

HealthSpeak

A publication of North Coast NSW Medicare Local



NCML rides to the PHN frontier

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The dogs may bark but the wagons roll on



Editor
Janet
Grist

THIS EDITION OF *HealthSpeak* is the final issue published under the North Coast Medicare Local banner. As the organisation prepares for the transition to become the North Coast Primary

Health Care Network on July 1st, I look forward to continuing to bring you *HealthSpeak* into the future.

It's likely there may be some changes to the magazine in light of the priorities of the new organisation, but these are yet to be discussed. You can be assured that the magazine will remain a quarterly publication bringing you news of health programs, services, research, profiles and features.

There's a lot that I hope you

will find of interest in this issue. On page 2 our clinical editor Andrew Binns takes another look at Advance Care Directives and their potential impact among our older residents.

We also take a look at two projects coming out of the University Centre for Rural Health – one on maternity services planning (P 7) and the other focussing on equipping the Aboriginal health sector for the online world (P14).

And there's much more. I hope you enjoy this Winter edition.

Fast-paced action ahead



CEO
Vahid
Saberi

IN OUR BOOTS AND BLUE denims, we ready ourselves to saddle up our favourite horses and ride off into the new frontier of Primary Health Care. We leave behind what are now the empty streets, homesteads and saloons of the Medicare Local wilderness.

However, as we venture forth into this brave new world, we don't leave everything behind to blow around like tumbleweeds in the wind.

In our stage coaches and wagons we carry with us lots of good things, useful things, that we've collected along the way – the HealthPathways program, integration projects, clinician support and education programs, Aboriginal health and mental health services, the tool we have developed in co-locating services and the partnerships we have built and experience we have gained. We were fortunate

on the North Coast that our Primary Health Network and Medicare Local geographical foot prints are identical. So we did not have to merge with other organisations, thereby not being involved in shoot-outs and showdowns. This means that we have the steady hand of our Board to guide us - and retain our experienced and ace-high staff at the reins.

We have six months to complete the journey and create a functioning Primary Health Care Network. This means fast-paced action.

In this time we have to establish all our organisational requirements including staffing; governance and advisory structures; new management structure; service delivery; and all logistics. Among the most important new things to achieve are the establishment of two Clinical Councils and better ways of engaging and consulting with the community and clinicians.

The key battle ahead is to defeat the bandits of health care fragmentation; to integrate care so that we improve the patient experience; reduce waiting time; reduce avoidable hospital admissions, and reduce duplication and waste. This is the archetypal

battle across the world that we will all fight.

In this battle our Stetsons, spurs, lassos and Colt 45s are our partnerships and our determination is to put the care of our clients before anything else.

Recently, I participated in a mental health integration planning exercise. Among the 80 or so participants, almost all organisations who are involved in the delivery of mental health were represented. There was much expectation that the time was right to defeat the dark forces of fragmentation; that the task of integrating health care required all working together and no one organisation could do this on its own.

I also participated recently in a workshop for the integration of physical health services. Again, among the 120 or so participants, almost all key services were represented; all singing from the same sheet; all committed to the same objectives; all having high expectations that change was on the way.

This high expectation for change is crucially important as we ready ourselves for the new dawn of Primary Health Care. This is because the more we expect the more we achieve, and conversely, the less we expect the less we achieve.

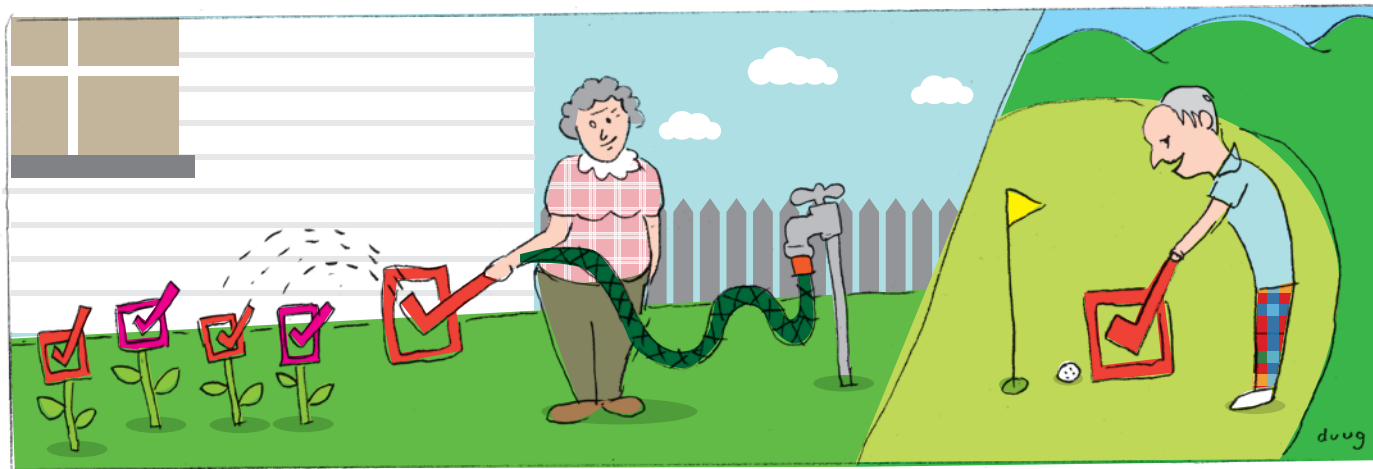


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Who should have an ACD?

Opinion
Andrew
Binns



AS WE DIGEST THE 2015 Intergenerational Report, which was tipped to surprise, or even shock us, care should be taken about how the trends identified may impact on our older population. (See link to report at bottom of article).

The language is often around the ‘burden of chronic disease’, and whether the nation can afford to provide high quality service for an ageing population in the longer term.

The impact of this can result in older people with advanced disease thinking they are a burden on their families and on the health system. The latest Quarterly Essay (issue 57), by Dr Karen Hitchcock, a staff physician in general medicine at a large city public hospital, suggests the medical profession may declare a situation hopeless and further treatment futile, despite encountering a number of older people when such a view could be questioned. She cites a number of compelling and emotional stories to illustrate her views, based largely on her own family and experience with older patients as a treating general physician.

One of her concerns is advanced care directives (ACDs) – once bearing the more ominous name of ‘end of life plans’ – which have gained much popularity in recent times. Some are touting these as the answer to avoiding expensive

end of life care.

As an example, Kate Carnell, CEO of Australian Chamber of Commerce and Industry on ABC’s *Q&A* 17 March 2015 said all older Australians should have an ACD to address futile overtreatment that contributes to rising health costs.

Judgment even for the best trained physician as to what treatment could be regarded as “futile” is fraught with danger. So often people with advanced chronic disease live longer than

“ Who should have an ACD should be based on good communication with the patient ”

we predict, while others can die unexpectedly. Our judgment tends to be subjective and can be clouded by experiences with other patients, family pressures, hospital bed resources and health cost issues.

A recent paper from the Simpson Centre for Health Services Research, South Western Sydney Clinical School, UNSW was published in the *BMJ* (1) has attempted to address this issue in the acute emergency hos-

pital setting. A newly developed checklist screening tool called CriSTAL – Criteria for Screening and Triaging to Appropriate alternative care - is aimed at reducing the uncertainty around who are likely to die within the next three months and helping to initiate useful discussions with patients and their families about end of life care.

In the current general practice setting it is good medical practice to discuss an ACD for people whom we believe are within six months of dying. Whether we should encourage all people around 70 years of age or older to have an ACD is questionable. While there has been a push for this over the last few years there can be problems with this approach due to changing circumstances in people’s lives. In addition ACDs really should be regularly reviewed and updated and this may not happen. Once the ACD box has been ticked the matter is usually left alone, and plans sanctioned by the patient rarely, if ever, revisited.

There is research to show that with proper assessment, planning and end of life care for individuals, including an ACD, a number of positive things will follow from this (2). For example, the level of active intervention requested by the patient and families/carers will be moderated, the carers and families will cope better and the

bereavement process will be less traumatic for those close to a person who has passed away.

As can be seen, and as common sense would dictate, who should be advised to have an ACD cannot be based on a precise science but rather based on good communication with the patient, carers and family. GPs and their practice nurses who know the patient well are ideally placed to have these discussions with patients with advanced disease.

If the CriSTAL screening checklist is trialed in selected hospital emergency departments, as is being planned in Sydney (3), close liaison with local GPs and palliative care teams is essential in this process. This is another good reason for the roles of the primary health teams and the state’s Local Health Districts to be well aligned in the interests of good quality and affordable end of life care.

(1) Cardona-Morell M, Hillman K. *BMJ Supportive & Palliative Care* Published Online

<http://spcare.bmj.com/content/early/2014/12/09/bmjspcare-2014-000770.full>

(2) Wright et al, Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment, *JAMA*. 2008 Oct 8; 300(14): 1665-1673

(3) <https://www.scimex.org/newsfeed/imminent-death-made-cristal-clear>

Link to report: http://www.treasury.gov.au/~media/Treasury/Publications%20and%20Media/Publications/2015/2015%20Intergenerational%20Report/Downloads/PDF/02_Exec_summary.ashx

ICE Symposium draws up four point plan

THE ONE-DAY Methamphetamines Symposium, organised and led by North Coast Medicare Local held in Lismore in April drew up a plan to address four pillars of action.

The Symposium was co-sponsored by North Coast Medicare Local, Bulgarr Ngaru Aboriginal Medical Corporation and the Northern NSW Local Health District.

Participants included representatives of the Northern NSW Local Health District, North Coast Medicare Local, police, ambulance, Aboriginal Medical Services, The Buttery, Northern Rivers Social Development Council, Rekindling the Spirit, Communities for Children, the Department of Family and Community Services, headspace and the Australian Drug Foundation.

The four pillars of action are

- 1) Preventing uptake of methamphetamines
- 2) Reducing supply
- 3) Reducing the impact of



NCML's Substance Misuse Project Officer Christine Minkov leading a small group discussion during the Methamphetamines Symposium in Lismore.

- 4) Building health workforce capacity to deal with the problem

Some funding is being made available by the sponsor organisations for the implementation of these initiatives to address the harm related to the use of methamphetamines.

At the beginning of the

Symposium North Coast Medicare Local's Substance Misuse Program Officer Christine Minkov said that while a steady 2.5 per cent of the population had used methamphetamines over the last 12 months, what had changed was that people were turning away from powder and pills (speed) and turning to crystal meth (ice) for a variety of reasons.

Richmond Area Command's Detective Inspector Cameron Lindsay said that while 345g of methamphetamines had been seized in the Richmond area last year, more than 600g had already been seized this year. He said that the use of ice meant that police were dealing with a level of aggression and violence not faced before by methamphetamine users.

