Painting Home: Bagot telling its story

Rural place - friend or foe?

Securing equitable access to radiation therapy for rural people

Respite for carers in Top End remote communities
GOOD HEALTH AND WELLBEING IN RURAL AND REMOTE AUSTRALIA
## IN THIS ISSUE:

<table>
<thead>
<tr>
<th>Page</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Editorial: Big issues, big responsibility</td>
</tr>
<tr>
<td>8</td>
<td>Rural place - friend or foe?</td>
</tr>
<tr>
<td>10</td>
<td>Painting Home: Bagot telling its story</td>
</tr>
<tr>
<td>12</td>
<td>A traveller in a strange land</td>
</tr>
<tr>
<td>14</td>
<td>Snakes in the washing machine</td>
</tr>
<tr>
<td>16</td>
<td>The cost of caring</td>
</tr>
<tr>
<td>17</td>
<td>Using data to inform and improve public health policy</td>
</tr>
<tr>
<td>18</td>
<td>Respite for carers in Top End remote communities</td>
</tr>
<tr>
<td>20</td>
<td>Securing equitable access to radiation therapy for rural people</td>
</tr>
<tr>
<td>22</td>
<td>Outreach: health care where it’s needed most</td>
</tr>
<tr>
<td>24</td>
<td>Nutritious and affordable food for everyone</td>
</tr>
<tr>
<td>25</td>
<td>CPD for rural and remote health practitioners...yes please!</td>
</tr>
<tr>
<td>26</td>
<td>The lucky few</td>
</tr>
<tr>
<td>28</td>
<td>Pain management education in rural and remote Australia</td>
</tr>
<tr>
<td>30</td>
<td>A new tool for diagnosing acute rheumatic fever</td>
</tr>
<tr>
<td>32</td>
<td>WeCare: financial support for families of children with cancer</td>
</tr>
<tr>
<td>34</td>
<td>Educational needs of students on the autism spectrum</td>
</tr>
<tr>
<td>36</td>
<td>A new way forward for country kids</td>
</tr>
<tr>
<td>38</td>
<td>Caring for Country Kids Conference - Registration Now Open!</td>
</tr>
<tr>
<td>39</td>
<td>Tackling trachoma</td>
</tr>
<tr>
<td>40</td>
<td>Eye care for Indigenous Australia</td>
</tr>
<tr>
<td>42</td>
<td>Suffer the country</td>
</tr>
<tr>
<td>43</td>
<td><em>Friends</em> welcomes a new committee</td>
</tr>
<tr>
<td>44</td>
<td>Filling the gap</td>
</tr>
<tr>
<td>46</td>
<td>RACGP rural general practice awards</td>
</tr>
<tr>
<td>48</td>
<td>Awards support rural health research and leadership</td>
</tr>
<tr>
<td>49</td>
<td>Addressing domestic violence in rural and remote Australia</td>
</tr>
<tr>
<td>50</td>
<td>Online mental health resources for Indigenous people</td>
</tr>
<tr>
<td>51</td>
<td>SANE Australia Peer Health Coaching Program</td>
</tr>
<tr>
<td>52</td>
<td>Sharing information about Aboriginal and Torres Strait Islander healing</td>
</tr>
<tr>
<td>54</td>
<td>The Weenthunga Health Network</td>
</tr>
</tbody>
</table>
With much public attention being given to the transition to a Coalition Government under Malcolm Turnbull, people in rural and remote parts of Australia may be asking where they stand in the new constellation.

Rural health and wellbeing interests may be reassured by the fact that Sussan Ley, the Senior Minister, Fiona Nash, Minister for Rural Health, and Ken Wyatt, Assistant Minister with responsibility for aged care, are all people with lived experience of life in more remote areas of the nation.

However a number of things stand between their lived experience and their aspirations and action to improve things on the ground in remote and rural areas.

First, the Government is pleading penury and, despite the growing chorus to act, seems reluctant to make major changes to fiscal policy such as adjustments to tax concessions for superannuation, housing investment and the energy sector, and changes to the GST. This means that there is grave pressure on existing expenditures in health, community and aged care. The National Disability Insurance Scheme thankfully has bipartisan support and there is still the hope and possibility that the same might apply to the national government’s efforts to close the gap in Indigenous health and wellbeing.¹

For as long as the Government remains unwilling on the matter of reform of the taxation and tax concession systems, the mantra will be “There is no new money”. The emphasis within the health and aged care sectors will therefore be on reallocation. But that is a slow process, with the pattern of expenditure on the big ticket items – the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme - hostage to numerous powerful interests and a pedestrian approach to generating evidence about under-performance or misallocation.

¹ as we go to press Minister Nash has launched the long-awaited Implementation Plan to help Close the Gap.
This means, among other things, that Australians will continue to pay, by international standards, a high and possibly increasing proportion of their health care costs from their own pockets.

It means that there must be doubts about the speed at which the recommendations from the Mental Health Commission, some of which would be most beneficial to people with poor mental health in rural and remote areas, can be adopted.

It also means that the much-needed and previously-promised additional resources for public dental health services (under the National Partnership Agreement on Public Dental Services) may be in jeopardy.

It is to be hoped that this is not the case. Australian adults have terrible dental health by international standards, which impinges on other health conditions, and most of which is entirely preventable. This approach reflects an unfortunate mindset that sees all outlays as costs rather than investments. A more discerning approach would benefit us all in the long run.

Finally, the perception of fiscal pressure will be used as the main rationale for significant savings targets against the 14 Flexible Funds which provide front-line services and secretariat support to peak organisations.

Some of these major contextual policy issues are being dealt with by the strategic work in the health portfolio. The premise for the review of the MBS is that it is desirable to reallocate resources from lower to higher value interventions and practices. The work of the Primary Health Care Advisory Group, led by Steve Hambleton, is the best bet where a more flexible model for primary care is concerned - one that would be less focused on fee-for-service medicine.

All of these high-level national developments are of great importance to the daily experiences of the patients of doctors and psychologists, of hospitals and residential aged care facilities, and of maternity, alcohol and other drugs and community mental health services.

Prime Minister Turnbull is hopefully acutely aware of the particular characteristics and needs of country communities where all of these issues are concerned. People in rural and remote areas report higher levels of happiness than their cousins in the major cities. But, on the contrary and on their behalf, statisticians report a whole raft of greater social and economic disadvantages and health risk factors experienced by people in rural and remote areas.

These people need and are just as capable of developing the new industries and jobs of the future as people in the major cities. Or maybe more: agriculture has been losing jobs for decades and the mining sector having ‘come off’ means fewer
‘traditional’ jobs in rural and remote areas.

There are industry and employment opportunities that uniquely exist in rural and remote areas. There is carbon sequestration, sunshine, wind, and waves. There is Exmouth, Uluru, the Flinders Ranges, green Tasmania and the Great Barrier Reef. There is infrastructure to be maintained and built - including for telecommunications. There is Indigenous culture and untapped artistic and creative capabilities. There are innovative, adaptive and resilient people. And there is additional employment required in the education, health, aged care and disability sectors for rural people.

We are strong. We are productive. With the basic prerequisites like education, health, work and fresh food we are happy. And we are nearly seven million people. Prime Minister, please don’t forget us.

“We are strong. We are productive. With the basic prerequisites like education, health, work and fresh food we are happy. And we are nearly seven million people. Prime Minister, please don’t forget us.”
Ask yourself these questions:

• Does poverty increase your risk of becoming sick?
• Does your occupation influence your health?
• Does your educational background affect your chances for a long and healthy life?
• Do people living in a small rural town have the same opportunities for income, occupation and education as those living in a large city like Sydney?

Answers: yes; yes; yes; and almost certainly no.

Where we live does affect our health – but the reasons are complex.

We know that health professionals are in short supply in rural, and especially remote, areas, and that this affects our ability to manage our health and to access diagnosis and treatment.

But what is less appreciated is that the fundamental causes of ill health lie elsewhere - not in the health sector at all.

The British Academy suggests that only 20 per cent of our experience of health is influenced by our access to health professionals. The other 80 per cent is a consequence of factors like our environment, our risk factor profile (whether we smoke, exercise etc.) and the social determinants of health (such as our level of education, what sort of job we have, and our social interactions).
We sometimes hear commentators arguing that health in rural and remote areas is worse than in Australia’s major cities not because of where people live, but because of rural people’s lower levels of education and lower incomes, poorer access to health services, and higher health risk factors.

All these observations are at least superficially true. But they miss a vital point: the physical characteristics of ‘place’ affect levels of education, income and access to services, and they also affect the likelihood of being a smoker and being overweight.

Obviously, the health of people living in rural areas is not uniform. There are many rural places where people have good health and there are many healthy rural people; but there are also places where things are not so good. It is on average that the health of people living in rural areas is worse than that of people living in Australia’s major cities.

So how does the physical nature of a rural town influence jobs and incomes? The answer is that there are not many jobs in rural towns managing major corporations, nor for academics, scientists, orthopaedic surgeons or senior public servants. While there will be a small number of jobs for some professionals and managers, the majority of available jobs are in transport, retail, labouring, service, trades, tourism, agriculture and other primary industries. These tend to be occupations which either pay modestly and/or which may not require substantial levels of education.

In addition, income from these sorts of occupations in rural areas may suffer a degree of uncertainty, either based on the quality of the season, or because of the relatively small nature of the local economy. This mix of lower income, lower educational level and lower levels of control over one’s income all affect health negatively.

