if/how the WoSSP program contributed to student educational outcomes.

Results and discussion: One of the challenges of implementing sustainable clinical placement innovations in smaller rural settings is the need to move beyond siloed approaches to teaching and
placement planning. Substantial organisational and educational change work is required to embed collaborative, interprofessional placement models across different health settings. The WoSSP project is tackling clinical placement complexities at the health service/health education interface. Prior to WoSSP, there was no shared mechanism that brought health practitioners, supervisors, students, community members and health education providers together to have direct involvement in shaping locally customised clinical education strategies. This mutual professional engagement cycle has the potential to drive information exchange and health service linkages that can inform theory and practice and increase workforce capacity.

**Gomeroi gaaynggal: empowerment of Aboriginal communities to understand the health implications of research in pregnancy**

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In recent times the work of many research teams around the globe, looking at all of the physiological systems indicate that the long-term health conditions seen in later life are programmed during intrauterine life. It is becoming increasingly important that pregnant women’s health is optimal to reduce the impact of maternal health on the development of diabetes, kidney disease and cardiovascular disease in the next generation.

The Gomeroi gaaynggal study in Aboriginal women in pregnancy is committed to understanding the stressors (physical, environmental, psychosocial) on the mother that impact on their health and on the long-term health of their infants. Aboriginal Australians are 70 times more likely to suffer end-stage renal disease and this study is one of the few to identify the underlying causes of this imbalance.

In a pilot study, the research team have identified the current renal status of our Aboriginal women in pregnancy. Reduced glomerular filtration rate occurred in 12.5% of women, 34% of our cohort had microalbuminuria and 37% had high plasma glucose levels. Our ongoing studies include ultrasound evaluation and determination of birth outcomes to analyse of the effect of maternal stressors on foetal renal development.

It is already apparent to the Gomeroi gaaynggal research team that Closing the Gap has to be a long-term investment by the researchers and by the Indigenous community in partnership. Empowering Aboriginal research participants to understand the data as it unfolds will assist with driving changes to improve health through education. Researchers need to commit to enduring community-based programs that directly feed their results into promoting health literacy.

More importantly, our ongoing promotion of health education through the Gomeroi gaaynggal ArtsHealth program has the potential to reduce the risks of chronic kidney disease in Aboriginal mothers and their children. Our presentation shows: preliminary data related to maternal renal health and foetal health outcomes; how the Gomeroi gaaynggal staff are empowering participants; and how the ArtsHealth program is developing health literacy.

**Giving rural children the best chance: improving multidisciplinary screening strategies**

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¹Deakin University, ²University of New South Wales, ³Royal Far West

This presentation outlines the journey of the Royal Far West (RFW) to increasing the disclosure requirements within the intake process and developing direct, closer liaison with referrers and local service providers to help ensure that the intake process includes a holistic assessment of the child within the broader family context.

The RFW is a children’s health care service charity that offers a secondary referral service for children living in remote and very remote NSW, and a tertiary referral and multidisciplinary developmental assessment service for children with developmental, behavioural and mental health concerns. These children have limited or no access to local services due to their rural and remote locations.

Utilising a grant from the Australian Government Department of Families, Housing Community Services and Indigenous Affairs under the Child Aware Approaches initiative, RFW took an action
research approach to reviewing and enhancing their screening processes to improve the delivery of health services.

The RFW journey used a cyclical period of observation, reflection and action supported by literature reviews and evidence-based best practice to lead to a strengthened screening tool and intake procedures. Having the right questions, and knowing how to ask them, enables health services working with children in rural and remote areas to better identify health issues and approaches to care tailored for the children, their families and their communities. RFW has been able to improve the development of achievable and targeted plans that support improved outcomes for the young people requiring their services through the strengthening of local partnerships and better identification of service gaps.

The presentation shares the evidence and experience gained through the research and the implementation of multidisciplinary screening strategies and tools. It explores the key challenges and successes achieved when developing screening tools and processes that are appropriate for children living in rural and remote areas (and how they differ from strategies used in urban areas).

The improvement made through the multidisciplinary screening approach within the RFW have helped to inform and improve the health performance outcomes of country children accessing RFW services and have progressed an integrated model of care for improved safety and wellbeing of the children. It also builds the capacity of families, local communities and partnership with local referrers, health agencies, schools and community groups.

Reaching ‘in’ remote technologies and service delivery in rural and remote communities

Fiona Reid

Women’s Health and Family Services (WHFS) is the largest women’s health centre in Western Australia, providing health and wellbeing services to women, their families and communities. WHFS has a number of specialist programs in the following service areas: medical and health, alcohol and other drugs, family and domestic violence, mental health, community development and Aboriginal family support.

Often rural and remote communities are too small to support traditional models of health delivery locally, so residents must access care from larger urban centres. Unfortunately, access to health services provided in larger centres remains a problem for many residents of isolated settlements. In many cases, their inability to access health services when required leads to health needs not being adequately met, lack of continuity of care and an absence of monitoring of the effectiveness of services in terms of health outcomes. It is clear that models of care in rural and remote areas must differ from those in metropolitan communities, incorporating strategies to account for these problems. WHFS endeavoured to develop a service delivery model that challenged the traditional delivery methods by developing an innovative and creative program that attempted to meet communities’ specific needs and gaps in service provision.

After extensive planning and consultation with key stakeholders, including over thirty community resource centres across WA, regional commissions, regional women’s health centres, WA country health and the Department of Regional Development and Lands, WHFS launched its Rural in Reach Program. The first of its kind in WA, the program uses the latest videoconferencing communication technology, to deliver long-distance one-on-one counselling, family consultations and group education sessions with trained professionals to over thirty rural towns across WA. Nearing a year of service provision the program is now set to expand to 60 rural communities at the beginning of 2013. Major successes of the program include the continued engagement, and the trust and relationship building that has developed between the Rural in Reach Program staff and the participating CRCs. Through consultation and feedback, challenges presented have not been seen as a barrier but as an opportunity to ensure that the program is consistently evolving to meet community needs.

Resilient rural clinicians: role models for medical students

Janet Richards

Women’s Health and Family Services (WHFS) is the largest women’s health centre in Western Australia, providing health and wellbeing services to women, their families and communities. WHFS has a number of specialist programs in the following service areas: medical and health, alcohol and other drugs, family and domestic violence, mental health, community development and Aboriginal family support.

It has been argued that medical students need to be prepared for the challenges they face, not only in practice, but also during training itself, and that addressing and maintaining one’s mental health and wellbeing should become a lifelong focus for all medical students. This study seeks to understand
how rurally located program administrators develop personal resilience and how they promote the growth of resilience in medical students on an individual and collective level. For the purpose of this study, resilience is defined as ‘a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma’ (Luthar et al 2000).

The Parallel Rural Community Curriculum (PRCC) is a longitudinal integrated clinical training program at Flinders University in which medical students undertake a 40-week rural placement for their first clinical year. Each PRCC site is administrated by two non-faculty staff that have a unique role encompassing role modelling, mentoring and providing pastoral care to a small group of students during the academic year. These administrators are also important in setting the context and the culture of the PRCC, and have their own resilience tested by the unique challenges they face.

Participants have been recruited through purposeful sampling of past and current PRCC medical students, PRCC administrators and clinical educators across the four Flinders University Rural Clinical Schools. The qualitative data will be obtained through semi-structured interviews. All participant transcripts will be coded and analysed using the grounded theory approach aiming for theoretical saturation and utilising the NVivo 10 software.

The best educational setting for promoting resilience is thought to be one that enhances socialisation between peers and other adults, facilitates goal setting, monitors student wellbeing and provides positive role models. Understanding how PRCC administrators develop and role model resilience and thereby contribute to the development of student resilience is important to ensure academic success and professional development of the future PRCC cohort and sustainability of the program.

Key lessons in implementing a rural GP spouse mentoring program

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¹New South Wales Rural Doctors Network

Aims: While a multitude of programs focus on retaining rural GPs, few give this same focus to their life partners. Yet research confirms that spouse orientation to rural life plays a major part in GP decisions to remain in rural practice.

To investigate the retention potential of this largely unexplored group, in 2011 the NSW Rural Medical Family Network (RMFN) established the Bush Friends Mentoring Program to match individual GP spouses newly arrived in rural NSW with experienced rural spouse ‘mentors’. The program utilised a previously untapped resource (experienced rural GP spouses who already have many skills), and targeted a largely forgotten group (newly arrived rural GP spouses).

The Bush Friends approach, while largely new, is constantly evolving, delivering critical methodology lessons on the way. This paper will identify and discuss the key learnings harvested to date.

Method: With no prior programs to model upon, Bush Friends adopted an action research approach where consistent monitoring and program participant feedback is used to refine the program model. Consequently, the personalised contact with newly arrived spouses has risen from 64% to 98% of all arrivals, and a myriad of design benefits have been realised.

Relevance: Australian rural GP spouses continue to influence GP retention rates across the nation. Well designed and implemented programs targeting spouse retention may hold a previously unexplored key. Albeit in its infancy, this program shows enormous potential in NSW, and with changes to suit different environments, offers that potential to other states and territories.

Results: Just one year after inception, it is not yet possible to demonstrate a link between a successful ‘transition to rural life’ and the mentoring received through this program, nor a longer term influence on GP retention.

However, alterations in methodology have produced remarkable benefits for program uptake by both mentors and mentees, as well as benefits for all program participants. For example, the initial structured method of recruiting and training mentors, based largely on approaches popular in industry, has mostly been abandoned in favour of lower key initial ‘triage’ contact with newly arrived spouses followed, if required, by an informal contact from the nominated mentor.

Conclusion: Bush Friends will continue into its second year in a highly modified form, aiming for contact with 100% of newly relocated spouses. It will continue to grow and evolve methodologically. The key to successful longer term outcomes lies in using
an action research approach and continually refining strategies as they evolve with experience.

**Bush babies: sustainable obstetric care for rural communities**

*Marian Robinson*

1Bogong Regional Training Network

2010 was a record year for births in Australia, particularly in rural centres. However, as the birthrate climbs, the literature reveals that there is a serious shortfall of GP and specialist obstetricians in country communities. Consequently, rural women are often forced to travel long distances to large health service providers in order to access high-quality medical care and deliver their babies.

Rebuilding and maintaining maternity services in the bush relies in part upon attracting and retaining a critical mass of committed medical professionals close to the women who need their services. This paper describes how collaboration between GP proceduralists, specialist obstetricians and a local health service in one regional community has developed a decentralised and sustainable model of obstetrics training and care that both nurtures the next generation of GP and specialist obstetricians and ensures high-quality and appropriate maternity care for rural women and their families.

Key features of the model are:

- A high-quality training system that attracts doctors to rural and regional practice and supports succession planning and the retention of both specialist and GP obstetricians after training.
- The importance of trust and collaboration between GPs and obstetricians that facilitates personal and professional back-up in a safe and supportive environment.
- A coordinated and structured approach to leadership that maximises clinical and operational outcomes and ensures appropriate clinical responses for women with differing degrees of risk.
- A public roster system that provides sufficient exposure to procedural work to maintain and maximise skills while ensuring the ability to balance work and family life and prevent 'burn out'.

There are only a handful of regional birthing units that retain, as their core component, a team of specialist obstetricians working collaboratively with GP obstetricians to share wisdom and provide around-the-clock care. While this model of obstetric care is unusual, it offers a practical and viable option for expanding regional and rural centres that wish to attract, retain and sustain a critical mass of procedural GPs and obstetricians in their communities.

**Women’s Development Project—empowering women in the bush**

*Alison Rogers 1, Madeleine Bower 1*

1The Fred Hollows Foundation

The Women’s Development Project (WDP) is a community development initiative that utilises an Indigenous framework to ensure that every component of the initiative is driven by the Jawoyn women from the Katherine east region of the Northern Territory. The WDP is based on the premise that strengthening cultural identity and increasing self-determination will result in positive health outcomes. The WDP works in partnership with the Jawoyn Association Aboriginal Corporation to deliver culture regeneration projects such as: healing and cultural camps; leadership initiatives; maternal and child health programs; and nutrition, medicinal and spiritual wellbeing activities for families. All activities occur under the direction of the Banatjarl Women’s Council—‘STRONGBALA WOMIN GRUP’.

A recent evaluation of the WDP found specifically that the initiative has made significant progress towards this overall goal of increasing self-determination that in turn will enhance positive health outcomes. Furthermore, the evaluation found that the WDP is successfully contributing to a sustainable environment where the Banatjarl Women’s Council and the Jawoyn Association are the lead agencies achieving and maintaining increased self-determination.

The WDP draws on the strong evidence of the social determinants of health (including socio-economic and cultural factors) as the key contributors to the living circumstances, quality of life and in turn the health and wellbeing of individuals and communities. The WDP understands that empowerment strategies, in socially excluded populations, will improve health outcomes and reduce health disparities. The WDP attempts to
contribute to the body of evidence that addresses 'control of destiny' and 'empowerment' at the community level to increase the capacity of the communities to take control of their health and wellbeing and build community norms.

The paper elucidates the challenges and benefits of working on a long-term, capacity building and culturally appropriate initiative from the personal perspectives of two community development workers. It reflects the WDP achievements of working with Indigenous and non-Indigenous people to strengthen the capacity to achieve health outcomes; advocating for better food security through nutrition projects, improving mental wellbeing and providing opportunities for economic development. The public health components, cultural diversity and community development approaches have created a strong foundation enabling knowledge and learnings from the WDP to be discussed with other Indigenous and non-Indigenous community development workers in an attempt to share good practice and encourage other agencies to adopt this approach.

Return to country—addressing Indigenous health and homelessness in far north Queensland

Bronwyn Honorato1, Bernadette Rogerson1, Michelle Coleman1

1James Cook University

Compared to the whole of Queensland, Cairns has a very high number of homeless people (6.3% versus 11.6%), 10% of whom are from remote areas of Cape York. Many of the Indigenous homeless people become stranded in Cairns following visits to health services or upon release from local prisons. Financial constraints, such as low incomes and overpriced flights (up to $550 one way), prevent them returning to their home communities. Many also suffer from substance abuse, chronic health problems and mental health disorders, compounded by homelessness. The response to homelessness is also a drain on medical resources, due to high numbers of hospital admissions, and on police resources, due to many public nuisance calls.

At present, there are 28 service providers in Cairns to assist the homeless population in securing adequate housing and related services. To date, however, there has been no meaningful engagement in order to determine the health, social and economic needs of Indigenous homeless people. Indigenous concepts and understandings of homelessness, health and illness are decidedly different to that of other Australians, and the individual’s perspective is critical to service delivery and outcomes. Only through the voice of these Indigenous itinerants, using ‘an Aboriginal lens’ to establish histories and current social and economic situations, will appropriate services be developed to address the cyclic, ongoing difficulties experienced by these individuals.

This research will follow-up participants (n=75) who were returned to their remote communities in 2012 under a pilot program offered by the Cairns police, the Return to Country project. The project assists homeless individuals who want to return to their communities by providing advances from Centrelink, booking flights subsidised by the local airline, undertaking medical health checks, obtaining clothes/hygiene packs, transport to airport and ensuring the individual is on board the aircraft. Participants who have consented to participate in a follow-up study will be interviewed to ascertain their satisfaction with the Return to Country project, to determine their trajectories to homelessness, their health and housing needs, engagement with services, and current situation in their home community. The interviews will provide information on how the program can be improved and how services may be delivered within their home communities.

The outcome of this study will be to develop and implement a revised, sustainable Return to Country project, by collaborating with the 28 homelessness service agencies, Indigenous health services, Qld Health and the Qld Police Service.

Identifying maternity service catchments—a data gathering and mapping exercise

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1University Centre for Rural Health—North Coast

Aims: To develop and test methods to identify rural maternity services and the number of births in their service catchment areas.

Methods: To develop an evidence-based index of need to support policy decisions on maternity services, we first needed to identify those services and their annual (averaged over 5 years) birth numbers in communities of 1000 to 25 000 people in rural and remote Australia (R2 and above, ARIA). Data were gathered from publicly available sources and from contacts within the Maternity Services Inter Jurisdictional Committee for use with geographic
information systems mapping tools. Two rural hospitals in SA were chosen as exemplars.

Initial identification of rural maternity services was based on: published reports by jurisdictional perinatal data collections, health departments’ websites and the AIHW hospital lists, ‘My Hospitals’ website, AMOSS website, ABS birth registrations. Geographic locations were identified from the websites of health departments, and ‘My Hospitals’ and from AIHW hospital lists.

Catchments were identified from the geographic location and GeoScience Australia 1:250 000 road network, where driving speeds were allocated by type of road. GIS methods were used to identify a facility’s catchment using how far you can drive (road based) in 60 minutes in any direction from the facility. Small geographical areas with known estimated population and birth numbers were overlaid onto the catchment area and the area-weighted populations were obtained.

**Results:** The process and development of these maps is complex. A selection of maternity service catchments based on road travel has been obtained. Their population and birth numbers are averaged for the period 2005 to 2009.

**Conclusions:** The process of obtaining medical facility service catchments can sound like a straightforward undertaking, however the data gathering that is required in order to undertake this task is not trivial and can be very complex.

**Relevance:** Even though our research is focused on rural maternity services, their population and birth catchment numbers, this methodology is applicable to other medical service provision areas.

**Important points:** Data for identification of hospitals with maternity services is widespread. The identification of catchments requires the bringing together of knowledge from many sources, ABS populations, geographical boundaries and birth registrations, state departments of health, road geographical information, AIHW and GIS skills.

**Original content:** This work is based on a Canadian model, this is the first time that catchments for Australian maternity services have been undertaken.

‘Palya: good.’ Acknowledging achievements in Aboriginal health and welfare in central Australia

**Stewart Roper**

‘Nganampa Health Council

Improving the poor state of Aboriginal health and welfare must remain a national priority. However, coverage of only the most dire health and social problems sometimes afflicting communities risks generating disillusionment. The presentation draws on years working with some noteworthy central Australian Aboriginal-controlled organisations to highlight historical and direct experience of some significant achievements.

The Pitjantjatjara Council was formed in Amata in 1976 to fight for land rights, their efforts culminating in the granting of inalienable freehold title in 1981. The Council has been responsible for delivery of a wide variety of vital services over vast areas in an environmentally challenging setting.

The Ngaanyatjara Pitjantjatjara Yankunytjatjara (NPY) Women’s Council has supported families and communities since formation in 1980 and is involved in programs to improve child nutrition, combat domestic violence, alcohol and drug abuse and support community-based initiatives in youth development, family support, aged care and the arts.

Nganampa Health Council was formed in 1980 to improve Anangu health and living conditions on the Pitjantjatjara/Yankunytjatjara lands. Since then rates of infant mortality and infectious disease have been reduced dramatically through improvements in primary health care, medical intervention and environmental living conditions.

Petrol sniffing had a devastating impact on communities and a particularly high media profile for over twenty years from around 1980. Some communities had up to sixty of their young children and youths sniffing. During the last five years to 2012 I have seen only one person trying to sniff in my regular travels to all communities, a situation I would have thought impossible when I first started work in the area in 1990. The reason usually given for this is that there is now a fuel throughout central Australia that cannot be sniffed. In reality, however, communities persevered for decades with rehabilitation programs to try to save their children. The framework for the success of the intervention was laid through the extensive collaboration, research and advocacy of all of the above Anangu controlled...
organisations, Aboriginal communities, health and education services throughout central Australia and the Northern Territory, state and federal government bodies and businesses.

Observations on improvements in schooling and housing are also presented. To keep these achievements in perspective, it is still a relatively common experience for health staff to be called at night to a sick child on a sheet of foam for a mattress in a house with no furniture and bare cupboards. Such poverty severely curtails chances for improving health and education outcomes.