Detective Inspector Lindsay talked about one man stabbing himself while walking along the street with a broken bottle until he died.

Addiction specialist, Dr David Helliwell said that while methamphetamine users were a small percentage of the population, those who used it got into lots of trouble.

A working group has been formed to further the action plan and it also drew up a submission to the National Ice Taskforce meeting which was held in Lismore on May 19 organised by Federal MP Kevin Hogan.

HealthPathways celebrates its first birthday

AN ONLINE TOOL THAT helps GPs provide the best quality care for their patients on the North Coast celebrated its first birthday last month.

HealthPathways is a web-based information portal that helps clinicians and GPs link patients to the best treatment and best service in a timely manner.

North Coast Medicare Local (NCML) and its partner, Mid North Coast Local Health District (MNCLHD) hosted an educational event for local clinicians at the University of NSW Rural Clinical School in Port Macquarie to mark the milestone, which was also attended by NCML CEO Mr Vahid Saberi and MNCLHD Chief Executive Mr Stewart Dowrick

Mr Dowrick said HealthPathways was an important investment for both health organisations.

"It's important because it strengthens the links between GPs, other primary care services, as well as hospitals and the Mid North Coast Local Health District.

"HealthPathways is delivering significant improvements to the way hospitals and General Practice share the care and



NCML's Dr David Gregory with MNCLHD CEO Stewart Dowrick.

clinical management of patients," he said.

Mr Saberi said that by connecting these services and streamlining the patient journey, local residents can get the best possible care in the most timely manner.

"It is clear to us that all parts of the health system are better when they work

together, as one," he said.

Port Macquarie Respiratory Specialists, Dr Steven Chung and Dr Baerin Houghton gave presentations at the event attended by 95 local clinicians. The topic was managing the chronic health condition chronic obstructive pulmonary disease (COPD).

COPD is one of the highest potentially preventable hospitalization causes on the Mid North Coast and accounts for more than 7,000 hospital bed days a year, with an average length of stay of 6.7 days. The condition is considered potentially avoidable through preventative care and early disease management.

COPD requires constant collaboration and communication both internally across clinicians within a hospital, and externally between the hospital, GPs and specialist treatment centres. The COPD HealthPathways allow clinicians to follow detailed management guidelines and to ensure that patients are referred to the right local specialist at the right time, thereby preventing potentially preventable hospital admissions.

What the transition to a PHN means

By Dr Tony Lembke

NCML Chair

THE NORTH COAST Primary Health Network (NCPHN) will commence operations on July 1st this year.

This new organisation will build on the work of the North Coast Medicare Local over the last three years. It will aim for a health system in this region that works 'as one', so that people can access the care team that they need, that team is of high quality, and their care feels 'joined up'.

The North Coast Primary Health Network will achieve this by partnering with general practices, the Mid North Coast and North Coast Local Health Districts, Medical Specialists, Allied Health Providers, Pharmacists, Nurses, Aged Care



Providers and other members of the health care team.

There will be 32 new Primary Health Networks across the country, replacing 61 existing Medicare Locals. We are fortunate in that our boundary has not changed. This will make our

transition smoother than most.

These changes have given the Board and management a chance to review the activities of the new organisation, and to plan where we can have the most impact. We will engage more general practitioners and other clinicians in our work to achieve the best outcomes.

The Primary Health Network (PHN) will form two Clinical Councils, one north and one south. These important new bodies will advise the network on all clinical issues. This includes advice on health integration and health care gaps, professional development and education, general practice support, quality improvement

programs and Health Pathways. You are invited to nominate for this council by contacting David Lacey on (02) 6618 5421 or dlacey@ncml.org.au

The Australian government has set PHNs six key priority areas. These are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care.

PHNs are to be 'commissioners' of clinical services, rather than providers of services. This means that wherever practical we will contract with other services or clinicians to provide care, rather than providing care ourselves. There are some services that had been provided by the Medicare Local and these will transition to new arrangements over the next 12 months, if possible.

The PHN will have a greater focus on supporting general practice, with the aim of making it easier for GPs to provide the care needed by their patients. The PHN will also increase its support to other primary health care providers.

We always welcome your input and advice. Please feel free to contact me at tlembke@gmail.com and remember to nominate for the Clinical Council.

Palliative approach to aged care

THE AUSTRALIAN MEDICAL Association (AMA) has released a new *Position Statement on Palliative Approach in Residential Aged Care Facilities*.

AMA Vice President Dr Stephen Parnis said the statement outlined the appropriate considerations in taking a palliative approach to the care and management of patients in residential aged care facilities.

"Acute medical care settings prioritise preserving and, where possible, extending life," Dr Parnis said.

"Transferring residents of residential aged care facilities to acute care settings when their condition deteriorates can often impose unnecessary pain and distress.

"It may also not necessarily respect the needs of patients living with life-limiting illnesses, who prefer to receive palliation within the residential aged care facility.

"The AMA would like to see the introduction of templates for palliative care plans in aged

care. Palliative care plans are an excellent way to ensure that everyone involved in the person's care follows the same agreed approach."

Dr Parnis said that according to research by the Grattan Institute 70 per cent of Australians want to die in their home, which includes in their aged care facility.

At present, up to 70 per cent of people die in acute care hospitals, and many are actively treated right up until the moment of their death. By contrast, a palliative approach to care for residents of aged care facilities, living for extending periods of time with life-limiting illnesses such as cancer, dementia, Alzheimer's, neurodegenerative and renal diseases, aims to maximise quality of life through appropriate needs-based care.

The Position Statement is at <https://ama.com.au/position-statement/palliative-approach-residential-aged-care-2015>

Snapped: THE PITCH photo competition



RESIDENTS OF the North Coast are invited to enter North Coast Medicare Local's SNAPPED Photo Competition. The competition is part of NCML's PITCH innovation series. PITCH

stands for Practical Ideas to Change Health Care.

NCML wants to see your take on what good health means to you presented visually in a photograph. Your photo should visually complete the phrase: "Good health is..."

Your image could relate to diet, fitness, meditation, friends, family, pets etc. Great prizes are in the offing.

For entry criteria and how to enter, go to www.healthynorthcoast.org.au/competition

Girrwaa First Aid Wellness Day

FOR MORE THAN EIGHT months, NCML's Closing the Gap team in Coffs Harbour has been organising monthly Wellness Days for residents of Bowraville, an isolated community without a GP or pharmacy.

The health topics covered at these seminars are chosen by the participants. For the month of February the health topic for the seminar was Basic First Aid and this event was facilitated by NCML staff member Kate Hillenbrand.

Participants were taught how to treat snake and spider bites and stings, wound care and bandaging and how to apply a sling.

Sixteen residents from the Nambucca Valley attended at Girrwaa at Bowraville and all were keen to learn first aid to help in the event of a medical mishap. Surveys taken of those taking part in the Girrwaa Wellness Days show that the group found the seminars very useful and were looking forward to using their new skills to provide help in emergency situations – administering first aid for minor conditions.



Aunty Loretta Riley tying up a sling for Aunty Anne Edwards.



Participants at the First Aid event at Bowraville.

Looking for youth to advise headspace at Tweed

HEADSPACE TWEED heads opened its doors in March and its official opening is coming up on June 26. Management is looking for more youths living in the Tweed area to join its Youth Advisory Group.

One member of the headspace Advisory Group told *HealthSpeak* about his experience of being part of a team of young people influencing the centre.

“My name is Keiah, I am 20 years old and from Carrara. I am one of the youths that are a part of the Tweed Heads Headspace Youth Advisory Group. Being a part of this is not only rewarding for myself but also to the other youth that are in it! It gives us all great pride to be a part of decision-making and helping the new centre evolve into something wonderful.

We were able to help with the colour scheme, furniture, art and even chose the building it is in and help in recruiting some of



headspace Tweed Heads is located at 145 Wharf Street (Camarco Building, entrance on ground floor). Ph 07 5589 8700.

the staff! For a change it's awesome to have 'adults' ask youth what they think. Normally it's youth asking them!

Now that the centre is up and running we are planning for the headspace Tweed Heads official opening at the centre. It's a

public event for the whole community. At our last meet up we brainstormed different activities, performances, music, workshops and lots of other things that we could do to make it a blast!

I personally want to be a part of the group because I love to help people and give back to my community and especially with mental health as I and people I know have had their individual experiences. This is why headspace is amazing! They don't sweep it under the rug and pretend it's not there, they support and help you face your individual challenges. This is where the Youth Advisory Group is so important because us youth are able to give our advice on how other youth will benefit from it.”

If you know of a youth who might be interested, let them know about this opportunity. They can contact Leigh Ferguson on 07 5589 8718.

HealthNet is live across NSW Health

What's HealthNet?

It's a state-wide enabler of integrated care that enables efficient sharing and access to patient information for clinicians from across LHDs and a patient's Electronic Health Record (PCEHR) via the NSW Clinical Portal. It also includes secure electronic messaging of discharge summaries to GPs using national standards.

Discharge Summaries

HealthNet will send discharge summaries to three places:

1. Directly to a patient's nominated GP via secure messaging
2. To the NSW Clinical Portal with an eMR connected to HealthNet
3. To a patient's PCEHR if they have one and have given permission for this to happen

What does it mean for GPs?

LHDs will continue sending discharge summaries electronically to your desktop clinical software using the Argus GP broker. The format of the summary sent electronically will however look different. The hospital will send via two additional brokers, HealthLink and Medical Objects.

HealthNet discharge summaries use the Clinical Document Architecture standards, so they will look different to printed discharge summaries, but the content will be the same.

For more information: www.ehealth.nsw.gov.au/programs/clinical/healthnet

Core of Life: Education for a positive parenting future

CORE OF LIFE – AN innovative approach to providing interactive, evidence based information about pregnancy and parenting topics in the North Coast region - was delivered to grade nine and ten students from Kadina, Southern Cross and Kyogle High Schools in Term One this year.

Focusing on the realities of pregnancy, birth and early parenting, the program is run over three hours using role play, storytelling and multi-media. Local support services are discussed so that young people are aware of these networks should they or their friends need to access them now or in the future.

The comprehensive program is delivered by at least two Core of Life facilitators with backgrounds in health, teaching or youth work. In Term One this included 10 facilitators from government and non-government organisations including Ballina High School, NSW Department of Education and Communities, Far North Coast Family Refer-



Kyogle High students enjoying the interactive role playing during the Core of Life program.

ral Service, Kyogle Community Health, Lismore Base Hospital Women's Care Unit, Lismore Community Health Centre, Youth and Family Education Resources and North Coast Medicare Local.