On the other hand, work by the Melbourne Institute provides proof of what many of us intuitively know: that people living in rural towns have substantially greater life satisfaction compared with people living in large cities. In fact the effect is so large that the improvement in life satisfaction from living in a small rural town is greater than if you were to move from the poorest to the wealthiest city suburb.

So, are there a range of health benefits to living in rural areas which work against the often-cited health disadvantages? How do we minimise the effect of the health disadvantages of rural living while maximising the advantages?

It’s time we started to understand what really drives rural health. Only by understanding can we address the challenges, advance the health of our Indigenous people living in rural and remote areas, and further enhance and celebrate the health benefits associated with living in those areas.

Andrew Phillips
National Rural Health Alliance
Delegates to the 13th National Rural Health Conference in May 2015 who took the bus trip to Bagot were rewarded with a special experience of the Out of School Hours Care program. Artwork exploding off the walls and exuberant children demonstrated that the Bagot community is full of life.

This year, with the valued assistance of Child Australia and the Out of School Hours Care Program, the Bagot community has begun a large-scale painting project led by Larrakia artist Dotty Fejo and Roper River artist Les Huddleston working with urban street artist, Andrew Bourke (Komplex Graphix). The Painting Home Project will harness the imaginations of young and old and bring together traditional and contemporary art styles to animate the Bagot community as a place of hope. Local artists Anna Weekes, Dotti Fejo (Dotty’s niece), David Collins and Jesse Bell are also working on the project.

For Bagot residents the notion of ‘home’ is a powerful subject because the place they call home has a contested history that has been shaped by the political forces of colonisation. Bagot was cleared and constructed by the Aboriginal people from the Kahlin Compound in 1937. Occupied by the Australian military during World War 2, Bagot was restored as an Aboriginal reserve by 1948. Throughout its history Bagot has been regarded variously as a place in need of development, a place for ‘long-grassers’ (itinerant visitors), or a place of ill health and trouble.

In recent years, through local initiatives such as the Out of School Hours Care program and the Bagot Festival, Bagot has been developing a new community spirit. The Painting Home project takes as its starting point the proposition that good health begins with housing and that this is the platform for physical, cognitive and social health and development.

In Painting Home, the artists work collectively with the residents to re-imagine their home (their house; their street) as a canvas for a large
scale painting to tell a story - their story - to the world. The Painting Home Project is working with the residents of Bagot community to create artworks of enduring value that reflect the pride residents feel about the place where they live.

Additionally, the project will include an online interactive digital archive that documents the history of Bagot. The archive will show the events, places, family names, houses, languages, leaders, families, playgrounds and totem animals which are culturally significant for those who call Bagot home.

The Painting Home Project is auspiced by Child Australia and has been assisted by the Australian Government through the Australia Council, its arts funding and advisory body.

Kieren Sanderson
Creative Producer and Community Facilitator, Painting Home Project

“The Painting Home Project will harness the imaginations of young and old and bring together traditional and contemporary art styles to animate the Bagot community as a place of hope.”
Despite rumours that I moved to Tasmania to retire, the past 18 months have seen me working and enjoying a variety of clinical experiences. I have joined that roving band of 60-plus-year-old rural doctors who now have the freedom to work in a form of medicine they were trained for and can re-explore.

I have worked in rural and remote communities in three Australian States and have gained an understanding of the similarities and differences across the rural health landscape. We all know the statistics of rural disadvantage, and the past year has enabled me to contemplate what makes rural medicine tick despite them.

Prior to the slump in mineral prices, the Pilbara in Western Australia provided an example of a well-equipped rural hospital. But mining towns have their own unique profiles and problems. Affluence amidst rural disadvantage often results in a two-tiered health service where only the well-off can afford to see a private GP, with a resultant impost on hospital emergency services.

The Kimberley is an amazing and beautiful place. However, I found working in the remote hospital and outreach clinics around Fitzroy Crossing rewarding but often sad and challenging, despite having worked in North Queensland Indigenous communities with similar issues. The burden of grief that comes from social disadvantage and cultural dislocation was disturbing. Alcohol and drug abuse issues, especially in young adults, permeate the society and result in a mixture of anger and futility. The community elders who preserve their cultural identity struggle with the day-to-day impact of such sadness. The staff in the hospital are keen and friendly, and they deal with everything that comes their way with calmness and professionalism.

The wildness and beauty of Tasmania, my new home state, are beyond doubt, but the State’s health system is struggling. The rural doctors and nurses may be dedicated and committed, but their facilities lack equipment and investment. This has resulted in a deskilling of the rural health workforce and a more negative attitude towards community health in rural areas.

To date, the response to poor services and planning has been to replace rural services with a long patient commute to one of the four major hospitals. Unfortunately, very little appears to be on offer in the State Government’s recent Health White Paper to improve rural facilities and the health of the rural population in Tasmania.

Forty years of working and travelling in Queensland has provided me with first-hand experience of most of the State’s rural and remote towns. In the 60s and 70s, rural health services had deteriorated to the extent that rural medicine did not provide an attractive
career option to newly graduated doctors. Large numbers of incumbent rural doctors had aged and were tired and burnt out. Facilities were ageing and services diminished.

All this started to change in the 90s and the ‘noughties’. Much of this was due to an enlightened approach from a few State Health Ministers who had a longer-term vision and an understanding that investment in rural health was a priority which should be outside of party politics. The emergence of initiatives such as Rural Health Student Clubs, University Departments of Rural and Remote Health, Rural Intern and Junior Doctor placements and the Rural Generalist training program were significant contributing factors.

The result is that over the past ten years, birthing services have been restored to eight rural communities and by 2020 there will 400 graduates providing rural Queensland with highly skilled and motivated young medical practitioners.

So there are some bright spots on the horizon. But the Australian health system is unnecessarily complicated. There are too many bolt-holes which allow Governments to avoid their responsibilities, especially to rural communities. The disparities persist. Rural communities deserve better.

Dennis Pashen
Rural Doctors Association of Australia
On Monday 22 September 2014 Council of the NRHA was taking the case for improved health and wellbeing to Parliament House in Canberra. Suddenly that was the first day of heightened security measures in and around the House. We found it hard to get in. But friends ‘on the inside’ finally prevailed.

We celebrated our entry with a Press Release.

Perhaps the highlight of the positions we took to Parliamentarians that year was this reminder from New England, NSW:

“Telehealth should be seen as an adjunct to local services, not an adequate or sensible replacement for them. Telehealth cannot get a snake out of your washing machine’s water intake.”

This year we were in the House on Monday 15 September. Everything seemed pretty normal. That was until a small number of Coalition Members and Senators we were meeting with after Question Time upped and left us with uncharacteristic abruptness. With the benefit of hindsight we believe that some of them went a little pale.

Malcolm Turnbull celebrated his entry with a Press Conference.

There is now a rejoined and rather encouraging battle of ideas: Liberal v National v Labor v Green; Left v Centre v Right.

And tax reform is squarely on the agenda - including the GST. As discussed in the Editorial, this promises to release some of the pressure on savings on the expenditure side of the ledger. Despite the good health overall enjoyed by Australians, there is no shortage of ideas about how our health system can be improved. This requires government monies to be available for new models of care to be tested and applied, without the need beforehand for commensurate savings elsewhere in the health portfolio.

This is not to say that a greater proportion of GDP needs to be spent
on health. But a certain amount of new money is required for changes to be effected. In the medium term money may be saved by closing down policies and programs that are not as effective as the new ones.

It’s rather like unemployment. In some ways it would be good to have zero unemployment - no-one actively seeking work. But the result would be damaging inflexibility in the structure of the economy, with no labour force readily available for new industries and start-ups. So the level of unemployment deemed desirable because of the economic or sectoral flexibility it supports is 2%-3%, not zero.

As well as the financial resources needed to trial and launch new policies, there are also some key areas of health which are crying out for additional funds. This edition of Partyline includes an article on the parlous but avoidable situation relating to oral and dental health in Australia, particularly for its rural and remote people. And mental health and the National Disability Insurance Scheme are two other areas where the need for and likely returns to further investment are clear.

And what, you might ask, was the 2015 equivalent of ‘the snake in the washing machine’ of 2014? There was nothing quite so colourful, but we discussed a number of very important issues.

They included the importance of high-speed broadband for distance education. Telstra has a new package to allow unlimited downloads from 38 educational websites. (Are other providers following suit?)

There was also the matter of rural health workforce scholarships. Six of the medical, nursing and allied health scholarships in the Health portfolio “will be streamlined to increase consistency and fairness, reduce costs and administrative overheads and improve agility to respond to changes in supply and demand for particular parts of the health workforce”.

It seems likely that there will need to be special consideration of the pressing need for continuing professional development in rural and remote areas.

And Parliamentarians took a strong interest in the situation relating to small maternity units (defined as those with up to 100 births a year). 209 such units were closed in the nineteen years to 2011. Not surprisingly, this has resulted in a significant increase in the number of babies born before arrival at hospital - and not just in rural and remote areas.

Another gross rural-metro inequity exists where health research is concerned. In its 2011-12 Annual Report, the NHMRC reports that over $1 billion was allocated to medical research through its various grant schemes. Expenditure for rural and remote research in that year was about $7 million - or 0.6% of the total.

We’re not getting a fair share. Except for snakes.

Gordon Gregory
National Rural Health Alliance
THE COST OF CARING

As we contemplate our increasing lifespans, so too might we consider the financial and personal cost to our family or other loved ones who may end up caring for us at home.