In early October, 1990, I finished packing the back of the Valiant ute, pulled over the tarpaulin and farewelled family and friends. I was on my way to work as a nurse on an Aboriginal community in remote north-west South Australia, 1500 km from Adelaide. I had never before been further than Port Augusta, only 300 km north of Adelaide. My original intention was to stay for six months to a year. I eventually left after nine and a half years full time and still return regularly to relieve other nurses some twenty years after my arrival. I’m still not completely sure how this happened, but somehow the spirit of the people and the magic of the landscape overcame the hardships of living and working in such an isolated setting.

I have taken thousands of photographs reflecting the spirit of the people and the beauty of the country and would like to show a few of these over the presentation. I am in the process of getting a book of images and recollections published and would like to launch the book at the conference.

Promoting best practice in the provision of rural mental health student placements

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Building an adequate and appropriately skilled health workforce to service regional, rural and remote Australia has been at the core of efforts to address inequities in health outcomes between urban and non-metropolitan environments. Multiple strategies have been considered to develop health workforce capacity, including the expansion of rural placements for students. In 2012 the Mental Health Tertiary Curriculum (MHTC) project commenced to explore the unique features of mental health clinical placements across regional, rural and remote Australia. Funded by the Australian Government Department of Health and Ageing and using the eleven University Departments of Rural Health, the project aimed to develop a deeper understanding of rural mental health placements.

Rural placements are thought to offer students a chance to experience rural practice and lifestyle with opportunity for wider scope in clinical and interprofessional practice and community engagement. Evidence is accumulating that the quality of the student experience on placement is paramount to equip the emerging workforce to adapt to rural practice. Little is known, however, about the factors that contribute to a quality rural placement, particularly in the mental health sector. The MHTC project surveyed and interviewed education providers, service providers and students across rural Australia. Qualitative and quantitative data highlighted the student learning experience, barriers and enablers to effective placements and unique features of rural and remote mental health practice.

The findings from the MHTC project emphasise the importance of maintaining relationships and defining expectations between education and service providers to adequately prepare students for placement. Of critical importance to students are the quality of supervision and the culture of the service provider in terms of their acknowledgment of the importance of students to the overall values of the organisation. Students report that understanding of and connection to community is a vital component of rural mental health placements and that they need to be supported to develop this capacity alongside the development of their clinical skills.

Based on the findings of the MHTC project, this paper will present ten essential ingredients that are necessary to provide students with an authentic and well-supported rural clinical placement. It is intended these recommendations will maximise the potential for students to gain the foundational knowledge to effectively deal with mental health presentations upon entry to the workforce. The recommendations presented will be of interest and benefit to the academic sector, service providers and health professionals who support students in their workplace.
Collaborating for carers at a grass-roots level

Kylie Ryan

1Bay of Isles Community Outreach Inc

Historically, activities in the South East Coastal Region of WA that were aimed at carers or people with disabilities were driven by individual agencies and the success of these efforts was often ‘hit and miss’. Also, because there are only a limited number of staff in regional areas, the workload associated with planning and implementing events was usually left to only one or two people. About two years ago, the Carer and Disability Services Working Group was formed in Esperance with several of these agencies coming together to reduce and share this workload. The group has been able to reach a broader range of the community when conducting activities due to their shared networks and contacts. A major challenge for the group, however, was being able to find the funds to cover the costs of running events. Towards the end of 2011, the development of another partnership with Carers WA enabled the group to secure some funding under the ‘Linking Together’ Program for the purpose of running a pilot program that would include a series of events being held in Esperance that would aim to engage with and bring carers together. The group ran four events during the first half of 2012, which were effective in both identifying new carers and also engaging with existing carers. This presentation provides an overview of how the group was established, details of the events and activities that were implemented and how this initiative has supported duplication of similar projects in other regions.

Living with dementia in country South Australia

Phil Saunders

1Alzheimer’s Australia SA

There are over 7100 people living with dementia in South Australia’s country regions. This group of consumers experience particular challenges that are exacerbated for those living in remote regions and for those from diverse groups. Many more people in these communities are impacted by the disease, including family members and the health and other professionals providing services for them. These numbers are expected to triple by the middle of the century, placing enormous burdens on the health and aged care sectors in particular. There are few dementia-specific services outside of metropolitan Adelaide with most agencies providing a multidisciplinary response across a range of social issues, diseases and disabilities. These country service providers encounter a number of challenges given the diversity of their service delivery and lack of access to affordable, timely and effective dementia training.

To build an up-to-date, evidence-based picture of the situation facing country people living with dementia, their families and carers, Alzheimer’s Australia SA undertook the Get Your Voice Heard: Living with Dementia in Country SA project.

From July to October 2012, the project offered a series of focus group consultations providing people living with dementia, their families and carers, and agencies that provide services for them, an opportunity to discuss issues affecting the lived experience of dementia consumers and to explore practical ways of improving their situations.

Over 300 consumers and service providers across country South Australia participated in the consultations.

The stories of the 140 consumers who participated put a human face on the issues, translating the knowledge about their experiences with a focus on both the personal and financial cost to them of dementia. They spoke of their isolation; the lack of or limited support structures; access to health and other professionals and the differences between country and metropolitan support and services.

Proposals for key actions required to improve their lived experiences centred around a greater presence by dementia-specific organisations, services and support and significant dementia awareness and education programs for the general community and in particular for health and aged care professionals.

Service providers examined their current dementia service provision and explored how to improve delivery within their existing programs and build new initiatives.

The research poses serious questions for all levels of government and for government and non-government providers in further supporting and building services for people living with dementia and their families across country regions.
Hospital use of the Mental Health Emergency Care—Rural Access Program

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Aims: The aim is to examine the use of Mental Health Emergency Care (MHEC) by hospital emergency departments throughout western NSW.

Method: A descriptive analysis of routinely collected data reporting MHEC service activity for hospital contacts from its introduction in 2008 to 2011.

Relevance: Access to mental health care, including care for patients in crisis, is limited by geographic isolation and workforce shortages. Without specialist assessment and support, clinical decisions made by generalist staff result in the inappropriate transfer of some patients out of community to a mental health inpatient unit (MHIPU) and for others a delay in diagnosis and/or referral to appropriate care.

MHEC is pioneering the way for emergency telepsychiatry by providing 24-hour access to mental health specialists and offering timely information, emergency telephone triage, and video assessment via telehealth technology when local specialist care is not available.

Results: While MHEC can be accessed by providers and lay people alike, hospital use alone doubled in four years (from 30% in 2008 to almost 60% of all calls by 2011), while other providers and lay users have stabilised or declined. Hospital use increased in both communities without established inpatient mental health services as well as those with a MHIPU.

Hospital staff called the MHEC service for patients of all ages though most were 25–44 years old or younger (74%) and included Indigenous (18%) and non-Indigenous persons (51%, not specified—31%). Most patients were classified as urgent by the MHEC team (68%) and the majority presentation was threatened or actual harm or suicide (55%). After a MHEC service, most patients were managed locally (75%) as either an inpatient in the local hospital or as an outpatient with community care and the transfer of patients to a MHIPU has decreased over the study period.

Conclusion: The MHEC service has been successfully adopted by rural and remote hospitals for the management of mental health emergencies. Early indications are that the service may result in fewer patients being transferred out of community for ongoing care.

Workshop: Images, messages, health and social media

Moya Sayer-Jones¹
¹Only Human

Moya Sayer-Jones has a special interest in health, welfare and the arts, including the challenges and opportunities new technology presents to individuals and organisations. She says: ‘A lot of people are stuck and even defeated by new communication channels but the trick is to understand that online isn’t really about technology, it’s about people. And that’s good news. As health workers, we KNOW all about them!’

In this workshop Moya will share her own experiences working in the sector and her favourite best-practice story-based solutions from international organisations. Specific areas covered include:

- understanding how new media works ... and what doesn’t
- connecting with modern audiences using our personal strengths (storytelling, authenticity and purpose)
- finding your community
- using creative approaches get users tuning in and sharing your content
- the ‘too busy to blog/tweet/post/do one more thing’ guide
- Moya’s tools, apps and tricks.

Moya’s workshop is an inspiring and fun exploration of what’s possible when we take ourselves and our organisations ‘social’.
Geographical classifications and incentives for rural allied health workforce recruitment and retention

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Background: Government policy is used to enhance health workforce and to facilitate equity across regions as well as between rural and urban areas. For example, policy can create incentives for graduates to take up rural or remote positions by waiving HECS fees. For policies to be most effective they need to be based on an unbiased classification system that recognises areas of greatest health workforce need. Access to quality rural health care that uses team-based care needs to be encouraged.

Aim of the study: To use existing allied health workforce data to examine the validity of models of geographical classification employed for the allocation of workforce incentives in the context of the need for greater interprofessional collaborative practice.

Method: Between 2008 and 2010 the Combined Allied Health Workforce (CAHW) survey collected data in New South Wales, South Australia, Tasmania and the Northern Territory. It included rural as well as urban-based professionals from 25 disciplines. Survey data include demographic characteristics, employment, education, and recruitment and retention characteristics.

Relevance: In August 2012 the Senate Community Affairs References Committee (SCARC) noted that the Australian Standard Geographical Classification for Remoteness Areas (ASGC-RA) is unsustainable for the purpose of allocating workforce incentives. It has been suggested to replace it with a structure that considers more up-to-date geographical, population, workforce, professional and social data to identify locations for workforce recruitment and retention incentives. Although SCARC is supportive of the methodology and suggested outcomes of the Humphreys model, that model is based on medical workforce data. SCARC noted disparity in support provided between allied health professionals and medical practitioners to work outside the cities.

Results: There were almost 5000 respondents to the CAHW survey. The eight largest occupations made up 78% of the sample, with physiotherapy the largest, in line with findings of an older Victorian survey. Rural-based professionals were less likely to indicate being part of a multidisciplinary team and felt more isolated compared with their urban-based colleagues. Demographic data allowed for testing the proposed revised classification system by SCARC and results will be presented.

Conclusions: Rural professionals perceive themselves to be more isolated and are less likely to be part of a multidisciplinary team in comparison to urban professionals. This needs to be taken into account by policy makers to facilitate team-based care. Also, a revised workforce incentive scheme needs to align with allied health, as well as medicine and nursing workforce data.

The Roma Agreement: changing the face of rural generalist training in Queensland

Tarun Sen Gupta1, Dan Manahan2, Denis Lennox3, Natalie Taylor2

1James Cook University School of Medicine and Dentistry, 2The Cunningham Centre, Queensland Health, 3Rural and Remote Medical Support, Queensland Hospital and Health Services

Aims and relevance: Queensland Health’s Rural Generalist Pathway commenced as a new stream of rural training in 2007. This pathway, which has changed the face of rural medical recruitment and training across the jurisdiction, arose from a number of sentinel events relating to workforce recruitment and retention, work practices, and industrial processes, culminating in a forum in the rural town of Roma in 2005.

This seminal meeting of Queensland Health, colleges, educational providers, rural doctors and other stakeholders led to the so-called Roma Agreement, which agreed to: ‘develop and sustain an integrated service and training program to form a career pathway supplying the Rural Generalist workforce that the bush needs’.

Methods and results: This agreement, which fulfilled the state government’s promise of a specialist career pathway for rural generalists, developed a pathway for junior doctors (including government scholarship holders with return-of-service obligations), which was integrated with their training and linked to industrial recognition. The training program has a
jurisdictional focus—supplying rural generalists to both public and private sectors. The nine principles articulated, which underpinned the pathway, are still relevant today, and are being adopted in other jurisdictions as the pathway is rolled out nationally.

Conclusion: The principles enunciated in the Roma Agreement have served the Queensland Rural Generalist Pathway well. But does everyone need such an agreement? This paper will explore with the audience:

- Would similar agreements be useful in their own context? How would they work?
- Who are their stakeholders and communities of interest?
- What are the key lessons from this experience?

Target audience: This paper/workshop presentation will be relevant for anyone interested in rural medical/health professional education, including educators, policy makers and rural clinicians.

The changing pattern of emergency medical evacuations from remote South Australia

John Setchell¹, Stephen Ballard¹
¹RFDS Central Operations

Much has been written about the changing nature of the workforce in rural and remote Australia with numerous references to issues relating to the fly-in/fly-out workforce. The Port Augusta Base of RFDS Central Operations has provided emergency primary medical evacuation services to remote South Australia since 1956 and over the last decade has conducted approximately 150 evacuations each year.

In the past decade there has been a significant shift in the make-up of the population living and working in remote SA and this paper will review the nature of emergency aero medical evacuations at the start of the decade and compare them with data collected in the last 12 months. Changes in patterns of evacuations will be discussed in the context of the changing demographics and consideration of the impact on future health service delivery requirements will be undertaken.

The data will cover the locations from which primary evacuations have taken place, the age and gender of the patient, the ICD-9 chapter heading diagnosis to describe the reason for the evacuation, the severity of the illness and the level of clinical care required.

Beyond dreaming—nursing education for rural Aboriginal women

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Aim: The Aboriginal women’s health and education project aimed to provide rural Aboriginal women with a pathway into the health service that was previously unobtainable.

Method: The women were initially engaged in a health and fitness program that provided an environment that was culturally safe and inclusive. This approach led to improvements in the women’s fitness levels and also their social and emotional wellbeing. The strength, confidence and resilience the women gained was derived from a strong sense of trust that evolved throughout the program. The women’s new-found confidence led them to the university for information sessions on basic life support, injury prevention, Aboriginal health information and health career promotion. From these sessions the women developed an interest in nursing; however TAFE enrolment criteria limited mainstream enrolment for the majority of those interested in pursuing a nursing career. With creativity, teamwork and partnerships an alternate entry was developed to allow the women to aspire to their dreams of a career in rural nursing.

Relevance: Aboriginal people are the focus of ongoing reporting and legislation. The Council of Australian Government identifies many initiatives that aim to address the discrepancies across many key areas in relation to Aboriginal people, forming the basis of the Closing the Gap policy. Improved outcomes in Aboriginal health is one such key area. National and international research has identified that Aboriginal people respond favourably to Aboriginal health professionals, leading to improved access and better health outcomes. With the training and employment of more Aboriginal people within the health profession, gaps may be addressed in rural health workforce shortages and improvements may be had in access and treatment of Aboriginal people.

Results: The target was to enrol ten women; however, interest had spread to the wider Aboriginal community and two classes were established to accommodate twenty enrolments. All twenty women completed Certificate II Health Service Assistant. Ten went on to complete Certificate III Health Service Assistant and from those ten, five gained cadetships with the NSW Ministry of Health under
the Aboriginal Nursing and Midwifery Strategy to study as endorsed enrolled nurses.

**Conclusion:** The successful outcomes achieved throughout this program began with the commitment and foresight of all involved. The passion and community spirit kept it alive and the dedication of the women and their families saw obstacles overcome and dreams and goals realised. It cannot be underestimated that successful initiatives in Aboriginal communities require trust and transparency. No decisions were made throughout this program without ongoing open discussions with all parties. This provided the women with a safe environment where they grew and learned together.

**Community engagement integral to pharmacy success in remote community**

**Lynn Short**

1Pharmacy Guild of Australia

The aim of the presentation is to showcase a positive remote location workforce story focusing on the role of community engagement in the provision of health care. The presentation will spotlight how living in a remote location provides an opportunity to fine tune skills such as resourcefulness, teamwork, and flexibility due to the unique set of issues living in an isolated community. Similarly, there are common health care themes that resonate with allied health professionals across localities, whether it be about medicines literacy or managing chronic disease.

The presenter, Lynn Short, will provide an overview of key elements required to enable ongoing responsiveness to community needs. Adopting a strengths-based approach, the pharmacy team seize issues enthusiastically as opportunities, motivated by the desire to integrate community engagement philosophies into the working culture and practice of their community pharmacy.

The presentation will provide examples of how community pharmacy engages with community members. The presentation will illustrate that working locally through to the national level has benefited the community through increased health care services and health workforce development opportunities.

**Under watchful eyes: clinicians’ perceptions of the use of online mental health resources in the rural context**

**Craig Sinclair**1, Kristi Holloway2, Geoff Riley1, Kirsten Auret1

1Rural Clinical School of WA, 2Curtin University

Recent years have seen the development of a number of online mental health resources, which can be accessed for internet-based treatment of conditions including anxiety, depression and phobias. Some have suggested that these resources may assist in the delivery of rural mental health services. Research has established the efficacy of online mental health resources, but little is known about clinicians’ perceptions of effectiveness, particularly in the rural context. Referral patterns will likely depend on clinician perceptions of the effectiveness of online mental health resources.

Twenty rural clinicians (primarily psychologists and general practitioners) were recruited for individual interviews and focus groups, exploring perceptions of online mental health resources, factors influencing referral and factors specific to their use in the rural and remote context.

Most clinicians were aware of some of the available resources, and referred some clients to the resources. Interprofessional differences in referral practices were explained in terms of different case mixes for psychologists and general practitioners. Clinicians were generally optimistic about using the resources, particularly as an adjunct to face-to-face therapy. Specific benefits included access for remote clients, user anonymity and the potential for psycho-education to normalise symptoms and encourage further help-seeking. Concerns included the lack of follow up, reinforcement of social isolation, and potential for misinterpretation of web-based information leading to adverse effects. Many of these concerns were allayed if the resources were employed as an adjunct, rather than alternative, form of therapy.

Online mental health resources show promise in helping to overcome barriers in accessing mental health services in the rural context.
Providing a remote area dental health service for Aboriginal and regional communities

Tricia Slee1, Gabrielle West1
1Royal Flying Doctor Service—Western Operations

Aim: Aboriginal people living in remote communities have difficulty accessing dental care, driven by issues of affordability and geographic location. The RFDS in WA has embarked on the development of a Remote Area Dental Health Service (RADS) to try to address these needs.

Approach: While the RADS project is in its early development phase, our approach is planned to be two pronged:

- working in partnership with dental health services to identify and address gaps in current dental health service provision to remote communities with available dental clinic infrastructure
- seeking to fund and trial the delivery of dental health services from a mobile dental unit, which will provide RFDSWO dental teams with direct access into remote communities without dental clinic infrastructure.

Relevance: The RADS mobile unit will allow the provision of local, affordable high-quality dental service, including oral health advice, preventative care and simple routine dental care, and also provide a referral service for more complex dental procedures.

It is thought that the early phases of the project will see a focus on acute, interventional dental care with a shift towards prevention and maintenance of good oral dental care over time.


Results: In 2011–12 a pilot program providing a visiting dentist to Roebourne was such a success that after further discussions with dental health services, funding was made available to provide regular clinics in Wiluna and Warburton communities.

In six months the dental team conducted 10 clinics, saw over 500 patients and performed over 2200 dental procedures. The RADS is expected to continue to grow over the coming year and expand into other areas.

During 2012 RFDS developed a corporate partnership with Karara Mining to fund the purchase of a mobile dental clinic and the delivery of a dental and PHC service to residents across the mid-west region of WA. Pending successful application for supporting funding, the project is expected to be implemented in the second quarter of 2013.

Conclusion: The goal of the Remote Area Dental Service is improved oral health for Indigenous people, leading to improvements in general health and quality of life. We look forward to sharing the results of our RADS journey.

One voice matters, many voices make a difference

Deborah Smith1
1Consumers Health Forum of Australia

News breaks first on Twitter.

If Facebook were a country, it would be the world’s third largest.

The power of social media and the internet to connect people, share ideas, news and generate momentum is increasingly evident and accepted.

The same is true for the need for consumers and consumer experience to play a critical role in health care policy and planning if we are to improve health outcomes and sustain our health system into the future.

Australia is undergoing pivotal health reform, informed by the work of the National Health and Hospitals Reform Commission (NHHRC), which said that ‘the health system of the future should be organised around the integral roles of consumer voice and choice, citizen engagement and community participation,’ and that there is a need to ensure ‘that the experience and views of consumers and whole communities are incorporated into how we redesign and improve health services in the future.’