Results from the program are promising, with a survey from

Kyogle High suggesting that participants improved their short-term knowledge of the common first signs of pregnancy, the physiological process of childbirth and the benefits of breastfeeding. In addition, 72% of participants said that the session made them think

more about the responsibilities of having a baby. Kadina High and Southern Cross will receive a second follow up session in Term Two.

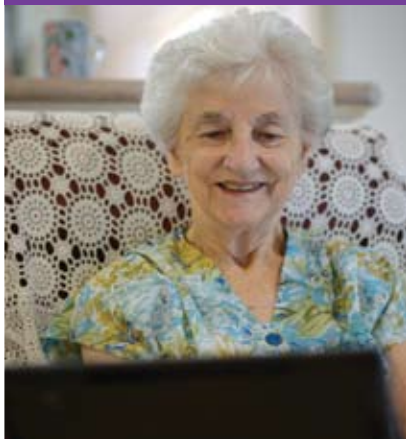
The Core of Life Program is a joint initiative of North Coast Medicare Local, Northern NSW Local Health District and Youth and Family Education Resource Program.

North Coast Medicare Local Program Officer and Regional Core of Life Coordinator Claire Malseed supports Core of Life collaboration between schools and organisations to ensure a sustainable program model engaging both the health and education sectors. Core of Life will continue to be rolled out to High Schools and Community Groups in the North Coast region in Term Two.

If you feel there is a need for this program in your school or community group or you would like to learn more about becoming a Core of Life trainer, please contact Claire at NCML on cmalseed@ncml.org.au or (02) 6622 4453.

Join eVillage and earn up to \$110 per video consult

All equipment and IT support provided



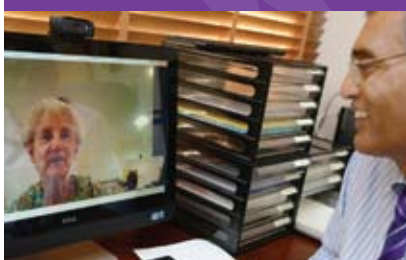
Feros Care's eVillage program connects seniors with their healthcare team, using video conferencing.

Earn up to \$110 per video consult and demonstrate the MBS should include funding video conferences between GPs and seniors living in residential aged care.

Save time and money using eVillage!

eVillage is not designed to replace 'hands-on' care, participating GPs still conduct scheduled appointments. However, video conferencing replaces fax and phone calls, reducing travel time and empowers clinical decision making, allowing the GP to see the patient, ask questions and consult care staff.

All equipment provided including a laptop or tablet, IT support and up to \$110 per video consult.



For further information please call 1300 763 583

Shelly Fletcher
eHealth and Primary Care Manager

Kelly Anderson
eVillage Telehealth Registered Nurse



Integrated Care: setting a path



Broadcaster Julie McCrossin led the workshop at Ballina which identified barriers to integrated care in the Northern NSW health system.

MORE THAN 100 participants gathered at the Ballina Beach Resort in late May for the Northern NSW Integrated Care Strategy Planning Workshop.

Northern NSW Local Health District CEO Chris Crawford opened a lively and interactive day facilitated by broadcaster Julie McCrossin. After the morning's discussion on *What is Integrated Care?*, participants worked in small groups to identify local barriers to achieving this.

Recurring themes throughout the day were the need for

good relationships between health providers, the ability to electronically share up to date patient information and the importance of a seamless and empowering patient journey. A number of consumer representatives shared how vital it was for their health providers to work as a team.

The final panel for the day gave their thoughts about directions for the future and North Coast Medicare Local CEO Vahid Saberi summed up a fruitful and energising day, thanking organisers and participants.

Allied health gather in Lismore



IN APRIL THE FIRST Lismore breakfast seminar for members of the North Coast Allied Health Association (NCAHA) was held at The Gateway motel.

Regular events for allied health practitioners are being staged throughout the North Coast.

NCAHA Chair Professor Susan Nancarrow gave a presentation about the Association and its aims. Discussion then followed on the key issues facing allied health practitioners on the North Coast. These included:

- Unmet need for service delivery and training in senior's mental health.
- Need for improved communication between allied health professionals and other professions particularly to clarify referral pathways
- A professional 'speed dating' event suggested to improve relationships between different disciplines
- Desire for educational opportunities, case reviewing and inter-service activities

Briefs

Saunas reduce fatal events

A FINNISH STUDY of 2300 men aged 42 to 60 has found frequent and long sauna baths

reduce the risk of fatal CV events and lower mortality by all causes in middle-aged men.

The 20-year study found that those who participated in two to three sauna sessions each week had a 22% lower risk of sudden cardiac death than those having just one

weekly session. Men who had four to seven saunas a week had a 63% reduced risk of sudden cardiac death.

The researchers found similar levels of lowered risk for fatal coronary heart disease and for all-cause mortality.

The saunas were at a mean

temperature of 79 degrees Centigrade and the men who had sessions lasting 20 minutes or more had a 52% lower risk of sudden cardiac death compared to those who spend less than 11 minutes.

JAMA Intern Med 2015; online 23 Feb

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Index to help with maternity services planning

THE AUSTRALIAN Rural Birthing Index (ARBI) project, led by Professor Lesley Barclay, Director at UCRH, will be completed by the end of the year. It will provide the first evidence gathered about the location and types of maternity services available in rural and remote Australia, enabling improved planning and policy making.

Drawing up such an index was first thought about 10 years when Lesley became aware of similar work being done in Canada. She said many in the health sector were frustrated that there hadn't been an evidence base for making decisions about services.

"We became aware of the Canadian work, we lobbied the Commonwealth and we started to work with our Canadian colleagues. The project got off the ground due to a grant from the NHMRC.

"Essentially, we've taken the Canadian idea, we've mapped every birthing service around the country and then we've calculated and tested the Canadian model here.

"We've also looked at Ab-



Professor Lesley Barclay

originality and socio economics and distance from emergency services and found that the Canadian model works quite well. We've tweaked the model a bit, but importantly we've also developed a tool kit so that the model is used taking into account other factors that need to be understood about health service design and delivery," she said.

Some of these factors include the number of Aboriginal people in the population and the capacity for proper manage-

ment and clinical governance.

"If you have a small rural area and you are offering a service, you need to look at how that service is networked with other facilities and make sure that the clinical governance is in train for these rural and remote health services so that they can be linked in," Lesley explained.

The comprehensive tool kit that's been developed helps planners calculate whether there should be a service in a particular location or not, taking into account the factors that would influence such a decision.

Recently, Lesley and Lismore surgeon Dr Austin Curtin spent time overseas writing with Canadian colleagues and speaking to the British Columbian Government about some of the work the Australian research team has done.

Canada is a good fit as a research partner with Australia as both countries have similar populations.

"The Canadian health system is also closer to ours than some others. It's a fully government funded system, they don't have a private health insurance sector, but in rural and remote Australia private health insurance is pretty much non-existent," Lesley told *HealthSpeak*.

It's envisaged that the ARBI model and tool kit could also be used to map surgical or ED

services.

The project has an impressive team of investigators and there is also a PhD associated with the research.

Lesley said that the project included Aboriginal leadership at senior levels, leading clinicians from the major states and expert advisors.

"We've had experts who feed in and critique the work we do as we do it and that's happened all the way through," she added.

Congratulations to the team on a much needed piece of work that will have far reaching implications in planning rural and remote services.

The ARBI team

Chief Investigators: Prof Lesley Barclay, UCRH; Prof Sue Kruske, University of Queensland; A/Prof Geoff Morgan, UCRH; Prof Sue Kildea, Australian Catholic University; Prof Jeremy Oats, University of Melbourne; Prof Stefan Grzybowski, University of British Columbia; Ms Deborah Donoghue, University of Sydney and A/Prof Terry Dunbar, Charles Darwin University.

Associated Investigators: Dr Jude Kornelsen, University of British Columbia; Ms Rachael Lockett, NT Dept Health and Families; Mr Vahid Saberi, Chief Executive, North Coast Medicare Local; Dr Mark Tracy, University of Sydney.

New clinical trials website

AUSTRALIAN PATIENTS and health professionals now have access to an online register of clinical trials.

The International Clinical Trials website will help boost patient participation following data that indicated just under half of all Phase Three clinical trials conducted in Australia did not meet their patient recruitment targets.

"Clinical trials are an essential part of ensuring that the life-saving treatments and drugs we use are safe and effective," Health Minister Susan Ley said.

"This reform will provide Australians right across the country, including regional and rural patients, greater access to clinical trials and

will help to improve health outcomes," Ms Ley added.

At the launch, Minister for Science Ian said in addition to offering easy access to information about the trial, who can enrol, and what is required of patients, the tool also puts patients in contact with the head researcher with just one click.

"For trials to be scientifically rigorous, they need the involvement of many patients and this online tool will make it is easier for patients to be aware of the trials available across Australia and how they work," he said.

Visit the website here: <http://www.australianclinicaltrials.gov.au/>

Dr Steven Stylian - Haematologist and Medical Oncologist

Byron Bay Specialist Centre, Suite 6, 130 Jonson St

Dr Stylian wishes to announce that he has commenced practice at the Byron Bay address above.

Over the years he has wanted to address the need for specialist care in peripheral regions. He has also remained grateful for his patients travelling to the Gold Coast to access care and now wishes to minimise the need for them to do this. Dr Stylian provides care for all aspects of haematology and medical oncology and specifically provides tertiary level care for complex disorders including leukaemia, all types of malignant conditions, apheresis and stem cell transplantation.

Urgent cases will be prioritised and all patients will be bulk billed. Dr Stylian is happy to provide phone advice if needed and is now ready to accept GP referrals.

Ph: (07) 5597 1305 Fax: (07) 5597 1205
Email: reception@gcho.com.au www.gcho.com.au

MNC Parkinson's nurse



From left: Parkinson's NSW Board Member and Support Group member Vera Heil, Parkinson's Nurse Vincent Carroll and Parkinson's NSW CEO Miriam Dixon.

PEOPLE LIVING WITH Parkinson's disease and their carers will benefit from the appointment of a specialised Parkinson's Nurse to the Coffs Harbour, Bellingen and Nambucca areas.

The appointment is the culmination of a team effort involving a community group, a Coffs Harbour charity and local health providers. Vince Carroll joins other Parkinson's nurses across NSW as the Neurology Clinical Nurse Consultant for the Mid North Coast.

The three-year project is a partnership between Parkinson's NSW, the Mid North Coast Local Health District (MNCLHD) and North Coast Medicare Local. The Parkinson's Support Groups of Coffs Harbour and Nambucca Valley, and Coffs Harbour charity The Pink Silks, are also supporting the project.