According to a 2012 Australian Bureau of Statistics report, there are 2.7 million at-home carers in Australia looking after the most vulnerable in our society, including approximately 140,000 people who need help with bladder or bowel control.

We know the care needs of people with incontinence are much higher than those of others needing care. At-home carers living in remote and rural communities are further disadvantaged, often having to contend with physical isolation, fewer services and the large distances involved in accessing these services.

The 2009 Australian Institute of Health and Welfare report, *Incontinence in Australia*, revealed there were nearly 73,000 primary carers looking after people with severe incontinence; the majority of the carers were female (81 per cent), most spending 40 or more hours each week caring, and more having their sleep interrupted (42 per cent) than other primary carers (19 per cent).

There’s also a financial cost; Deloitte Access Economics has estimated that the productivity loss to people who work unpaid as carers of people with incontinence is $2.7 billion annually.

And of course there’s an emotional cost; we know these carers are twice as likely to report stress-related illnesses as other carers.

To draw attention to the plight of carers of people with incontinence, the Continence Foundation of Australia launched a national campaign, *Tell someone who cares*, during World Continence Week (June 22-28).

The campaign, supported by Carers Australia, launched new resources for carers of people with incontinence, including a carer guidebook, dedicated web pages and short videos on the Continence Foundation website. The new resources also outline the available support services, including the National Continence Helpline, which can assist with information and referrals to health and support services.
The Continence Foundation’s chief executive Barry Cahill said support and recognition for the extraordinary contribution carers made to society was long overdue.

“If we want people to be cared for in their own homes longer, then carers need to be better supported through resources and education, preparing people for the challenges they face and reassuring them help is available,” Mr Cahill said.

Carers Australia’s chief executive Ara Cresswell said involvement with the Continence Foundation’s campaign would have ongoing benefits for carers.

“Providing unpaid family and friend carers with information and practical advice can be vital to ensuring the sustainability of the caring relationship and to the health and wellbeing of both the carer and the person they care for,” Ms Cresswell said.

Carers and health professionals living in rural and remote regions can phone the National Continence Helpline (1800 33 00 66), which is staffed 8am-8pm (AEST) Monday to Friday by continence nurse advisors who can provide advice, referrals and resources to consumers, carers and health professionals. Further information is also available at continence.org.au

Author: Maria Whitmore
Continence Australia

**USING DATA TO INFORM AND IMPROVE PUBLIC HEALTH POLICY**

Issue 4 of *Public Health Research & Practice* (www.phrp.com.au) is out now, with a focus on Big Data and how it can be harnessed to improve health service delivery and population health.

*Public Health Research & Practice* is Australia’s first online-only open access peer-reviewed public health journal and has a strong focus on the connection between research, policy and practice.

This issue takes a broad look at the burgeoning availability and analysis of routinely collected data, and how best to use it to inform and improve public health policy and practice, and the health of our communities.

You can subscribe at www.phrp.com.au and follow us on Twitter @phrpjournal

Megan Howe
Sax Institute
The Carers NT Remote Program is giving respite and support for carers living in remote areas across the Top End and Katherine region - an area which includes more than 33 communities.

Carers NT is a not-for-profit organisation dedicated to improving the quality of life for carers of the Northern Territory: those people who provide unpaid care and support to family members and friends who are living with a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue, or who are frail.

Carers NT Remote Program offers flexible, culturally appropriate respite for carers in their own community and addresses some of the needs around respite for carers in our remote Indigenous communities. The support includes urban respite in Darwin and Katherine and residential respite for carers who are from remote communities. This is done through respite camps and the Carers NT troop carriers (‘Troopies’) giving the carers a break from their caring role.

The Program is also able to give respite and support for families caring for a person with mental health issues. It provides training and education in the community around mental health and supports community members to attend conferences and information sessions in Darwin and beyond.

There are many factors to take into account when considering respite options for our carers.

Residential respite in a major centre like Darwin or Katherine can have drawbacks for care recipients from remote communities. Being away from country may not be suitable for frail/aged recipients. This often means that respite doesn’t happen at all and there is no break from the caring role for the carer. Recipients who do go into residential respite often speak of being
lonely away from country and family. There can be huge distances to travel by bus, vehicle or plane, depending on available resources.

The Carers NT Troopy and the Mental Health Troopy programs give some control and self determination to remote carers and their communities. The programs are managed on community by a local service provider and usually have a community member heavily involved in the coordination of the program in their community. Eligible carers are able to make use of the fully funded Troopy to enjoy respite of their own choice, for example bush camping, hunting, fishing, ceremony, a visit to country or a visit to family.

There is also a small budget for each Troopy outing; enough to buy provisions such as bait, bread and bully beef. The Mental Health Troopy program specifically targets carers of people who have a mental illness. The Troopy programs are very well received and highly regarded in our communities.

The Remote Respite Camp program is a solar powered, tent-style nursing home in the bush. We cater for up to nine low care, frail aged care recipients for ten days at a time. Camp locations are chosen after consultation with relevant stakeholders, carers and recipients from the community to maintain equity and access to services. The camp is set up nearby to the community (around ten minutes' drive maximum); close enough to be able to return to the clinic in an emergency but far enough away to avoid any humbugging of the care recipients. This year we have been moving towards a new model in staffing our camps by subcontracting a local aged care worker from the community as our third support worker on camps. This results in further culturally enhanced respite for our recipients.

For more information about the remote program and the services available contact the Remote Team at Carers NT on 1800 242 636 or email on carersnt@carersnt.asn.au

Sheena Baillie
Carers NT

“The Carers NT Troopy and the Mental Health Troopy programs give some control and self determination to remote carers and their communities.”
Radiation therapy is an indispensable element of cancer treatment. Radiation therapy can be utilised as a curative or palliative treatment, for tumour control or for symptom management. For certain types of cancer, evidence-based best practice treatment involves a combination of chemotherapy, surgery and radiation therapy. It is estimated that in excess of 52 per cent of patients diagnosed with cancer would benefit from radiation therapy but, for a variety of reasons, only 38 per cent of patients receive it.

Radiation therapy facilities require highly specialised, expensive equipment and highly trained staff including radiation oncologists, radiation therapists, medical physicists, nursing staff, administration staff, and allied health professionals. Radiation therapy centres are predominantly located in capital cities and some larger regional centres. Many rural Australians live hundreds of kilometres from a radiation therapy centre. Some types of cancer are more prevalent and often are detected at a more advanced stage in rural areas than in urban areas. The fact that a smaller proportion of rural patients receive radiation therapy contributes to poorer clinical outcomes for rural cancer patients.

Radiation therapy commonly involves a course of treatments administered each weekday for several weeks. Because of this intensive and extended treatment regime, radiation therapy can be a logistically daunting option for some rural patients. Studies have shown that rural women with breast cancer are less likely to undergo radiation therapy, due in part to the need to relocate for the duration of their treatment. Patients may have to consider the personal cost of relocation, and the impact on family commitments. Other patients experience difficulty retaining employment or accessing leave, and this may also apply to spouses/carers. Cultural reasons may also contribute to people being reluctant to leave their homes to access radiation therapy.

"Planning for the future must consider the increasing demand for radiation therapy, rational justification of where to locate services and how to ensure there is an adequate workforce."
Government subsidies are available to assist with travel and accommodation costs, but these are often complicated to claim, differ from State to State and are financially inadequate. Patients may be left thousands of dollars out of pocket after radiation therapy treatment.

Accessibility to radiation therapy services may be complicated by whether a centre is a public or private facility. Additionally, waiting lists can exacerbate access issues. Smaller centres may operate only single radiation therapy machines, which impacts on bookings and patient care if the machine is out of service. In urban areas, these issues can be overcome by transferring patients between facilities, but these solutions may not be available in rural areas.

Planning for the future must consider the increasing demand for radiation therapy, rational justification of where to locate services and how to ensure there is an adequate workforce.

The Regional Cancer Centre initiative was launched in 2009 with $560 million of Commonwealth funding. In Northeast Victoria this program has helped with the development of the Albury Wodonga Regional Cancer Centre. Currently, the radiation therapy facility in our region is a private service in Wodonga. The nearest public radiation therapy services are in Melbourne or Bendigo (over 200 kilometres away). It is hoped that the Regional Cancer Centres will address many of the barriers to equitable access to radiation therapy for rural people, and assist in improving health outcomes.

Kristen Glenister,
*University of Melbourne*
*Department of Rural Health,*
*Maggie Ray and Jodie Finlayson*
Health care in rural and remote communities in Queensland is now more accessible than ever, thanks to a record number of Outreach health services that were delivered over the last year. The Outreach program is funded through the Commonwealth Department of Health and aims to deliver vital health services to people living in rural and remote areas of Australia who frequently don’t have access to specialised care.

In Queensland, the Outreach program is coordinated by CheckUP, in partnership with the Queensland Aboriginal and Islander Health Council, and both organisations are working hard to ensure that health services are being delivered in those areas of the State that need them most. A health needs assessment survey is conducted annually and regional planning and coordination committees, which are comprised of local health providers, meet quarterly in each of the six Queensland regions to discuss and plan for the delivery of Outreach services in their region.

In the last twelve months there were almost 13,000 visits by Outreach health providers to towns and communities throughout Queensland and a total of 123,000 consultations were undertaken. Almost 70 per cent of these consultations (85,000) were delivered to Aboriginal and Torres
 Strait Islander people in a concerted effort to help address the vast health and life-expectation inequality between Indigenous and non-Indigenous Australians.