Consumers know what works—and what doesn’t—in health care in their local community. So how do we use the opportunities afforded by the internet and social media to give consumers, especially consumers confronted with the barriers of distance and time, a say in improving health care in their community? What about those who do not have ready or reliable access to these mediums? And how do we enable the voices of many consumers to contribute to an informed and constructive consumer voice in health policy and decision making?
The presentation draws on the work of an NGO project funded by the Australian Government to support one of the key levers identified by the NHHRC for achieving system change and better health care for all Australians: ‘strengthened consumer engagement and voice’.

It will share learning from the three-year project that leverages the opportunities of the online environment to give consumers around Australia the opportunity to contribute to improving Australian health care, and provides professional development for consumer and community board members, chairs and CEOs of Medicare Locals and local hospital networks to support consumer and community engagement in the organisations charged with leading health reform for local communities.

The TCPPP—a Tasmanian interdisciplinary experience of clinical leadership

Catherine Spiller¹,², Annette Marlow¹,², Roseanne Brumby¹,², Craig Zimitat¹,², Kate Andrews¹,², Marnie Bower¹

¹Faculty of Health Science, University of Tasmania, ²Department of Health and Human Services Tasmania

Background: This abstract describes a partnership project between a faculty of health science at a local university, the Department of Health and Human Services, a general practice training organisation and a number of private hospitals. The project finishes in December 2012.

Aim: To increase clinical placements with an emphasis on interprofessional placements in novel settings in rural and remote areas for medical, nursing and midwifery, pharmacy, psychology and physiotherapy students using a multi-professional team of academic clinical leaders (ACL).

Method: The ACLs worked collaboratively identifying barriers and opportunities to facilitate clinical placement growth. Interdisciplinary working promoted fertilisation of ideas between the disciplines and collectively identified areas of growth. Each ACL developed activities to support placement growth based on the discipline-specific priorities using a team of academic clinicians. An overarching project workplan was developed. An action learning style approach was adopted to discuss progress, provide peer review and to re-evaluate priorities to ensure a cohesive and collaborative theme remained the focus.

A number of common issues were identified for all disciplines:

- inadequate knowledge about clinical placements and student abilities
- inadequate access about placement management and processes
- differences in interdisciplinary and school interactions with placement organisations
- resourcing for coordination/coordiators/contact people to arrange placements
- resourcing for student accommodation and travel

Results: Overall the numbers of clinical placements for 2012 has been increased in line with the project objectives. New placement agencies have been identified leading to a greater understanding of the scope for rural and remote and non-traditional health care settings to provide quality clinical placements. A series of targeted activities were conducted to enhance knowledge, capacity and processes supporting clinical placements for clinical supervisors in these areas. Common resources and processes were developed for use across disciplines, and on a statewide basis, to support placement organisations.

Conclusion: The project has strengthened relationships between the agencies involved in relation to clinical placements of health science students, with a focus on remote and rural settings using a leadership model to deliver a targeted range of activities. The team found that there is a strong desire from rural communities to host students and provide a holistic placement/community experience. There is great expertise and willingness to support student learning, potential for growth in interdisciplinary learning and opportunities now exist for school-specific interdisciplinary projects that can be built on for the future sustainability of clinical placements.

The family referral service

Julie Steffner¹, Annamarie Cohen¹

¹The Benevolent Society

The Family Referral Service (FRS) is a key initiative of the NSW Keep Them Safe child protection reform agenda funded by the NSW Ministry of Health. Keep Them Safe: A Shared Approach to Child Wellbeing is the
NSW Government’s response to the Commission into Child Protection in NSW lead by Justice James Wood and is a 5-year plan to improve the safety, welfare and wellbeing of children and young people. A key part of Keep Them Safe is the improvement of universal services and collaboration between organisations.

The FRS was a direct recommendation of Justice James Wood and commenced operation in May 2010. The Family Referral Service engages with families that do not meet the statutory threshold of ‘risk of significant harm’. Through assessment and referral to services and supports the FRS works with families, children and young people to increase strengths and capacity and reduce the risk of escalation of risks and vulnerabilities.

The FRS commenced with three pilot services in Newcastle, Dubbo and Mt Druitt. Since this time a further five services have commenced and the program is now rolled out across eight regions within NSW. Family Referral Services offer an augmented service model with both telephone and outreach services.

The FRS engages with vulnerable families, children and young people with the objective of developing referrals plans and connections with targeted services and supports in order to provide early intervention and prevent escalation to a statutory response. The Family Referral Service provides a coordinated and collaborative approach to assist in the promotion and provision of child safety, welfare and wellbeing between both government and non-government agencies.

Drawings on the Benevolent Society’s experience in implementing the FRS across three sites in NSW, and using both qualitative and quantitative data, this presentation will explore:

- learnings regarding service models and service implementation, including developing and implementing a best-practice service model while providing a localised response to communities
- challenges of working in regional and rural areas, including access to services in rural and remote locations, location of service providers and frequency of outreach
- working collaboratively with partner agencies to provide culturally safe services and having a flexible service delivery model to provide responses in line with community needs.

Responding to child maltreatment by learning with, from and about each other

Kylie Stothers1,2, Karen Piper1, Annette (Nettie) Flaherty1
1Centre for Remote Health, 2Flinders NT

Objective: Health and other professionals frequently experience complex ethical and professional dilemmas when forming an opinion about child abuse and neglect. This presentation will describe the key aspects of an evaluation of a federally funded program that aims to provide a platform of core skills and knowledge requirements about child abuse and neglect and the importance of multidisciplinary team work to keep children safe and promote their development.

Purpose: This workshop emphasises the diversity of professionals and community in order to allow for impact of integration of learning. While core learning objectives of the training are fixed, flexible delivery allows for training to respond to the specific learning objectives of diverse groups. This evaluation was designed to supply both immediate and long-term feedback of the program, which enables an ability to respond to the needs of a diverse and multi-professional workforce.

Methodology: Evaluation in this area is scant. The evaluation integrates process evaluation, impact and outcome evaluation into a continuous and thus responsive quality assurance model. The process and impact evaluation consists of an anonymous and voluntary survey given to all participants at the conclusion of the two-day workshop. Most projects usually end here. To evaluate outcome, whether learning has been integrated or had an impact on practice, we contact voluntary participants three to six months following their attendance and conduct a telephone interview.

Results: Feedback showed that for issues that require a multidisciplinary response, the training requires the same approach. A frequent response has been the strength of the universality of the material and the multidisciplinary networking and understanding that takes place as participants’ problem solve case studies together. The evaluation has assisted us to offer education and information that is relevant, applicable and current.

Conclusion: Evaluation is needed in child protection programs to inform service providers of what works best and why. While immediate post-workshop
feedback gives an indication of satisfaction, it does not provide evidence that learning has been integrated into practice. We recommend following up workshop participants once they have returned to the workplace to determine whether learning has been integrated into practice.

**Sowing the seeds of change: Urapuntja food gardens project**

**Susannah Summons**

1Northern Territory Medicare Local

**Aims:** Urapuntja (Utopia) is a remote Indigenous community located 280 km north-east of Alice Springs. Diabetes and obesity pose a significant health burden, and the healthy food required to address these issues is expensive and difficult to source. Community members requested assistance to establish food gardens to supplement the fresh food supply of families living in the area.

**Methods:** The dietitian worked with community members to establish food gardens in remote outstations. Gardens were constructed in partnership with community members, who maintained the gardens on a day-to-day basis. The dietitian and two project workers visited regularly to support community members in the running of each garden.

**Relevance:** Poor access to healthy food is one of the key determinants of poor health outcomes in remote Indigenous communities. In the Urapuntja region, the fresh produce available in the community store would not be adequate to meet the dietary requirements of the community, should they eat according to the 'Australian Guide to Healthy Eating' recommendations. Food is expensive, and for some people the community store is 40 km away. Therefore, establishing an additional source of fresh produce in community outstations has the potential to improve people’s health and the management of chronic diseases such as diabetes.

**Results:** Twelve gardens have now been established in the outstations of the Urapuntja area, using a community development approach. A number of factors have impacted on the success of the gardens over a two-year period. These include the levels of sustained interest in the garden among community members, sorry business or bad weather that may influence people to move away from a garden site, success or failure in food production, and the level of support available. Of the 12 gardens that have been established, five are functioning independently.

**Conclusions:** Many factors affect whether a garden will be successful in terms of ongoing fresh food production, and food gardens should be considered as one strategy in a multi-strategy approach to address nutrition as a determinant of chronic disease.

The establishment of all gardens provided an opportunity for meaningful physical activity, and did lead to measurable changes in health parameters, such as blood sugar levels. Involvement with gardens generated a large amount of discussion about healthy food and how it is included alongside bush and store foods, and community members reported that the availability of fresh produce did lead to increased inclusion of fruit and vegetables in family meals.

**Will recent funding initiatives impact on recruitment and retention rates of allied health professionals and nurses in rural and remote Australia?**

**Joanne Symons**

1Health Workforce Queensland

The recruitment and retention of allied health practitioners (AHPs) and nurses in rural and remote areas of Australia is problematic. Policy makers face significant challenges trying to meet the health needs of rural and remote Australia by providing access to trained health workers. A shortage of qualified health workers in remote and rural areas impedes access to health care services for a significant percentage and often disadvantaged section of the population.

In 2012, the Rural Workforce Agencies received funding from Health Workforce Australia under the Rural Health Professionals Program (RHPP). The RHPP is designed to affect recruitment and retention rates by ‘growing and supporting an allied health and nursing workforce for rural Australia’. The RHPP supports Australia’s rural and remote health workforce by recruiting new international and Australian-trained allied health professionals and nurses into rural and remote areas of Australia, and into Aboriginal Community Controlled Health Services. Significantly, it then provides them with appropriate support services over a two-year period to improve retention rates.

There has been a plethora of research investigating the factors associated with recruitment and retention of health professionals, and there is now evidence for AHPs and nurses specifically in rural and remote areas, including a workforce retention framework. It is paramount that the research, evaluation of existing service providers, and current frameworks and tools
are considered so that a raft of strategies required to enhance the recruitment and retention of allied health professionals and nurses in rural and remote areas can be designed. The choice of interventions to be included as part of the RHPP roll-out in Queensland will be informed by an in-depth understanding of the health workforce and an analysis of the factors that influence the decisions of AHPs and nurses to relocate to, stay in or leave rural and remote areas. Giving due consideration to this will help to ensure the choice of services provided to AHPs are anchored in and tailored to the specific needs of the individual, their profession and their location.

This presentation aims to summarise the available evidence on factors that influence recruitment and retention of allied health practitioners and nurses in rural and remote Australia, and strategies that have been developed to address them. It will then articulate how the program will be implemented in Queensland in accordance with available evidence, and provide some recommendations for the continuation of the program.

**Rural and metropolitan placements rated equally well by Australian university paramedic students**

**Julie Thacker¹**, **John Cowell²**

¹School of Medicine, Griffith University, Qld

**Aims:** This research assessed rural and metropolitan placements from the emergency paramedic student’s perspective to identify how placement location impacts on student learning and the placement experience.

**Methods:** Second-year undergraduate university paramedic students (n=128, 61 male, 67 female; about 80% response rate) volunteered to complete a paper-based questionnaire on their previous six placements. The questionnaire comprised 38 five-point Likert scale questions from 1 (strongly disagree) to 5 (strongly agree), with optional free responses. Questions covered specific areas of learning, affective support and personal logistics during placements.

**Relevance:** Student perceptions provide important feedback to universities and placement providers on the efficiency and effectiveness of placements. Responding to feedback is paramount in the current climate where placement availability and resource and time management for providers and students are becoming increasingly restricted.

**Results:** Students reported liking rural and metropolitan placements equally well (M_rural = 4.1, SEM = 0.04; M_metro = 4.2, SEM = 0.05), with no findings for age, gender, placement order, distance to placement or time to travel to placement and liking the placement. This is despite average travelling distances of 25.8 km (SEM 2.69) to metro and 195.8 km (SEM 9.75) to rural placements, requiring average travelling times of 29 min (SEM 1.46) and 2 hours 10 minutes (SEM 4.47) for metro and rural respectively. Reported maximums were 180 km and 3 hours for metro and 600 km and 7 hours for rural. Minimums were 1 km and 1 min for both locations.

Placements allowed developing anatomy and physiology knowledge (M_rural = 3.6, SEM = 0.10; M_metro = 3.5, SEM = 0.2), clinical skills (M_rural = 3.65, SEM = 0.1; M_metro = 3.53, SEM 0.18), rapport-building skills with patients (M_rural = 4.34, SEM = 0.09; M_metro = 4.47, SEM 0.15), and information on equipment (M_rural = 4.46, SEM = 0.59; M_metro = 4.50, SEM 0.13). Students reported feeling welcome at both rural and metro placements (M_rural = 4.342; M_metro = 4.395).

Locating suitable accommodation and travel while on placement revealed near-symmetric bimodal distributions for each variable, with rural less (n.s.).

**Conclusions:** From the paramedic students’ perspectives, rural placements are performing as well as metropolitan placements and students are prepared to travel for the rural placement experience. Both rural and metropolitan placements would rate higher if more suitable accommodation were available and rural placements should rate higher if they addressed consolidation of clinical skills.

**Public health: governments abrogating their responsibilities**

**David Templeman¹**

¹Alcohol and other Drugs Council of Australia

The broad role of the Alcohol and other Drugs Council of Australia (ADCA), as the national peak body for the non-government sector, brings with it an overview of the state of public health and social welfare programs that may be lacking in organisations focusing more on single issues. Several changes of government have occurred in the past two years at state and territory level. With these new administrations has come a pronounced move away from public health commitments, with many programs suffering under the guise—particularly in rural and remote Australia—of ‘belt tightening’. This
presentation will observe how NGOs attempt to maintain a level of support for the areas of society they support as governments cut programs and projects—apparently with little thought of the consequences of their actions. The effect this is having among those least able to articulate their position is a major concern, which raises the question whether governments are abandoning the concept of social responsibilities.

Integrated Cardiovascular Clinical Network—improving cardiac care in rural centres

Philip Tideman¹, Rosy Tirimacco¹, Paul Simpson¹, Limei Siew¹, Penelope Cowley¹
¹Integrated Cardiovascular Clinical Network CHSA

Background: Clinical networks link groups of professionals and organisations from primary, secondary and tertiary care shifting emphasis from institutional to patient needs and outcomes. The Integrated Cardiovascular Clinical Network CHSA (iCCnet CHSA) provides an integrated solution to ensure patients presenting to rural health facilities receive access to appropriate cardiac care. Solutions include clinical tools, resources and systems designed to support the practice of evidence-based acute cardiac care by practitioners, including remote area nurses from a diverse range of backgrounds and with varying levels of experience and training. Integral to the service is timely access to cardiologist support, point-of-care testing (PoCT) managed by clinical network scientists and continuing medical education for rural doctors and nurses.

The iCCnet CHSA model of care to facilitate evidence-based cardiac care is designed to address the inequality in cardiovascular outcomes between metropolitan and rural/remote areas, including access to pathology to facilitate risk stratification of patients.

Method: To evaluate the effectiveness of the network we compared acute coronary syndrome (ACS) length of stay, time to angiography, readmissions and in-hospital deaths for the south-east of South Australia pre and post adopting the iCCnet CHSA model of care. Primary diagnosis data was collected from the South Australian Department of Health hospital separations database (ISAAC). All sites were expected to participate in a quality program to ensure PoCT testing meets quality standards required for clinical use. Cardiologist paging service is continually monitored to ensure calls are answered within ten minutes.

Results: Adoption of iCCnet CHSA model of care has seen marked improvements in cardiac outcomes. These included:

- reduced length of stay
- reduced 30-day re-admission for ACS
- reduced total length of stay for patients transferred to metropolitan hospital for invasive cardiac testing
- reduced in-hospital ACS deaths, making death rate comparable to metro hospital.

All sites participated in the quality program managed by experienced clinical network scientists. PoCT across CHSA sites was performed meeting recommendations of professional societies. Average cardiologist paging service response times remained less than the expected 10 minutes.

Conclusion: A network approach to cardiac care appears to markedly improve cardiac outcomes. Results indicate that PoCT pathology can be integrated into clinical care to facilitate evidence-based cardiac care. Reduced 30-day readmission along with a reduction in ACS in-hospital deaths supports the implementation of cardiac clinical networks to facilitate the practice of evidence-based acute cardiac care in country health facilities.

Medicines must be administered … in more ways than one!

Heather Volk¹
¹National Aboriginal Community Controlled Health Organisation

Australia lacks a quality use of medicines (QUM) policy specifically designed for the needs of Aboriginal and Torres Strait Islander people in both urban and rural areas. This sector has a well-documented burden of disease requiring access to medications and medication advice but experiences poor access to timely, culturally appropriate, planned, integrated and well-structured pharmacy services.

Lack of an Aboriginal and Torres Strait Islander medication policy has resulted in fragmented service delivery, inadequate and inconsistently trained workforce and poor uptake of current QUM initiatives.
Aboriginal and Torres Strait Islander people may receive medications under several different subsidy programs. Eligibility to the different subsidies is dependent upon geographic location, annual registration, and self-identification as being of Aboriginal or Torres Strait Islander heritage. It also depends on who writes and where the prescription is written. Not all prescribers can write prescriptions enabling the patient to receive subsidised medications under the Closing the Gap Co-payment Relief Measure (CTG) program. Hospital prescribers are unable to prescribe under this scheme. Specialists are restricted to prescribing only if the patient is referred by a doctor eligible to prescribe CTG prescriptions. This convoluted, disjointed process struggles to provide the desired health outcomes. For the consumer it is complex and confusing.

Programs such as Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX) and Good Medicines Better Health (GMBH) have experienced restructuring or cessation of program funding resulting in decreased pharmacist support for QUM initiatives and health workforce education in QUM. Lack of recognition and no funding at a service level for a dedicated QUM position in every Aboriginal health service and no policy and framework, to support dedicated pharmacists in each service means those who have most to gain through safe and informed access to medications and health advice from pharmacists, have the least access.

Pharmacy was omitted from telehealth. Inclusion of pharmacists and the network of pharmacies as sites for consultations with specialists would greatly increase access to telehealth services. Telehealth could be extended to include the provision of medication advice and home medicines reviews and allow pharmacists to receive remuneration for these consultations.

A QUM policy for Aboriginal and Torres Strait Islander people implemented through a dedicated workforce of pharmacists and QUM support positions, in conjunction with a medication access system that is consistent irrespective of location and who prescribes your medications would greatly improve health outcomes.

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Primary Care Partnerships in rural Western Australia: nurse practitioners leading the way

Melissa Vernon¹, Lesley Pearson²
¹WA Country Health Services, ²Silver Chain

Aims: To enhance access to effective multidisciplinary primary care for people with chronic complex conditions living in rural and remote areas in the southern inland catchment of Western Australia.

Methods: Under the Southern Inland Health Initiative, funded by Royalties for Regions, primary care nurse practitioners have been subcontracted through Silver Chain to work in close coordination with local public and private health providers, especially general practitioners and the regional country health services. They plan and coordinate clients’ care and monitor key health indicators to enhance seamless access to appropriate treatment options for chronic complex conditions in order to maximise wellness and prevent/reduce hospitalisations. Telemedicine innovations, including electronic health records and home-based self-monitoring systems aimed at enhancing chronic disease management, are being used as part of an evaluated trial with appropriate clients.

Relevance: This will ensure that rural and remote West Australians have greater access to affordable and timely local health care, thereby enabling them to stay within their local communities while ensuring better health outcomes. Nurse practitioners having access to relevant technology will enable timely and local diagnosis and care planning.