Mr Carroll was officially introduced to the Coffs Coast community at a special morning tea. He joins the Neurology Outreach Clinic, which is co-located with the Mid North Coast Brain Injury Rehabilitation and Rural Spinal Cord Injury Service in Victoria St, Coffs Harbour.

Mr Carroll has extensive nursing experience, having

worked in the acute hospital sector and in residential facilities in senior clinical and administrative roles.

He will work with the Health Service, visiting Neurologists and GPs in supporting people with Parkinson's disease and other neurological conditions, keeping patients functioning and avoiding inappropriate hospital and/or Residential Aged Care Facility admission.

A full house at Aboriginal Services Forum



North Coast Medicare Local's Closing the Gap team hosted the 4th annual Aboriginal Services Forum in Coffs Harbour in late April

THE FORUM AIMS TO improve service delivery through coordination and collaboration with local organisations that offer services and programs to the Mid North Coast Aboriginal and Torres Strait Islander communities.

NCML's Closing the Gap Aboriginal and Torres Strait Islander Health Project Officer, Helen Lambert, said there was an unexpectedly high response to the forum with 50 people taking part from 40 government and non-government organisations.

"A total of 18 organisations presented short talks on the programs they offered and how to access their services, including eligibility criteria.

“18 organisations presented short talks on the programs they offered”

"Each service was invited to display resources and we have six tables full of information which people collected to refer to in the workplace. It was great to see the room busy with networking conversations and those who came are looking forward to next year's forum," she said.

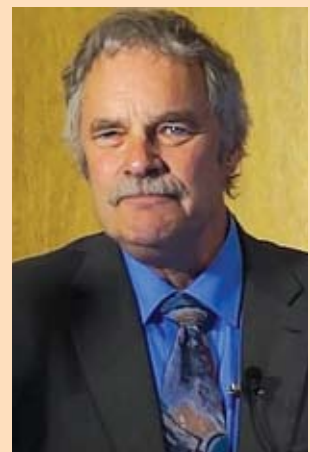
Workshop: The Power of Compassion

THIS ONE-DAY workshop *The Power of Compassion: How to manage stress by cultivating your compassionate mind* is for people interested in finding a different path for their relationships with themselves and others.

Led by the founder of Compassion-Focused Therapy Professor Paul Gilbert from the University of Derby (UK) and A/Prof James Bennett-Levy from the University Centre for Rural Health, the workshop offers effective methods to reduce stress at work and home.

Research has shown that by deliberately cultivating self-compassion people can reduce stress levels and silence unhelpful self-criticism and shame. Compassion-focused practice enables us to develop greater wellbeing and more effective home and work lives.

The workshop is on Friday June 19 from 9.30 to 4.30 at the Lismore Workers Club. North Coast Medicare Local is one of the workshop sponsors. The cost is \$90 or concession \$60. To book go to: www.cbtraining.com.au



Professor Paul Gilbert

Psychogeriatric SOS: Mental Health and Dementia Service

PSYCHOGERIATRIC SOS is a clinician-to-clinician web-based service offered by St Vincent's Hospital in Sydney.

Health practitioners such as GPs, psychologists and allied health professionals can access advice, supervision, case conferencing, and education from its multidisciplinary team – it's available for any clinician involved in psychogeriatric care in rural or remote NSW

With mental health services for older people unevenly distributed between the city and rural and remote NSW, this has traditionally been addressed using clinically-focused doctor-to-patient e-health solutions and FIFO services.

However the uptake of telehealth remains low and the current FIFO services are unable to meet mental health service demands. It was suggested that a stronger solution might be timely advice, supervision, training, education and support to existing rural clinicians.

St Vincent's Hospital in Sydney, supported by the Ministry of Health, The NSW Institute of Psychiatry and the Curran Foundation has established Psychogeriatric SOS which is run by clinicians for clinicians, to increase capacity and expertise in psychogeriatrics throughout NSW.

Psychogeriatric SOS



NSW Health Minister Jillian Skinner with (from left): Toby Hall, A/Prof Anthony Schembri, A/Prof David Burke and Paul Robertson at the launch of Psychogeriatric SOS on April 13

- uses web-based teleconferencing
- is accessible via the website but can be accessed by telephone, fax or email
- allows individuals or groups to conference with the St Vincent's psychogeriatric team, for
 - case review meetings
 - clinical supervision
 - education and training
 - information and advice

Dr David Burke, senior staff specialist and head of Psychogeriatrics at St Vincent's Hospital has been heavily involved in the establishment of Psychogeriatric SOS.

"Psychogeriatric SOS

clinicians can offer rural GPs expertise in old age psychiatry, nursing, clinical psychology, clinical neuropsychology, social work and occupational therapy.

"The service can reduce delays in rural GPs getting timely psychogeriatric advice, can help avoid ED presentations, can alleviate the need for rural patients to travel and can enhance continuity of care," he told *HealthSpeak*.

The best way to contact Psychogeriatric SOS clinicians is via www.psychogeriatricsos.com.au

To find out more, email Dr Jackie Huber at Jacqueline.huber@saha.org.au

Briefs

Autism diagnosis delay

RESEARCH HAS found that fewer than three per cent of Australian children with autism are being identified by the age of two. La Trobe University researchers found the average age of diagnosis was four years and one month.

They say that delay in diagnosis means many children are missing out on help at an early age.

The study found the most common age for autism diagnosis was five years and 11 months, which the authors believe can be attributed to children being identified as they start school.

Children from non-English speaking backgrounds were, on average, diagnosed five months earlier than those from the broader population.

Helping people stay in their homes

ADVERTORIAL



Coffs Home Mods supports the frail, elderly and people with disabilities and their carers to stay in their own home and be supported in the workplace.

We design and build safer environments using quality materials and contractors. No job is too big, we provide affordable minor and major modifications in the home and workplace along with ongoing maintenance like plumbing, electrical and gardening. If you have a client who needs some work done, contact us for the latest referral form or pop into our office to check out our fully functioning accessible bathroom and ramp.

Hazel is an example of one of our satisfied customers.

We met Hazel back in 2010 and have since completed numerous modifications for her including her smart door installed in her toilet (a door which opens both ways), wedges and grab rails.

"The smart door is a great help to me that I



won't get stuck on the other side. It's so easy to push one side to the other side when I get out, I don't have to squash myself around the corner and do 'whirlies'. Coffs Home Mods also put down little wedges so I can get out the back door. There is no step now and I can wheel my walker up and down there, so that's very nice."

Office Address: Unit 12, Lot 5, Druiett Court, Coffs Harbour NSW 2450.

Phone 6651 2143, Fax 6652 9430.

Email: admin@coffshomemods.com.au

Website www.coffshomemods.com.au and www.facebook.com/coffshomemods

Feros Care connects seniors and GPs using videoconferencing technology

THE DEPARTMENT OF Social Services is funding a national trial to assess whether the Medicare Benefits Scheme (MBS) should include a billing item for GPs to conduct video calls with seniors living in residential care. Feros Care is implementing the trial in Northern NSW and has titled it Electronic Village (eVillage).

eVillage connects residents at Feros Care villages in Byron Bay, Bangalow and Wommin Bay (Kingscliff) as well as Alstonville Adventist and BaptistCare Maranoa with their GP. Participating GPs use advanced videoconferencing technology to assess and discuss the resident's health.

Feros Care's CEO, Jennene Buckley, said it was important to incorporate technology as part of a holistic approach to improving health outcomes and social interactions among seniors in community and residential settings.

"Over an 18-month period we've facilitated more than 230 videoconferencing calls. Connecting residents with their GPs has resulted in improved access to health care providers, fewer hospital admissions and increased integrated care," said Ms Buckley.

A recent example is a resident who had a fall and hurt



Virtual presentations are a great way for GPs to connect with seniors.

his wrist. Within 30 minutes of the fall, the RN and resident were able to virtually consult with the GP. The GP ordered an x-ray and a follow-up video call. Traditionally, the resident would either have to wait for the GP to visit the village or attend the Emergency Department.

Dr Neil Hannah of Bay Medical Centre commenced virtually assessing patients at Feros Village Byron Bay in December 2014 and has conducted over 50 telehealth consultations rotating weekly between face-to-face and virtual clinics.

Dr Hannah said that

eVillage was an innovative approach that improved patient care and allowed GPs to be paid for work that they often found themselves performing free of charge.

"Virtual consultations are a great way to connect with patients who can't come into the surgery," he said.

"It doesn't equate to any additional work and the GP is remunerated for performing associated tasks such as completing paperwork and liaising with registered nurses," said Dr Hannah.

Robert, a resident of Feros

Village Byron Bay said: "It's great to be able to talk with my doctor from the comfort of my own room; it's a big win for me not having to travel and to also have the support of Natalie (Village Care Manager) when speaking to the doc."


While the main focus of the funding is to increase access to GPs, Feros Care is also committed to using technology to improve seniors' well-being. Feros Care has launched its Wheel-I-Am (iPad on wheels) to allow seniors to access places of interests such as museums, virtual games day and virtual chat clubs.

Feros Care believes technology is integral to assisting the healthcare sector to meet the increasing demands of an ageing population. To ignite the discussion, Feros Care is hosting a Smart Technologies Bootcamp from 27-28 August. The Bootcamp will provide a platform for organisations to share information and to review the 'trials and errors' experienced in rolling out new technologies.

For more information about the eVillage package, please contact Feros Care on 1300 851 771 or visit www.feroscare.com.au

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- Are you currently on CPAP?

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- CPAP therapy - problems solved
- Sleep studies - what is involved
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Asthma preventers under-used

THE MOST EFFECTIVE medications for managing asthma, COPD and other obstructive airways diseases are under-used in Australia, according to a report by the Australian Centre for Airways Disease Monitoring (ACAM).

The report, *Respiratory medication use in Australia 2003-2013: treatment of asthma and COPD*, shows that prescription respiratory medications were dispensed to over two million people in Australia in 2013, but that most people only used them occasionally.

'Inhaled corticosteroids were the most common type of prescribed respiratory medication, dispensed to 1.4 million people,' said Professor Guy Marks, Director of ACAM.

'The surprising finding was the low level of regular use of this type of medication, once prescribed', Prof Marks said.

Even among people aged 65 and over only 30% of those who were dispensed any inhaled corticosteroid appeared to use it regularly over the course of a year, he said.

LBH Stroke Unit: a tight multi-disciplinary team

By Janet Grist

IT IS 16 MONTHS SINCE LISMORE BASE Hospital's Stroke Unit commenced operations.

HealthSpeak paid a visit and spoke to Stroke Unit Coordinator Kim Hoffman and its Medical Director Dr Stephen Moore.

