ONCE UPON A TIME in 1994 a young mum woke up. She felt that she was stuck to the bed; she had no energy; she felt that she hadn’t even been asleep; she had been tired for many months.

Her husband was working away, as he did regularly. If nothing else, she had to get her three young kids off to school. Now come on really - how hard was that?! Make them breakfast, pack three lunches, walk them across the road to their school. But even those simple everyday tasks had become impossible. She lay in bed, tears streaming down her face, with the kids jumping at the end of the bed shouting for their breakfast.

She phoned her Dad, who lived twenty minutes out of town. She cried and explained she needed help to get the kids to school. It was a desperate cry for help.

Her Dad was surprised, as the school was in walking distance. But as a caring and concerned parent, he came into town and helped get the kids off to school.

For her family, Trish’s spiral into depression came as a shock accompanied by a feeling of inadequacy in not knowing what they could do to help her – or even where on earth they could begin to find help. The problem is not always clearly enunciated. For her it surfaced as “I need help getting the kids to school”.

Her Dad made a doctor’s appointment that day. She was diagnosed as having clinical depression. Her husband returned home as soon as possible. She had been too proud to admit something was wrong, too proud to accept that she needed help, wasn’t coping and, of course, there was the stigma.

Trish stayed in hospital for over a week. She was referred to the community mental health team for ongoing counselling. She was encouraged to walk half an hour every day, not just during her recovery, but as an ongoing preventative strategy. Part of her recovery was also getting help from family and friends. Her husband, her Dad and extended family got pamphlets about the illness to be more informed.

The key is knowing about the signs and symptoms so that people can get help early.

The woman in the story took about eight months to recover from that severe episode of depression. It was ten years ago. She had a very small relapse a few years later.

She is now the Mum of teenagers, has remarried and is working full time. She is an active member of her local community. She still incorporates a walk into each day and she doesn’t ignore early warning signs of stress any more.

She asks a favour of you – be an advocate for better mental health.

For more information on signs, symptoms, fact sheets on depression and beyondblue primary care research visit www.beyondblue.org.au or www.ybblue.com.au (Youth website); or phone Just Ask on 1300 13 11 14 (Lifeline’s rural mental health information service)

Happy ever after

in this issue:

› The Independent Living Centre goes Bush
› The joys of Port Augusta
› Stories of personal recovery from depression
› Support on incontinence, cancer counselling and road trauma

Additional stories appear in PART-e-line, the on-line supplement at www.ruralhealth.org.au
A Fair Go in remote Australia

THE NRHA BELIEVES that all Australians, wherever they live, should have access to high quality and appropriate health services, and that rural and remote Australia should be healthy and health-promoting places in which to live and work.

Rural, regional and remote Australia is very diverse. In general it is people in remote areas who are most disadvantaged.

A worrying view seems to be developing that our remote areas can be ignored and written off. The impact of allowing this to happen would be dramatic in both economic and cultural terms. Remote communities need to be supported and the disadvantages faced by remote people minimised.

There are many dimensions to this disadvantage. In aggregate people in remote areas have lower incomes. Goods and services are in short supply and more expensive. Telecommunications are poor and/or expensive. Many small communities have poor water supplies. Even reliable roads cannot be guaranteed.

The health of Australians also deteriorates with increasing remoteness, and at the same time their exposure to health risk factors becomes greater.

There are two reasons for this worse health: the greater proportion of Indigenous people, and remoteness itself. Lack of access to health facilities is a health risk factor. Sometimes the cost of access is so great that in effect people in remote areas do not have access at all. They tend to be diagnosed later. This contributes to poorer survival rates for people in remote areas with cancer and other cumulative diseases.

No health and well-being issue in Australia is worse or more urgent than the appalling health status of Indigenous people. Part of the challenge is to improve access to good food and nutrition, and in remote areas this poses particular cultural, transport, economic and management issues.

Recent evidence from the National Health Survey shows that 60% more adults in remote areas ran out of food because of a lack of money at some time during 2004-05 than in 2001. In a country as wealthy as Australia this is an outrage.

Governments should pursue a whole-of-government approach to food security, including through training, supporting price control, reducing freight costs, requiring adherence to food safety and transport regulations, and work on issues relating to store governance. Indigenous Health Workers should be supported to play a central role in improving food security. Cold water fountains should be provided at schools, clinics, stores, sports venues and community offices in remote areas.

The Alliance is among those who would like to see the taxation system supporting people and businesses in remote areas. The remote zone tax rebates were last reviewed in 1993 and some people in Zone B are currently receiving a rebate of $57 a year!

continued on page 3
A Fair Go in remote Australia

continued from page 2

The taxation zone rebates recognise the disadvantages faced by taxpayers living in remote zones. If the beneficiaries of the current round of tax reform are to be those who are currently most heavily taxed, people in remote areas must be near the top of the list: they pay the same basic rates of tax but have access to far fewer tax-funded services and facilities.

By targeting the rebates more closely, the net cost of increasing the zone rebates to incentive levels would be small.

Wherever there are shortages of health staff, they are most severe in remote areas. It is not just the absence of GPs, but also nurses, allied health professionals, dentists and pharmacists.

‘No doctor’ means ‘No Medicare’. People with no access to a doctor do not benefit from the notional contract between the Australian Government and its people that no-cost or low-cost primary care will be provided through Medicare.

The extent to which people in more remote areas are missing out has been estimated at over $500 million a year.

The national rate of GP bulkbilling was 75% in the December 2005 quarter, with the rate for people in rural and remote areas at 69%. However it is still probably as low as 40% in some rural areas. Coupled with higher costs of accessing medical care due to travel time and average prices charged, the lower rate of bulk-billing means that out-of-pockets costs are both higher and more up-front in rural areas than in the cities. (Some years ago the Alliance estimated the extra out-of-pocket costs for people in rural and remote areas at $43 million a year.)

The Medicare shortfall and the extra out-of-pocket costs in rural and remote areas are among the key factors which justify special national programs for rural and remote health. For rural and remote areas a whole the four-year cost is around $830 million. Health funding systems must continue to support the special rural and remote interventions, and if the deficit persists they should be augmented.

The absence of public transport and personal transport difficulties are pervasive factors inhibiting access to services in remote areas.