Almost $2 million has been invested in the Central Queensland region and 13,000 consultations have been provided there over the past 12 months. The Outreach Regional Coordinator in Central Queensland, Anita Williams, said: “The Outreach services delivered in Central Queensland supplement the local health services that are available; more medical procedures can now be delivered locally and this means fewer trips to Brisbane for patients”.

Over the next 12 months, even more services will be delivered in rural and remote areas of Queensland, with an emphasis on those conditions identified through the local planning processes – diabetes, mental health, cardiovascular disease and chronic disease management.

One of the health providers who will be delivering health services in the Central Queensland region over the next 12 months is paediatrician, Dr Tommy Tran. Tommy began providing Outreach services in 2013 and particularly enjoys travelling to the smaller communities to deliver health care. He runs a private practice in Brisbane but is spending more and more time in rural medicine.

“I’ve really cut down on my private practice time. I used to work there full-time but I’ve dropped it down to about one and a half to two days a week and I hope to fill the rest of my time with my Outreach services,” he said.

Tommy says the service has been welcomed by the community. “In areas like Central Queensland, where there are difficulties accessing specialists, the local people are very appreciative of the services,” he said.

“I get a tremendous amount of job satisfaction because a lot of people have trouble accessing services and being able to provide services for the kids in their home town is really great.”

For more information about the Outreach program in Queensland, visit www.checkup.org.au/outreach

Outreach paediatrician Dr Tommy Tran

David Millichap
CheckUP
The National Rural Health Alliance is undertaking a project looking at issues of food security in rural and remote communities. Food security isn’t about terrorism. It is about ensuring that people have access to affordable, nutritious food and are able to make healthy, nutritious meals. Importantly, it is about making sure that this food is available all the time.

The Alliance is exploring:

- the cost of fresh food, including fresh fruit and vegetables;
- how regularly fresh food is available – continually or only for a short time after delivery;
- whether the store is handy to where people live; and
- the impact of these issues on the health and wellbeing of people in rural and remote communities.

Australia produces over 90 per cent of the food we eat - and it exports even more. But despite producing such a huge volume of food, there are parts of Australia where fresh food is not available at a price that everyone can afford. The Alliance will be examining what can be done to improve this situation. Possible options might be to support community gardens; identify problems in the food supply chain; and look at the need for policy responses, including whether fresh food needs subsidy and if so, in what circumstances.

Having access to fresh, nutritious food is one of the bases of a healthy diet. Eating a healthy diet is vital to improving health and wellbeing and reducing both the incidence and the impact of chronic diseases. The project will produce a discussion paper in early 2016 which will be circulated widely seeking views and opinions. That feedback will then be incorporated into a report to governments setting out the nature of the challenges and suggested responses to support better food and better health in rural and remote communities.

Fiona Brooke
National Rural Health Alliance
Between July and November 2015 the National Rural Health Alliance hosted 10 one-day roundtables across Australia (as foreshadowed in Partyline No. 53) to discuss the provision of Continuing Professional Development (CPD) in rural and remote areas and what the role of the new Primary Health Networks (PHNs) might be in the area.

These consultations have demonstrated the number of bodies involved in providing and seeking CPD and the critical importance of ensuring that CPD is available when and where it is needed. Representatives of PHNs, universities, professional organisations, private/public training providers and individual health professionals have all agreed that there must be new collaborative and cooperative arrangements for improved access to CPD.

Participants have indicated their appreciation for the role played over the past five years by Stream 2 of the Rural Health Continuing Education (RHCE2) program, and are anxious about the gap in rural CPD that will be left when it ends in December 2015.

A selection of RHCE2 funded projects was showcased at the roundtables to demonstrate how valuable CPD is for rural and remote health professionals, and the benefits and opportunities of undertaking inter-professional learning and working in multidisciplinary teams.

Extensive discussions explored what is happening in each jurisdiction, how CPD issues need to be addressed to meet local workforce needs, who will be involved in the future, and how CPD could be funded.

The Alliance is now investigating options for continued work on the issue.

To facilitate continuing access to CPD resources developed by projects funded by RHCE2, the Alliance is collecting information from project personnel for the Intellectual Property register being prepared for the Department of Health.

If you wish to add to our stories and ideas, contact me at wendy@ruralhealth.org.au or phone 02 6162 3374.

Wendy Downs
National Rural Health Alliance
Osteopaths in remote and rural locations around Australia are crying out for Associates to work with them in some of the country’s most desirable destinations. The biggest selling point for living and working in the country is the ease of becoming an integral and valued part of the community, whether that’s through work, family life, sport or hobbies.

Anthony Rogan, Ballarat, Victoria

Anthony Rogan’s first child, Sol, was born during Anthony’s final year of study in 2000. It prompted him and his partner, Lisa, to buy 20 acres and a house 20 minutes north-east of Ballarat in Victoria.

“We planted hundreds of trees, a large orchard, a vegetable garden and reared sheep. It was very affordable and gave us lots of space to bring up our boys (Felix arrived in 2003). Having our kids grow up surrounded by nature was important to us and they loved it,” he says.

Anthony and Lisa have since moved into Ballarat for convenience now that the boys are doing so many extracurricular activities.

Ballarat is a strong sporting town with a huge variety of choice, which means that Anthony is able to indulge his love of mountain biking and the boys get to try many different sports. There’s also a strong music and arts community.

In his work Anthony sees a large diversity of patients and problems, treating babies through to his oldest patient who is 91.

“Osteopathy is still relatively unknown in Ballarat and I find there is a constant need to educate the public and other health professionals about how we can help people,” he says. “More osteopaths and clinics in town would be a great boost to the profile of osteopathy here – there is no shortage of patients and only two clinics.”

“Having our kids grow up surrounded by nature was important to us and they loved it”
Anthony’s clinic, Eureka Osteo, is prospering. The affordability of housing has seen an influx of Melburnians, many of whom have seen osteopaths before. Long term Ballarat residents are also now more familiar with the benefits of osteopathy, although continuing to raise the profession’s profile among the community and other health care professionals requires persistence.

Eve Schoenheimer,
Byron Bay, New South Wales

Eve Schoenheimer grew up in the outer suburbs of Melbourne which, she says, was natural bushland at the time. She credits this experience as helping her make the decision to move to Byron Bay.

“I love the sea. I moved to Bondi, in Sydney, after living overseas for five years, and now that I’m in Byron Bay I can’t imagine not living by the sea,” she says. “I always thought about moving out of the city to some place beautiful.”

Eve says that Byron Bay has its positives and negatives, but that it’s such a beautiful place it’s hard to beat.

“Word of mouth spreads like wildfire, so I built a busy practice very quickly when I first came here and that continues. In my experience people in small towns are more relaxed and friendly than in the city,” she says.

The refreshing part about treating patients in rural areas is that they’re actually there to get better. Eve says that they’re willing to take responsibility for their own health and follow through on instructions and treatment, as well as address their health on other levels such as multi-modality, diet and exercise.

Irina Aristova
Osteopathy Australia

“Word of mouth spreads like wildfire, so I built a busy practice very quickly”
A clinical trial of evidence-based online education for people with chronic pain is improving access to essential information in rural and remote Australia.

In its first three years the Pain Course delivered by the Macquarie University’s online eCentreClinic, has been completed by more than 700 people.

On average, participants have lived with chronic pain for between eight and nine years, with a pain score of between six and seven out of ten and pain in multiple areas – people for whom travel to appointments may be a burden.

“The Pain Course is a really convenient option for people outside urban centres, and those for whom accessing support outside the home may be difficult due to pain-related disability,” said Co-Director Dr Blake Dear.

“For those who are unsure about which health professional to approach, it is a safe first step, with clinicians ready to suggest appropriate local support.”

Intended to work alongside pain clinics and allied health services rather than replace them, the Pain Course is also being used as a refresher course, with about 50 per cent of participants having previously undertaken an education course through a pain clinic.

“Face-to-face specialist pain management clinics are essential for a lot of people, but not everyone needs to go there,” said Blake.

“What’s really exciting is that we are now getting GPs and specialists referring patients to the Pain Course for the non-medical aspect of pain management.”

Acknowledging that not everyone can access education online, there is also a Pain Course Workbook under development, which is being trialled with about 170 participants.

“It’s very easy to think everyone has a good computer and the Internet, but that’s not the case,” said Blake.

Based in Cognitive Behavioural Therapy, the Pain Course is designed to teach people about chronic pain and how to manage it, in order to improve physical function and emotional wellbeing.

The online course is delivered as five lessons over eight weeks and is
designed so that participants can work through it at their own pace.

Currently, different models are being trialled, from self-guided only to 60 minutes of clinician support with a Clinical Psychologist.

With a 12-month follow-up just completed and a 24-month follow-up of 470 people underway, the results are promising.

Outcomes are consistent with the original trial of the Pain Course, published in the journal *Pain*, which revealed significantly greater improvements in participants’ reported disability, anxiety and depression. More than 90 per cent of participants reported they would recommend it.

The 24-month results will help further tweak the online program, before transitioning it to the Federal Government-funded Mindspot Clinic, where it will be given a more permanent home and offered every month.

Participant feedback is currently helping to identify those conditions and circumstances that do not benefit from the Pain Course, in order to encourage those people into a face-to-face program.