For nearly 15 years, the Stroke Unit was just a glint in the eye for clinicians urging Lismore Base Hospital (LBH) to open one. The unit, which opened in February 2014, is a four bed room located in the medical ward at LBH.

Stephen Moore explained how it came into being.

"LBH was part of a stroke trial 15 years ago and several staff were very keen to open a dedicated unit. While there was a lot of momentum at that time there was no funding or support forthcoming. That momentum fizzled out but was renewed again when LBH stroke clinicians (nursing and allied health) participated in a national rural stroke audit program, which once again showed the need for a coordinated stroke service and a Stroke Unit," he said.

At that time, Kim was a senior physiotherapist treating a great many stroke patients and although there was a big resurgence of interest in setting up a Stroke Unit, once again the funding didn't materialise.

So, it was really something to celebrate when the funding finally came through.

"Kim in particular was instrumental in pushing for the unit. Her position as Stroke Coordinator commenced in October 2012 and after that things took off," Stephen explained.

The benefits of a Stroke Unit are well documented.

"Research shows that if you care for your patients in an acute stroke unit you have a 20 to 30 per cent reduction in mortality and morbidity. So Stroke Units have been the gold standard in Australia and around the world for many years.

"With a dedicated unit, our stroke patients receive the routine care and monitoring so vital in their first three days. During this time it's important to properly monitor patients and pick up whether or not they are deteriorating.

"The first three days are the most important to prevent stroke complications and stroke expansion. The monitoring is important to ensure the patient is not febrile and not hypoglycaemic, because that can affect the infarct area. Early access to rehab is important, too, so that the neuroplasticity of the brain can start happening to give patients the best functional outcomes."

While the Stroke Unit comprises four beds, its numbers ebb and flow. Sometimes the unit has 10 stroke patients. After three



From left: Allison Wallis (Nurse Unit Manager), Alison Gould (Occupational Therapist) and Kim Hoffman, Stroke Unit Coordinator.

days the patient gets moved to a bed within the medical ward, remaining on the same ward with the same staff. The average length of stay in hospital is six to seven days, just below the state average.

The Stroke Unit has been able to employ

conferences are held with Stephen and the multi-disciplinary team to discuss patients' progress and discharge planning.

Part of Kim's role is to ensure stroke patients are given one on one education about risk factors and what they need to do to prevent another stroke.

LBH is the hub for the whole of the Richmond health network and it's to this hospital that stroke patients are sent to receive the high quality care and management the unit provides.

Treating more than 300 stroke and TIA patients a year, nearly 60 per cent are discharged straight home. Those needing rehabilitation go down to Ballina Hospital which has close links with the LBH stroke team. There is also a home-based rehabilitation service run through the Carroll Centre at St Vincent's Hospital campus in Lismore. Patients going home can be referred to the Carroll Centre for follow up therapy.

Stephen said it's the continuity of care that sets the Stroke Unit apart.

"In coordinating the unit we've brought together clinicians involved in the pre Stroke Unit phase – Ambulance personnel and the patient's treatment in A and E and the post stroke phase, discharge planning and rehab. Tying all these different phases together results in a much more streamlined model of care which works really well," he said.

As Medical Director, Stephen is one of a number of physicians who look after LBH's stroke patients.

"The other physicians are very keen and well aware of how the service runs, we have good lines of communication. But perhaps more importantly, the junior medical staff

Signs of stroke

Use the **FAST** test if a stroke is suspected.
FACE – Check their face, has their mouth drooped?

ARMS – Can they lift both arms?

SPEECH – Is speech slurred? Do they understand you?

TIME is critical. If you see any of these signs dial 000 immediately

Other signs include

- Weakness or numbness of the face, arm or leg
- Dizziness, loss of balance or an unexplained fall
- Loss of vision, sudden blurring or vision problems
- Severe headache with an abrupt onset

additional allied health staff.

"We have physiotherapy, occupational therapy, speech therapy, social work and dietetics. We also employed allied health assistants who provide extra therapy seven days a week, four hours a day, as directed by the allied health therapists. It's all about early rehabilitation and monitoring patients which gives better outcomes in Acute Stroke Units," said Kim.

The Stroke Unit is now a streamlined, highly functioning unit where weekly case

come to our weekly meetings as well and have become much more aware of stroke and its manifestations.

“Kim gives lots of staff educational talks and I give a few,” he added.

Kim is keen to emphasise one aspect of the LBH Stroke Service – that stroke thrombolysis is provided at LBH. (Thrombolysis is the breakdown of blood clots by pharmaceutical means.)

“It’s good for GPs to know that we use thrombolysis and that we only have a window of four and a half hours after a stroke to carry out this procedure.

“Unfortunately, in our area we have low numbers of acute strokes presenting to hospital in under four and a half hours, as many people don’t recognise the symptoms of a stroke early on. Last year we only had 29 per cent of our ischaemic strokes present to us under the four-hour mark. The quicker the patient can get to hospital, the better,” Kim told *HealthSpeak*.

“So, if patients ring their GP or visit their GP first with stroke symptoms or a TIA, the GP needs to say ‘go straight to hospital’. The other important point is that the GP should never give aspirin to a suspected stroke patient in case the stroke is haemorrhagic. We’ve had a couple of cases where the GP had given aspirin and it ended up being a haemorrhagic stroke, so while the GP can give aspirin for a cardiac event, do not do so for strokes,” said Kim and Stephen.

Stephen said some doctors who’ve worked in the health system for a long time may not be aware of the advances made through thrombolysis.

“For a long time a stroke patient was just put in the back room in casualty and staff ‘got around’ to treating the patient, but in the past 20 years the importance of treating stroke rapidly has become realised both in A & E and at physician level as well.”

Stephen explained more about thrombolysis.

“It’s a relatively new procedure for stroke and there are significant benefits, they have done big trials, but there are significant risks as well. It’s not a benign treatment. A sizeable minority bleed, 7 out of 100 of which 3 out of 100 will be fatal.

“However, with thrombolysis the longer term outcome is significantly better and there are very strict criteria for administering it and very strict monitoring required. It’s a much more difficult treatment than thrombolysis for a heart attack.”

Naturally, with a small window of opportunity to thrombolysate patients, it’s important that the A & E doctors are aware of the needs of a stroke patient.

“One of the strengths of Lismore Base compared to many hospitals is the fact that our A & E doctors are really on board with this. A lot of the larger teaching hospitals have dedicated stroke teams but sometimes A & E aren’t even involved. Someone pres-



“The treatment of stroke has changed quite dramatically in a relatively short period of time”

Lismore Base Hospital

Messages for GPs

- A stroke is always a medical emergency
- Do not give a suspected stroke patient aspirin
- Direct a stroke patient to hospital ASAP – to LBH in the Richmond area, to The Tweed Hospital in the Tweed area or to Grafton, Coffs or Port Macquarie further south
- To be thrombolysed, a patient needs to reach a hospital that provides thrombolysis in under four hours.

ents and they just call the stroke team who come down and take them back to the ward. In a place like here you are so dependent on the A and E staff but we are lucky. Dr Chris Gavaghan, our A & E Medical Director, is very proactive in this regard,” said Kim.

As thrombolysis is not available at smaller hospitals, stroke patients in the Northern Rivers need to get to LBH quickly. Further south there are Stroke Units at Coffs Harbour and Port Macquarie and these hospitals thrombolysate. Tweed Hospital is in the planning stages of setting up a Stroke Unit. In that area, the John Flynn Hospital offers thrombolysis.

Strangely, stroke is not considered to be a priority one health condition by the federal government despite the fact that it’s the leading cause of disability in Australia and the second cause of death. So without the funding to run awareness campaigns, the general public remains somewhat ignorant about whether or not they are having a stroke.

And sadly, the Stroke Unit gets patients arriving a day or two after a stroke. While really severe strokes where the patient is completely paralysed and can’t talk are only experienced by 10 per cent of stroke patients, most patients will have mild to moderate symptoms and don’t realise the importance of getting to hospital.

It’s clear speaking to Stephen and Kim that they are excited and proud of the work the Stroke Unit is doing.

While there are no Stroke Unit figures

yet available to accurately map the impact of the unit (these will be available after June), the unit is meeting its monthly clinical indicators around 90 per cent of the time, which Kim describes as pleasing

With endovascular therapy in use and other drugs being trialled for use in stroke, the management of this condition will continue to evolve.

“The treatment of stroke has changed quite dramatically in a relatively short period of time. It’s come from something you couldn’t do much for to something where there’s the potential to do a lot of good,” said Stephen.

“So it’s been exciting to be involved with it and Stroke Coordinators and Stroke Units have popped up all over the place now, creating a very close community where Stroke Coordinators meet regularly for educational events and sharing information.

“In my experience it’s been one of the better coordinated areas in health, certainly providing the best coordinated response to treating a condition,” he added.

Online resources: www.strokefoundation.com.au/health-professionals/
www.estroke.com.au

CHIROPRACTIC IS BASED upon the understanding that good health depends, in part, upon a normally functioning nervous system.

Chiropractic works by helping to restore your own inborn ability to be healthy. When under the proper control of your nervous system, all the cells, tissue, and organs of your body are designed to function well and resist disease and ill health. The chiropractic approach to better

health is to locate and help reduce interferences to your natural state of being healthy.

A common interference to the nervous system is the 24 moving bones of the spinal column. A loss of normal motion or position of these bones can irritate or impair the function of the nervous system. Chiropractors aim to improve nervous system function primarily through chiropractic adjustments (with particular attention

to the spine, skull and pelvis), to help remove any interference that may be impairing normal function.

They are the spinal health experts and a consultation begins with a case history. After reviewing the history and discussing the specific problem, a thorough orthopaedic, neurological, and chiropractic examination is performed and X-rays may be taken. These examinations help identify areas

of spinal malfunction and resulting nervous system deficit. The findings are explained and a plan of chiropractic adjustments may be recommended.

Australian chiropractors are five year university trained, and are government registered and government regulated professionals.

Information from the Chiropractors' Association of Australia: www.chiropractors.asn.au

Profile Maree Chilton, chiropractor

FIRST INTRODUCED TO chiropractic by her father, Maree was a talented athlete at a young age. One particular injury required treatment before a competition and the results achieved meant that this chiropractor became a mentor.

"I worked in his practice as a massage therapist from the age of 14 and did odd jobs. This taught me how to interact with people and I was able to develop an appropriate bedside manner. The results he achieved inspired me to pursue a career in chiropractic" said Maree.

Maree attained a Bachelor of Science in Anatomy and Masters of Chiropractic from Macquarie University, graduating in 1993. She came to realise after working in private practice for some time that while university was useful in providing the foundations to graduate, one's working life is spent refining this knowledge.