There have been some encouraging recent changes in Medicare’s shape including some new items for practice nurses and, in certain circumstances, for allied health, dentistry and antenatal checks. Nevertheless the diabetic foot can be treated by amputation under Medicare but not in a prophylactic manner by a podiatrist.

Medicare is administratively efficient and progressive – the more you earn the more you pay. However its universality is under threat. The universality of Medicare means that medical care is a right and not an aspect of a safety net. It is a relatively simple system and is politically stronger and safer than a targeted safety net.

Co-payments and private health insurance do not have these positive characteristics. They are regressive, more complex and partial.

People in remote areas should also be assured of affordable, first-rate telecommunication access. There should be a Government commitment to equalise rural and urban broadband services, not just to address gaps identified.

The Australian Government responded generously to the recommendations of the two inquiries into regional telecommunications by Besley and Estens. Nevertheless there are still real fears for what the situation might be in remote areas five and ten years after a full privatisation.

Governments, organisations and private individuals make substantial use of internet resources to provide health services and support in rural and remote parts of Australia. The internet, especially through broadband, can provide some minimum access for country areas where on-ground services are only intermittent or not available, and provide some emergency coverage for health issues that typically require as much support outside normal business hours as within.

The NSW Farmers’ Association reported in July 2005 that almost a third of people beyond the Dividing Range were unable to rely on their basic landline telephone service. There were also major deficits related to mobile telephone availability and internet speed.

Government initiatives to increase the supply of young, well-trained health and medical workers in rural areas are reaching maturity. This newly educated rural workforce will take for granted their ready access to the tools for advanced telecommunications. Good telecommunications at work and at home will become crucial to maintaining the health workforce’s willingness to serve in remote communities.
Port Augusta Adventure

by Katie Fitzgerald

BORN AND BRED IN SYDNEY, I have come to love its rolling surf, famous harbour, vibrant atmosphere and busy lifestyle. And because of this love for my home city I caused shock and alarm among family and friends when I told them I was moving to a town named Port Augusta in rural South Australia.

In August 2005 I accepted an occupational therapy position with the Child Health Team of the Flinders and Far North Area Health Service. I drove 20 hours via Broken Hill with my best friend, and as we crossed the Salt Lakes that welcome visitors to this town, I had little knowledge and no expectations of our destination, nor any idea what the months ahead would entail. I was motivated by a sense of adventure, lured by the chance to work with the Royal Flying Doctor Service and excited to be embarking on a unique professional experience.

From my first weekend here I was struck by the magnificent regions that surround Port Augusta. My past few months read like a South Australian tourist brochure, including treks through the Flinders, horse riding near Wilpena, cycling in Clare and exploring Port Lincoln. However my favourite adventures have been through outreach work to remote and rural outback communities. One trip in particular typifies the kind of experience you can gain when you take on a role like mine.

At 7.30am our group took off for the 45-minute flight to Roxby Downs. Our team comprised a speech pathologist, podiatrist, mental health worker and our trustworthy pilot. My two-day schedule involved home visits, therapy sessions at the health centre at the school and health centre, and childcare visits.

Upon arrival, a client was referred who needed immediate attention. He had suffered a workplace injury and was returning home from Adelaide after surgery. He required a home assessment, equipment and home modifications. I was concerned about the situation as I knew that modifications can take weeks and he needed them immediately. However when I arrived at his home, I was met by his family and work colleagues who had already begun work. They had installed a standard ramp and were waiting with tools and supplies to implement my recommendations as I made them. When I left, there was a large team measuring, sawing, removing furniture and organising materials, which for me was amazing to see. I was so impressed by such practical community support and I have come to be less surprised every time I encounter this spirit in this region.

Other outreach visits have involved a health expo in Woomera, presenting on the radio and talking to new mothers about child development. The exciting part of working in rural and remote areas is that you never know what to expect. You can be faced with new clients, new environments and new challenges, and you have to be able to make decisions and deal with situations on the spot.

My move to Port Augusta was the largest risk I have ever taken but it has become one of the most exciting and rewarding times of my life. I will return to my home in Sydney but I’ll return with a new appreciation for the country, knowledge of the resilience and spirit of the people I’ve met, amazed by the beautiful surroundings I’ve explored, and grateful I had the opportunity to come to Port Augusta.
Food for thought

by Ian Spencer

THE DOCTOR’S NORMAL ROLE is to study presented signs and symptoms in order to establish a diagnosis. However some of our interactions with patients can provide insight into still unknown scientific fields. The trick is knowing which they are and having the time to follow up on them. But if we have a constant hunger for ‘new’ information, through giving attention to these special interactions I believe we can contribute to the development of science.

I have had a number of these magnificent moments in my thirty-plus years of practice. One was with an elderly man I had looked after for over twenty years. He had been in the Kokoda campaign in the Second War and had seen a lot of suffering. He had lost his wife at a relatively young age. In the early years that I knew him he had suffered from an episode of depression which lasted just under one year. He came out of that depression and went on to live a very full life. In his last few years I diagnosed him with lung cancer for which he probably correctly wanted no treatment. I looked after him through the final palliative stages. He was more to me than a patient: he had become a great friend. He was a wise philosopher from my father’s generation. In the last stages of his illness he drew me aside and gave me some advice.

“I have lived a very full life and I am now happy to pass on. During the war I saw a lot of tragedy, sacrifice and waste and that made me very sad. I lost my dear wife when I was quite young and for many years, and even to this day, I have felt that great loss. As you will remember many years ago I had that wretched depression that thankfully passed. Now when all my friends have gone I feel a great loneliness.”

Much of your profession would think that sadness, bereavement, depression and loneliness are one of the same. I have felt all of the emotions and they are all completely different. Each of them comes via different processes and from different places in the mind. I want you to pass these things on to your colleagues and patients. Sadness is a feeling of unhappiness related to the events that surround you. These events may be to do with your friends, your family or others. It may be related to events in your life or indeed in your environment.

Bereavement is a feeling of great loss of something which is of immense importance to you. It may be something or somebody that you love or something of yourself which is very necessary and important to you.

Depression comes from a feeling of inadequacy that overwhelms you. It can be based on a feeling of worthlessness, guilt or shame and may or may not be associated with a feeling of anxiety, fear or even panic.

Loneliness is a feeling of being all ‘alone’. This is not to be confused with solitude which is a feeling of peacefulness from being on your own. Loneliness is a feeling of emptiness.”