“It’s not a panacea but everyone acknowledges there is a need to improve access to pain management education. With limited budgets and a vast country to cover, the Pain Course is a really encouraging piece of the puzzle,” said Blake.

Linda Baraciolli
*Pain Australia*
Preventable acute rheumatic fever (ARF) and rheumatic heart disease (RHD) continue to affect Indigenous communities in Australia due largely to social disadvantage. Timely and accurate diagnosis of ARF is a key factor in improving patient outcomes but identifying these diseases can be tricky, especially for health professionals who have little previous exposure to, or knowledge of, the illnesses.

In response to data and feedback from clinicians, RHDAustralia has recently released the ARF diagnosis calculator to assist clinicians with this complex diagnosis. The calculator is an update to the existing app version of the Australian Guideline for Prevention, Diagnosis and Management of ARF/RHD (2nd Edition).

Dr Anna Ralph is a specialist in infectious diseases and general medicine at the Royal Darwin Hospital, and was a medical advisor in the development of the calculator. Anna said of her experience in diagnosing ARF:

“The thing is that there is no definitive diagnostic test. The only way to diagnose ARF is to put together a whole constellation of signs and symptoms to see if a patient has the disease.”

RHDAustralia’s Christian James explains the impetus behind the initiative.

“It is particularly useful for doctors who are not experienced with the disease - and there are many of us.”

“The majority of cases are diagnosed in rural or remote locations away from specialist staff, so this project was designed to take the complex diagnosis and translate it into a simple, easy to use product that any clinician can employ in any environment,” he says.

“Due to the difficulty in diagnosis and disease awareness, many cases can potentially be under-diagnosed; patients who should be referred for specialist investigation can potentially be sent home”.

PHOTO: RHDAUSTRALIA
Anna adds:

“If the diagnosis is missed it’s a lost opportunity to prevent disease progression… you miss the window for regular penicillin injections, follow-ups with specialists and other interventions that improve outcomes for children and young people with ARF… I think this is the way forward.”

“Smart devices are becoming more widely used. For a complex disease like this where there is no specific test, we rely on complex algorithms. Apps such as this one from RHDAustralia put the algorithm into a simple form. It’s free and easy to use – without compromising on depth.”

After a rigorous testing phase, the updated app was released in September and is already being used by over 3,400 clinicians. Feedback on using the calculator in practice has been positive. Jessica Sommers, an intern at Royal Darwin Hospital, trained at the University of Western Australia in Perth. Jess had been taught about ARF in medical school but until moving to Darwin this year had never seen a case of ARF or RHD. She has since made regular use of the app.

“It is particularly useful for doctors who are not experienced with the disease - and there are many of us. Two particular cases come to mind. In both cases we suspected ARF but had other differential diagnoses, which we were not confident to exclude with certainty. I whipped out my diagnosis app and it revealed definite ARF for both cases. I also used the app to determine what exactly needed to be done, including liaising with the community clinic, the closest hospital, and the RHD registry in Broome.”

For more information and to download the free app go to RHDAustralia’s website at rhdaustralia.org.au

Catherine Halkon and Christian James
RHDAustralia
When Peter lost his job five months ago it came as an unexpected blow. Without qualifications and with minimal factory experience, Peter’s job prospects were limited. He’d been receiving Newstart payments while his partner, Stephanie, studied and received Austudy when their seven year old daughter, Alicia, was diagnosed with neuroblastoma.

The complex medical services the family needed were not available in their rural Queensland town, so arrangements were made for Stephanie and Alicia to travel to and stay in Brisbane to attend appointments and access the treatment Alicia needed. Stephanie suspended her studies and Peter stayed at home to care for their other three children aged 11, five and two.

Managing the costs of phone calls, food and accommodation, as well as the additional cost for the rest of the family to travel every week to visit Stephanie and Alicia, soon put a strain on the family’s finances. Within a couple of months bills began to mount up and they fell behind on their mortgage repayments. Peter became extremely stressed about his inability to find long-term work and the children were struggling to cope with the absence of their mother and sister.
Stephanie’s parents stepped in and offered to pay their mortgage for three months, which took some pressure off in the short term. Peter found some temporary work two days a week, but to be able to take it, had to pay for childcare for their two year old son. Alicia’s treatments would go on for several months and the family would have to continue to cover the cost of Stephanie and Alicia living away from home during that time.

This is not an uncommon story. When a child or young person is diagnosed with cancer it can have an enormous impact on any family’s financial circumstances, even more so for rural families. Often one parent must live-in at the hospital, while the other remains at home juggling work, childcare and other family commitments.

For Peter and Stephanie, the 850 kilometre round trip from their home to the Brisbane hospital to keep the family together, on top of living away from home expenses, stretched their resources to the limit. As well as dealing with the emotional turmoil of a seriously ill child, they were constantly worrying about the family’s livelihood.

Peter was referred to WeCare, Kildonan Uniting Care’s telephone financial support service. WeCare advised Peter on Centrelink entitlements, as well as concessions he was eligible for (utilities, car registration, rates and public transport). He was given information on corporate hardship programs, negotiating a hold on mortgage repayments, and early release of superannuation. Peter and Stephanie were able to put some plans in place for their future and reduce the financial stress they were under so they could focus on their family.

WeCare has already supported dozens of families in managing the financial impacts of chronic illness, providing immediate financial information and referrals to local financial counselling services to care givers. WeCare’s experienced financial counsellors support families and provide secondary consultation to social workers over the phone, ensuring all families questions and concerns are answered.

WeCare is a free, Australia-wide service based at Kildonan Uniting Care in Melbourne. It operates Monday-Friday, 9am-5pm AEST. Downloadable online financial information for families is available from the WeCare website, along with a brochure and referral form.

For more information contact WeCare 1800 545 366 or email: WeCare@kildonan.org.au, or visit the website http://www.kildonan.org.au/programs-and-services/financial-support/we-care/.

The WeCare project is a Cancer Australia Supporting People with Cancer Grant initiative funded by the Australian Government.

Kate O’Donnell
Kildonan Uniting Care
Australia’s first nationwide analysis of the educational needs of students on the autism spectrum has identified a lack of suitable education and training for staff as a key barrier for providing support in schools for students on the spectrum.

The Cooperative Research Centre for Living with Autism (Autism CRC) surveyed 1,468 educators, autism specialists, parents and students from every State, making it the largest study of its kind.

The preliminary findings were presented at the fourth Asia Pacific Autism Conference (APAC15) in Brisbane in September.

Autism CRC Director Education Research Program, Professor Suzanne Carrington, said educators face the challenge of meeting the complex needs of children with autism while maintaining an appropriate learning environment for all students.

“Autism CRC research outcomes aim to support teachers by developing interventions that are easy to implement for the teacher and will make a huge difference to a student with autism, and will ultimately benefit the whole class,” said Professor Carrington.

“We are working collaboratively with teachers and allied health professionals to ensure the most effective outcomes.”

“Our evidence-based interventions will ensure that all school staff have an understanding of autism, can provide appropriate support and that the whole school community is autism-friendly.”

The needs analysis is a part of the Autism CRC Education Research Program, Australia’s first national effort incorporating all school systems, across metropolitan and rural/remote areas, and set within the real life context of inclusive school environments.

The Research Program aims to provide autism-appropriate educational environments and programs that optimise students’ social, behavioural and academic success, and to equip teachers to manage even the most complex behaviours in the classroom.
“Children on the autism spectrum have a higher rate of exclusion at school because their academic and social needs are not understood or supported,” said Professor Carrington.

“We know many children with autism can go on to have successful adult lives, provided autism-specific strategies are implemented to enable the child to access the curriculum and school environments.”

Autism CRC has invested in a number of projects aiming to support students in regional and remote areas including a tele-classroom consulting project. This project will use remote technology to support existing face-to-face services and traditional teacher training, support and professional development approaches.

It will specifically look at addressing the needs of classroom teachers and students with autism and complex needs in rural and remote regions.

Visit autismcrc.com.au/education to find out more about our educational research program.

Tess Cosgrove
Autism CRC

ADVERTISE IN PARTYLINE IN 2016

Partyline is the premier national magazine for good health and wellbeing in rural and remote Australia. Partyline is the ideal place to promote your product or services to people and organisations who care about health ‘in the bush’.

Partyline has a large national and influential readership that spans rural, remote and metropolitan Australia.

For the technical specifications and advertising rates please see ruralhealth.org.au/publications/partyline/contributor-guidelines

WE ARE PLANNING THREE ISSUES FOR 2016.

Contact the Editor, Susan Magnay E: partyline@ruralhealth.org.au T: 02 6285 4660

about publication dates and copy deadlines for 2016

Issue sponsorship options are also available. To discuss how we can help you become a Partyline sponsor contact Susan Magnay
Country areas in Australia can be great places for children to grow up in. However, judging from scoring on the Australian Early Development Index (AEDI), children in those areas often encounter complex challenges with their growth and development.

The AEDI provides a snapshot of how children are developing by the time they reach school. It measures five domains of childhood development: physical health and wellbeing; social competence; emotional maturity; language and cognitive skills (school-based); and communication skills and general knowledge. These domains are closely linked to the predictors of good adult health, education and social outcomes. The proportion of children living in very remote areas who score in the lowest 10 per cent of the national population is twice that of those living in the major cities. The proportion is particularly high among Aboriginal children and those living in challenging socio-economic circumstances.