Her first chiropractic position was in Mackay and Maree then moved to England and spent seven years working and travelling abroad. At this time there was a push for dentists, chiropractors, body workers and nutritionists to work collaboratively with patients to treat temporomandibular joint disorders - conditions that cause pain and dysfunction in the jaw. For 10 years Maree



worked in this field.

While her original goal after university had been to do chiropractic outreach work in developing countries, it was some time later that an opportunity came up to work at a hospital on an island off Cuba at the request of Fidel Castro.

"This was a great challenge and an incredibly rewarding experience. The orthopaedic specialist would determine potential patients and then they would be assessed by the chiropractor and treated. Like any outreach scenario when people heard we were there they flocked and camped at the hospital for days."

Her next stop was India where she worked in a health clinic reading X-rays for local doctors. In 2008 Maree returned to the North Coast where she is based in Alstonville.

"Working in country areas

“I believe health comes from within, our role is to educate people how to look after themselves”

is very different to cities – you have to be more adaptable and this has led me to explore post graduate study in various areas."

Maree said that while there are many techniques in chiropractic, she works in the 'low force' category, Sacro Occipital Technique (SOT) which provides treatment suitable for people of all ages, From Pregnancy, neonatal and postnatal, sports people to health impaired.

"My professional journey has helped me develop a broad and valuable skill set, including rehabilitation, muscle taping and cold laser therapy"

Maree describes chiropractic as an art/technique, science and philosophy. What is exciting over time in practice as science improves our understanding of the human body and its responses we can utilise techniques and tools to

improve patient outcomes.

Maree recalls one of her rewarding patient experiences.

"I was found on Facebook, and thanked by a former patient for saving his life. He went on to share that before he saw me he was in so much pain that he was going to end his life as he could no longer cope. He had been in the UK police force and sustained an injury where he'd injured multiple discs. In addition, he had intractable back and leg pain.

"While the treatment I gave him was not remarkable, sometimes we don't realise how far reaching our words and actions can be for patients. He is now in a loving relationship with hope for the future and is active again," Maree added.

"Most importantly, it's the chiropractic philosophy that drives how I work – I believe health comes from within, our role is to educate people how to look after themselves, so they can ultimately be responsible for their own healthcare. I love working collaboratively with other professionals as this helps to get better outcomes for our patients which ultimately means healthier communities.

Summing up her approach, Maree said her practice was all about how she can better help people help themselves to live quality lives in whatever ways that resonates with them.

Contact Maree:
0413 289 942 or 66285464

Blooms Ballina: Store of the Year

CONGRATULATIONS to the staff at Blooms Chemist in Ballina, crowned Blooms Store of the Year for 2014.

Pharmacist Claudia Sampson joined the Ballina pharmacy nearly two years ago as a Partner, while Lauren, her retail manager, followed two months later. In November last year the pharmacy's win was announced.

Since Claudia took over, these women, supported by their fantastic team, have revitalised the store with their focus on customer service and connecting with the local community.

According to the judging panel, the Ballina team clinched the prestigious award for their outstanding customer service, prioritising stock intensity and heightening their presentation standards.

Blooms HealthChecks are also a drawcard for customers. They offer a wide range of services including asthma as-



Pharmacist Claudia Sampson and retail manager Lauren at Blooms Chemist Ballina, Store of the Year for 2014.

sessments, diabetes monitoring, blood pressure evaluation, flu immunisation and stroke risk assessment.

In addition Blooms Ballina offers free medication packing, a local delivery service and medication reviews.

"We did a lot of work on the

store layout and took all the giftware out. There was a lot of giftware at the front of the shop – and now the shop is much easier for customers to get around," Claudia told *HealthSpeak*.

Lauren said focussing on the service offered to customers had really paid off.

GP app for palliative care

A NEW SMART-PHONE app called palliAGED is available for GPs who care for older palliative patients at home or in residential care.

The app informs key clinical processes such as Advance Care planning, case conferencing and terminal care management. It also provides prescribing support for common symptoms that patients experience in the terminal phase.

The palliAGED app is free and can be downloaded at Google Play, Windows phone store and Apple iTunes

A time to celebrate, 2015 and all that!

THE UNIVERSITY HAS held its annual VC Awards dinner, celebrating colleagues who achieved academic success during 2014.

Within the School of Health and Human Sciences a number of colleagues were honoured by citations for teaching innovation and development. For example, the complexity of preparing the health workforce of tomorrow means we have to help students to see how the health care system itself is changing and the potential impact on traditional roles. Using digital media, in the forms of virtual worlds, or interactive social media are helping academics engage with student learning in ways not seen before.

Colleagues have also been acknowledged for their community engagement. Some of you may have seen students, under supervision, running health care 'shops' during Seniors Week, or providing student engagement services with a variety of societies.

By Prof Iain Graham

Dean, School of Health and Human Sciences
Southern Cross University

These efforts provide health care and teach students good citizenship skills at the same time.

Some students have been recognised too - achieving either regional or national recognition for evolving their skills base while also enhancing their understanding of person centred care.

Additionally, last year saw the School and its staff achieve major success in the field of research, with our research activities continuing to grow. The School employs 42 research active staff, who alongside heavy teaching commitments, published 145 papers in peer reviewed journals and generated more than one million dollars in grant income.

We await the outcome of our latest research submission to



the national review body. We have made submissions in the fields of Nursing - currently graded at a national excellence level of ERA 4 - Medical Science and Human Movement, which relates to our work in exercise science and with China.

Increasingly for health practice research, it is necessary to integrate basic science with applied health care research. The disciplines within the School are playing a major role, regionally, nationally and now internationally in this integration as we work with our provider colleagues

to translate our research into practice.

This year we have introduced the 'Professors in Residence' program, with two of the School's professors leading research work in the North Coast Local Health District with another supporting work with Feros Care, the aged care provider. We will shortly be interviewing for a senior lecturer/ consultant nurse with the Mid- North Coast Local Health District who will support research capacity development. These approaches reflect our strengths and values in applied research. To learn more about our research I refer you to the School's Facebook page and our 2014-2015 Research Report.

The School's journey, with regard to its research identity is growing, dependent on two things, the academic staff, who are gaining recognition for their work and our service partners and the patients for helping it happen. 2015 looks like being a good year too!

GP training bid for North Eastern NSW

NORTH COAST GP Training (NCGPT), the local Regional Training Provider (RTP) of GP Training, announced in May that it would be partnering with two other NSW RTPs to establish a new single general practice training entity.

The collaboration with Newcastle-based General Practice Training Valley to Coast and Blacktown based WentWest is in response to the Department of Health's decision to reduce the number of GP training regions in NSW from seven to three.

The tender for these new regions will take place over the next two months with successful organisations announced in August and beginning operations in January 2016.

The new "local" training region, North Eastern NSW, incorporates areas once controlled by four RTPs and covers the same footprint as the four Primary Health Networks, North Coast, Hunter New England and Central Coast, Western Sydney and Northern Sydney. The new North Eastern Training region is a mix of urban, regional and remote areas and will have the largest number of registrars in Australia. It will also have the largest intake of registrars next year with 262 registrars allocated to begin in 2016.

CEO of NCGPT John Langill is confident the collaboration with the two other RTPs will ensure that NCGPT will continue to have an ongoing role in



NCGPT CEO John Langill with Director of Training Dr Christine Ahern.

GP Training in our region.

"NCGPT has worked hard over the last 13 years to build a supportive and high quality training program which attracted the best and brightest registrars to the North Coast. We will do everything we can to see that legacy continue. The three partners are committed to working together as equal stakeholders to ensure quality GP training that best meets the needs of our registrars, supervisors, practices and their communities."

As the collaboration is between three of the incumbent training providers that currently manage the majority of the new North Eastern region, John believes the collaboration has a high chance of success. Currently the three RTPs work with over 250 practices in this region and currently train roughly 75% of the registrars

servicing there.

"This collaboration will enhance the quality of GP training across the new region by combining the individual strengths of each of the three partner organisations to create an even stronger, more efficient and more capable entity."

Although the collaboration means that NCGPT will be part of a much larger organisation, both the NCGPT Board and the management team are very comfortable with their decision.

"After numerous meetings with the three Boards and senior staff, it is clear that fundamentally we all share a similar vision for GP Training. Importantly, there is a common understanding that our training practices form the backbone of the training program, so we are all committed to implementing a strong program of support for our supervisors and their

practices," he said.

While the Tender documentation is yet to be released, it is anticipated the Department will be looking for cost savings from these larger organisations. John said the new entity would be looking to create additional training capacity through innovation and efficiencies while maintaining a focus on quality education and safety. He was also aware that there was a level of unease among some in the region about what the changes to GP Training would mean for them.

"NCGPT is aware that the long wait for the announcement of the new training regions would have caused concern for some staff, registrars, supervisors and practices, so I would like to thank them all for their patience, as well as their support. We are committed to ensuring a smooth transition during the implementation of the Government's re-structure of GP training and we will consult widely with all our stakeholders and keep them informed throughout the tender process. We plan to be working with our local practices and communities not just till the end of the year, but well into the future."

Pharma treatment for drug dependence slows

GROWTH IN THE number of people receiving pharmacotherapy treatment for opioid dependence has slowed, according to the Australian Institute of Health and Welfare (AIHW) website.

The website shows that over 48,000 Australians were on pharmacotherapy treatment for opioid dependence on a snapshot day in 2014. While the number of people receiving opioid pharmacotherapy treatment almost doubled between

1998 and 2014, growth in client numbers has slowed in recent years.

"Between 1998 and 2010 the number of people receiving opioid pharmacotherapy treatment increased by an average of 5% each year, but this dropped to 2% between 2013 and 2014," said AIHW spokesman Geoff Neideck.

NSW had the highest rate of people receiving opioid pharmacotherapy (26 clients per 10,000 people), while the

Northern Territory had the lowest (6 clients per 10,000 people).

"About two-thirds (65%) of clients receiving pharmacotherapy were male, and around 1 in 10 clients identified as Aboriginal and/or Torres Strait Islander," Mr Neideck said.

Heroin was by far the most common opioid drug of dependence for clients. Methadone continued to be the most commonly prescribed treatment drug, and most clients attended a pharmacy dosing point.

Health Speak

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Homelessness and health: how GPs can help

By Amanda Shoebridge

Communications Officer,
Northern Rivers Social
Development Council

HOMELESSNESS IN THE Northern Rivers is difficult to measure due to its hidden nature. Invisible to the public, the vast majority of homeless people live out of sight in unstable housing conditions, on the floors or couches of friends and families or sleeping rough.