My friend simply put four emotions from his life into a very clear context of human experience. As our understanding of the neuro-pharmacology of the brain and of emotions improves, perhaps it will be shown that the four emotions are from separate biological pathways and come from different centres in the mind.

In ten years’ time we may well look back on our practice of today and laugh at how much we thought we knew.

A local meeting

PHOTO: ARTHUR MOSTEAD

National Rural Health Alliance, Number 26, April 2006
Cruising together

by Kodie Bedford
Australian Transport Safety Bureau

ROAD CRASHES IN AUSTRALIA are unfortunately very common, costing the nation billions of dollars besides having a major mental, physical and emotional impact on the victims and their communities. One of the most alarming aspects of road safety in Australia relates to the safety of Indigenous road users.

Indigenous people are at least three times more likely to have a fatal road crash than non-Indigenous people. In Western Australia, for example, Aboriginal people make up 3% of the population but 9% of those who die on the roads.

In the past there have been difficulties in sharing information about initiatives to improve Indigenous road safety. In an effort to address this issue, the National Road Safety Action Plan for 2005-2006, endorsed by Ministers of the Australian Transport Council, commits to “complete the development of an Internet-based clearing house to share effective Indigenous road safety initiatives among stakeholders and communities”. Western Australia managed this project.

Edith Cowan University in Perth won the contract to develop the $218,000 road safety component of the HealthInfoNet website with funding from the Australian Government and the Queensland, Northern Territory, New South Wales, South Australian and Western Australian governments. Information was collected by the Edith Cowan University team through an extensive Australia-wide network.

An interactive website for Indigenous road safety was launched in early December 2005 by the Ministers whose jurisdictions contributed funds to the project. In a joint statement, they stated that the website will contribute to a significant improvement in research and strategies to address Indigenous road safety. “The development and implementation of effective road safety programs requires the cooperation of all levels of government, and the launch of the HealthInfoNet Indigenous Road Safety Website indicates that state and federal governments are working together to achieve road safety for Indigenous Australians,” the Ministers said.

The website contains up-to-date information on current initiatives and campaigns that state and territory governments are using. It also features an interactive component enabling the community to share and contribute relevant information about current strategies and initiatives in Indigenous road safety.

The road safety website is aimed at all levels of government tackling the issue of road deaths of Indigenous people, and is also useful for those working with Indigenous communities as well as Indigenous people themselves.

The Indigenous road safety website is at: www.healthinfonet.ecu.edu.au/roadsafety


A new road safety website is helping states and territories work together
IN DECEMBER LAST YEAR the Governor of South Australia, Her Excellency Marjorie Jackson-Nelson, launched a new independent centre of excellence in trauma and injury recovery for the State. TRACsa will work with community organisations, professional bodies and service providers to improve health and social outcomes for people with injuries arising as a result of road trauma.

TRACsa is funded by the Motor Accident Commission, South Australia’s Compulsory Third Party Insurer. It has its own Board of Management appointed by the Deputy Premier of the State, and chaired by the Hon Greg Crafter. TRACsa employs a small team led by Liz Furler.

The establishment of TRACsa is the culmination of five years of planning and research by the Commission in collaboration with key community organisations and professional bodies concerned with the outcomes for people who are injured on our roads and have a stake in the sustainability of SA’s Compulsory Third Party scheme. TRACsa is the direct outcome of their efforts. The collaborative approach which has characterised the history of this initiative is set to continue through TRACsa’s governance arrangements and the planning and implementation of its programs.

TRACsa’s first priority is to improve outcomes for people who have Non-Demonstrable Injuries, a broad class of injuries where the underlying pathology is unknown or unable to be detected with existing medical technology. Soft tissue injuries like strains and sprains, and in some cases whiplash, are examples of these types of injuries. They comprise a very large proportion of the injuries people experience as a result of road trauma, and it is an area where there exists considerable scope to improve recovery rates.

TRACsa will make an impact through programs and activities aimed at:
• improved access to recognised best practice assessment and treatment services;
• a more person-centred claims management process;
• increased community awareness of the complex issues concerning recovery from injuries as a result of road trauma; and
• greater opportunities to return to optimal function, community life and meaningful work in supportive settings.

While focusing on better outcomes for road trauma victims, TRACsa will work with WorkCover in South Australia to ensure a consistent approach to best practice management of injuries regardless of whether they arise from trauma on the road or in the workplace.

For more information about our activities and research visit www.tracsa.org.au or contact TRACsa at GPO Box 1045, ADELAIDE SA 5001 or email: TRACsa@sa.gov.au

Volunteer overseas

AUSTRALIAN VOLUNTEERS INTERNATIONAL has been placing skilled volunteers to live, work and learn in developing countries for over 50 years. There are currently a wide range of exciting and challenging positions available for nurses and other health sector professionals to make a real difference throughout Asia, the Pacific, Africa and the Middle East.

Positions include:
• GP or Obstetrician, Papua New Guinea
• Physiotherapist, Lebanon
• Registered Nurse / Midwife, Malawi
• Public Health Coordinator, Thailand
• Health and Nutrition Trainer, Timor-Leste
• HIV/AIDS Clinical Adviser, Swaziland

AVI is an international development organisation supported by the Australian Government’s international aid agency, AusAID. AVI volunteers exchange skills with local people and support organisations that deliver essential services to communities. AVI volunteers receive airfares, insurance, accommodation, a living allowance and ongoing support throughout their placement.

To find out more contact Max Campos on 03 9279 1752, freecall 1800 331 292 or email mcampos@australianvolunteers.com

More than 100 positions will be advertised on the AVI website from May 6th at www.australianvolunteers.com.
HealthyMinds posters

by Tameaka Marchant

IN JULY 2005 the HealthyMinds committee decided to look at a way of raising awareness of mental health issues and the HealthyMinds contact and referral numbers. It was decided to use the immense talent amongst the young people in this area. MacKillop College, the Swan Hill College and Tyrell College all agreed to take part.

What followed was amazing and far exceeded expectations. Given only the choice of a mental health topic on which to focus and the contact numbers, the young people from year 11 developed amazing posters of incredibly high standard. The eagerness of the teachers to get their students involved and funding from the Division of General Practice and Mallee Family Care made the creation of the posters possible.