Results and conclusions: This partnership has enabled the development of a new service delivery model to enhance health care to rural and remote Australians and will inform the rollout of the NP role nationally. The first year of operation has resulted in successful establishment of the role in one district, which will now be rolled out to three additional districts over the next four years. The importance of the leadership and change facilitation activities of the nurse practitioner have been recognised at the prestigious 2012 WA Nursing and Midwifery Excellence Awards by her winning the Emerging Leader award.
Rural Health West GP Obstetrics Mentoring Program

Heather Waite1, Sally Congdon1, Rosalie Wharton1
1Rural Health West

Program overview: Rural and remote Western Australia suffers from significant obstetric workforce shortages, with many areas not having resident specialist obstetricians and relying entirely on GP obstetricians.

To support rural women to give birth close to home, with services provided by skilled GP obstetricians, Rural Health West implemented the highly successful GP Obstetrics Mentoring Program, which has now been operating for six years. The program supports recent DRANZCOG (Diploma of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists) graduates to consolidate the skills and experience necessary to work independently as rural GP obstetricians.

The recent graduate is linked to an experienced rural GP obstetrician or specialist who can provide support, assistance and mentoring with deliveries and obstetric cases. Funding is provided to the graduate and the supervisor/mentor to support these aims.

Evaluation overview: To date, there have been 37 new DRANZCOG graduates funded under this program. Rural Health West is undertaking a formal evaluation of the program, which will include:

- collating and reporting on the current post-participation evaluations
- undertaking a survey of all previous participants to assess their satisfaction with the program and to identify opportunities for improvement
- seeking to determine whether involvement in the program lead to improved retention of participants compared to non-participating rural GP obstetricians.

Presentation content: The presentation will include:

- an overview of GP obstetric workforce issues in rural and remote WA
- description of the program
- evaluation process
- qualitative and quantitative evaluation outcomes.

Is remote health different to rural health?

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1Centre for Remote Health, Flinders University and Charles Darwin University, 2Monash University School of Rural Health, 3University of Melbourne, 4James Cook University

Introduction: In Australia the ‘rural health’ rubric has been used to include a range of geographical and social settings, and services. From the mid-1990s, there has been a growing recognition of ‘remote health’, as distinct from ‘rural health’. Currently, there is a renewed policy interest in remote Australia: for example, the 2007 Northern Territory Emergency Response, which has now been redefined as the ‘Stronger Futures’ policy; and a recent publication, Fixing the Hole in Australia’s Heartland: How Government needs to work in remote Australia (2012), which describes the failure of governance in remote Australia and provides recommendations for a way forward based on a deeper understanding of local context. But what do we know about remote health?

There is very little published about the distinct features of remote health (Wakerman 2004) or remote medicine (Smith et al 2009). From the literature, Wakerman (2004) describes a context of relatively higher mortality and morbidity; higher proportion of the population that is Indigenous; and a more dispersed population. Service delivery is characterised by a relative undersupply of health workforce; poorer access to services; a very strong multidisciplinary team approach with overlapping roles; and a greater reliance on visiting service models. Distinct features of remote health practice include generally non-procedural medical practice and a high degree of GP substitution, especially utilising remote area nurses and Aboriginal health workers.

Smith et al (2009) utilise expert consensus to describe remote medical practice as characterised by a cross-cultural context; isolation; the use of telehealth; the need for increased clinical acumen; extended practice; a strong multidisciplinary approach; public health and security considerations; and predominantly non-private employment.

Empirical evidence that describes the nature and distinct features of remote health is lacking.

Methods: We interviewed and surveyed 45 Australian experts in rural and remote health. Experts were identified by the research team based...
on experience, tenure, reputation and at least five years' work in rural and/or remote health. Selection was purposive to ensure coverage of four key areas: academic, policy, practitioner and advocate, as well as ensure geographical coverage. Within each category were professionals with experience in remote areas and in Aboriginal health.

Findings: Both quantitative and qualitative data were analysed to distinguish the characteristics of context and practice between rural health and remote health. Perceived differences with respect to isolation, the type of population, cultural differences, access to health care, the relative roles of GPs, nurses and Aboriginal health workers, socioeconomic disadvantage, and political power were all statistically significant. Some respondents suggested that 'remote is ... not well understood unless you’ve actually been there, worked there and are passionate about Indigenous health, especially in Australia.'

This paper describes in detail these and other differences, as perceived by the rural and remote health experts who participated, and draws out implications for policy and practice.

Governance at the heart of reform in remote Australia

Bruce Walker1, Fred Chaney2
1Desert Knowledge Australia remoteFOCUS Project, 2Desert Knowledge Australia Chairman

Australia has changed significantly, and continues to change, in fundamental ways.

Over the past 30 years, it has become the most urbanised continent in the world. Australia’s view of itself has shrunk to its coastal fringe. More than 85% of our population lives within 50 km of the coastline and our system of democracy and national economy and the accompanying policy and program settings have progressively been altered to serve the coastal areas and the large mass of people in urban Australia.

In numerous ways, this has been at the expense of how remote Australia and its people and communities are governed, leading to what is nothing less than a crisis in governance, and an urgent need for systemic change. The persistent efforts of policy makers in a multitude of sectors are likely to be frustrated in the absence of systemic reform of governance. This and the lack of a declared national interest in remote Australia hinders the policy and program efforts of many professionals, agencies and organisations.

The remoteFOCUS project initiated by Desert Knowledge Australia concluded that:

- governance arrangements are a threshold cause of policy failure in remote Australia
- policy for remote Australia needs to be separately conceived and framed, and ‘custom built’ to meet its specific circumstances and needs
- the challenge in designing new approaches to governing and administering remote Australia is that a paradigm shift in policy is required—and this cannot come from within the present governance framework.

A framework for governance reform is proposed in the recent report entitled ‘Fixing the Hole in Australia’s Heartland: How government needs to work in remote Australia’. This paper presents the next steps that have been taken to progress these findings, including building a public alliance and examples of the principles and framework in action in the Pilbara and Central Australia.

Increasingly place-based initiatives, co-production of service delivery and innovation strategies are being practised in sectors like health, disability services, etc to overcome the dysfunctions highlighted in the remoteFOCUS project. This paper suggests these concepts will not translate immediately into remote contexts or provide durable outcomes without a concurrent reform of governance and recognition of the unique operating environment in remote Australia.

This paper concludes by offering alternatives that address the systemic drivers that contribute to the difficulties of governing the vast, valuable and sparsely populated backyard of the nation.

Retention of nursing and allied health professionals in rural and remote Australia

Anthony Wall1, Jenni Baker1, Jane Farmer2
1Primary Health Planning Services, 2La Trobe Rural Health School, La Trobe University

Background: What keeps nurses and allied health professionals working in rural and remote Australia?

While substantial literature exists regarding issues affecting retention of medical practitioners, there is a dearth of research among nurses and allied health professionals, particularly in an Australian rural and remote setting.
The Rural Health Professionals Program (RHPP) is a new workforce scheme designed to increase the allied health and nursing workforce in rural and remote Australia.

RHPP is an initiative of Health Workforce Australia (HWRA), which is funding rural workforce agencies (RWAs) to attract and recruit allied health professionals from Australian metropolitan and approved overseas locations.

Each RWA is responsible for identifying vacancies within their jurisdiction and providing a fully case managed recruitment service to eligible candidates, including retention support for up to two years.

The national rollout of this program in 2012 provides an opportunity to undertake independent research among both locally and overseas-trained professionals currently working in rural and remote Australia.

Aims: The overall objective of this project is to identify factors related to the retention of nurses and allied health professionals in rural and remote Australia.

The project is collaborative, with involvement from three rural workforce agencies, a peak body and an Australian university.

In addition to accessing a range of allied health professionals, this multi-agency involvement will facilitate comparisons between regions of varying levels of ‘remoteness’.

Methods: A three-phase research program is being undertaken involving:

- Phase 1—a qualitative phase of n=15 face to face in-depth interviews among nursing and allied health professionals placed under the RHPP in three Australian states/territories
  - the purpose of this phase is to uncover in depth the range of issues potentially impacting on retention of nursing and allied health professionals in rural and remote Australia.
- Phase 2—a quantification of the issues identified through Phase 1, conducted online among n=75 nursing and allied health professionals. All professionals placed under the RHPP in the three states/territories will be emailed a survey.
- Phase 3—semi-structured telephone exit interviews among nursing and allied health professionals when they leave their RHPP-supported position.

Results and conclusions: This paper will deliver an outline of the study, its methodology and the findings from Phase 1 (which is being conducted in late 2012). At the time of preparing this abstract results were unavailable.

Building a Medicare Local as unique as the Territory itself

Diane Walsh1, Andrew Bell1
1Northern Territory Medicare Local

The NT has two parallel systems of primary health care delivery:

- a ‘mainstream’ system centred around private practitioners based in urban centres
- Aboriginal PHC in remote and urban centres delivered by a mix of Aboriginal Community Controlled Health Services (ACCHSs) and the Department of Health.

This structural separation has been reflected in different funding arrangements and different models of care. There has been duplication, gaps, poor integration of different parts of the PHC system and, at times, forced competitiveness between provider groups.

The federal health reforms offered an opportunity to bring these divergent systems together to maximise the resources, knowledge and skills of the three service delivery groups in the NT, with the vision of improved health and wellbeing for all Territorians.

Three partners with different perspectives came together as equal members of a new company to form the NT Medicare Local with a mission to lead the development and coordination of an equitable, comprehensive primary health care system driven by community needs.

Aboriginal Medical Services Alliance NT, the NT Department of Health, and the General Practice Network NT formed a partnership that is unique in Australia, and that aims to:

- address the complex challenges and opportunities for the delivery of comprehensive PHC services in the NT
- include the active partnership and engagement of ACCHSs and
Food for all Tasmanians: development of a food security strategy

Alison Ward\textsuperscript{1}, Sarah Connally\textsuperscript{1}, Julie Williams\textsuperscript{1}

\textsuperscript{1}Population Health and Wellbeing, Department of Health and Human Services

In response to a recommendation in \textit{A Social Inclusion Strategy for Tasmania} in 2010 the Tasmanian Government appointed a Tasmanian Food Security Council (TFSC) chaired by the Social Inclusion Commissioner to develop a Tasmanian food security strategy (TFSS).

This set scope of the TFSS to focus on the equity and access to a healthy, sustainable, affordable, appropriate and accessible food supply for all Tasmanians, particularly the most vulnerable.

The work of the Council was supported jointly by the Social Inclusion Unit in the Department of Premier and Cabinet and the Community Nutrition Unit in Population Health, Department of Health and Human Services. This effective partnership allowed cross-agency collaboration.

Evidence on which to set the strategic direction and content of the TFSS was gathered through a consultative, collaborative and action-based approach. In order to mobilise interest across a range of sectors, and to gather evidence on the need to address food security with a cross-sector approach, the TFSC dispersed a round of funding to coalitions of non-government and government organisations. Each coalition implemented community-based food security programs or developed tools for action. Tools for a monitoring and surveillance framework were also developed. This work was showcased through an event hosted by the TFSC. The inclusive process used to develop the TFSS-Food for All Tasmanians (FFAT) provided a mechanism for existing food security activity along with the newly funded activity to be considered as evidence.

The resulting Food for All provides a blueprint for action aimed at improving the equity and access of the food supply with a particular focus on vulnerable groups and those at a locational disadvantage. It will require joint collaborative effort between all tiers of government and governmental agencies, and with the private and community sectors. It will require the communities’ input through using a community-driven place-based framework.

Hearing loss, lifestyle loss

Sue Ward\textsuperscript{1}

\textsuperscript{1}Wimmera Hearing Society Inc

Background: The Wimmera Hearing Society Inc would like to make a presentation about hearing damage and prevention. The Wimmera Hearing Society Inc has many years of experience dealing with hearing loss and people that suffer hearing loss. Based in Horsham, the society has for 30 years operated in the Wimmera region and since 1998 the wider rural region of country Victoria. This service

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- improve sharing of expertise.

The partners shared a commitment to genuine reform and improvement of primary health care that includes:

- a system-wide equity-based approach to resource allocation

- developing consistent regional models of health service management with community engagement, sustainability and capacity

- mechanisms for engaging public health and PHC practitioners in regional health service planning and development

- agreed definition of ‘core comprehensive PHC services’

- health service performance indicators, including the NT Aboriginal Health KPIs

- system-wide continuous quality improvement

- well-developed functions of the Rural Workforce Agency

- proven engagement with PHC providers and consumers.

A further unique aspect of the NT model is the mandated inclusion in its independent skills-based board of at least three directors of Australian Aboriginal descent. A Community Advisory Committee and an Aboriginal Health Committee are also constitutionally mandated.

The NT Medicare Local has been built to reflect the real story of health need and service provision in the Northern Territory.

Recommendation: Medicare Local structures and governance should be closely tailored to the needs of the local community.

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provides free hearing assessment to everyone, along with a year 7 student program in many secondary schools. A weekend family camp is held annually for country families with hearing impaired/deaf members.

A free hearing assessment and counselling service is provided to each client, along with hearing results, referral for further investigation, communication strategies and information about hearing loss prevention.

Discussion: With the use of a helos machine and PowerPoint presentation, we have the ability to demonstrate exactly what it would be like to suffer from different degrees of hearing loss; this presentation would be focused on the high frequency area of hearing loss. This is the area that is depleted due to many hours and years of exposure to loud noise.

We are able to present dialog in different degrees of damage, and eventually demonstrating how difficult it is to cope with a permanent hearing loss, and in different situations. Which I am sure many attending will relate to.

The second part of presentation would be education and prevention strategies, along with communication tips. Finishing off the session would be information about hearing protection.

Case study: I will introduce you to a person who has had noise exposure all of his life, in working and recreation activities. This person has attended for his hearing assessment regularly over the past 30 years. He is now 54 years of age. Due to his regular hearing health checks while working in a ‘high-risk occupation’, he has maintained a satisfactory hearing ability. It is only of recent times, due to years of farming and advancing age, that he has recently been advised to seek assistance of hearing support.

The focus of this case study is to illustrate the importance of regular hearing tests for those considered at ‘high risk’, accompanied with relevant information on satisfactory prevention of early hearing loss through the use of hearing protection. Failure in seeking regular hearing tests would have most possibly resulted in his hearing being impaired at a far earlier stage of his life.

Ageing with an intellectual disability: support issues in rural localities

Stuart Wark1,2, Rafat Hussain1, Helen Edwards3

1CRN for Mental Health and Well-Being, University of New England, 2The Ascent Group, 3School of Education, University of New England

Relevance: In the past 100 years, the life expectancy for individuals with an intellectual disability has increased dramatically. This improvement is due to an improvement in a variety of social and structural support systems; however, a major knowledge gap has emerged in how to most effectively assist this cohort of people to age successfully. In particular, there has been very limited research examining how best to support the individual and their family who may reside in rural and remote locations, and what impediments non-metropolitan support workers experience in daily service delivery.

Aims: The goal of the research was to explore the social, economic and structural impediments facing staff who support people with intellectual disabilities who are ageing in rural areas of NSW. The results of the research allow for the identification of priority areas in policy change, education, training, professional development and cross-industry collaboration.

Methods: A Delphi research model was developed, and three rounds were conducted over a period of one year. There were a total of 31 participants from across rural and remote regions of NSW, and came from 14 different disability support organisations.

Results: A thematic analysis of the results identified a series of impediments that support staff considered to be problematic in the provision of appropriate support. These areas of concern include funding, access to relevant services, time constraints and family dynamics.

Conclusion: The findings of this study have implications for policy and practice for families, aged care and disability service providers, as well as the government funding departments for both the delivery of services to individuals with intellectual disabilities who are ageing, and for the training of all people who support this cohort of people.
Volunteers in health

Kate Warren¹
¹Uni SA

Background: The role of volunteers in health has generally been seen as passive, centred on fundraising, advisory boards/committees and other non-service delivery roles. There is, however, an opportunity for volunteers to be much more proactive in their communities and contribute to improving health outcomes by becoming peer educators. In this role, with adequate support from health services and organisations such as the University Department of Rural Health (UDRH)—previously known as the Spencer Gulf Rural Health School—it is possible for them to become leaders in service provision and health education that is predominantly the domain of health professionals.

Methods: Over the last ten years one such organisation in Whyalla, ‘Health In Our Hands’, has been working closely alongside the UDRH in Whyalla, and with local, state and federal health services to achieve just this goal. Volunteers have, over this period, undergone a range of training in providing a variety of health-related programs based on the Stanford Chronic Disease Self-Management Program. This community capacity building commenced during the federally funded Sharing Health Care project in 2002 and has continued to the present time resulting in the volunteers acquiring a vast amount of experience, expertise and qualifications in this field.

Much research has been conducted on the benefits of community peer educators and the results from Health In Our Hands experiences adds to the body of knowledge that this concept works well to increase the capacity of the community to adapt and to self-manage. Volunteers have developed a range of programs all aimed at giving community members the opportunity to make changes to improve their health and increase health literacy. These include education workshops, Tai Chi, exercise classes, social meetings and health-related information. Training for the volunteers has been pivotal to the success so far; and the UDRH has provided the opportunities for volunteers to learn new skills and has continued to provide the valuable support network needed for an enterprise such as this. This training and support has been so successful that some of them are now qualified to train not only other volunteers but health workers too, not just at a local level but nationwide. Not all volunteers wish to work at this level and this has been respected; however, they have always been encouraged to widen their scope and most have risen to the challenges and taken part in areas of their interest. Training has been provided in Tai Chi instruction, exercise instructor, volunteer management, organisational management and public speaking. Over the past ten years the centre has also successfully submitted abstracts and presented at a number of national conferences on a range of topics.

Major findings and lessons learnt: This paper will outline the impact this capacity building has had on the community, specifically the volunteers and the participants in the activities they deliver, as well as how the collaborative relationship between the volunteer group and the UDRH as part of the University of South Australia have strengthened the resilience of the community as a whole.

The important role of the regional eye health coordinator in NSW

Pauline Wicks¹, Daniel Cook², Colina Waddell³, Brian Layland³, Sandra Bailey⁴
¹Wellington Aboriginal Corporation Health Service, ²Durrig Aboriginal Corporation Medical Service, ³The Brien Holden Vision Institute, ⁴Aboriginal Health and Medical Research Council

Aims: In 1998, the Commonwealth Government and NACCHO agreed that Aboriginal people were more likely to seek eye care within Aboriginal Community Controlled Health Services (ACCHSs). The NSW Aboriginal Eye Care Program was rolled out, in partnership, by the state’s peak body for ACCHSs and a non-government organisation who provide optometry services. The Commonwealth-funded equipment for eye clinics and regional eye health coordinator (REHC) positions within seven ACCHSs within NSW (and similar positions in the other states and territories). This presentation aims to showcase the role of the REHC in coordinating and facilitating access to eye care for Aboriginal people across NSW.

Methods: The roles of two NSW REHCs were outlined, and the common job tasks listed. Key factors contributing to success of these programs were identified.

Relevance: Appropriate and accessible eye care programs for Aboriginal Australians are important, given the largely preventable rates of visual impairment and blindness. Eye care within ACCHSs ensures services are accessible. REHCs play a central role in enabling access for Aboriginal people, by:

- facilitating outreach services
• engaging ophthalmologist that bulk bill
• ensuring rural and remote areas receive an equitable level of services
• networking to enable the eye health program to grow.

**Results:** Key roles of REHCs in NSW include:

• vision screening for Aboriginal people (including school screenings)
• network with partners and communities to ensure culturally appropriate services
• overcome barriers to accessing eye care for Aboriginal people
• organising clinics for visiting optometrists
• organising annual recalls for diabetic retinal examinations
• make specialist appointments for patients
• follow up with patients after surgery (eg cataracts).