The National Rural Health Alliance has long held the view that there is a pressing need for a national strategy which focuses on the health and development of country children. The need for action on the poor state of children’s health in rural and remote Australia was identified as a top priority at the 13th National Rural Health Conference earlier this year in Darwin.

Any new approach or strategy to improve the growth and development opportunities of country children would first need to address the social
determinants of health. It is vital that
countries living in Australia
have access to education, income
and employment, appropriate housing
and nutritious and affordable food.
This will require close cross-sectoral

The approach or strategy would need
to cover the full spectrum of the child’s
life - from conception right through
to adolescence. There is a range of
issues that warrant urgent attention.

The proportion of women who smoke
and use alcohol in pregnancy is higher
in rural communities, and the tendency
to breast feed is lower. Babies born in
more remote areas are more likely
to be of a low birth weight and rural
women experience higher rates of
maternal, neonatal and foetal deaths
than their urban counterparts.

Childhood obesity is becoming a growing
issue in some rural communities, with
rates particularly high in those which
are more disadvantaged. The rates of
tooth decay are twice as high in remote
areas as they are in the major cities,
suggesting there are some major holes
in the current system - and not just in
children’s teeth.

The challenges extend right through
into adolescence with higher rates of
under-age drinking and smoking in
some rural communities. There is much
room for improvement with regard
to literacy and numeracy; children in
remote areas are significantly less
likely to meet the reading and numeracy
minimum standards than those in the
cities, and less than half complete Year
12. The proportion of young people
who go on to university decreases
significantly with remoteness.

The challenges are complex,
intertwined and many. The *Caring for
Country Kids* Conference, to take
place in Alice Springs on 17-19 April
2016, will be a fantastic opportunity
to develop a new approach and will
potentially lay the foundations of a
national strategy. With the wealth of
experience, enthusiasm and new ideas
that will be on hand in Alice Springs,
the Conference looks set to chart a
new way forward.

**Dane Morling**

*National Rural Health Alliance*

PHOTO: STEWART ROPER
The National Rural Health Alliance and Children’s Healthcare Australasia are joining forces to host a conference on quality healthcare for children and young people living in rural, regional and remote communities across Australia.

The Conference will be in the Alice Springs Convention Centre on 17-19 April 2016.

It will be a two-day event providing learning and networking opportunities to public and private healthcare providers; families and carers; students and researchers; and interested people from health-related sectors such as education, transport and housing in rural, regional and remote areas.

The Conference will focus on placing rural and remote children and their families at the centre of social, community and health care. The goal is to improve access for country kids to the right care, in the right place, at the right time - including by building the capacity of rural communities, families, carers and services. It will consider the health and wellbeing of Aboriginal and Torres Strait Islander children and young people. There will be some emphasis on health care for children with chronic and complex conditions, and on emergency care and mental health.

The Conference will have an impressive line-up of keynote speakers, including Pat Anderson, Chair of the Lowitja Institute; Dianne Jackson, CEO of the Australian Research Alliance for Children and Youth; Jo McCubbin, Paediatrician from Gippsland in Victoria; Megan Mitchell, National Children’s Commissioner at the Australian Human Rights Commission; Nigel Stewart, Paediatrician from Port Augusta, South Australia; and Michael Williams, Director of Child and Adolescent Health with the Mackay Hospital and Health Service in Queensland.

Visit www.countrykids.org.au for more information and to register.

Contact the Conference Team on (02) 6285 4660 or at conference@ruralhealth.org.au for information about the sponsorship and exhibition options on offer.

National Rural Health Alliance
TACKLING TRACHOMA ON WORLD SIGHT DAY

Australia is the only developed country in the world today where trachoma still exists.

This disease, the number one preventable cause of blindness, remains rife in some of the nation’s remote Aboriginal communities in the Northern Territory and Western Australia.

While rates of the infectious disease have decreased more than 10 per cent in the past six years, more work needs to be done to close the vision health gap for the nation’s Indigenous communities.

As part of World Sight Day on 8 October 2015, the Remote Area Health Corps (RAHC) and the Aspen Foundation, the charitable foundation of RAHC’s parent company Aspen Medical, championed and continued to work towards the World Health Organisation’s goal of eliminating trachoma in Australia by 2020.

For the past six years, the Aspen Foundation has joined forces with the University of Melbourne’s Indigenous Eye Health Unit (IEHU), spearheaded by Professor Hugh Taylor, and with the Christian Blind Mission.

Through this partnership, the Aspen Foundation has supported the development of the Trachoma Story Kit, which is now being used to raise awareness of trachoma prevention and treatment in remote Indigenous communities.

The Kit features culturally-specific and engaging health education that health professionals, including Aboriginal Health Workers, community elders and teachers can use in clinics, schools and communities.

RAHC has been providing health professionals to assist health services deliver essential primary healthcare to Aboriginal and Torres Strait Islander people in the Northern Territory since 2008.

The RAHC team and the hundreds of health professionals RAHC has deployed, all passionate about improving Indigenous health, are familiar with the debilitating impact of trachoma on remote communities.

RAHC launched an eLearning module on trachoma last year as part of a suite of 15 free online modules, which are available to all health professionals wanting to learn more about Indigenous health. There are also modules on diabetic retinopathy, also developed...
with IEHU, and on eye health care in the primary healthcare setting developed with the Brien Holden Vision Institute with support from the Fred Hollows Foundation.

Hundreds of health professionals have already tapped into the Continuing Professional Development (CPD) point-recognised modules. This year the CPD modules were awarded the Northern Territory’s iAward in the Health Services category for outstanding ICT innovation.

Lizzie Uhr
Aspen Medical

VISION FOR EVERY AUSTRALIAN, EVERYWHERE: EYE CARE FOR INDIGENOUS AUSTRALIA

Funded by the Vision Cooperative Research Centre (Vision CRC) and building on current evidence and guidelines for Indigenous eye care for Aboriginal Australians, the Brien Holden Vision Institute has worked with Aboriginal Community Controlled Health Services and a national network of people from the Indigenous eye and health care sector over the last five years to review eye care service delivery patterns at locations in the Northern Territory and New South Wales.

The Vision CRC program worked to build service capacity in a comprehensive way. It researched the gaps and opportunities for improving eye care services and systems, and explored and recorded ‘real-life’ patient and community experiences in eye care. Change was guided by making services more accessible and culturally appropriate and through collaborating with the regional networks to determine and work toward common goals. The program partnered with Aboriginal Community Controlled Health Services to support integration of eye care within primary health care and to implement the developed solutions to support stronger eye care systems and better outcomes regionally.

Rigorous research processes focused on identifying practical solutions for improving eye care to integrate with
primary health care and existing systems for health care delivery. This enabled the solutions and tools that were developed to be disseminated to other States, to enable sustainable change for all Indigenous Australians needing eye care.

The key tool developed during the program is the Eye and Vision Toolkit – soon to be launched as an interactive online resource through the Brien Holden Vision Institute Academy’s new education platform. The Eye and Vision Toolkit is a practical set of approaches supporting stronger eye care systems for Aboriginal and Torres Strait Islander communities. The Toolkit can be used by anyone wanting to increase capacity and improve delivery of eye care services provided by the health service in which they work. It includes step-by-step guidelines and topics for discussion by the work team, suggestions on timeframes and future goals, and provides all the practical templates and assessment tools required to get the job done.

For more information visit: https://academy.brienholdenvision.org/

Anna Morse
Brien Holden Vision Institute
Suffer the country

I would love to breathe in your diesel and fumes
Get stuck in your traffic and grey office tombs
An urban existence is what I would choose
But alas, I live in the country.

I’d love to look out into someone’s apartment
While washing my dishes or cleaning my carpet
And have a strange neighbour stare straight back at me
But sadly, I live in the country.

The city has theatres and cafes and more
You have shopping on tap, while my tap’s at the bore
I wish I could watch for muggers and more
While I’m jogging, but I’m in the country.

If I’m lucky one day I’ll move to the city
Where the grime is alive and the sidewalks are gritty
But until that time comes I’ll keep sitting quietly
Dreaming I’m free from the fresh air a-plenty
And the magical views
And the people more friendly
The minute’s commute time from workplace to home
...And continue to suffer the country.

Patrick Daley
Sixteen champions of better rural health and wellbeing have been elected to the Friends of the Alliance Advisory Committee (FAC) for the next two years. They will help the National Rural Health Alliance in its work to try to ensure that people living in rural and remote communities have fair access to services and equivalent health outcomes.

Here are some shared moments with the new Chair of the FAC, Robyn Williams.

Q: What experience do you bring to the FAC?

I have nursing and education qualifications and have over thirty years’ experience of working with Indigenous people from rural and remote communities, primarily in the Northern Territory. My fields of expertise include cross-cultural curriculum development and program implementation; evaluation of community based programs, Continuous Quality Improvement programs in remote communities and qualitative research in Indigenous and rural and remote health issues.

Q: Why did you decide to volunteer for the Committee?

I wholeheartedly believe in and support the National Rural Health Alliance. It is an amazing advocate for rural and remote community members and provides a collective voice for those that otherwise would struggle to be heard.

Q: How long have you been involved with Friends of the Alliance?

I’ve been a member since 2002 and I’ve seen Friends grow over the years and provide a crucial link and stronger voice, in addition to those already working and connecting with the Alliance as a whole.

Q: What would you say to encourage people to join Friends of the Alliance?