There are 15 posters in the set, all available for sale (laminated $10 per print; not laminated $6 per print). For further information, or to order copies, please contact Tameaka Marchant, Health Promotion Officer, Swan Hill District Hospital on 03 5033 9337, or email: tameaka.marchant@swanhillhosp.vic.gov.au

Mensheds Australia, saving an endangered species

There are growing problems with men’s health. Isolation, loneliness and depression are now looming as major men’s health issues, especially in rural areas. Men’s sheds is a uniquely Australian movement dedicated to promoting the health and wellbeing of men and to supporting their communities. A men’s shed is a place for social interaction, for gaining information on health and well being, and for making things together. They are locally based and structured to service the particular needs of their local community.

The men’s shed movement is supported by Mensheds Australia which supports the planning, development and operation of men’s sheds. They provide advice on “getting going”, on-going operations and becoming sustainable in terms of management structure, programs and funding through commercial activities and partnerships. Guidance is provided on building the links to the community, developing leadership and a culture of learning and innovation and communication with both members and the community.

For information see www.mensheds.com.au
Life was meant to be easier

by Chris Kingsnorth

THE COUNTRY SERVICES MOBILE UNIT (MU) is a unique service provided by the Independent Living Centre (ILC) of WA. It specialises in information and advice on assistive technology to enable people of all ages and abilities to manage tasks at home and school, to work more comfortably and to pursue recreational activities.

Last year we visited towns in the Southwest, Midwest, Goldfields, Wheatbelt and Pilbara regions.

We are excited about heading up to the Kimberley in May 2006, where we will be participating in the Northwest Expo in Broome and then on to Derby, Fitzroy Crossing, Halls Creek, Kununurra and Wyndham. It will be a great opportunity for people in the area to use our service in person and take advantage of opportunities for training and community information. Health care workers will have opportunity to update knowledge and skills regarding equipment for themselves and their clients.

The ILC launched a new MU caravan last year which lowers to the ground via a hydraulic chassis and allows easy access for all. The Senior Occupational Therapist has up to 500 items of equipment to show and trial on board as well as access to over 6000 items on the computer database. Specially requested equipment may be brought on the MU visit to assist the client/therapist resolve a problem with independence.

Equipment can range from something to assist a person with arthritis to open a jar, to a cushion to absorb vehicle vibrations contributing to back pain, and includes suitable mobility aids and computer access. Information is available so that people are able to make informed choices.

The ILC has videoconference facilities available, and it is helpful when people make use of this service prior to a visit. The ILC’s videoconferencing facilities are now linked to the health network, so those sites that are IP-enabled for videoconferencing can use the service at no cost for direct client contact.

The Mobile Unit can be requested to visit a town as part of a community activity.

Contact details for the ILC are
Phone: 1300 885 886, Fax: 9381 0611
Email: countryservices@ilc.com.au,
Web: www.ilc.com.au

Talking Together
Contemporary issues in Aboriginal and Torres Strait Islander health: HIV, hepatitis and sexual health

THE AUSTRALASIAN SOCIETY FOR HIV MEDICINE (ASHM), in conjunction with the Indigenous Australians’ Sexual Health Committee and with funding from the Office for Aboriginal and Torres Strait Islander Health has recently produced Talking Together, a distance learning kit for those working in Indigenous health.

This kit will support primary care health workers who see Indigenous clients at risk of sexually transmitted infections and blood-borne viruses. Metropolitan, rural and remote settings are covered, as well as the importance of delivering information about sensitive topics in culturally appropriate ways. It contains:

• the ASHM Indigenous sexual health video;
• the ASHM monograph HIV/Viral Hepatitis: a guide for primary care;
• a user’s guide with training material; and
• all of the kit materials are available as a CD-ROM, either as part of the kit or as a stand-alone resource.

To order a copy of this kit, phone Simon Hill on ASHM Resources Hotline: 02 8204 0740. Please mention that you saw this article in PARTYline.

To view other ASHM resources, visit the ASHM website at www.ashm.org.au
Letters to the Editor

Global workforce issues

THE COMPETITION FOR WORKFORCE both within and without the health industry has become too strong to make the use of overseas trained health professionals a valid strategy for rural recruitment. The situation is such that it is hard to imagine how we can meet the NRHA’s goal for Australia to be a net exporter of health services rather than net an importer. This is a very tricky public policy for Australia and European countries with low or negative growth rates. We rely on increased immigration to remain viable.

It is important to adhere to the principles of the Melbourne Manifesto. There are big barriers facing some nations in achieving anything like the required number of health professionals. In some nations the challenge is compounded by ethnic strife or all out civil war. In such countries a medical degree or equivalent education, if it can be obtained, is a ticket to freedom in another country. If we can’t contribute to the world with more health professionals, can we contribute in other ways - for example through training?

It would appear that some South East Asian countries are strongly gearing up towards international standards in education and technologies so they can

be net exporters to the first world. They would prefer we import their teachers, nurses, etc on two-year visas. What they earn in dollars sent home and the advanced training that professionals can take back from countries like Australia is of great significance to developing nations.

So we have a challenge with workforce policy: how do we balance our needs against those of countries that are less well off? For our own good and for theirs, can we afford not to import health workers like doctors, nurses and allied health professionals? Can we afford not to import workers to a range of other sectors? And if we do continue to import large numbers to fill the gaps in our own workforce, can we provide systems of adequate engagement in society to ameliorate the risk that largely comes from alienation?

Owen Allen, QLD

Sharpening the axe

A recent newspaper article began with the assertion: “While most health dollars are spent on acute care, experts argue the money could be better used for prevention...” Even if it’s true (and it probably is) how do you refuse the sick and needy? This is an old and familiar discussion for rural doctors – where it is alleged we should do more with counselling and preventive measures: the ‘more’ to be done by clinicians who must deal with a room full of urgent problems (often after a sleepless night of similarly urgent problems)! The discussion about this is essential to the critical business of developing our health workforce and our health teams – hopefully making the transition from reaction to prevention and planning – ‘sharpening the axe as well as chopping the wood’.

Bruce Harris, NSW

Accepting responsibility for health

We need a change of attitude from all people. We must take some responsibility for our own health instead of popping pills or thinking medical science has an answer when we let ourselves get bushwhacked.