This program has been very successful. REHCs are seeing more children and adults with vision problems, through Aboriginal health checks and school and preschool screenings. The reaction of the Aboriginal community has been excellent. Collaboration with local eye practitioners enables more Aboriginal people to access treatment for refractive error, cataracts, diabetic retinopathy, or any disease/trauma.

**Conclusions:** REHCs play a very important role in the holistic care of Aboriginal communities by organising eye clinics in rural/remote areas. Eye health is vital and just as important as oral and ear health, yet doesn’t receive as much attention. REHCs taking these clinics to Aboriginal people are providing part of the holistic health care process that is working towards ‘closing the gap’.

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**Deconstructing the barriers to engaging families with complex needs in early intervention services**

*Katrina Wilkop¹, Christy Clothier¹*

¹Yorke and Lower North Health Service

Play2Grow is an interagency supported playgroup run by the Clare Healthy Families (HF) Team and the Clare Medical Centre (CMC) in rural South Australia. The Play2Grow playgroup is based on a transdisciplinary model of care where boundaries between disciplines are deliberately blurred to enable a flexibility that promotes broad positive outcomes for children and their families. Transdisciplinary practice is especially relevant in a rural context where staffing issues necessitate a sharing of responsibilities for the fluid provision of client services.

Early intervention (EI) clinicians need to consider a multitude of factors that may prevent families from engaging in EI services. Factors may include parent mental health, access to transport, financial or employment stress, housing and social isolation. For some families the barriers to accessing ‘traditional’ EI services have meant that those with complex needs have not received adequate intervention or have disengaged from services prematurely. Play2Grow targets this population with its primary purpose being engagement with EI service.

Two sessions of Play2Grow are run weekly, for two hours each, at the EI space, which is co-located with the Clare Valley Children’s Centre. Each semi-structured playgroup is facilitated by allied health clinicians from the HF team and a mental health nurse from CMC. Throughout each session, social and play skills are modelled by clinicians and gentle coaching of parents is provided as appropriate. Clinicians provide a warm, empathetic, supportive and safe environment that harnesses the key elements of mindfulness practice: interest, curiosity and reflection without judgment. All clinicians involved in facilitating the group engage in their own reflective practice and have a deep understanding of the benefit of responding to the evolving needs of a group. Building relationships is considered an integral component of continued engagement with service. This is supported by providing continuity of access to a designated team of EI clinicians as well as a key contact person.

Play2Grow has evolved over the last two years and is now accepted as core business for the HF Team. Positive outcomes for families with complex presentation have been beyond expectation. Children with poor developmental projection have reached age-appropriate milestones; allied health intervention has been initiated for children of parents with mental illness where unintentional neglect has delayed development; Families SA and Uniting Care Wesley have withdrawn services as parents grow in confidence; child care and other community supports have been accessed by families and, most recently, the collaborative construction of a ‘mini racetrack’ in the
playground was supported by all playgroup families. The outcomes are multifaceted and exciting as a team of EI clinicians we look forward to celebrating with families as they ‘Play2Grow’.

The Alere Health and Wellness Index, powered by Roy Morgan Research

Nick Williams1, John Lang2
1Roy Morgan Research, 2Alere Health

Historically wellbeing indices have integrated measures of personal wellbeing with impacting social contexts that affect how people feel about their lives. The Alere Health and Wellness Index (AHWI) has been developed to measure health and wellness, pursuant to the self-reported health behaviours of Australian adults. The aggregated wellness index scores form a bell curve ranging from 50 (unhealthiest) to 130 (healthiest) with a mean of 99.4 and a standard deviation of 14.1 and is based on the weighted average of seven sub-indices: nutrition, exercise, psychological health, alcohol consumption, tobacco consumption, medical state and BMI. The sub-indices are informed by responses to questions involving around 400 factors from the Roy Morgan National Consumer Poll.

The poll informs a comprehensive single source database of demographics, beliefs, health and behaviour, derived from weekly surveys of Australian households, and accrues around 50 000 respondents’ per annum. The AHWI tracks changes in health and wellness, providing a snapshot of around 4000 Australians per month, and adds to insights derived from the five National Health Surveys that have been conducted since 1995. Rises or falls in the aggregated AHWI scores among specific populations can be analysed by drilling down through relative changes in the seven subindices to the specific behaviours and factors that underpin them. Consequently the index represents a research tool that can be used by Commonwealth and State Health Authorities to monitor and measure impacts and outcomes of Public Health Programs such as the National Partnership Agreement on Preventive Health, WorkHealth or the ‘Get Healthy’ coaching service.

The current focus of preventive funding by COAG targets poor nutrition, physical inactivity, tobacco smoking and excessive alcohol consumption. The presentation will include examples of how the Health and Wellness Index can be analysed to inform health program evaluation and implementation for defined populations over discreet periods, including by state, Australian Standard Geographical Classification—Remoteness Areas, and by demographic segments. The index enables trend as well as point-in-time analysis; for example, a snapshot of the quarter to December 2011 showed an Aggregated Health and Wellness Index score of 100.2 in the major cities versus 98.3 in the inner regions, 97.9 in the outer regions and 96 in the remote/very remote regions. The factors contributing to the decline in health with increasing remoteness can be readily identified and used to inform future public health strategy for regional Australia.

Extreme heat and rural health: perspectives from health service providers

Susan Williams1, Peng Bi1, Jonathan Newbury1, Guy Robinson2, Dino Pisaniello1, Arthur Sanitots1
1The University of Adelaide, 2The University of South Australia

Introduction: Climate change and the projected increase in extreme heat present new challenges for rural health in Australia. Extreme heat can lead to heat-related illness and mortality, particularly among vulnerable groups. The adverse health effects of heat are largely preventable. A combination of physiological, social and contextual factors can influence these outcomes, and an understanding of these factors at a community level can direct the development of locally appropriate heat emergency and adaptation plans. There has been limited research on these factors in rural Australia.

Aim: The aim of this study was to explore how rural communities in South Australia experience extreme heat and the factors that limit or enhance their capacity to adapt to this challenge.

Methods: A qualitative study was undertaken, using interviews with rural health service providers to explore their views and experiences in relation to extreme heat. Thirteen participants from 11 locations across the state were interviewed by phone, between March and June 2012. The interviews were transcribed and a thematic analysis undertaken. Themes were assigned to five domains according to a social ecological framework: individual characteristics, interpersonal networks, community characteristics, organisational issues and the natural environment.

Results: A common narrative was that rural residents are experienced, independent and aware of extreme heat and modify their behaviour accordingly.
However, the elderly were considered to be a vulnerable group. The key barriers for managing the heat were the cost of power and the reluctance of elderly residents to use air-conditioning routinely. These issues may be compounded in rural communities by a higher proportion of transportable or thermally inefficient housing. There are fewer available cool refuges, and their access can be restricted by limited transport and travel distances. There are also potential social consequences of extreme heat, as daily interactions are diminished and activities and sport are cancelled. Participants suggested this could lead to social isolation and diminished quality of life during these times. The service provided by many rural community health providers covers a large footprint, and extreme heat and related bushfire risk was a common concern in relation to travel. The conflicting requirements of maintaining client support while managing risks was a salient issue among participants.

Conclusions: Locally appropriate, low-cost strategies to mitigate the effects of extreme heat will be needed to assist rural communities adapt to a warmer climate.

Building excellence in remote Indigenous aged care: Tjilpiku Pampaku Ngura

John Wilson

This paper charts the development of Nganampa Health Council’s regional aged care residential and respite facility, Tjilpiku Pampaku Ngura, situated in Pukatja community on the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands in the remote north-west of South Australia.

Opened in 2000, Tjilpiku Pampaku Ngura (a home for older men and women) is a 16-bed facility that also provides a base for the delivery of Home and Community Care (HACC) services in Pukatja community.

The facility is managed and governed within the broader organisational structure of Nganampa Health Council, an Aboriginal community-controlled health organisation delivering comprehensive primary health care to its Anangu members (as well as 24-hour emergency clinical care to all residents of the APY Lands).

Formally reviewed in 2008 by external consultants (the Broe/Arch Review) and more recently as part of the national Indigenous Aged Care Quality Framework process, Tjilpiku Pampaku Ngura is regarded as a centre of excellence for the national flexible Indigenous aged care services program.

Following a brief overview of funding, staffing and services, this paper identifies and discusses key elements of service development, strategic management and day-to-day operations that contribute to excellence.

In particular, the paper explores the importance of extensive community consultation in the development of the service, governance arrangements securely grounded in consumer/member participation, and the benefits that accrue from the service being embedded in a wider organisational structure and resource base.

The paper then goes on to identify and briefly discuss learnings from this experience that may apply across the national program.

Finally, the paper raises several key planning and strategic management issues for Tjilpiku Pampaku Ngura, and their implications for the national program. In particular the challenges resulting from unfunded capital maintenance costs, inflexible burgeoning regulation and the absence of an effective services and management support network are explored.

Heatwave disasters in rural Australia: planning for an ageing population

Leigh Wilson, Craig Veitch, Deborah Black

Relevance: Heatwaves are increasing in frequency, intensity and duration due to global climate change, and account for more deaths in Australia than any other natural hazard. Research has identified the aged—and those living in residential aged care facilities (ACFs)—are at increased risk of heat-related morbidity and mortality. Rural Australia experiences high summer temperatures and is home to proportionally more elderly residents than urban settings. Rural ACF buildings are more likely to be older, or not ‘purpose built’ compared to their urban counterparts.

Aims: The study aims were to:

- investigate current heatwave planning policies and heat prevention strategies in rural ACFs
• identify barriers to successful implementation of adequate heatwave health care in rural ACFs in three Australian states (NSW, Queensland and South Australia).

Methods: Residential ACFs were identified across three states using Department of Health and Ageing databases, the White Pages and internet searching. After removal of duplicates, 450 rural facilities were invited to participate in the study. Each participating facility was asked to provide informed consent and invited to select one administrative and one clinical staff member to participate in a 15-minute computer-assisted telephone interview. Participants were asked to detail current plans and policies that addressed residents’ heatwave health, strategies used to keep residents well during periods of extreme heat and barriers to the implementation of heatwave health care. Data was entered into a purpose-built database and analysed using Statistical Package for the Social Sciences (SPSS) Version 19.

Results: One hundred and seventy five rural ACFs participated in the study. Ninety per cent of facilities had a current ACF emergency plan, although only 30% included heatwave emergency planning. Staff used a range of strategies to keep residents cool in extreme heat, although strategies were not consistent across all states or facilities. One-third of ACFs did not have air-conditioning, instead relying on other cooling methods such as fans and evaporative cooling. Barriers to heatwave health included poor building design, low staffing levels and poor cooling equipment.

Conclusions: This study identifies the current policies and strategies rural ACFs use to keep residents well, and highlights the barriers to maintaining wellness in the residential aged facility during periods of extreme heat. As the Australian population ages, planning for the health effects of extreme heat in elderly rural residents is critical to ensure wellness in this population group is maintained.

Predictors of rural practice for graduates from Australia’s first regional medical school

Torres Woolley¹, Tarun Sen Gupta¹

¹School of Medicine and Dentistry, James Cook University

Aim: This presentation describes the pre-medical, undergraduate and postgraduate factors that predict James Cook University (JCU) MBBS graduates’ likelihood to practise rurally (ASGC-RA 3 to 5) in their fourth postgraduate year (PGY4).

Relevance: Maintaining an adequate medical workforce in rural and remote areas of Australia is challenging. To address this challenge, the regionally located JCU medical school was established in 2000 with a mandate to select and educate medical students prepared to work as doctors in rural and regional locations. By 2011, 194 JCU MBBS graduates had completed PGY4. Of these, 80 (41%) were practising in an ASGC-RA 3–5 town (outer regional, remote or very remote locality) during PGY4. This study describes the factors associated with JCU graduates’ choice of rural practice location in PGY4.

Methods: Multivariate analysis was undertaken on the collated data of JCU MBBS graduates at application (age, gender, location of hometown, school leaving score, interview score, ethnicity), during undergraduate years (scholarships, honours program, academic achievement, location of rural placement), and post-graduation (internship location, practice location, specialty training).

Results: Multiple logistic regression analysis of 191 JCU MBBS graduates identified that practise in a ‘rural’ town (ASGC-RA 3–5) in PGY4 was predicted by:

• internship in an ASGC-RA 3–5 location (p<0.001)
• postgraduate training as a general practitioner or rural generalist (p=0.001)
• hometown at application in an ASGC-RA 3–5 location (p=0.035).

Conclusions: The new JCU medical school appears to have produced graduates who tend to practise in rural areas over the medium term, with many choosing careers as general practitioners or rural generalists. This study provides the first Australian evidence that likelihood of rural medical practice is enhanced by:

• establishing a medical school in a regional location
• selecting students with a rural origin at application
• having a selection process orientated towards choosing students with a genuine desire for rural practice
• providing regionally located internship places.

This early evidence supports the proposition that investment in rural medical education will produce an appropriately trained medical workforce to meet the needs of rural Australia. However, findings also suggest that regional workforce may be further enhanced with additional training opportunities in regional tertiary hospitals for specialties other than general practice and rural generalism.
Lunch time session abstracts

Note: for delegates wishing to attend these sessions, lunch will be served in Foyer 5 outside Meeting Room 3

Arts and health and the Arts and Health Foundation

Deborah Mills1
1Arts and Health Foundation

Good things are stirring on the arts and health front. Government departments of both health and arts are collaborating on the first-ever National Arts and Health Framework. The sector has been widely consulted, including at a roundtable in Canberra last year, and with leadership from the Arts and Health Foundation.

The National Rural Health Conference will again be showcasing arts and health activities and providing a venue for papers relating to the evidence of the efficacy of arts and health, and for exchanges and demonstrations of practice.

Come and express your support for these valuable endeavours and hear about the Arts and Health Foundation’s renewed focus. This short lunch time meeting will be an opportunity to meet with people closely involved with the movement and to build the network of interested individuals and organisations.

Rural areas and the NDIS

Roland Naufal1, Denis Ginnivan2
1Disability and Carer Alliance, 2NRHA

The launch sites of the National Disability Insurance Scheme (NDIS) start their work on 1 July 2013. Much preparatory work is under way, led by the NDIS Launch Transition Agency. A number of community groups and service agencies have been supported by FaHCSIA to contribute to the planning. The National Rural Health Alliance and the National Disability and Carer Alliance are collaborating on a special project relating to the characteristics the NDIS will have to have to make it successful in rural and remote areas.

This short lunch time meeting will be an opportunity for those unable to get to the NDIS concurrent session (C7 in Riverbank 2) to meet and indicate their interest in the ongoing work on the NDIS—particularly for rural areas. Come and meet Roland Naufal of the Disability and Carer Alliance and Denis Ginnivan of the NRHA and make sure you are ‘on the map’ with the work so you can get and remain involved.

Supporting clinical governance in Indigenous health: an AHCWA/APHCRI partnership

Dan McAullay1,2, Karen Gardner3, Bev Sibthorpe1, Michelle Dowden1, Donisha Duff3,4, Mier Chan2, Terry Pitsikas2, Des Martin2, Robert Wells3
1Australian National University, 2Aboriginal Health Council of Western Australia, 3Australian Primary Health Care Research Institute, 4Ngalkanbuy Health Service, 5National Aboriginal Community Controlled Health Organisation

Changes in the policy environment, including the Australian Government’s ‘Closing the Gap’ reform agenda, impact significantly on the clinical governance structures required to support quality improvement across the community controlled sector. The Aboriginal Health Council of Western Australian (ACHWA) and the Australian Primary Health Care Research Institute (APHCRI) have entered into a partnership to progress the quality improvement agenda in WA through enhanced clinical governance. This research aims to test a new approach to embedding quality improvement activities within an affiliate supported clinical governance framework to increase health assessments and improve outcomes in ear health, sexually transmitted infections (STIs) and smoking. A second project examining regionalisation of the planning and delivery of primary health care services is planned.
Looking beyond fractures: multidisciplinary care of acute orthopaedic injuries in older people

Holly Bannon-Murphy1, Timothy Amos1, Helen Haines1, Alison Kosche2, Rick McLean2
1University of Melbourne, Vic, 2North East Health Wangaratta, Vic

Current issue: Depression, dementia, polypharmacy drug interactions and poor nutrition frequently remain unrecognised during the acute admission of the elderly person with acute orthopaedic injuries. This leads to potentially avoidable physical, psychological and social decline. Protection against functional decline is imperative to maintaining quality of life and remaining in the family home. In rural areas where public transport and infrastructure is limited this need is heightened. At Northeast Health Wangaratta (NHW), a multidisciplinary early intervention approach to managing older patients with acute orthopaedic injuries was recognised as important to predicting poor outcomes.

Method: physician-led multidisciplinary team review of all acute orthopaedic admissions over age 70 during a six-month period in 2011–12. Audit was undertaken by final-year medical students to document investigations, surgical and medical complications, length of stay and discharge status. Patients in the intervention group were compared with a control group over a similar six-month period in 2010–11.

Results: 52 patients had physician reviews in the audit period. Ninety-two patients were in the control group. There were no differences between the groups in demographics, orthopaedic diagnosis or known co-morbidities on admission. The audit showed both the intervention group and control group had similar treatment and investigation to reduce the likelihood of immediate post-operative complications. Screening by the multidisciplinary team in the intervention group identified clinically significant depression, vitamin D deficiency and functional decline. The average modified Barthel’s score deteriorated from pre-admission to discharge, indicating that acute orthopaedic injuries have a significant effect on long-term functioning. Importantly post-operative delirium was more readily recognised and treated in the intervention group. This was attributed to the identification of symptomatology by the gerontology nurse practitioners who work alongside physicians at NHW.

Insights: This project raised awareness of the high prevalence of unrecognised depression and vitamin D deficiency. Importantly, multidisciplinary teams showed the potential to improve care through recognition of delirium and functional scoring. The next step is further integration with primary care, including better communication with GPs and carers to ensure that depression, vitamin D deficiency and functional decline identified with the Barthel’s score is followed up.

As medical students we are committed to a brighter future for elderly members of our rural community. This audit highlighted for us the importance of teamwork and looking beyond fractures.

Increasing the quantity and quality of rural placements for undergraduate nursing and midwifery students: achievements and challenges

Morgan Smith1, Kym Medlicott1, Christine Bartel1
1Inner North Country Health Services, Country Health South Australia

This presentation reports on a Health Workforce Australia funded joint initiative between Country Health South Australia Local Health Network—Inner North Country Health Services and the University of South Australia. The aims of the project were to develop the quantity and quality of placements available to undergraduate University of South Australia nursing, midwifery and physiotherapy students and in doing so expose students to the opportunities available when working rurally and the knowledge and skills required to do so. The project is funded until December 2013. The presentation explores initiatives in the area of nursing and midwifery clinical education.

Strategies were implemented to increase the number of placements available to nursing and midwifery students in Inner North Country Health Services. An education facilitator and two clinical facilitators were appointed to manage the cohorts of students in conjunction with clinical staff who were responsible for the client load.

Strategies to improve coordination and communication of placements were implemented.
Increased numbers of students were managed through closer coordination with the university and improved communication with clinicians. Approaches to provide clinicians with greater information on the students’ learning needs were developed, as well as careful rostering of students over seven days of the week.

Strategies to educate staff to educate students more effectively were also implemented. This included staff development sessions and hard copy and electronic resources.

Strategies were implemented to enable students to identify knowledge and practice skills unique to rural health care settings. Focus was also placed on enabling students to understand the knowledge and skills required of the rural health workforce of the future in which they could play a role.

Some interim findings from the evaluation of this project will be presented to illustrate the effectiveness of some of the strategies. Lessons learned from the project to date will also be explored.