Friends provides a voice for people interested and involved with rural and remote health who wish to be heard on issues that matter to them. It is a reasonably informal (but well structured) and supportive network of people who believe in the power of combined contributions by individuals to the big picture. It is one way of putting and keeping rural and remote health at the forefront of the debate. We are a collection of ‘all sorts’ from health professionals to country women to consumer advocates to educators to bureaucrats. In short we rock and you’d be mad not to join!

For a full list of members of the Friends Advisory Committee, or to find out more and to join Friends, visit www.ruralhealth.org.au/friends

Kellie Sydlarczuk
National Rural Health Alliance
No one will be surprised to know there are more dentists in cities than in the bush. But some of the consequences might be unexpected to those who are not familiar with rural Australia. There is much greater decay in the mouths of country people, particularly children. The situation is entirely preventable - and it’s making people sick.

Research shows that oral disease, particularly when left untreated, is associated with certain cardiovascular diseases, respiratory illnesses, and other chronic diseases. Other diseases that trigger emergency evacuation of patients by the Royal Flying Doctor Service (RFDS), including endocarditis (inflammation of the lining of the heart), stroke, aspiration pneumonia, diabetes, kidney disease, and some adverse pregnancy outcomes, are also associated with poor oral health.

A new RFDS research paper has gathered the evidence on, and suggests solutions to, the disparities in oral health access and outcomes between major cities and remote and rural Australia.

So what is the state of the oral health of country Australians?

• The average number of childhood cavities is 55 per cent higher for remote area children than children in major cities, and the number of filled teeth is double.
• A quarter of adults in major cities have untreated tooth decay, but this rises to one third of remote area residents.
• More than half of Australia’s Indigenous people have one or more teeth affected by decay.
• On average, 63 per cent of adults living in a major city visit a dentist in a year, compared to 45 per cent of those living in remote areas.
• One in three remote area residents had a tooth extraction in a year compared to 12 per cent of people from major cities.
• There are 72 dentists working in the cities for every 100,000 people, compared with only 22 for every 100,000 people in the country.
The disparity in oral health outcomes between city and country is directly related to disparities in the availability and accessibility of dental care.

But it is also influenced by a greater prevalence of oral health risk factors in country Australia. Poorer diet, higher tobacco use, harmful alcohol use, stress, poorer dental hygiene, limited health literacy, lack of access to fluoridated water, the cost of dental products and limited access to fresh fruit and vegetables all contribute to the challenges in country Australia. For example, a basket of healthy food has been found to cost $24 more per fortnight in rural areas than in a major city.

The RFDS provided dental treatment to 11,519 country residents in the 2013/14 financial year. If extra charitable funding can be secured, the RFDS expects to provide dental treatment to around 15,000 people in the current financial year.

The Federal and State Governments have been working on the National Oral Health Plan 2015-2024 and RFDS research suggests remote and rural Australia should be the focus of that strategy, with dental outreach programs like those of the RFDS a solution to service gaps.

In early 2015 a new Research and Policy Unit was established for the Royal Flying Doctor Service, coincident with the establishment of a new office in Canberra. The Unit’s role is to gather evidence about, and recommend solutions to, overcoming barriers to poor health outcomes and limited health service access for patients and communities cared for by Royal Flying Doctor Service programs. Filling the Gap: disparities in oral health access and outcomes between major cities and remote and rural Australia is the first research paper produced by the RFDS. You can access the full paper at www.flyingdoctor.org.au/what-we-do/research.

Lana Mitchell
Royal Flying Doctor Service

Country kids face twice as many tooth fillings as their city cousins
At the recent GP15 conference in Melbourne, the Royal Australian College of General Practitioners (RACGP) National Rural Faculty (NRF) celebrated its champions of rural general practice with the presentation of three awards.

The awards represent the various categories of the NRF’s 13,500 membership: the NRF Medical Student Bursary Award, the Rural Registrar of the Year Award and the Brian Williams Award for practising GPs. Each award recognises the winner’s contribution to general practice in rural and remote Australia.

Dr Hannah Visser from Casino, New South Wales, was named the 2015 NRF Rural Registrar of the Year. This award is presented to a registrar enrolled in the FARGP who is committed to learning and developing as a rural GP and who is dedicated to the rural community and the rural patients they support.

Dr Ayman Shenouda, Chair of the RACGP National Rural Faculty, presented Hannah with the award, commending her commitment to the health of the Casino and Tabulam Aboriginal communities in New South Wales. Originally from Germany, Hannah entered Medicine with the aim of working with those most in need. Her interest in foreign languages and cultures has enabled her to be accepted quickly by her patients in the remote Aboriginal Health Service where she works. Ayman also praised Hannah’s research work in Aboriginal health which has the potential to benefit many others, beyond her community, across Australia.

Ayman described Hannah as a wonderful role model for other general practice registrars. “She not only loves to work in rural general practice and Aboriginal Health, but also promotes it at every opportunity.”

The RACGP NRF Medical Student Bursary Award is awarded to a medical student who is a member of a rural health student club at an Australian
Maureen Krasnoff, a final year medical student from the University of Western Australia, impressed with her passionate plea for a strong primary care model with multidisciplinary teams providing a ‘healthcare home’ for each patient.

Maureen was drawn to medicine through her love of science and people, having grown up with an interest in health through the lens of her father’s experience of multiple sclerosis. She is passionate about mental health, Indigenous health and the environment and hopes to integrate these into her future practice.

The Brian Williams Award is awarded to a GP who looks after the wellbeing and welfare of their peers so they can safely dedicate themselves to their patients, their families and their communities.

Dr Kenan Wanguhu, a rural procedural GP from the Riverland in South Australia, was the 2015 recipient for this year’s highest NRF accolade.

Ayman applauded Kenan’s passion for the health and safety of the rural population, his countless efforts to assist overseas trained doctors settling in the Riverland area, and his dedication to his community.

Kenan said he felt surprised and humbled by this honoured peer recognition and expressed his thanks to his professional and personal family for their ongoing support.

Royal Australian College of General Practitioners National Rural Faculty
Dr Edward Strivens has received the 2015 Louis Ariotti Memorial Award in recognition of his commitment to innovation and excellence in rural and remote health. Edward is the Clinical Director for Older Persons’ Subacute Services for Cairns and Hinterland Hospital and Health Service and has been instrumental in the development of aged care services in North Queensland.

Kristin Edwards and Heidi Grodecki have received 2015 Infront Outback Research Grants. These are seeding grants to promote and support health-related research relevant to practice and policy in Australian rural and remote health.

Kristin is a registered nurse and PhD candidate at the Central Queensland University in Rockhampton. She will use her grant to investigate clinicians’ perceptions when requesting an aeromedical transfer to confirm suspected appendicitis patients from rural and remote Central Queensland.

Heidi works as a Senior Environmental Health Officer for the Queensland Department of Health’s Health Protection Unit. Heidi’s project will explore the alignment between actual and perceived risks associated with private non-domestic drinking water supplies in rural Queensland.

The Louis Ariotti Memorial Award and Infront Outback Research Grants are presented and sponsored every two years by the Toowoomba Hospital Foundation and the Cunningham Centre. For more information visit https://www.health.qld.gov.au/cunninghamcentre/html/funding.asp

National Rural Health Alliance
The Country Women’s Association of Australia (CWAA) is shining a light on domestic violence. I attended the CWAA 2015 conference, held in August, where I spoke about the particular challenges posed by the issue in rural and remote areas.

While urban centres may have access to refuges and other support systems to assist those in crisis, this is not always the case in smaller rural and remote towns.

Communities can work together to build safety nets through a variety of means.

• Speak up if you are concerned for someone you know.
• Offer what help you can – providing a short term home for a family pet can be the difference for someone.
• Don’t accept excuses – alcohol does not excuse violent behaviour.
• Talk to Police about how serious the matter is and ask what support they need to help make a difference.
• Ask the local Men’s Shed and other groups to get involved.

• Invite the local Magistrate to talk to community groups about what they see and what they have found works – and doesn’t.

Domestic violence isn’t a ‘women’s issue’. It damages women, children, men, animals and communities. It stops families and communities from being the best they can be. Solving domestic violence needs commitment from everyone. And talking about it is the start of changing the situation. If it is underground, it is hard to get a handle on the challenge you face as a community.

Often alcohol is a contributing factor – but don’t accept that if you get rid of the alcohol you solve the problem. The issues underlying the violence are likely to include anger, boredom, mental health issues and unemployment.

There is no easy fix. But unless you start talking about it and decide that enough is enough, it will never stop.

Fiona Brooke
National Rural Health Alliance
In its media release in February 2015 the National Rural Health Alliance made some excellent suggestions for action we could take to help improve the distressing rate of suicide in rural communities. Among the suggestions was the idea that we should “in consultation with Indigenous experts, speed up the availability of culturally-appropriate online mental health resources specifically for Aboriginal and Torres Strait Islander people”.

This work is well underway. Examples of the variety of resources available or under development follow.