The obesity epidemic is a good example, as are diabetes and smoking-related illnesses. I watch some local people dig their own grave and, when nearly there, expect the overworked local GP and health system to find a miracle cure.

Having said that, I will now walk an extra half hour a day!

Irene Mills, WA
Fare's fair

I feel strongly about IPTAAAS/PATS and read your media report on the subject. There was a recent news report that due to a linear accelerator breaking down here in Canberra, some cancer patients will need to have their radiotherapy at Wagga, Wollongong or Sydney. The Minister and Secretary of the Department, when alerted to the fact that IPTAAS in the ACT doesn't even cover a park bench in Sydney, said that they'd look at making special arrangements for those cancer patients forced to travel. While I have enormous sympathy for the cancer patients concerned, I'm outraged that these few cancer patients are considered a special case whereas other residents are forced to travel regularly to inter/intra state appointments and bear the enormous burden of the cost as a matter of routine. We should have a system that is consistent, transparent, and actually pays for the necessary travel and accommodation.

People in rural, regional and remote Australia are supporting a health system that doesn't provide all the high tech services within their own communities - they pay their Medicare and private health insurance levies yet they are forced to pay enormous costs to travel to the city to receive their care.

We are all Australians, paying national taxes and expecting at least a minimum set of services for those taxes. Why on earth people from rural, regional and remote Australia have to pay further, and hugely, for those services is beyond my comprehension.

Hot under the collar

Lynham, ACT

Mental health problems increasing

During the nearly 10 years I was Chair of Southern Area Health there was an increase in the number of people seeking help about mental health issues. WHO predicts mental health will account for 15% of the total disease burden by the year 2020. The figure is currently 11%.

I understand in NSW 9.5% of the current population will have a mild mental illness, 4.5% a moderate and 2.5% severe illness. That seems to add up to 16.5%! (The figures are from a recent Cooma Health Plan. I don't know how they break down into different mental illnesses.)

The increase in calls for help may well be because of a more open approach to mental illness but it covers a period of tension for agriculture in the area covered by the former Southern Health. Government recognised this and appointed Counsellors to help people with personal problems. It was also a period of considerable social change flowing from government policies.

While it is good to see more action to help people suffering from depression and other mental health problems, we need a parallel effort to develop a better understanding of the reasons for the increases in Australia - seemingly above the world figure at least in NSW. Is it because of greater awareness? Or are mental health sufferers increasing as a percentage of population? If so, why? Is it diet? Environment? Family/social or work related?

We know changes in workplace impact on some mental health issues. Pressures of present day living and changes in social structures have an impact.

A better understanding of why and the economics of care and prevention are necessary to stop the increase. There is a parallel with early childhood intervention. We understand why it is successful and the economics are positive. How to convince government to act for long-term benefit? Perhaps all Cabinet Submissions should have attached a Mental Health Impact Statement. Senator Field's declared policy of a “Family Impact Statement” for all legislation could be enlarged to encompass a “Social Impact Statement” that included mental health as well as other social fabric concerns.

Gratton Wilson, NSW ✷
Our journey with depression and prostate cancer

MY HUSBAND WAS WONDERFUL, intelligent, talented, loved by everyone, a real gentleman, had a great sense of humour and was a workaholic! We came to Adelaide in 1970 for a job he regarded as worthwhile and which he really loved.

At the age of 56 years he said he was considering early retirement, as he had research work he wanted to do and there was never any time or money to do it. This was a shock and almost unbelievable as he truly loved his work, and had previously hoped to work until at least 65.

So the following year, at the age of 55, I returned to work full-time and my husband did his research three days a week *gratis*, going into his same office, sitting at his same desk in his same business clothes, carrying his briefcase and using their facilities.

Our marriage deteriorated somewhat over the next few years, particularly when I became aware, as did other friends, that as well as aging rapidly he was also becoming anti-social, cutting out most of the things we had done together.

Our life became that of two strangers living under one roof. I spoke to his doctor who advised that he was depressed and sent him to a psychologist. This doctor recommended some strategies for a happier relationship and sent us home to practise, but after several sessions John decided he wanted to separate and moved out.

Some time later John called around early one morning with flowers in hand, tears in his eyes and wanting to talk. He couldn’t understand why he was living in the unit; he was longing to be home with me.

With all the anxiety over the previous five years I was finding it difficult to cope and insisted that he have a very comprehensive medical examination. John agreed, sold the unit, moved home and became the wonderful loving and caring man that I had known some years before. However, his medical tests confirmed prostate cancer and also that the cancer had already spread.

The result came through on a Friday and John spent a very distressing weekend contemplating his future. On the Monday, he waved me off to work with the usual peck on the cheek. He ended his life that day. John was 62 years old.

I later discovered that John had been pushed out of his job at the age of 56 which resulted in his onset of depression. I have coped over the past few years by remaining as active and positive as I possibly can.

I had to make plans and future goals for the remainder of my own journey to recover from the sadness, anxiety and depression which had surrounded me. I decided that I needed to move to a country area for my own health. I have chosen a dairy farming area, which is similar to the area I grew up in as a young girl, linking my life to my youth. This country experience has been a very spiritual journey for me and has allowed me to move on.

I also made the decision to keep very busy and chose to combine my love of wine with a desire to raise funds for prostate cancer research. For many years now I have been organising a monthly wine appreciation group to raise awareness of prostate cancer and in support of the work of the Prostate Cancer Foundation of Australia. ❖
Cancer Counselling Service

by Margret Ryan
Cancer Council South Australia

THE CANCER COUNSELLING SERVICE (CCS) provides the community with access to a program specifically designed to reduce the emotional, social, spiritual, physical and practical distress associated with cancer. The service is offered face-to-face or by phone to ensure it is available to people irrespective of their geographic location.

However, 40% of patients and 60% of carers who participated in the survey were not offered an opportunity to talk with a counsellor, psychologist or social worker. This supports previous findings in the NHMRC Psychosocial Guidelines that people will not raise their concerns unless explicitly invited to do so.

The guidelines cite two reasons for this.

Firstly people are reluctant to mention their distress because of the stigma associated with mental health. Secondly, health professionals hesitate to ask about psychological problems because they believe that depression and anxiety are normal responses to cancer.

Not raising concerns exacerbates this common perception despite there being evidence that most people with cancer experience symptoms of anxiety and 12-30% will have clinically significant problems.