**Rural mental health: a collaborative approach to improving client’s health-related behaviours**

Tracey Stringer¹, Jenny Biven², Lee Martinez³, Jorg Strobel⁴, Rama Ramathan⁵, Marcus Connelly⁶

¹Port Pirie Regional Health Service, CHSA Mid North Cluster, ²CHSA Murray Mallee, ³CHSA/University of SA Centre for Regional Engagement, ⁴Country Health SA, ⁵CHSA Population Health Portfolio, ⁶CHSA Mental Health Directorate

This project is fostering and developing a collaborative approach between mental health workers and lifestyle advisors for consumers living with mental health issues. ‘Mental illnesses affect people’s ability to participate in health-promoting behaviours. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery’. Country Health SA Local Health Network (CHSALHN) offer a free program ‘Do it for Life’ (DIFL), which addresses health-related behaviour change with a client-centred approach, including smoking, poor nutrition, risky alcohol consumption, physical inactivity and stress. The program aims to support high-risk individuals to better understand the health impact of their risk behaviours, identify goals and strategies to enable lifestyle changes to prevent or delay the onset of chronic disease and enhance their quality of life.

DIFL has been designed to foster a collaborative approach between consumers, GPs and other health professionals, to promote awareness and understanding of the benefits of accessing other services and help breakdown the barriers to engagement. In early 2012 a pilot project was implemented to ensure CHSALHN Mental Health consumers were given an opportunity to incorporate healthy lifestyle changes into their mental health and wellbeing plan towards recovery. Since then the CHSALHN Mental Health Services noticed that consumers who had been referred to the DIFL benefited from the program.

A pilot project was implemented with Mental Health Services in Murray Bridge and Port Pirie. The team consisted of DIFL workers, mental health teams, health promotion and non-government organisations, such as Life without Barriers and Red Cross, with the aim to improve the health behaviours of consumers with mental health challenges. Regular meetings with key partners were held. Opportunities to improve referral pathways, communication and services were identified to ensure positive outcomes for consumers.

Insights identified within the pilot program included:

- time is required to engage with consumers due to illness and forgotten appointments
- working with NGOs can assist in engaging with consumers
- all workers involved need to have an understanding of healthy lifestyle behaviours to encourage the uptake by the consumer
- issues with weight gain due to medication—emphasis is needed on longterm health outcomes with a shift away from short-term unsustainable weight loss.

Outcomes of the project have included:

- integrated into staffs’ everyday work is the referral process for DIFL
- improved partnerships and strengthened communication with NGOs
- involvement with personal support workers strengthened
• involvement in the clients’ care through joint visits was established (when appropriate)
• linkages with Country Mental Health Promotion team established and strengthened
• some mental health staff trained in the Flinders Tool for chronic disease risk factors
• mental health workers’ knowledge has increased about local facilities, healthier options, walking tracks and programs
• some mental health staff opted to be part of healthy lifestyle programs to improve their own health.

Adolescent caffeine use: associations with other substance use and depression in an Australian rural population

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Introduction and aims: Research suggests that caffeine use is increasing in the adolescent population and that it may have adverse effects for their health and wellbeing; however, there is little evidence to support these findings in Australian non-metropolitan samples. This study aims to describe caffeine use in an Australian rural adolescent sample, and its relationship to depression and other substance use.

Design and methods: Participants were 531 high-school students from rural South Australia, who completed the 6-Item Kutcher Adolescent Depression Scale (KADS-6) and measures of caffeinated beverage consumption and other substance use.

Results: Caffeine use was frequent for the sample, and was shown to increase across adolescence. Associations were found with use of alcohol, tobacco and illicit substances. A significant relationship was found between caffeine use and depression, and specifically with experiences of low mood, anxiety and low energy. Hierarchical regression analyses revealed low energy to be the strongest predictor of caffeine use, when controlling for age.

Discussion and conclusions: This study supported findings that Australian rural adolescents frequently use caffeine and that caffeine use may be associated with adverse mental health outcomes, including depression, and alcohol and substance use.

Simulated learning environments—a behind-the-scenes look at managing maintenance for simulation equipment across Western Australia

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Background: Western Australia is geographically challenged and is the largest state, covering over 2.5 million square kilometres. Simulated learning environments (SLEs) are increasingly being utilised to deliver multidisciplinary clinical training in rural and remote locations. SLE equipment is becoming more sophisticated; it is therefore imperative that this equipment is maintained so that team-based clinical training can occur.

Western Australia has been successful in securing Health Workforce Australia (HWA) funding under the Simulated Learning Environment Program. HWA is providing support to tackle insufficient clinical placements.

Method: WA Health established the Clinical Simulation Support Unit in January 2012 to coordinate simulation learning across all sectors. WA Health has recently invested in over $5 million in capital simulation equipment. An identified issue for WA Health was how to look after its simulation equipment, particularly when it is utilised in many rural and remote regions. As part of its recurrent business plan, the CSSU has been successful in securing funds to establish a centralised maintenance unit (CMU) to provide maintenance for its simulation equipment.

This poster presentation will draw on the experience of WA Health and how we tackled the problem of maintaining equipment across the state by:

• the establishment of a registry of SLE equipment for WA Health
• logistics for breakdown cover and servicing for equipment in remote locations
• preventative maintenance protocols and check lists
• how the CMU drives quality and safety for clinical training
• enhanced cross-sector relationships and collaboration.

Relevance: Many jurisdictions face similar geographical challenges in delivering clinical training for rural clinicians. The WA model could be applied to other states and territories to ensure SLE equipment remains operational for clinicians in remote locations.

Conclusions: Utilising a central hub for maintenance is an efficient and cost-effective solution for maintaining SLE equipment across WA Health.

How integrated medical student placements in rural communities can be a win–win

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Aims: From the perspective of medical students and health professionals, we hoped to understand the benefits of integrated medical placements when they are delivered in rural and remote settings.

Methods: Qualitative data, collected using semi-structured interviews with students, their supervisors and other health clinicians in a rural and remote setting, were analysed using framework analysis.

Relevance: With major increases in the number of medical students and critical workforce shortages in the bush, the opportunity to develop doctors who are capable and interested in working in rural and remote settings has never been so strong. This research is designed to look at how we can enhance and optimise student learning opportunities in the bush and potentially promote rural career intention at the same time as providing authentic benefit to the local community.

Results: Benefits were identified that related to three distinct groups: the medical student community, the medical professional community and the local community. Medical students on integrated rural placements gain unique clinical, professional and cultural learning opportunities that are not necessarily available to their peers on specialist urban rotations. Local medical professionals gain opportunities for professional development through supervisory roles and mentoring opportunities, as well as support from students taking on pseudo-intern roles. The local community appears to benefit from ‘young blood’ being injected into the fabric of the wider community. This helps bolster a positive community vibe as well as providing role models to the youth community. With more medical students considering a rural career, there is the potential to help alleviate future work shortages leading to better patient outcomes in the long term.

Conclusions: When medical students head out to the bush on extended rural placements it is a win for the student community, a win for the medical professional community and an important win for the broader local community.

University community engagement: a story of a unique partnership between the ‘Banatjarl Wumin’s Group’ and Flinders University NT Katherine campus

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1Flinders University, Northern Territory Katherine Campus, 2Fred Hollows Foundation, 3Banatjarl Aboriginal Corporation, Katherine, NT, 4Flinders University, Northern Territory Darwin Campus

‘Building supportive communities by being outwardly engaged, with strong links to our stakeholders and serving the communities in which we operate’ is key strategy 1 outlined in the Flinders University four-year strategic planning 2010–2014.

This presentation will expose how the FNT Katherine campus fulfilled this key performance indicator.

At the Remote Health Experience (RHE) of the year one NT Medical Program, the students were invited to a talk presented by some women from the ‘Banatjarl Wumin’s Group’. This women’s group is composed of Jawoyn women who have positions as Elders in the local community, who have the knowledge of bush medicines and essentially who have an aspiration to educate and pass on their knowledge before it is too late. The women built a garden in a healing place that will be opened to the public in late October; they intend to produce commercial bush medicine and bush tucker products from this garden, as well as creating a sustainable resource for future generations. To the medical students participating in the RHE, they explained the importance of understanding Aboriginal spirituality and the importance of working with the local healers. They invited the students to visit their garden and participate in healing ceremonies. This was the start
of the new partnership for the Katherine campus. A second group of year two Flinders students were invited to help in the planting and weeding of the garden during their Regional Community Week in Katherine. They better understood how spirituality is intertwined with everything happening in the life of an Aboriginal person, and that a patient holistic approach is the sensible way to address the health issues faced by the Australian Aboriginal populations.

This presentation will address the following key aspects of a successful partnership:

- work with the community to build a stronger, more integrated and supportive community.
- enhance collaboration and coordination between partners
- demonstrate the commitment of the university to participation and involvement in the educational, cultural and social life of the community
- improve the quality of teaching and learning by educating students as responsible and reflective professionals who are able to act critically, morally and responsibly in a variety of contexts.

It is expected that the medical workforce educated in the NT through the Flinders NT Medical Program will have a unique opportunity to experience two-ways learning, starting with the application of mutual respect and based on reciprocity and relationships.

**An empowerment approach to group work with people experiencing anxiety**

Rohena Duncombe\(^1\), Martin Fox\(^2\)
\(^1\)Byron Bay Community Health Centre and Charles Sturt University, \(^2\)Tweed Byron Mental Health Service

One in seven Australians are affected by an anxiety disorder. After the closure of a local specialist anxiety service, we developed a group intervention and ran it six times. The group provided information and management strategies empowering participants to identify their own anxiety experience and develop self-management skills.

The group was advertised publicly so people could enter from the community rather than via a clinical pathway, avoiding labelling by an expert to access resources. The pre-group interview was by telephone and focused on their ability to attend the group and participate, not on diagnosing the type or severity of disorder. In the first session participants described their own experience of anxiety and the impact it was having on their lives and relationships. This narrative-style self-assessment was validating rather than pathologising.

A range of evidence-based anxiety management material was offered, including neurological information, relaxation, mindfulness, cognitive, behavioural and psycho-education. Participants chose their own combination of therapies, thus ‘diagnosis’ and ‘treatment’ were self-driven.

Evaluation indicates a positive participant journey, with marked decreases in anxiety at the end of the group.

**Take home messages:**

- effective interventions can be developed locally within teams
- using people’s inherent strengths is an alternative to the expert/patient model.

### Arts in Health at Flinders Medical Centre: a model of practice

Sally Francis\(^1\), Christine Putland\(^2\)
\(^1\)Flinders Medical Centre, \(^2\)Flinders University

Introducing art and culture into the life and fabric of health care services is now regarded as best practice internationally. There are many demonstrated benefits for health and wellbeing: from clinical outcomes for patients, support for staff in providing high-quality care, to the creation of welcoming and therapeutic physical and cultural environments for all. This poster presentation demonstrates the specific ways in which a multi-artform Arts in Health program contributes to health and wellbeing in a busy, acute care hospital environment. Based on a detailed analysis of the Arts in Health at FMC program in South Australia, it will show how different approaches to practice can produce different benefits, and suggest how the findings from this example can be translated to a range of rural health settings.

Arts in Health at FMC is one of the most ambitious and long-running programs of its kind in Australia. Since its inception in 1996, it has grown through many phases to its present role based within the Department of Allied Health, offering a comprehensive program encompassing exhibitions, performances, workshops, art-based therapies, environmental and public art works and special...
projects. In 2009 it was the subject of an in-depth, program-wide evaluation that captured feedback from many different perspectives, and led to a collaborative research process to analyse and articulate a ‘model of practice’. Drawing on learning from artists, program and hospital staff, different perspectives on practising art in an acute care setting were explored and analysed by means of a range of tools developed for the purpose. The process and its outcomes are being disseminated through two recent publications: *Arts in Health at FMC—Program Report* and *Arts in Health at FMC—Towards a Model of Practice*. The key elements of these publications will be featured, highlighting their significance for understanding how different approaches to art practice are applicable to a range of settings. Free hardcopies of *Arts in Health at FMC—Towards a Model of Practice* will be available for interested delegates.

**The changing face of the Victorian rural GP**

**Christian Fulton**

1Rural Workforce Agency Victoria

Annually, our organisation undertakes a General Practitioner Workforce and Skills Survey. The information provided is used to assist in identifying the critical recruitment, retention, professional development and support needs for GPs in rural and remote Victoria.

In this presentation, we plan to show some of key changes that have taken place over the past five years in the characteristics of the ‘average rural Victorian GP’.

Each year, we send a hardcopy questionnaire to around 1600 rural Victorian GPs, collecting information about their qualifications, experience, practice location, workload and personal characteristics. Response rates are supported by a follow-up survey and a round of phone calls to non-responders. By feeding back our results to participants, we are able to establish strong working relationships with local medical professionals and demonstrate our commitment to research in rural health.

This project aligns with the conference’s focus on quality quantitative data and previously unpublished research in the field of rural health. Our findings show that over the past five years that this survey has been conducted, the characteristics of the average Victorian rural GP have changed. Longitudinal data show an increase in the intake of female GPs into the workforce over this time. Over the same period, the proportion of male GPs decreased from 70% to just over 65%. For those aged 35 years and under, we now see an approximate 50/50 split between both genders—which demonstrates that gender distribution/balance has improved over time. The average GP has also reported a deduction in the hours worked, with practising GPs now working around 1.6 hours less per week than in 2007.

Demographically, we have also noticed a substantial increase in the number of overseas-trained doctors—in 2011, 46% of the workforce were reported as graduates who obtained their qualifications overseas.

By collecting information about the skills and personal characteristics of Victoria’s rural GPs, trends can be analysed and future changes predicted. For example, the ability to predict movements within the current workforce allows us to identify potential areas of workforce shortage, as indicated by GPs approaching the average age of retirement or expressing a desire to significantly reduce working hours in the future. In this case, policy makers can take steps to mitigate these risks.

**Victorian Paramedic Mentor Program—a model to prepare undergraduates for the future**

**Susan Furness**

1La Trobe Rural Health School, La Trobe University

Students entering an undergraduate university paramedicine program may have had little if any exposure to the profession outside of television shows depicting somewhat unrealistic images of paramedics and the work they do. Students sometimes enrol with limited understanding of the complexity and nature of paramedicine. They assume the majority of work involves lights, sirens and plenty of action (often involving attractive emergency service personnel with well-defined muscles and perfect one-liners). Other myths relate to the frequency and nature of a paramedic’s workload, with movies showing the urban (usually American) paramedic dodging gunfire and speeding through busy streets from one major trauma to the next. It is no surprise that students are perplexed when they are informed of the reality of Australian rural and regional paramedicine.

It is important that students have an understanding of their chosen profession centred on reality and not entertainment industry hype, but there is currently no standard way in which this understanding is
achieved. Limitations to ambulance industry clinical placement opportunities are a current reality across Australia. This has meant that university staff members have to find innovative ways to transfer knowledge about the profession, its work practices and culture. Within the La Trobe University paramedicine course, students do not go on placement until the second year of the program, a situation that has potential to affect student understanding of paramedicine, as well as level of satisfaction and overall retention numbers.

La Trobe Rural Health School Paramedicine has designed and implemented a Paramedic Mentoring Program that links each enrolled first-year paramedic student to a qualified rural or regional advanced life support or intensive care ambulance paramedic. These paramedics are currently working in communities throughout central and northern Victoria. The vision of the program was to encourage students to remain in country Victoria given the current deficit of paramedics in many rural and regional towns, and foster a sense of belonging to a community. This presentation focuses on the benefits the program provides without glossing over any of the negatives. It provides a good example of successful collaboration between academia and the paramedic workforce, and serves to inform students of the realities of working in rural and regional Victoria.

**Getting to the bones of the problem: challenging boundaries of practice**

Hazel Harries-Jones

1Department of Rural Health, University of Newcastle, NSW

Rural and remote communities present challenges to health care providers. The provision of emergency X-ray facilities is such an example.

Radiographers may work in isolation with no service in their absence. In even smaller communities, there may not be a radiographer at all. Two approaches to this problem are discussed with case studies of successful models of increased scope of practice for radiographers (UK) and support by training an assistant level workforce (remote X-ray operators (RXO)).

The first role enhancement is the extension of radiographer remit to the diagnosis and treatment of minor injuries. Radiographers are experienced in dealing with patients with minor injuries and are already informally undertaking image interpretation.

In rural areas they often convey the X-ray findings to the referrer ahead of the formal radiology report, which may take several hours to obtain. This experience renders them well placed to extend their role to clinical examination and appropriate referral for imaging. They are also very well placed, with further training, to advise patients on treatment of minor injuries. This may make better use of skills and time and draw on the expertise of the radiographer while freeing up other staff.

The UK audit, although small, showed interesting results to support this. The radiographers were trained in a Minor Injuries Nurse Treatment Scheme (MINTS) and worked alongside nurse practitioners and doctors in a large emergency department. Outcomes will be discussed in the presentation.

The other role enhancement relates to supporting the training of nurse practitioners and GPs in their role of basic radiography. A remote X-ray operator course exists, enabling these staff to carry out basic X-ray projections by qualifying them as a NSW Limited Licence X-ray Operator. However, there is no formal provision or requirement for continuing education.

This support could be provided by enhancement of the mentor arrangement for X-ray operators. Recruiting radiographers to help provide this service in rural and remote areas would not confine them to imaging, thus ensuring good use of their time. It would also widen the knowledge and support the RXOs. This has the potential to develop a high standard of service provision to the communities. It may also lead to increased job satisfaction and improve recruitment and retention of staff. Role extension in minor injuries is an appropriate career progression for both nurse practitioners and radiographers. Working together as part of a multidisciplinary team could be the answer to workforce shortages in the future.

**Veterans and their families: national rural and remote services**

Katherine Hawkins, David Blenkiron, Lucy Werner

1Veterans and Veterans’ Families Counselling Service

The Veterans and Veterans Families Counselling Service (VVCS) provides counselling and group programs to Australian veterans, peacekeepers and their families. It is a specialised, free and confidential Australia-wide service. VVCS also has a comprehensive Outreach Program throughout Australia, providing veterans and their families living...
in rural and remote areas with access to contract counsellors and group programs. Our poster demonstrates the efficacy of the services provided to our rural and remote clients through collected pre-and post-data. We have shown significant reductions in depression, anxiety and stress through our outreach counselling services, as well as significant therapeutic outcomes for clients through a selection of group programs.

A service of value—GPcare Health Assessments

Gina Highet1
1Adelaide Hills Division of General Practice, SA

Introduction: GPcare Health Assessments commenced in 2010 and provides a valuable service for general practitioners and their patients in the region of the Adelaide Hills Division of General Practice. Comprehensive health assessments are provided to patients 75 years and above living in their own home, to ensure better health outcomes and provide a preventative approach to primary health care.

Aims: To develop and implement an innovative and collaborative strategy that will assist general practitioners and their staff to engage their community in health and ageing opportunities and discussions regarding chronic disease management.

Methods: GPcare Health Assessments is a subsidiary of the Adelaide Hills Division of General Practice Inc, providing a fee-for-service health assessment program. A health assessment of an older person is an in-depth assessment of a patient aged 75 years and over.

The purpose of this health assessment is to help identify any risk factors exhibited by an elderly patient that may require further health management. In addition to assessing a person’s health status, a health assessment is used to identify a broad range of factors that influence a person’s physical, psychological and social functioning.

Results: Approximately 460 health assessments have been completed by a Gpcare Heath Assessment nurse and referrals made for home support and allied health services to assist the aged population in remaining in their own home.

Benefits resulting from the work of the Division program are:

- engagement of the general practice community in the positive ageing and chronic disease management message
- providing evidence-based information to the GPs, community and health providers that increases the understanding of positive ageing and chronic disease management
- community service providers have an improved knowledge of where to access support services and resources for their communities
- data and feedback collected from the community can assist in population health planning.