“It is the hidden nature of homelessness that means that the Australian Bureau of Statistics data often washes over the truth,” said Shay Kelly, Manager of the Connecting Home Program based in Lismore.

“Because so much of the homeless population is hidden from view it is very difficult to measure the number of homeless people in the Northern Rivers region, and if we can’t see them, we can’t help them,” Ms Kelly said.

This is where GPs can help. Commonly it is the GP who is the first to know about issues their patients are facing, such as mortgage stress, financial difficulties, rental stress, work stress or relationship difficulties.

“As soon as GPs get a sniff of issues like these which can lead to homelessness, they can contact Connecting Home. The earlier we get engaged, the more opportunity the person has to remain housed,” Ms Kelly added.

The cycle of homelessness and health issues is well documented. Some health conditions can lead to homelessness, for example poor mental or physical health which reduces the ability to maintain employment. Other health problems are a direct consequence of being homeless – poor nutrition, poor hygiene, poor dental health, or substance abuse. Homeless people also experience significantly higher rates of death, disability and chronic illness than the general population.

Finally, homelessness can exacerbate pre-existing health problems and complicate treat-



ment due to reduced access to medical treatment, financial restrictions, or lacking identity cards for Medicare payments.

Introducing Connecting Home

The Connecting Home program is being delivered throughout the Northern District by the Northern Rivers Social Development Council and the Communities North Consortium. In the six months since its inception the Connecting Home program has worked with 1,101 young people from 16 to 25 years of age across the district from Tweed Heads to the Clarence.

Connecting Home works with people who are homeless, or at risk of homelessness, to achieve long-term housing goals, whether that be supporting people to reconnect with their families or to find secure accommodation options. It provides early intervention and prevention and engages people prior to crisis to ensure people stay housed. It also provides crisis response through emergency short-term accommodation in collaboration with Housing NSW and the state-wide Link2Home Service.

Because there is often a great deal of shame around the issues people face which lead to homelessness, it can be difficult for people to speak about them

“Some health conditions can lead to homelessness, for example poor mental or physical health”

and acknowledge there is an issue.

“Often GPs have an amazing rapport with their patients and there is a great deal of trust between them. If a doctor thinks their patient would be more comfortable, we could meet their patient at a consultation to talk about what options are available and how we can help them,” Ms Kelly says.

On the reverse side, it is not uncommon for case workers to identify health issues and the need for assistance from health practitioners.

“The health problems experienced by people who are homeless are very full on. Disabilities, mental and other health disorders, a diminished ability to maintain work, high costs in terms of medications and things like substance abuse and environmental factors are all adding to the extra pressure. So working closely with health

professionals, especially GPs, is key to holistic outcomes for vulnerable people,” Ms Kelly said.

GPs can help by

- Expressing interest in working with people experiencing homelessness - you can contact Connecting Home so that caseworkers know which GPs they can refer people to.
- Identifying if you would be prepared to bulk bill someone affected by homelessness in times of need.
- Considering holding a block of time for homeless patients accompanied by their caseworkers.
- Referring your patients to us by either passing on our details to them, or by contacting us directly (details below).

If you are assisting a person requiring support, the best contact for state-wide information and referral to the appropriate Specialist Homelessness Service provider is: Link2Home: 1800 152 152

For referrals direct into Connecting Home email firstresponse@connectinghome.com.au or phone 02 6698 5609.

Imaginative solutions to local concerns



The township of Comboyne

THE COMMUNITY VOICES program run by North Coast Medicare Local (NCML) gives residents of isolated communities a chance to get together, raise health and wellbeing issues of concern and find solutions appropriate to that community.

NCML Health and Equity Program Officer Ted Greenwood said that on the surface some of the issues brought up at these consultative meetings might not appear to be health related, but many have a big effect on the mental health of these residents living without immediate health care. This in turn can affect their physical health and the resilience of the community.

“It is really positive when members of the community identify the issues that make

their day to day lives more difficult. Then, through the process of a facilitated conversation, together we can find solutions that suit the particular needs of that community,” he said.

Recent community consultation meetings in Comboyne (60km south-west of Port Macquarie) and Rollands Plains (35 km north-west of Port Macquarie) have produced some unique solutions to residents’ health and wellbeing concerns.

Creating an NBN digital hub

While the NBN is available in Rollands Plains and Comboyne, not everyone will have access to the service. To ensure access to the NBN for all, the Com-

munity Hall at Rollands Plains and the Neighbourhood Centre in Comboyne will be set up as Hubs to provide broadband access for everyone. The Hubs will also be used as a training spaces for upskilling some of the less tech savvy seniors to get the most out of their mobile devices or their desk top computer. The training will be provided by local volunteers. This will increase the engagement of some of the more isolated residents in the wider community.

Improving mobile phone access

Mobile phone service is poor in these two areas but there are a number of locations where the service strength is good. These spots will be identified by residents and marked by a phone symbol placed on an

adjacent tree, post, fence, star picket etc. These locations will also be marked on a local map which can be distributed to all residents and emergency services and made available to visitors and tourists.

Communicating in an emergency

A recent incident occurred where a farmer was seriously injured on his property and his family wasted valuable time trying to get help to direct emergency services to his location. This is because in these villages, residences are not marked with street numbers.

To prevent this happening again, a telephone “tree” will be set up to enable all members of the community to be contacted in the event of an emergency. The tree will also be used to maintain contact with outlying residents to regularly check on their health and wellbeing and to be a point of contact in the event of a natural disaster. The template to be used will see each household storing five contact numbers in their mobile phone that can be called in an emergency.

These solutions show that the answers to local problems are so often with the community. NCML’s role is to facilitate the process of getting the community together to allow these solutions to develop.

CVD evening sparks interest



General Cardiologist Dr Stirling Carlsen’s presentation at a Ballina Byron Clinical Society event in April on CVD treatment in general practice created a lot of audience participation around three case studies. More than 30 GPs and specialists attended the evening at North Coast GP Training in Ballina. In the Spring issue of HealthSpeak, Dr Carlsen has kindly offered to write an article on this topic.

Briefs

Zinc helps a cold

AN AUSTRALIAN meta-analysis has shown that high-dose zinc lozenges cut many symptoms of the common cold.

Researchers found that the duration of nasal discharge was shortened by 34%, cough by 46% and muscle ache by 54% when patients took 80—92mg/day of zinc acetate in lozenge form.

Backing up previous research, pooled data from

three small randomised and placebo-controlled trials found that the use of zinc acetate lozenges in high doses cut the cold duration by 42% overall.

A zinc intake of 80—92 mg/day is far higher than the recommended dietary intake of 14mg/day and 8mg/day for Australian men and women, respectively. However, previous research has shown that intake of 150mg/day of zinc for two months does not cause permanent harm.

BMC Family Practice 2015; online 25 Feb



CTG Day: sharing front line stories

NORTH COAST MEDICARE Local's senior Aboriginal Health Programs officer Emma Walke organised a Close the Gap Day event at the University Centre for Rural Health in Lismore on March 19.

About 40 people gathered and were treated to some traditional dance by three young local men, a talk about where things are at with Closing the Gap, and local Aboriginal service providers also spoke about their work.

Emma said that since the Closing the Gap Health Equality Plan was drawn up in 2008, she had seen 'heaps of wins'.

"There's a better understanding of health in our communities across Australia, remembering that all our communities are different. There's been continuous funding to NACCHO health services, New Directions, Closing the Gap (CTG)



and there's now the ability for people to get CTG scripts.

"There are also the Complementary Care and Supplementary Service (CCSS) programs enabling people with chronic

diseases to access medical aids and get assistance when travelling to care."

Emma said the CTG campaign had ensured that the health of Aboriginal people was at the front of Australian minds and created much improved communication between GPs, local health districts and Aboriginal health services and programs.

She also outlined the many related research projects at the University Centre for Rural Health in Lismore.

"The UCRH is also partnering with AMSes and other Aboriginal organisations to provide students with amazing and rich experiences in their services, by creating opportunities for students to learn in a meaningful way about what affects us as a community, from past government policy to the effects of trans generational trauma, and as much as possible see through the eyes of our mob, not just being told information.

"This means that our students, future doctors, nurses, specialists, allied health pharmacists are coming to the Northern Rivers area and going through UCRH and will be much better placed in my

Final year med student Alan Dyason created this painting within hours so that each visitor to the UCRH Close the Gap event could sign it. It will be hung in the common area at UCRH.

opinion than any other to work with our people in a culturally appropriate way - with care and understanding," Emma told the gathering.

Wendy Knight from Foundations Care in Ballina talked about the out of home care that Foundations Care provides and the fact that Aboriginal children were often placed with non-Aboriginal carers as there were simply not enough Indigenous carers available.

"As far as Closing the Gap goes, we rely heavily on allied health services for our kids. Aboriginal children are over represented in the child protection system and we strongly encourage our carers to access these health services, whether it's speech therapy or a GP or going to an AMS.

"We encourage our foster carers to get to know Aboriginal people in the local area so that these kids are still holding some sort of cultural family ties," said Wendy.

Cathy Tarrant, a case work manager for Ngunya Jarjum Aboriginal Child and Family Network based in Lismore, said her organisation had around 140 children in out of home care.

"It's very important for our kids to have a health assessment right away, to be reviewed by a paediatrician and a care team. So we are working very hard in forming relationships with the AMSes in our area, local paediatricians, child psychologists and child psychiatrists.

"But there is a major gap - we don't have culturally appropriate specialists in psychology and psychiatry for our kids," she added.

New ENT outreach at Ballina

BULLINAH Aboriginal Health Service (Bullinah) hosted their first Regional Doctors Network (RDN) ENT clinic earlier this year.

Dr Puneet Titoria, who visited the Aboriginal service in Ballina from Lismore Base Hospital, said that more than half of the 20 Aboriginal paediatric and youth patients who attended the clinic would require further follow-up for surgical intervention.

RDN is working closely with local organisations to provide Aboriginal children and youth with access to ENT procedures by expanding ENT surgery lists at Lismore Base Hospital.

The ENT service at Bullinah is funded through the Healthy Ears, Better Hearing, Better Listening program which supports



Aboriginal Health Service (Bullinah)

access to complete ear health pathways – that includes detection, treatment and ongoing management services – for Aboriginal children and youth up to 21 years of age.

The need for additional ENT surgery services has also been identified in Port Macquarie.

The Amazing Race to Happy: a fun way to learn

NORTHERN RIVERS Regional Tackling Indigenous Smoking and Healthy Lifestyle Program (SOLID MOB) is based in Ballina and hosted by Bullinah Aboriginal Health Service, but works across NSW Northern Rivers from Tweed Heads to Grafton and inland to Tabulam.