In response to these barriers and the economic implications to the health system of undetected depression and anxiety, The Cancer Council changed its practice. The organisation has integrated a model of psychosocial assessment using a simple Distress Thermometer (J Holland, NCCN) into its cancer support programs. This allows people with cancer, their carers and families to be effectively triaged to an appropriate tertiary and/or community support program based on their level of distress and the individual’s identified needs.

The CCS offers up to six sessions with counsellors who have training and experience in the needs of people affected by cancer. The counsellors predominately use supportive psychotherapy and cognitive behavioural therapy in their practice. Emphasis on the person’s strengths is paramount in building on the individual’s existing resources and coping mechanisms.

Services can be accessed through The Cancer Council Helpline by phoning 13 11 20 for the cost of a local call, Free call 1800 188 070 or emailing tcc@cancersa.org.au

1 NHMRC Clinical practice guidelines for the psychosocial care of adults with cancer (2003)
2 National Comprehensive Cancer Network Practice Guidelines in Oncology - v. 1. 2005 Distress management
THE LINK BETWEEN INCONTINENCE (poor bladder or bowel control) and depression is frequently overlooked or demeaned - by the person with the problem, those around them, and clinicians. The situation can slowly, secretly - often almost unnoticed – get worse over time until quality of life has been seriously affected.

There are so many deep-seated emotional issues surrounding the control of such ‘basic’ functions! There is a considerable weight of cultural baggage born by bladders and bowels.

In aged care, for example, the taboo nature of incontinence can still be a hurdle to fully understanding ‘poor behaviours’. It is often assumed that incontinence goes hand-in-hand with ageing. Certainly its incidence (along with that of other health conditions) increases in with age, but it is not solely a condition of the mature years. Young mothers can battle with incontinence during pregnancy and this may continue after the birth, the circumstances of which may further aggravate the condition. A woman coping with a tiny and demanding newcomer to the family may understandably ignore her own bladder or bowel control problems. It’s easy to dismiss these as ‘small’ or to hope that they will disappear in time of their own accord. Neither attitude is founded in fact. So-called small problems have a habit of getting bigger. And incontinence will not get better on its own.

As if coping with the embarrassment and insecurity around ‘leaking episodes’ were not enough, there is the underlying issue of how this health condition affects lifestyle. A continence clinician tells the story of one distressed young mother whose incontinence was the source of escalating depression. Her marriage was breaking down, her social life and friendships suffering, her wider family relationships becoming fragile because of her increasing sadness, loss of self-esteem and her spiritless attitude to life generally. (Unfortunately, for incontinence this is not an uncommon scenario.)

The incidence of depression with incontinence is higher in women (around 19% of women with incontinence; 14% for men). Poor bladder and bowel control (particularly faecal incontinence) can be very isolating and damaging to self-esteem. These are certainly fuel for depression.

In all age groups, whether it is children who are persistent bed-wetters, young mothers, or older Australians, incontinence can lurk as a de-motivator, a depressor, as an isolating and life-shrinking secret. It shouldn’t be. Nowadays, it can be improved, treated and frequently cured. Talking to a nurse continence advisor or a GP skilled in dealing with this complex, sensitive and too often demeaned condition is the way to go.

Contact details for Continence Foundation of Australia:
Phone: 03-9347 2522  Email: anne@continence.org.au
National Continence Helpline (Australia-wide Free call 1800 33 00 66)

Bladders behaving badly

by Anne Haag

The National Continence Helpline staff are not only clinical experts, but are well aware of the sensitive and complex emotional issues experienced by callers. Here they chat to Barry Cahill (R), CEO of the Continence Foundation of Australia.

Arts Access Arts Classes

OVER THE PAST TEN YEARS Arts Access has been running the Saturday Morning Art Class (SMAC). Many people have enjoyed the high level of tuition, the variety of classes and the support of being part of a group who share similar experiences and interests. Art-making and creative writing skills have been learnt and developed, and friendships made.

For adults who have a mental health issue, SMAC has been an important step towards enabling a feeling of connectedness to their community. Without focusing on the illness, SMAC has provided a place of support and understanding.

Arts Access employs professional artists who have considerable experience working with people with mental illnesses, to provide expert tuition and guidance. A support artist is also employed to assist participants.

Classes are small and suitable for those people with no experience, as well as emerging and experienced artists, performers and writers. Classes are held in accessible community venues, near public transport. There are many classes and activities held at these community venues which participants are encouraged to join at the end of the SMAC class.

We invite you to contact Arts Access and chat, or to join our mailing list so you can receive information about upcoming programs.

Arts Access can be contacted at:
24 Eastern Road, South Melbourne, Victoria 3205. Phone 03 9699 8299
Email: info@artsaccess.com.au
Web: www.artsaccess.com.au
THIRTEEN YEARS AGO I was diagnosed with manic depression after an attempted suicide. I was 17 and had gone off the rails in a big way. I remember feeling so alone. I didn’t know why I couldn’t be just like everyone else or why I had been burdened with such an illness...it seemed so unfair. I was well on the road to self-destruction when I fell pregnant with my first child. For the sake of the little person I was bringing into the world, I knew I had to do something to help myself...fast!

I started spiritual healing workshops and emotional release healing. Becoming aware of my emotions and accepting them was a huge step for me. I eventually came to an understanding that at the base of all my misery was self-pity. It was hard to admit at first, but I had to accept my self-pity in order to let it go. With the help of my partner, I made a plan. Every day I allowed myself 20 minutes of ‘self-pity time’. I would go to the bedroom and cry ‘why me?’

When my time was up, my partner would bring me a cup of tea to indicate that pity time was over. This went on every day for a few months. At first, 20 minutes did not feel like long enough, but after a few months I ran out of things to feel down about. There soon came a time when I would walk into my room and laugh at the thought of having to find something to feel down about. Through acknowledgement and acceptance came the ability to finally feel good about myself and my life. I have not had a day of depression in six years and I have not taken an antidepressant in seven years.

Second chance
by Rosie Saxton

WALWA IS A VERY SMALL COMMUNITY on the Victorian/ NSW border in the Upper Murray region. It has one of the lowest per capita incomes in Australia, the major economic base being grazing. Before the days of economic rationalism and road improvement, Walwa was a thriving little country town but its population is now around 250. I am Walwa’s female GP, working 2 days a week while my colleague, David Hunt, works 4 days a week.