Conclusion: Our health care model and service supports both the patient and the general practitioner and is in response to a demand for experienced nursing care that will both assess and promote quality of life for the elderly person in the community or aged care setting. Assessing these patients in their own homes or residential aged care facilities can result in better health outcomes for them and for the general practice.

A snapshot of palliative care service provision in rural Western Australia 2010

Kristi Holloway1, Ruth McConigley1
1School of Nursing and Midwifery, Curtin University

Background: Palliative care services in rural Western Australia developed in an ad hoc nature. A state-wide audit of rural health services in 2006 reported great diversity in palliative care provision (n=139). The services had varied access to experienced palliative care staff, differing models of service provision and limited links with specialist palliative care providers. A follow-up survey was conducted to examine service provision in 2010.

Aim: The aim of this paper is to present a snapshot of palliative care in rural WA in 2010 and changes in care provision between 2006 and 2010.

Methods: A telephone survey was conducted with regional health services in WA. The survey comprised 36 questions in four areas: provision of services and patient care/outcomes; delivering palliative care; assessment and care planning; and support to deliver services.

Results: 136 health services reported 2781 people who received palliative care and 1178 palliative care deaths in regional WA in 2010. This was a 42% increase in patient numbers since 2006 and the
number of patients with non-malignant illness significantly increased. There was an increase in services with access to multidisciplinary teams and an increase in formalised links with metropolitan palliative care providers. There was a reduction in services providing after-hours care and a decrease in bereavement support provided.

**Relevance:** The results of this survey highlight improvements and ongoing challenges for palliative care service provision in rural WA. Findings may assist in further development of services.

**Conclusions:** There have been some significant changes to palliative care service provision in the last few years. These changes reflect an increased workload in palliative care and may also represent greater recognition of the need for palliative care provision for patients previously not considered for palliative care.

### Substance use and mood disorders as a cause of death in Australia

**Guinevere Hunt**, **Lauren Moran**, **Allie Evans**, **Krys Sadkowsky**

1Australian Bureau of Statistics

**Background:** The impetus for this research came from the recent Australian Bureau of Statistics publication *Suicides, Australia, 2010* (cat. no. 3309.0), which presents data on suicides by a range of demographic characteristics, including geographic location. Rates of suicide for the period 2006 to 2010 were higher in regional and rural areas than in capital cities, and over half of all suicides with multiple causes of death identified had a mental health condition as one of those causes.

When the relationship between suicide, mental health conditions and geography was explored further, it was found that many rural and regional areas of Australia had higher rates of mental health conditions as an associated cause of suicide deaths than city areas. This raised the question of whether the higher levels of associated mental health conditions in rural and regional Australia extended to deaths other than suicide.

**Aim:** To investigate the distribution of mental health conditions as associated causes of death across Australian regions.

**Method:** Causes of death (CoD) statistics are recorded for underlying cause (the disease or injury that initiated the train of morbid events leading directly to death), and multiple cause (causes and conditions reported on the death certificate that contributed to, were associated with, or were the underlying cause of the death). CoD are classified using the 10th revision of the International Classification of Diseases (ICD-10).

As mental health conditions encompass a range of disorders that require varying policy responses, it was decided to group ICD-10 mental and behavioural disorder categories to distinguish between psychological and somatic disorders, and present data for each group separately.

Data were analysed by associated cause mental health grouping; for all deaths, and for deaths with selected health conditions as the underlying cause (heart and circulatory conditions, cancers, dementia, diabetes and intentional self-harm). This data was then disaggregated by capital city statistical divisions, other urban (regional), and rest of state (rural) for each state and territory.

**Findings:** Preliminary results suggest that there is unequal distribution of mental health conditions as associated causes of death across Australian regions, with deaths in rural and regional areas having higher concentrations of these associated conditions.

This data provides evidence to support mental health care and prevention policies targeting regional and rural communities.

### Rurality, domestic relocation and intimate partner violence in young women

**Gina Dillon**, **Deborah Loxton**, **Saifur Rahman**, **Rafat Hussain**

1School of Rural Medicine, University of New England, NSW, 2Research Centre for Gender, Health and Ageing, University of Newcastle, NSW, 3Faculty of The Professions, University of New England, NSW

**Aims:** This research aims to investigate the prevalence of intimate partner violence (IPV) within a cohort of women surveyed as part of the Australian Longitudinal Study on Women’s Health (ALSWH). The occurrence of IPV was analysed with regard to area of residence, frequency of relocation and distance moved across the 13-year survey period.

**Methods:** This research utilises data from the cohort of 14 247 women (born from 1973 to 1978). These women have been surveyed every three years since 1996, giving five completed survey waves for analysis. Information about area of residence was ascertained
by the ARIA+ measure of remoteness for each participant and the distance moved in relocation from one survey to the next was computed.

Relevance: There is a link between IPV, adverse health and social circumstances. Data from police reports on domestic assault indicates that the occurrence of IPV is higher in rural/remote areas than in urban centres. However, the links between IPV and relocation remain mostly unexplored. The large-scale, nationally representative Australian Longitudinal Study on Women’s Health provides a unique quantitative dataset for exploring these issues.

Results: Lifetime prevalence of IPV for this cohort of women was lowest in the major cities (18.4%). This rate was significantly lower than inner regional (25.7%), outer regional (25.2%) and combined remote and very remote areas (25.8%) (P < 0.001).

The survey participants moved frequently, with over 30% of all women changing ARIA+ classification during the 13-year study period. This figure is, however, much higher for women who lived in regions outside of the major cities at commencement of the study in 1996. While only 17.3% of inner city women changed regional area, over 40% of women from inner regional or outer regional areas registered a change in ARIA+ classification and 65% of women from remote or very remote areas had a change to their ARIA+ classification over the 13-year study period. Relocation was overwhelmingly, but not exclusively, towards urban and inner regional areas.

Conclusions: This study contributes new knowledge about regional prevalence of IPV in Australia and gives a perspective beyond police reporting and small-scale studies. Findings on IPV as a factor in relocation will provide an interesting dimension to information regarding mobility of young Australians. The link between frequent IPV, frequent relocation and mental health will be discussed.

Developing a sustainable model of service delivery for oncology services in regional Australia: case example

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1Monash University (student), 2Border/East Hume Cancer Network, 3Albury–Wodonga Health

Although outcomes for Australian cancer patients have seen dramatic improvements over the past 20 years, there remains an unacceptable variation in cancer outcomes for certain communities. These include those from an Aboriginal and Torres Strait Islander community, those from a rural area and those from a lower socioeconomic group.

Around 32% of the Australian population live outside state capital cities. Patients with cancer from rural and remote areas are diagnosed later than those in the city, and are more likely to die from cancers such as lung, cervical and uterine cancer the further they live from major cities.

There are clear deficiencies in cancer service availability in regional and rural Australia. The increasing lack of specialist cancer services and expertise with increasing remoteness correlates with the patterns for cancer morbidity and mortality.

This raises the challenge of overcoming the unique issues in delivery of oncology services in regional Australia.

Cancer treatment in rural areas has often been fragmented and involved long travel between services and time away from home, work and loved ones for patients receiving treatment.

This presentation will use a patient example to explore the development of a sustainable model of service delivery within the Border/East Hume region in northern Victoria and southern NSW. The model is designed to coordinate the patients’ care from different services and allow them access to the highest quality care closer to home.

The multidisciplinary team/cancer network model used in this region has attempted to overcome the issues of division across boundaries, including professional, state border and public and private. It has worked to implement linked cancer networks focused on the needs of the patient and their families. The system also has benefits for practitioners, making it easier for them to work with and refer to different services. It also gives opportunities to work in public, private and research fields, thus attracting specialists bringing further expertise and making this a sustainable model.

This presentation will illustrate the benefits and limitations of this model, which is highly regarded as an example that could be used in the delivery of cancer services both in regional Australia and even metropolitan areas. The presentation will take into account views from stakeholders, including oncologists, other health professionals and patients.
Primary Health Care Research and Information Service: a knowledge exchange organisation for rural health

Ellen McIntyre\textsuperscript{1}, Petra Bywood\textsuperscript{1}, Christina Hagger\textsuperscript{1}

\textsuperscript{1}Primary Health Care Research & Information Service, Flinders University, SA

\textbf{Purpose:} This study explores how a knowledge exchange organisation has assisted its policy, practice, research and consumer stakeholders to strengthen PHC with a specific focus on rural health.

\textbf{Theory:} Knowledge exchange includes information management, linkage, capacity development, and support. Knowledge exchange bases its practice on exchanging information and knowledge in the most appropriate format with the right people at the most suitable time.

\textbf{Methods:} We describe the knowledge exchange methods used by this organisation and illustrate how well they have been taken up by our stakeholders.

\textbf{Findings:} In the five-year period (2007 to 2011), this organisation has:

- developed an extensive, searchable website that includes 2092 items on rural health
- convened five national conferences where 240 rural health abstracts were presented as papers or posters
- produced weekly eBulletins and bi-monthly newsletters that included 536 items on rural health
- developed a publicly available online searchable register of researchers and research that includes 351 rural researchers and 171 rural projects
- published short papers on current PHC topics plus policy issue reviews relevant to rural health
- created online fact sheets on how to carry out knowledge exchange that are applicable to rural health researchers, providers and policy makers.

Data show that these are accessed by our stakeholder groups while evaluations indicate these have been useful.

\textbf{Discussion:} Our website, suite of publications and resources and researcher profiles show a significant proportion of what PHC RIS does is related to rural health. PHC RIS has and continues to make a strong commitment to rural health.

Improving cultural responsiveness of health professionals through education reform

Craig Dukes\textsuperscript{1}, Faye McMillan\textsuperscript{1}

\textsuperscript{1}Indigenous Allied Health Australia

\textbf{Aim:} To explore how the introduction of a nationally consistent Aboriginal and Torres Strait Islander health curriculum framework into undergraduate health qualifications will improve the cultural responsiveness of Australia’s rural and remote allied health workforce.

\textbf{Relevance:} Our peak organisation for Indigenous allied health professionals asserts that a culturally responsive health workforce is imperative in order to ensure Aboriginal and Torres Strait Islander people receive the culturally safe health care required to improve health outcomes. We have strongly advocated for the development and implementation of a framework similar to the existing CDAMS Indigenous Health Curriculum Framework within allied health courses.

The medical profession’s CDAMS framework was endorsed by all the deans of medicine and has been included in the Australian Medical Council’s accreditation guidelines for basic medical education since 2006; requiring all medical schools to include core Indigenous health content in their medical curricula.

\textbf{Approach:} Our organisation has successfully argued for the development of a culturally inclusive, interdisciplinary Aboriginal and Torres Strait Islander Health Curriculum Framework to be integrated into tertiary entry level health profession training since our inception in 2009. Health Workforce Australia (HWA) is now funding its development.

Our organisation has laid the foundation for the development and implementation of a framework by establishing strong relationships with HWA, the Australian Council of Pro Vice-Chancellors and Deans of Health Sciences and other key stakeholders to ensure that the framework developed is implemented and embedded within health profession course accreditation. We believe education providers need to be held accountable for the cultural responsiveness of their health graduates.
Results: It is anticipated that health outcomes for Aboriginal and Torres Strait Islander people will be improved by health care delivered by health professionals who are better prepared to work with Aboriginal and Torres Strait Islander people. All health profession graduates need to be both clinically competent and culturally responsive to affect positive Aboriginal and Torres Strait Islander health outcomes.

The implementation of the framework will facilitate a high standard of knowledge and competency within health profession graduates and set the benchmark for teaching the importance of Aboriginal and Torres Strait Islander health within all tertiary health profession courses.

Conclusions: This presentation will focus on the rationale for and progress of the development of a nationally consistent Aboriginal and Torres Strait Islander health curriculum framework.

Rural and Regional Cystic Fibrosis Physiotherapy and Support Training Project

Kate McQueen¹
¹Cystic Fibrosis Victoria

Background: The Cystic Fibrosis Victoria (CFV) rural and regional physiotherapy and support project was developed in response to identified needs from those families living with the genetically inherited chronic illness cystic fibrosis (CF) and located outside metropolitan Melbourne, which is over one-third of the CF population. Following a survey, it was discovered that: CF adults and families living in rural and regional Victoria had less access to local physiotherapy and respite services, as there is often no one in the community with the appropriate skills/knowledge; they do desire and need local physiotherapy support and respite; and this may help prevent disruptive, unplanned and expensive travel.

Aims

• To upskill and provide rural and regional physiotherapists with up-to-date training regarding the latest in CF physiotherapy management.

• To educate rural and regional community health and council services about CF.

• To link in the regional physiotherapists with the three Melbourne CF specialist centres—The Royal Children’s, The Alfred and Monash Medical Centre.

• To ensure that all rural and regional CF families are aware of the program and can be referred for local assistance if they request.

Method: Victoria was divided into regions based on hospital and council catchment areas and number of CFV members with CF. CFV employed a physiotherapist to travel to the main public hospital of each region to implement an education seminar developed in conjunction with the Melbourne CF specialist physiotherapists, titled 'Comprehensive physiotherapy management for CF', which included theoretical and practical components. Regional hospitals were issued an up-to-date CF resource folder and contact lists for the Melbourne CF centres. A comprehensive resource consisting of physiotherapists and other community health and council services was compiled for each region. All CF patients were advised regarding the program and encouraged to seek a referral from their Melbourne CF treating physiotherapist, to a local physiotherapist in their area.

Results: A total of 17 regions/hospitals were visited over 12 months, with a total of 168 rural and regional physiotherapists attending. From the post-seminar evaluation questionnaire, on a scale of 1 (not at all) to 5 (completely), 98% reported 4s and 5s that 'they feel more comfortable with and have a greater understanding of the multi-systemic disorder CF as a result of attending this course’, and 96% reported 4s and 5s that 'they feel better equipped to provide and monitor physiotherapy for a patient with CF’. In a client questionnaire post-program, so far at least 47% of regional families with CF reported that they would access local physiotherapy for support.

Conclusion: The feedback from the rural and regional physiotherapists was very positive and 100% of the regional hospital physiotherapists reported that they would like to participate in the program and take referrals from Melbourne CF centres. The most important factor for success in this program is the communication and ongoing link between the Royal Children’s, The Alfred and Monash and the regional physiotherapists regarding the CF patients’ ongoing care and management. Further evaluation is required to determine the numbers of rural and regional CF families accessing local physiotherapy services, if they are happy with the quality and quantity of support, and whether it reduces unplanned admissions to Melbourne.
Connecting with the outback

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1Townsville–Mackay Medicare Local, Qld

Introduction: As a newcomer to rural and remote programs, Townsville–Mackay Medicare Local (TMML) has looked for opportunities to promote primary health care in outback areas. TMML were invited to participate in the inaugural ‘E-Village Outback Health and Fitness Muster’. This was held at Oak Park in far north Queensland, approximately 400 kilometres west of Townsville.

This poster will illustrate the program activities enjoyed by families living in the area who attended the muster.

Aims: TMML used this event as a two-fold opportunity. The first goal was to gather data for a needs analysis in remote areas to establish gaps in services and, secondly, to educate local residents about accessing primary health care and how to make the best use of a visit to a GP.

Key areas identified:

• allied health services appeared to be unavailable in this remote area

• people interviewed expressed the opinion that distances to access regular primary health care was a deterrent, especially to adult males

• adult males interviewed expressed the opinion that they only accessed primary health care for acute situations

• it appeared evident that no forward planning was made by patients to discuss chronic disease and preventative health plans

• participants of the Health Muster showed reticence to approach primary health care providers for information.

Conclusion: The event was well attended, with almost all of the 30 families living within a 200-kilometre radius of the area taking part. Children’s activities were the most utilised by the families; therefore for 2013 a focus on children’s activities would be concentrated on including education for parents on immunisation, thus creating opportunities to talk to parents about primary health care and a preventative approach to health for the whole family. Families living in remote outback areas face many challenges in accessing appropriate health care and this can have a major impact on the overall quality of their lives.

This poster highlights the importance of engaging families in the outback and creating working partnerships with key stakeholders to achieve common goals.

From urban to rural—Townsville–Mackay Medicare Local

Leigh-Anne Metcalfe1

1Townsville–Mackay Medicare Local

Introduction: With the health reform introduced in 2010, the then Townsville General Practice Network (TGPN) became Townsville–Mackay Medicare Local (TMML). One of the most challenging tasks before TMML was engaging and becoming a useful service provider for our members in rural areas. This was extensive as every area outside of Townsville (where TGPN had previously concentrated) was considered to be rural.

Method: The implementation required significant changes to the TMML board structure, communication systems, program delivery and our understanding of what our new rural members needed and wanted. Firstly, we had to increase our capacity to deliver services, so TMML more than doubled its employee base in 2011–12. At end of June 2011, there were 64 staff/38.48 FTE, which expanded to 127 staff/90.15 FTE at 30 June 2012.

The population health unit (PHU) was developed and implemented in late 2011 so TMML could gain an understanding of its population needs. This included gathering data from numerous sources, conducting community, stakeholder, health professional and consumer consultation and collating all the information into a comprehensive document. The PHU now has a ‘snapshot’ of each town/area in TMML, giving information about demographics, health needs and outcomes, health services and consultation. Any gaps in services are also recorded in these documents.

Monthly program development meetings are held by team leaders to allow strategic planning based on evidence supplied by the population health unit. Population groups or geographically defined communities are systematically reviewed to ensure our future programs are meeting the needs of the entire region, in particular our diverse rural communities. The outcomes of this planning process are annual plans for each program area.
**Summary:** The last 12 months has been a roller-coaster ride for the health system with many areas still to be decided and finalised. TMML (previously TGPN) has been working through the minefield to develop the best plans for delivery of its services to its members, particularly rural members who are now a large part of TMML’s ‘work’.

**Clinical placement orientation—a transferable approach**

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1Flinders University Rural Clinical School, 2Greater Green Triangle University Department of Rural Health

How collaboration between a rural clinical school and local hospital improved work readiness in students and patient safety.

Throughout any year students from two universities in the disciplines of medicine and allied health participate in placements at our regional hospital. In 2012 forty-six medical students spent between six and nine weeks on placement and seven allied health students spent six months.

**Motivation:** To provide a comprehensive orientation to health science students undertaking placements at rural and regional hospitals so that they may complete their rotation, fulfilling their educational requirements in a safe manner and meeting the administrative requirements of the hospital.

**Problem statement:** It was identified that there had been an increase in needle-stick injuries, blood and body fluid exposure, and medication errors by students on placement at the local regional hospital. The orientation to equipment or roles and responsibilities relating to safety in this area was inconsistent and some students were not receiving orientation to the hospital at all. Students entered the hospital with limited understanding of the legislative requirements for confidentiality or other hospital responsibilities and agreements.

**Approach:** The rural clinical school worked to support and assist the hospital to adhere to CHSA accreditation standards. It was decided to create and implement an orientation program at the rural clinical school to cover these areas of significance, in the best interest of patient safety and the wellbeing of the students on placement. A questionnaire was developed to gather student feedback in regard to the value of the orientation.

**Results:** The value of the orientation to the student has been measured since its introduction in early 2012. This poster will present the results, which ideally will find minimal OH&S incidents amongst students on placement and greater confidence in transition to placement.

**Conclusion:** This poster will demonstrate the necessity of appropriate orientation to health science students on clinical placement. Our orientation model will develop a benchmark for all rural clinical school students on placements.