A suicide prevention app called i-Bobbly has been developed by researchers at the Black Dog Institute in conjunction with a group of Indigenous advisers from the Kimberley and is currently moving into final clinical trials. [http://digitaldog.org.au/programs/ibobbly-black-dog-institute/](http://digitaldog.org.au/programs/ibobbly-black-dog-institute/)

The MindSpot Clinic, Macquarie University’s ‘virtual clinic’, has expanded its suite of online treatment programs to include an Indigenous Wellbeing program, based on its very successful Wellbeing programs for adults and Wellbeing Plus for seniors. The program is already available. It was developed with Indigenous expert input and aims to build resilience in users as well as to help treat mild to moderate common mental health problems. [https://mindspot.org.au/treatment-courses](https://mindspot.org.au/treatment-courses)

The AIMhi Stay Strong app, from the Menzies School of Health Research and the Queensland University of Technology provides a set of tools for Aboriginal Health Workers to use to help them develop care plans and deliver brief interventions. [https://itunes.apple.com/us/app/aimhi-stay-strong-app/id912289264?mt=8](https://itunes.apple.com/us/app/aimhi-stay-strong-app/id912289264?mt=8)

These initiatives are built on the back of two decades of research and development funded by the Federal Government to develop a range of evidence-based online mental health treatment programs and resources that are already available to all Australians.

Since 2013, Black Dog Institute has been working with a consortium of other organisations to increase community and practitioner awareness of reliable online resources for mental health care and how to use them. These resources, which include online treatment programs, are particularly useful to rural practitioners and consumers where distance and the existence of few practitioners provide a distinct barrier to care. The groundswell of interest in the last two years has been such that in September this year the RACGP released guidelines for the use of e-mental health in general practice, a comprehensive document available online to help GPs optimise the use of these resources [www.racgp.org.au/your-practice/guidelines/e-mental-health/](http://www.racgp.org.au/your-practice/guidelines/e-mental-health/)

Online treatment programs that are currently available range from purely self-help programs for specific diagnoses or for general wellbeing, to
the Mindspot ‘virtual clinic’ where the online self-help is accompanied by regular phone or email contact with a counsellor from the clinic. Details of these programs and educational material about how to use them can be found at www.blackdoginstitute.org.au/emhprac.

Jan Orman
Black Dog Institute

SANE AUSTRALIA PEER HEALTH COACHING PROGRAM

The SANE Mind + Body project’s Peer Health Coaching Program was developed in response to the poor physical health and significantly reduced life expectancy of people living with a severe mental illness.

The Peer Health Coaching Program increases health literacy and improves participants’ skills and understanding around their physical health and wellbeing, through one-on-one or group sessions with a trained Peer Health Coach. The Peer Health Coaches are not ‘health experts’, but bring their lived experience to model recovery and use coaching techniques to encourage change.

The Peer Health Coaching Program can now be adopted by other community mental health organisations. The program includes individual consultation to tailor the implementation process to your organisation’s needs. SANE Australia also provides Peer Health Coaching training for qualified Peer Support Workers who wish to specialise as a Peer Health Coach.

To learn more about the program contact SANE Australia’s Mind + Body initiative https://www.sane.org/health-professionals.

Catriona Bastian
SANE Australia

Catriona Bastian, SANE Australia (left) and Katie Peters, Neami National, receiving an award at the Mental Health Services Conference for the Peer Health Coaching Program
In September 2015, Edith Cowan University’s Australian Indigenous Health InfoNet, in partnership with the Healing Foundation, launched a new portal for Aboriginal and Torres Strait Islander healing. The Healing portal is a web resource aimed at engaging users from a broad range of areas including healing, child protection, justice, health, family violence, education and employment.

The portal provides quick and easy access to quality, plain language material about healing for Aboriginal and Torres Strait Islander people, and is designed to encourage information sharing and collaboration across sectors and locations. It brings together information about what is working in Indigenous healing and includes examples of best practice healing initiatives, the latest research from around Australia and tools people can use to develop healing opportunities in their communities. The portal includes a page dedicated to promising practice where community members have the opportunity to submit their successful healing programs [http://www.healthinfonet.ecu.edu.au/related-issues/healing/promising-practice-story-submission](http://www.healthinfonet.ecu.edu.au/related-issues/healing/promising-practice-story-submission)

At the heart of the Healing portal is a dedicated Yarning place, a free online network that enables people working in the area of Aboriginal and Torres Strait Islander healing to share knowledge and experiences.

The Healing portal provides information categorised into specific topics including Stolen Generations, trauma, traditional healing, community healing, men, women, children and young people, and education, training and employment.

The portal contributes to the body of knowledge about healing for members of the Stolen Generations. Between 1910 and the 1970s up to one in three Aboriginal and Torres Strait Islander children were forcibly removed from their families and communities. These children, who became known as the Stolen Generations, were often subjected to abuse, exploitation and racism on top of the grief and suffering caused by separation from their families, communities, identity and culture.

Colonisation and subsequent policies including the forced removal of children have created unresolved trauma for Aboriginal and Torres Strait Islander people, which has passed down from generation to generation. This trauma contributes significantly to the social disadvantages experienced by Aboriginal and Torres Strait Islander people.

The Healing portal contributes to culturally strong, community-led healing solutions by providing an understanding of the impact of colonisation and the resulting trauma and grief and raising awareness about the impact of trauma. It outlines how
building cultural identity and enabling people to reconnect with their strengths supports healing. The Healing portal promotes the benefits of healing solutions that are designed and delivered locally by Aboriginal and Torres Strait Islander people. It assists in building knowledge and understanding of what works in Indigenous healing and is supporting the efforts of our communities in developing quality healing environments for Aboriginal and Torres Strait Islander people.

The Healing portal and Yarning place can be accessed at http://www.healthinfonet.ecu.edu.au/related-issues/healing

For more information contact Michelle Elwell, Research Officer, Australian Indigenous HealthInfoNet m.elwell@ecu.edu.au

Renee Lynch
Australian Indigenous HealthInfoNet

PHOTO: AUSTRALIAN INDIGENOUS HEALTHINFONET

Neil Drew, Director, Australian Indigenous HealthInfoNet (left) and Richard Weston, CEO, Healing Foundation, at the launch of the Healing portal
Victoria’s Weenthunga Health Network brings together health workers who are devoted to improving the health of Indigenous people.

As is well known, First Australians do not enjoy the same health outcomes as other Australians. More First Australians are needed in Australia’s health workforce to help deliver culturally respectful services and Close the Gap in health outcomes for Aboriginal and Torres Strait Islander people. Collaboratively, we can contribute to strategies promoting equity in health for all Australians.

Weenthunga is led by First Australians and emphasises collaboration between all people. It has two key objectives:

- to improve the uptake of health careers by First Australian school leavers in Victoria; and
- to improve the knowledge, competencies and collaboration of Victorian health professionals working with First Australians, better equipping them to provide culturally sensitive services.

Steff Armstrong and Lin Oke of Weenthunga have commented:

“The key to success is our two-way model of working. First Australians who bring particular knowledge, experience and skills in working with First Australian organisations, communities and people, collaborating with Australians bringing knowledge, experience and skills in the mainstream health system.”

Weenthunga has an inclusive approach to membership, accepting people in any health role in Victoria. Its membership is drawn from a variety of fields, including Aboriginal health management, research, and hospital liaison; allied health; medicine; nursing; community development; mental health work; nutrition; and pharmacy.

Weenthunga supports members to improve their understanding, knowledge and competencies for working with First Australians, and to provide culturally responsive services. It maintains an online resource library and holds meetings and discussions for members around relevant topics.

Weenthunga welcomes First Australians and Australians in health roles who wish to contribute to the better health and wellbeing of Victoria’s First Australians and their communities. It is easy and free to join at www.weenthunga.com.au.

Tracy Smith
Weenthunga Health Network

Steff Armstrong (Weenthunga Health and Education Consultant) talking to the group of First Australian students at VACCHO during the Weenthunga ‘Women’s Talk’ Health Day.
Cover Photo: Kieren Sanderson

EDITORIAL DETAILS:

*Partyline* is the Magazine of the National Rural Health Alliance, the peak body working to improve health and wellbeing in rural and remote Australia. The Editorial Group for this *Partyline* was Susan Magnay (Editor), Jenny Freeman and Stephen Kingston (Graphic Design), the Friends Advisory Committee and staff of the NRHA.

Articles, letters to the editor, photographs, poetry and any other contributions are always welcome. Please email these to: partyline@ruralhealth.org.au or send to: Susan Magnay, Editor, *Partyline*, PO Box 280, Deakin West, ACT 2600; Phone (02) 6285 4660; Fax (02) 6285 4670.

The opinions expressed in *Partyline* are those of contributors and not necessarily of the National Rural Health Alliance or its individual Member Bodies. The Australian Government Department of Health provides the Alliance with core operational support. *Partyline* is distributed free. To subscribe, email your contact details to partyline@ruralhealth.org.au *Partyline* is also available online at www.ruralhealth.org.au

ISSN 1442-0848
Early-bird registration until 31 January 2016

MEGAN MITCHELL Children’s Commissioner, Australian Human Rights Commission
A human rights approach to the wellbeing of country children

FRANK OBERKLAID Director, Centre for Community Child Health
News from the Australian Early Developmental Index

KELVIN KONG Paediatric ENT Surgeon, Hunter New England Local Health District
Improving health outcomes for Aboriginal and Torres Strait Islander kids

DIANNE JACKSON CEO, Australian Research Alliance for Children and Youth
Ensuring wellbeing for children in rural and remote areas

MICHAEL WILLIAMS Director, Child and Adolescent Health, Mackay Hospital and Health Service
Telehealth: ‘right care, right time, right place’

TOPICS
- The current status of children’s health and health services in rural and remote Australia
- Consumer, family and carer panel session
- Innovations and approaches that work; and the role of technology
- Meeting the needs and improving the health and wellbeing of Indigenous children
- The workforce needed to care for country kids