The area is slowly recovering from the worst drought locals can remember and rainfall remains lower than normal. The population therefore has a number of reasons to be under stress and we spend a sizeable proportion of our time addressing the effects of this on our patients’ emotional, mental and physical health.

I am married to a farmer and have two lovely children. A few years ago, our relationship had deteriorated and separation appeared a good option. I had lost interest in medicine and was on the point of ‘burn-out’; I would probably have met the criteria for clinical depression (although, like most doctors, I was reluctant to seek professional help).

A friend pointed me in the direction of ‘Phoenix Rising’, an organisation which provides seminars on emotional healing. The founders, Graeme and Gayle O’Brien, have over 20 years’ experience in a wide variety of counselling techniques which they have blended together to incorporate the best in mind-body medicine. These are used with incredible skill in experiential workshops of up to 50 people. I have found their work to be profoundly life-changing; it has enabled me to regain joy in my work, the love in my marriage and has given me a new passion. I have completed two intensive blocks of facilitator training and am doing two more this year.

In my practice, I now use the ‘Phoenix’ techniques in almost every consultation and I have run 3 workshops of my own in Walwa, with plans for many more. I am able to address issues of relationships, self-worth, the effects of emotional states on physical health and a myriad of other topics. Doing this in a workshop setting has the advantage of the group energy and the discussion generated - which is illuminating. Individual counselling is delivering great results but tends to be less time-efficient. The self-awareness I have gained helps me to avoid taking work home. This means that my own mental and emotional health is maintained so I have more energy for my work and my family.

I cannot recommend highly enough the work of Phoenix Rising and urge readers to visit their web-site at www.phoenixrising.com.au and consider attending a seminar. I would also be very happy to be contacted for further information.

'Self-pity time' and a cup of tea

PHOTO: BARBARA GURNEY

A special moment at the Glenn Innes Celtic Festival
IT WAS JULY 2002. I was heartbroken, torn, in the depths of despair. I was alone, in an empty house; dust and broken toys lay strewn on the floors, remnants of a life that used to be. A marriage and a family – mere photographs on a wall. The silence was distracting, unnerving, and incomprehensible.

And so began my journey with depression - a journey that led me to great depths and to the heights of discovery. Never before had I felt such pain and loss. I was grieving and alone. I found it hard to breathe some days; days without end, and nights without peace. I blamed myself for it all. I didn’t want to die, but I couldn’t see a point in living either. I decided to leave, to run and hide. I felt ashamed and as though there was no one in the world I could turn to.

I jumped on my Kawasaki and, without any plan, decided to ride off into the sunset. On a broken highway through the Mount Morgan ranges the bike stalled, the throttle choked and I came to a halt looking out over the plains and grasslands of the Fitzroy basin. In that moment my mobile rang and my life was changed.

It was a friend, a mate, concerned he hadn’t heard from me for weeks. He simply asked me where I was. What was I doing? Could he meet me somewhere so we could talk. Mark is a good mate who had intuitively sensed things weren’t right. He arranged for me to see someone to help make sense of my turmoil. From that point on, things began to change.

I was saved from an uncertain fate by a mate who, through a simple process called “Priority One”, started my recovery. You see, I am a Paramedic and a member of the Queensland Ambulance Service. The Queensland Ambulance Service (QAS) provides a personal counselling service that enables employees and members of their immediate family to have face-to-face counselling with one of the 30 Professional Counsellors available throughout Queensland. These Counsellors are in no way connected with the Ambulance Service, and paramedics can simply make an appointment and attend without the knowledge of any QAS personnel.

Mark was a mate, a peer supporter. There is a peer support network throughout the state whose members undertake unique tasks as part of their normal work. They are located in Stations, Communications Centres and other QAS locations throughout the state. They provide a first line of contact following an incident or life event that might generate strong psychological reactions.

It’s been four years since that day and I have since travelled the world, experienced exciting changes in my career, danced with cancer and survived, and reconciled my past hurts. I see my children every day and I can’t imagine not living. I have a new perspective and a new life. The moral of this story is simple.

Talk to someone, get help. You won’t regret it.

You can obtain information on reducing depression, anxiety and related disorders by improving your lifestyle by reading beyondblue fact sheets entitled “Keeping Active”, “Reducing stress”, “Sleeping well” and “Reducing alcohol and other drugs”. These can be downloaded by visiting www.beyondblue.org.au or by contacting beyondblue on (03) 9810 6100.
A Way Through

by Beth Jackson

‘A WAY THROUGH’ workshops have been conducted to address various mental health issues including depression. These workshops are built around the ‘Map of Loss’ developed by Roslyn Snyder. The map is a simple, easy to remember picture that explains complex psychological processes which everyone goes through during their life. The Map presents a visual guide to the importance of balance in our lives, in particular the balance between actions, thought and emotions. The Map draws life as a series of relationships and asks the individual to see life as a journey on many alternate relationship highways. There are varying exit points referred to as a ‘catastrophe bridge’ or a ‘voluntary off ramp’; many people find themselves caught within the emotional landscape in ‘avoidance marshes’, the ‘swamp of feelings’, ‘anger or guilt mudflats’, or lost in the ‘desolate desert’.

Feedback from these workshops include comments such as: “my understanding of depression has increased dramatically”; “this course has been a fantastic help and has given me some good strategies to work through my depression”; “I can get through this depression, time is not important”; “a simple and effective model for understanding loss issues”; “life is a process and the journey is not all smooth”; “it is possible to get through the swamp”.

Indications are that the Map reframes depression in a way that empowers people to take control. With its visual representation of life and simple language, the Map normalises the condition of depression in a way that people are able to see that it is only one aspect of their lives, not their whole life. People are then able to consider ways of moving forward with renewed hope and vision for the future.

For more information on ‘The Map of Loss’ visit www.wisdominyourlife.com.au or email info@wisdominyourlife.com.au
‘A Way Through’ workshops have been conducted successfully in WA, primarily in the Peel region of the South West. The Map’s author, Roslyn Snyder, is a registered psychologist currently completing a PhD in community psychology.