**Optimising point-of-care testing services for diabetes management in the Victorian Mallee Track**

1Flinders University International Centre for Point-of-Care Testing, 2Community Point-of-Care Services, Flinders University, 3Mallee Track Health and Community Services

**Introduction:** Since 2004, the Community Point-of-Care Services Unit at Flinders University has assisted the Mallee Track Health and Community Services (MTH&CS) and its associated general practice at Ouyen in rural Victoria with a point-of-care testing (POCT) service for diabetes management. The POCT devices initially set up at MTH&CS were the DCA 2000 (for measuring HbA1c) and the Cholestech LDX (glucose and lipids). In recent years, further options for performing these point-of-care tests have become available on the Australian market. New POCT devices include the DCA Vantage (HbA1c), Nova StatStrip (glucose) and Abaxis Piccolo Xpress (glucose, lipids and liver enzymes).

**Aim:** The aims of this project were to compare the analytical performance of the original and new POCT devices, with a view to optimising POC services for diabetes management at Ouyen, and to assess stakeholder satisfaction with the POCT service.

**Methods:** A patient comparison study (involving 103 samples from 61 diabetes patients) was conducted by comparing POCT results for HbA1c, glucose, lipids and liver enzymes obtained on the original and new suite of POCT devices with the results obtained on these same samples by the local accredited pathology laboratory. The local nurse operator (GB) performed all POCT analyses on-site. Stakeholder satisfaction was assessed using a qualitative questionnaire for patients with diabetes (n=61) at Ouyen and by focus
interviews with the nurse POCT operator and the local general practitioner.

**Results:** The DCA Vantage and Piccolo devices exhibited the best analytical performance and met the analytical goals for both accuracy and reproducibility against which performance was assessed. Using these two devices, an improved suite of tests for diabetes management (HbA1c, glucose, lipids and liver enzymes) was available. Sixty of 61 diabetes patients completed the satisfaction questionnaire. A statistically significant improvement in satisfaction was reported with the new devices by diabetes patients (Fisher’s exact probability, p<0.05). Patients, as well as the POCT operator and GP, showed high levels of satisfaction with POCT in terms of convenience, acceptability, and confidence in test results.

**Conclusion:** This study supports the effective use of POCT in rural general practice settings and represents the first field evaluation of the Piccolo in Australia. Based on the study findings, the MTH&CS have purchased a DCA Vantage and a Piccolo device for continuing use in the diabetes clinic at Ouyen, and are intending to replicate the diabetes management service (in partnership with Flinders University) at the nearby town of Sea Lake.

‘**healthTrack’—Preventative Health Initiative**

Emily Murphy

1Mid West Health

‘healthTrack’—Preventative Health Initiative (PHI)—focuses on increasing levels of physical activity and good nutrition to prevent chronic disease and achieve better health outcomes for the Lower Eyre, Mid West, Ceduna and Aboriginal communities across the Eyre Peninsula.

‘healthTrack’ addresses levels of physical activity and good nutrition through working with communities using a capacity-building approach. Health services and the community have worked together to implement strategies to increase these levels through encouraging, resourcing and supporting communities to participate in activities, projects and training opportunities. These opportunities have created local ownership, individual responsibility, increased skills and knowledge and have worked towards communities developing sustainable outcomes to address the local barriers. This capacity-building approach strengthens positive impacts on people’s everyday lives through ensuring the activities within ‘healthTrack’ continually focus on and support enablers identified by the community.

‘healthTrack’’s focus on building local capacity has also assisted in sharing the responsibility of health between the individual and the health service, working towards decreasing the reliance on health services and the health budget, for example:

- community initiatives and projects supported through healthTracks’ ‘small grants program’ have been those that focus on promoting health and wellness and have encouraged members of the community to play an active role in their health

- the mobilisation and funding of resources throughout the community has built capacity to locally address the risk factors of low physical activity and not maintaining a healthy weight

- training and development opportunities targeting physical activity and good nutrition have been attended by community members, health professionals, key partners and stakeholders, working towards the ‘health in all policy’ of ensuring that the health of community is not merely the responsibility of the health care system.

This ‘sharing the responsibility’ aims to improve health outcomes within our communities and by growing community skills and leadership to ensure sustainability well beyond the project.

Feedback and evaluation processes have been implemented to capture quantitative and qualitative benefits both from an overall project perspective and a community ‘on the ground’ level. ‘healthTrack’ engaged the services of Flinders University (SACHRU) to facilitate and mentor the team through these processes over the life of the project.

The evidence from these reports will assist not only in future funding for similar projects, but also assist in local health service planning and develop strategies to incorporate learnings into our current RPHS and MPS service delivery plans.
Rural generalist allied health practitioner—a service model for rural emergency departments

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Emergency departments (EDs) are designed to manage medical emergencies that could be life threatening or cause serious disability. However, EDs are increasingly overcrowded with non-urgent patients, limiting hospitals’ capacity to provide care in accordance with defined targets. Recent research shows the demand on ED services can be attributed to the availability and cost of GP services; provision of 24-hour care; socioeconomic demographic factors; and self-perceived status of being ‘urgent’. These issues are particularly evident in rural districts.

Initiatives to meet health department activity targets, utilising extended scope practitioners in both allied health and nursing, is changing the conventional medical model of the ED.

This model of care project aims to develop, trial and evaluate a rural generalist allied health practitioner (RGAHP) working within the ED of a rural hospital. This will streamline assessment processes and care pathways for patients requiring allied health intervention from the point of primary contact. The project aims to define the scope of practice for the RGAHP within the ED, including the competencies and training required, by implementing the Calderdale Framework.

This model of a multi-skilled AHP may be useful in rural settings with limited budgets by reducing duplication of tasks and elicit improved patient satisfaction when the individual has contact with one multi-skilled professional with basic expertise across a range of disciplines.

The presentation will report on pre- and post-implementation phase data for evaluation of both quantitative and qualitative aspects of the model of care. The data will reflect ED activity, triage waiting times (ATS and NEAT), rate of representations and waiting times to AH intervention. Chart audits and surveys will explore patient pathways and staff satisfaction.

It is envisaged that outcomes of the project will include improved health outcomes for patients presenting to ED requiring AH intervention in rural locations, acceptance that a RGAHP role is integral to the sustainability of the delivery of AH services in ED, transferability of the role and model to other rural sites and development of career pathways for rural practitioners beyond HP4 into HP5 clinical roles.

The development and implementation of innovative service delivery models utilising highly trained allied health professionals that optimises their clinical and communication skills may prove to be a viable response to the widening gap between health service demand and delivery that cannot be filled by simply recruiting more staff, especially in rural districts where recruitment, retention and budget is an ongoing problem.

Community paramedics—a grass-roots movement

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Objectives: Community paramedicine is an emerging model of care where paramedics apply their training and skills in ‘non-traditional’ community-based environments, often outside the usual emergency response and transportation model. It has been implemented in small pockets of Australia, United States and Canada. A partnership between an Australian research team and a paramedic service in rural Canada provided an opportunity to observe and analyse the evolution of a community paramedic model as a community-driven initiative. One of the research questions was the extent to which the paramedic service and paramedics engaged with local communities during the introduction of the community paramedic model.

Methods: The study was undertaken in the County of Renfrew, Ontario, Canada, where a community paramedic role has emerged in response to demographic changes and broader health system reform. Qualitative data was collected through a combination of direct observation of practice, informal discussions, interviews and focus groups. An innovative component of this research was reference to the Australian rural domains of paramedic practice model and the use of boundary theory to identify and analyse how community paramedics are creating and maintaining new role boundaries and identities.
Results: The Renfrew community paramedic model emerged organically from existing structures and local needs. It is built on strong partnerships between the paramedic service and other health and social services. A wide range of disparate community health initiatives have evolved into a coherent and sustainable community paramedic program. The program consists of four key elements:

- Ageing at Home Program
- Paramedic Wellness Clinics
- Ad hoc Home Visiting Program
- Paramedic Response Unit Program.

The findings indicated that community paramedic programs are more likely to succeed if they are integrated within the local health system, have viable treatment and referral options for sub-acute and chronic patients, paramedic education that is broader than traditional paramedic emergency response competencies, and an appropriate and effective clinical governance system is in place.

Conclusions: Innovations in the delivery of rural paramedic services can be successfully developed and implemented at a community level if all agencies and health professionals work together. The outcomes of this community paramedic program are improved monitoring of the health and wellbeing of the aged living in their own homes, a more integrated local health system, and reduced costs to individuals and the overall health system. There have been no adverse impacts on the emergency response capability of the paramedic service in the County of Renfrew.

Rural people living with type 2 diabetes: a qualitative inquiry

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Study rationale: The objective of the study was to explore if and how rural culture influences type 2 diabetes management and to better understand the social processes that rural people construct in coping with diabetes and its complications. In particular, the study aimed to analyse the interface and interactions between rural people with type 2 diabetes and the Australian health care system.

Theoretical framework and methods: The research applied constructivist grounded theory methods within an interpretive interactionist framework. Data from 39 semi-structured interviews with rural and urban people with type 2 diabetes plus a mix of rural health care providers were analysed to develop a theoretical understanding of the social processes that define diabetes management in that context.

Results: The analysis suggests that although type 2 diabetes imposes limitations that require adjustment and adaptation, these processes are actively negotiated by rural people within the environmental context to fit the salient social understandings of autonomy and self-reliance. Thus people normalised self-reliant diabetes management behaviours because this was congruent with the rural culture. Factors that informed the actions of normalisation were the relationships between participants and health care professions, support and access to individual resources.

Conclusions: The findings point to ways in which rural self-reliance is conceived as the primary strategy of diabetic management. People face the paradox of engaging with a health care system that at the same time maximises individual responsibility for health and minimises the social support by which individuals manage the condition. The emphasis on self-reliance gives some legitimacy to a lack of prevention and chronic care services.

Success of diabetic management behaviours is contingent on relative resources. Where there is good primary care a number of downstream effects develop, including a sense of empowerment to manage difficult rural environmental circumstances. This has particular bearing on health outcomes for people with fewer resources.

Tools for planning rural and remote maternity services in Australia

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Aims: To identify tools that could be used for planning rural and remote maternity services, in line with recommendations from the Australian National Maternity Services Plan 2010 (ANMSP). To critique those variables used in the tools, for their potential use in planning maternity services in Australian rural and remote communities.

Methods: A review of the literature using electronic databases OVID SP and GEOBASE was undertaken to identify tools, indices or mathematical models that could be used in planning rural and remote health
services, and variables used in those tools were critiqued.

Relevance: Policy and planning that supports the delivery of rural and remote maternity services is relevant and important for the outcomes of the 30 per cent of Australian women and their babies who live outside the major cities. Rural and remote women, many of whom are Indigenous, have worse perinatal outcomes than other Australian women and babies. Currently regionalisation and closures of rural and remote maternity services have impacted on the ability of women to access services close to where they live.

Results: The literature search identified four relevant indices, two in the health literature (Canadian) and two from geography (Australian). Only one composite index was associated with maternity services—The Canadian Rural Birth Index (RBI). These indices identified access to a level of health service using a range of aggregated scores of geographic and socioeconomic variables. The RBI used a combination of variables, including measures of socioeconomic vulnerability; isolation from or distance to a caesarean section service, and the number of births in a catchment. The aggregated score was used to identify the optimal level of maternity service required by rural communities in British Columbia.

Conclusions: Evidence on which to base health services planning is scant. There are currently no tools in use that identify the optimal level of maternity service for rural and remote communities in Australia. The variables used in the Canadian RBI have some relevance to the Australian context. However, the application of the RBI in Australia may require additional measures and adjustments. An index could also be adapted for planning other rural and remote services with the addition of service specific variables.

Important points:

- no current index or tools that can identify the optimal level of maternity service for rural and remote communities
- recommendations from the ANMSP
- principles used in an index could be adapted for other services.

A work in progress: the Multipurpose Service model in New South Wales

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Health care delivery models for rural and remote communities have evolved over the past decades to better respond to the needs of the changing communities. The most successful models have service integration and provider collaboration their focus. These models present a ‘shared vision’ between consumers, providers and the government about how to best provide health care in a community. For NSW the predominant service reconfiguration and capital investment approach in small rural and remote communities has been through the Multipurpose Service (MPS) model.

Evaluations of the MPS model have been undertaken in 2001, and again in 2007. The early evaluation focused on the first MPSs in NSW, involving a small number of services. The 2007 evaluation, based on responses from over 80% of the operational MPSs at that time in NSW, involved a comprehensive review of the intrinsic and extrinsic benefits achieved and value to services providers and community, considered against the level of capital investment. The outcome of these evaluations demonstrated a new MPS improves access across the full range of services appropriate for the community, provides hub of health and other services for the community under one roof, delivers a more appropriate environment for residential aged care, brings a huge improvement in the work environment for the local staff, and introduces the concept of the inclusion of multifunctional space for use by the broader community (such as play groups, health and wellbeing groups and community meetings).

NSW Health has invested more than $400m on the redevelopment of small rural hospitals since 1994, to introduce the MPS model. There are now 55 MPSs operational under the formal Tripartite Funding Agreements with the Department of Health and Ageing; and overall, a total of 60 services have been redeveloped, delivering health services under the integrated care approach of the MPS model in NSW.

This poster depicts how the development of MPSs in NSW, over almost twenty years, demonstrates the benefits of governments and communities working together to ensure small rural communities continue to have access to an appropriate range of health services in contemporary and flexible environs,
ensures residents are treated closer to home, and where they have the support of friends and loved ones. The MPS model has been shown to be a successful and effective service model, with services reflecting local community’s needs achieved through the shared approach to service development.

**Cultural immersion—what impact does it have?**

*Janie Smith*¹

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What do we know about the rural and remote pharmacist workforce?

Really, we know little about the rural pharmacist workforce in Australia: who they are, what their background is, why they choose to work rurally and why they leave or stay. The workforce shortages compare only with medicine despite the pharmacist student intake having doubled over the past decade, along with a significant increase in the number of regional pharmacy schools.

Between 2008 and 2010 a large national pharmacist research project was undertaken, funded by the Pharmacy Guild of Australia, to describe the rural and remote pharmacist workforce for the first time. The findings include the rural origins of the rural pharmacist workforce, the factors that attract or detract pharmacists from working rurally and the barriers and drivers to rural practice. They also discuss the phenomena identified during the research whereby pharmacists were found to move from one rural area to another, yet this movement was not being captured as rural retention data. The findings from this landmark study will be presented at a national conference for the first time and it will draw out the impact it is having on policy and program development for the future of the rural pharmacy profession.

**Developing eligibility, prioritisation and discharge criteria for podiatry across country South Australia**

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**Aim:** To develop and implement state-wide criteria for patient eligibility, prioritisation and discharge guidelines that are accepted by all podiatrists working for Country Health South Australia (CHSA).

**Method:** Following the appointment of an advanced clinical lead (ACL) podiatrist in February 2012 a review of the podiatry services across the 11 clusters that make up CHSA was carried out between February and May 2012. This was done by meeting with all of the podiatrists in CHSA on an individual basis, as teams and in regional groups.

From this review it was established that there was no consistency in any aspect of podiatry practice.

A whole of CHSA meeting was held in June 2012 with 95% attendance. All the issues and barriers facing each of the teams were discussed in an open environment and four areas were chosen as priorities to be addressed.

Four working parties were established and each group was mandated to review the issue, collect information from each site with the agreement that for the first time there would be a culture of openly sharing information.

All of the separate teams’ documentation regarding eligibility, prioritisation and discharge policies, where it existed, was collated by the group. A search of the relevant evidence base was carried out. A draft set of criteria was developed and sent to all relevant stakeholders for consultation.

**Relevance:** By agreeing to implement state-wide standards the inequity and disparity of podiatry services can be addressed and the ‘post code’ element of service provision be removed.

**Results:** The establishment of a state-wide professional group has resulted in creation of state-wide standardised criteria for eligibility, a prioritisation matrix and discharge guidelines.

Service reform proposals were presented to their colleagues with ongoing implementation.

**Conclusion:** For the first time ever in CHSALHN, podiatry teams will be working to common standards in terms of eligibility, prioritisation of patients and services. With clear discharge guidelines, services will be equipped to review their caseload and tailor services to those patients with the greatest need or those who will gain the most health benefit from the services they receive.

Podiatrists will have the support of clearly written, evidence-based standards and advocacy and support of the ACL podiatrist through the change process of service remodelling.
Outreach optometry in central Australia—the power of partnership

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Aims

• To describe the collaborative relationship between an Aboriginal Community Controlled Health Organisation (ACCHO) and a non-government organisation providing optometry services, to increase the availability of culturally appropriate optometry services in remote Aboriginal communities of central Australia.

• To outline the successful outcomes of this partnership both in terms of volume of service delivery and increased patient attendance at clinics.

• To identify the complementary contributions of each partner towards overcoming some barriers to accessing eye care for people in remote central Australia.

Methods: Information on the program has been obtained through numerous sources, including the memorandum of understanding (MoU), feedback surveys completed by visiting optometrists and clinic managers, trip reports, and through personal interactions with clients and other local staff members.

These sources were used to identify the key contributions of each party, enabling an expansion of the outreach optometry program in both breadth and patient numbers. Data about service provision for consecutive six-month periods were compared to analyse trends in service expansion over time.

Relevance: Combining short-term contract visiting optometrists with a full-time local eye care coordinator has proven an effective means of providing optometry services that are culturally safe, efficient, locally responsive and therefore well attended.

Results: A comparison of the data collected for consecutive six-month periods (July to December 2011 and January to June 2012), shows that the number of patients seen under the Regional Eye Health Program has more than doubled. This success coincided with the appointment of a full-time regional eye health coordinator (REHC) in January 2012, which was previously encumbered. The program’s concurrent success attests to the vital role of the REHC for enhancing effectiveness of services provided by visiting locum optometrists.

Conclusions: This program demonstrates the 'power of partnership', where two organisations play complementary roles: linking optometrists with remote practice, and linking these services to local communities.

Such an approach is particularly useful where eye care services can be limited and infrequent, such as rural and remote areas, and therefore enhanced effectiveness is important. This example of success could be shown to other service providers who may be wishing to seek ways to connect with communities by utilising local coordinators.
About the NRHA

The National Rural Health Alliance is Australia’s peak non-government organisation for rural and remote health. Its vision is good health and wellbeing in rural and remote Australia and it has set itself the specific goal of equal health for all Australians by the year 2020.

Fundamental to the Alliance’s work is the belief that, wherever they live, all Australians should have the opportunity for equal health outcomes, and equivalent access to comprehensive, high-quality and appropriate health services.

Currently the Alliance comprises 34 Member Bodies, each of which is a national organisation. They include consumer groups (such as the Country Women’s Association of Australia), representation from the Indigenous health sector, health professional organisations (representing doctors, nurses, allied health professionals, dentists, pharmacists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service, the Rural Hospitals Forum of Catholic Health Australia, and Frontier Services of the Uniting Church in Australia).

With such a broad representative base, the Alliance is in a unique position to represent the views of people in rural and remote Australia. It collects and disseminates information so that it can determine the key issues affecting rural and remote areas and provide a coherent view on them to governments, the public, media, educational and research institutions and other bodies.

The Alliance takes a broad view of health and a long-term view of the development of rural and remote Australia. It supports initiatives that help the diverse communities of rural and remote Australia to be sustainable, healthy and health-promoting places in which to live and work.

The Alliance manages the biennial National Rural Health Conference and the Australian Journal of Rural Health, and produces position papers, submissions, media releases and newsletters. It is also the national management agency for the Australian Government of the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme and Stream 2 of the Rural Health Continuing Education program (RHCE2).

There are many and varied determinants of health, and work to improve it in rural areas will continue to depend in part on strong partnerships between individuals, organisations and governments in metropolitan as well as rural and remote Australia.

The core support the Alliance receives for its work from the Australian Government bears testament to the partnership between the government and non-government sectors that is bringing greater equity and access for rural people.

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