Go to www.ruralhealth.org.au for more PARTYline stories on-line

When we sought contributions for PARTYline with the theme “recovery from depression” we were overwhelmed with responses from people eager to share their stories or provide information about services that are available to people in rural areas. In order to publish most of them, as well as our regular articles, we are simultaneously producing:

• a joint NRHA/beyondblue edition of PARTYline (No 25);
• an extra ‘standard edition’ of PARTYline (No 26); and
• an electronic-only supplement, PART-e-line, which is available online at www.ruralhealth.org.au

Thank you to all our contributors. It is clear that mental health is a major issue in rural areas, and we hope that these special issues of PARTYline will make a useful and positive contribution. Ed.
RAMUS round up

IN THE 2006 ROUND 109 medical students are being offered Rural Australia Medical Undergraduate Scholarships from over 370 applications received. At the end of 2005, 116 RAMUS scholars graduated from medicine, including 60 who received RAMUS scholarships when the scheme began in 2000.

Since the year 2000 over 520 RAMUS scholars in all have graduated and embarked on their medical careers and more than 700 rural doctors have participated in the RAMUS Scheme as mentors. Rural doctors Martin Altmann from Murray Bridge and Peter Francis from Wodonga received the 2005 Mentoring Awards, in recognition of their outstanding contributions as mentors. Peter Francis has been a mentor since the scheme began.

Among the completing and continuing scholars, there were those who spent the summer break working in a variety of placements ranging from East Timor to Guatemala, while others worked in rural and remote communities in Australia with their mentors.

Beyond Borders: Guide to Health Placements (McGraw-Hill) by Hamish Graham, a RAMUS scholar from Devonport who graduated from Monash University at the end of 2005, was published recently. This practical guide is useful for both students and health professionals.

A new group of RAMUS Alumni ambassadors has been formed to advise on the alumnus scheme. The scheme will promote rural and remote careers, keep RAMUS scholars together after their graduation and provide a means of investigating the factors which lead to rural and remote practice. The ambassadors include four graduates, three current scholars, three rural mentors and the National Rural Health Network’s representative on NRHA Council.

The Age has published two in a series of articles about Emma Goeman following her experiences as an intern, most recently in Horsham on rotation. Formerly a RAMUS scholar from Ballarat, she graduated from the University of Melbourne at the end of 2005.

...friends of the Alliance

FRIENDS OF THE ALLIANCE provides a means for individuals and organisations who want it to have a closer relationship with the Alliance and to support its work. If you would like to join, email friends@ruralhealth.org.au or phone Leanne Coleman on (02) 6285 4660. (There is a membership form on the Alliance’s website.)

friends hear from the Alliance, are encouraged to comment on policy papers and receive a discounted Conference registration fee. There will be a friends photographic festival held this year with the announcement of the winners to take place at a fabulous friends function during the Conference in Albury in March 2007. Full details of the photographic festival will be provided in the next edition of PARTYline so start snapping now...
Whose shadow is this?

by Sara Creedy

WHI5 THIS WHO WALKS BEHIND ME, cloaked in despair and muttering failings in my footsteps?

For six or seven years now I’ve not known the ghost who follows in my stride, trying not to acknowledge its forceful existence.

I couldn’t understand myself at all: The night I bawled into the ripped faux leather of a kitchen chair, scribbling every ounce of denouncement into a tiny journal, it watched.

The night I sat perched on the linoleum under fluorescent lights, it watched. The endlessly repeated episodes of frustration and anger at nothing or everything, it watched.

I believed I was an artist, who suffered for my art - through pain comes inspiration. I thought I could not write without this cavern in my heart - without this rotting hole in my whole. It has taken me a long time to realise that being a success doesn’t equal pain, and beauty comes from the variety of life, not life’s despair.

Living with depression is like living with influenza as a housemate. You lack energy; the effort to get out of bed is immense. You stop wanting to see your friends, feeling worthless and judged and like you can’t face the world. You can’t pay attention, even if you wanted to. You can’t remember what you did last weekend, or what time your appointments are, even if you could be bothered to go. Life fades and sensations dull. Sex and chocolate are boring; exercise and cooking fall by the wayside. You wish you didn’t need to eat so that it would all be easier. You stop caring about your appearance, and the shadow moves over you.

Sufferers of depression may blame themselves. The scientist in me knows depression is an expression of my genetics through the filter of my life experiences. A dark half still tells me it’s my fault, that it is my reliance on the familiarity of feeling down that keeps me down. Sufferers may blame family or their past. Ultimately it is no one’s fault.

What has saved me? I am still being saved, still walking with the sun over me, so that this shadow is always at my feet, always being walked on, always remembering its place, beneath me. Know that the world cannot function as an organism without neatly organised, well-oiled, warm-hearted cogs. Know who you are and never be ashamed to learn. Forgive yourself. Find a good doctor, a good listener who will be able to make educated decisions about whether or not you need medication.

When is it still hard? That unforgiving time of night every sufferer knows about; when everything is quieter outside, but louder in your head. Sometimes you feel that if you were watching yourself you would find yourself more melodramatic than a midday soap. To you it is real. To you the world is a haystack of chaos and salvation the proverbial needle. It is when your shadow feeds on the darkness in the corners of the room.

Faith restores power. I’m not talking about religion. Faith brings resolution. What is faith? Faith is your inner soldier, the part of you that still gets up in the morning; the part of you still capable of smiling or making jokes. Faith is colouring the uniform of your outer façade, but needs to be fed to grow into the core of you. Faith needs to be identified and nurtured.

What feeds faith? Faith is fed in part by starving shadows. Faith is built on love, self-respect, communication, persistence, friendship and appreciation. It is essential to find a good doctor, one who listens and cares about you, makes you feel safe, and can direct you to appropriate services and manage your care. Find friends and family who care for you and enlist them in your war against depression.

About herself Sara says: I was born in Armidale NSW where I lived till 18. I chose to study medicine and was lucky to receive a RAMUS scholarship. I am looking to do internship in a rural area. Rural life appeals to me greatly and is essential for my soul. I wrote this piece after successfully getting on top of my depression with the help of a very dedicated GP and the rural lifestyle.

For more information on signs, symptoms, fact sheets on depression and beyondblue primary care research, visit www.beyondblue.org.au or www.ybblue.com.au (Youth website); or phone Just Ask on 1300 13 11 14 (Lifeline’s rural mental health information service)
Call for Papers now open
www.ruralhealth.org.au

No internet access?
Please call 02 6285 4660.