A team of six tobacco action workers and healthy lifestyle workers partner with Aboriginal and Torres Strait Islander communities to raise awareness of the health impact of tobacco smoking and chronic disease.

Providing a range of activities to educate and promote quitting tobacco and live healthier lifestyles, SOLID MOB has found a way to really engage school children with their messages. It's a team-based game called The Amazing Race to Happy.

Jody Irwin is SOLID MOB's Regional Tobacco Coordinator and she told *HealthSpeak* about the creation of this popular game.

"We employed an organisation called The Great Race and together we developed a game specifically for Solid Mob and the messages that we are trying to deliver.

"We've run the game in four schools so far, with all of Year 7 Kadina High students, all of Year 7 South Grafton High students, Coraki public school, years 5 and 6 and Gulmarrad Public School near Maclean," she said.



Lismore AMS Manager Christine Wilson with some of Kadina High's students during The Amazing Race to Happy.

The game will be played at Kingscliff High and Casino High as well as Ballina and Lismore Heights Primary schools this term.

The Solid Mob team wanted to get away from adults standing up in front of a class talking about healthy lifestyle issues and find a way to really get school kids involved in a fun way to learn these important messages. The game is portable and is set up at the school before class by Solid Mob and some volunteers, turning the school into a giant, amazing race.

Solid Mob likes to include local organisations in the two-hour game. In Lismore two Medicare Local workers came, along with Headspace staff, staff from the

“The team wanted to get away from adults standing up in front of a class talking”

NNSWLHD, people from the Quit for New Life program, the PCYC and Jullums, the Lismore Aboriginal Medical Service.

"It's so much fun and it's a way of introducing the workers to the kids. So at the introduction of the game and the debrief of the game we get a chance to say 'these are your local

Aboriginal Health workers from the medical health centre, this is Tanya from headspace. These are the youth and health workers in your community that you can go to for health and wellbeing support," said Jody.

The kids are broken up into teams of six and have to visit different checkpoints at which they are given a card which has a clue to the crossword on the back of their game card. Getting through the crossword will reveal a secret word.

Each checkpoint is related to health and wellbeing. Topics include smoking, mental health, sugar intake and chronic disease.

Each activity is fun, educational and interactive. For instance, the smoking segment of the game is an obstacle course and the participants have to get into wacky outfits and wear 'smoky eye' goggles which impair their vision. This stimulated discussion about what smoking can do to vision.

At the end of the game the kids are debriefed with the judges explaining how they've been judged along the way and providing feedback about how well they've worked together. The game ends with the kids being asked questions about what they've learnt and being awarded prizes.

To find out more about Solid Mob's activities contact Jody: 6686 3607

Boosting participation in health

NSW HEALTH HAS launched a website that aims to boost the number of Aboriginal people working in health professions across the state.

The website, *Stepping Up*, identifies job opportunities at NSW Health and provides clear guidance to Aboriginal people wishing to build a career in the health sector.

NSW Health Aboriginal Workforce Manager, Charles Davison, said the *Stepping Up* website helped Aboriginal applicants overcome the

challenge of finding a job that matched their experience and aspirations.

"The website also provides information and tools to help managers recruit and retain Aboriginal staff across the broad spectrum of health roles. "At NSW Health we offer a wide range of employment opportunities to people who are passionate about closing the health gap between Aboriginal and non-Aboriginal Australians.

"These roles include medical and primary care prac-



tioners, nurses, midwives, service and program manag-

ers, Aboriginal Health Workers, Aboriginal Mental Health Workers, administrators and leadership positions.

"We want to help Aboriginal people of all ages carve out a career path in the health sector where they can use their skills to deliver health services and culturally appropriate care in our communities, where it's most needed."

The *Stepping Up* website can be viewed at: www.steppingup.health.nsw.gov.au/.

Artwork by Jessica Birk, a Yaegl descendant of Northern NSW who lives in Sydney).

Yarning and creativity = wellbeing

NORTH COAST MEDICARE Local's Closing the Gap (CTG) team in Coffs Harbour has been instrumental in creating a number of community events to allow the local Aboriginal and Torres Strait Islander population to come together over the past three years.

One of the most recent was the Elders Art Day and Cultural Workshop held during Seniors Week in March.

This year's Seniors Week Cultural Art Workshop, organised by NCML's Helen Lambert, was a big success with 30 people attending. There were two art forms offered in the workshop – traditional weaving with a local instructor who supplied her own prepared grass fibres and an art workshop run by respected Gumbaynggirr artist Alison Williams.

Auntie Kerrie Burnett of Coffs Harbour was one of those who took part in the art workshop which was held in the Coffs Harbour Botanical Gardens. She told *HealthSpeak* that Elders were asked to bring along an old family photo which could be incorporated into their painting.

The photo that Auntie Kerrie took to the workshop was a stunning picture of her mother when she was just 17 years old.

"The artist who took our class asked me to come up with something memorable about my mother. We were raised on the land and lived in a humpy. And I remembered this particular day when our place was surrounded by bush fire.

"My father was away and my mother led us down to the river. We were all so scared and didn't know where we were going. My mother started yelling out to God. We didn't know who she was talking to, and all of a sudden it started raining," said Auntie Kerrie.

Understandably, this momentous day was etched in Auntie Kerrie's memory – she has a



Auntie Kerrie with friend Margaret Anthony holding the artworks they created at the workshop.



Four generations: Auntie Kerrie holding a photo of her mother who lives in Sydney with her granddaughter Hayley holding a photo of her deceased mother.

vivid recollection of burnt trees and the strong feeling of connection to the land.

Auntie Kerrie created an evocative artwork with her mother's image scanned and placed in the centre of the painting surrounded by blackened trees and the ochre earth underneath. The particular blue used for the sky perfectly communicates the eerie atmosphere of this memorable day.

With her mother's 92nd birthday coming up, Auntie Kerrie is going to frame her artwork and present it to her

Mum on this special day.

For Auntie Kerrie the Cultural Art Workshop was 'just fantastic', and it was the topic of conversation among her friends for weeks afterwards.

"It's the first time we've done such a workshop and it was unbelievable, so enjoyable. It was such a totally different event. We had lunch, it was a beautiful day and we all so enjoyed the social interaction, having a laugh and a yarn up. Without NCML we could never do all the organising for such events to take place. We all had a cry

“We all had a cry later. It was a major achievement for us to do painting and weaving”

later. It was a major achievement for us to do painting and weaving. We really appreciate such days," she said.

Auntie Kerrie said she loved being in the gardens and hearing the birdsong, getting covered in paint.

She said a lot of the Elders were very proactive with their health, doing a lot of things in the community, but that these special community events made a real difference to their lives.

"But some of the Elders don't get out much, some are pretty much housebound. Some are in wheelchairs or walkers but they still come to these events because NCML organises transport and the materials and everything. They make it easy for us to get out.

"You can catch up with your own mob and a great chance to interact with other Elders. The atmosphere was wonderful, there's no real competition. It's all about fun and engaging," Auntie Kerrie said.

Now that she's given the paint brushes a workout, Auntie Kerrie is busy doing bends and squats in preparation for the Elders Olympics coming up in Taree.

"We can't thank NCML enough for sponsoring us to go in the Elders Olympics. Twelve of us are taking part and we are all practising our moves. It's a very exciting build up to the day itself."

The art of self-mastery

By Janis Balodis

It matters not how strait the gate, How charged with punishments the scroll;

I am the master of my fate: I am the captain of my soul.

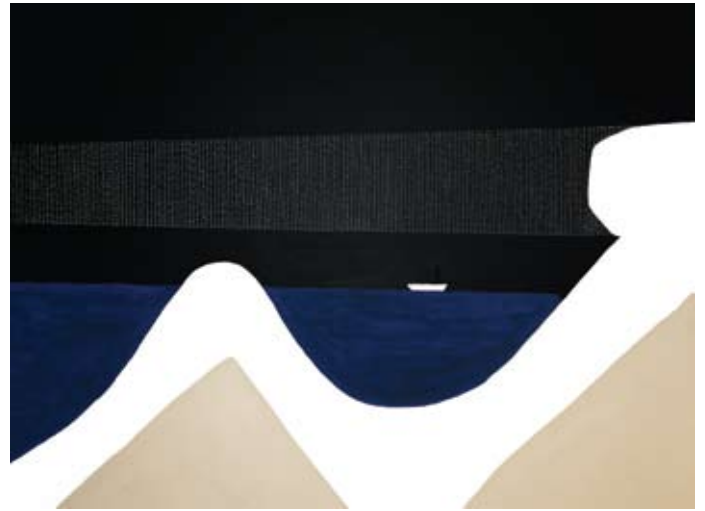
William Ernest Henley

ON A DARK NIGHT IN 2000, Michael Philp was at a “doof” party in the middle of a forest near Kyogle. He had years of alcohol abuse and drug use behind him and an uncertain future. Sitting alone in a car, away from the thumping music he felt a strange coldness, like the visitation of some spiritual presence. Reflecting on the turmoil of his life he offered up a silent prayer. He realized this was his life, that no one else was to blame. He fell into a deep sleep and on returning home the next day, scrubbed himself for ages in the shower wanting to get clean, physically, psychologically and metaphorically, and went to AA.

Michael is a Bundjalung man born to a white fisherman and a Murri woman. His father had been a hard-drinking, often violent man who was frequently away. Michael was determined to rebuild the bridges of trust with his ex-partner and to become a father to his own son who had been born in 1998.

The watershed moment came after 20 years of what Michael refers to as “doing a geographical”, running away from everything, difficult situations, responsibilities and life. He was just beginning a testing journey back to family, to himself and a meaningful life. Frustrating and depressing at times, it was ultimately and surprisingly rewarding.

The first outpouring of art was a cathartic purging of pent up emotions and thoughts that found expression in drawings and doodles of stick figures in swirling dreamscapes of eggs, seedpods, webs and trees, eddies, waves and turbulence, charts of inner and outer worlds, watchful spirits and eruptions of violent action. Insistent visions were franti-



Top: Michael in his studio; 'My Soul Beacon'. Above: 'Patience my Son'

cally captured in a series of A5 sketch pads, assuaging anxieties and providing a troubled soul with an active therapy.

Private doodles of deeply personal, subconscious imagery did not lead to other art and Michael put away his notebooks and got on with rebuilding his life. A few years later when he was feeling burned out from his work with Koori kids in primary school, a friend

suggested he should try painting. It was as if he had been struck by lightning, again, and he painted like a man possessed. His work soon attracted attention and he was invited to participate in group exhibitions. As his practice developed his work became more in demand for solo exhibitions, most recently at the Lismore Gallery, COSMOLOGY IN ME and MY SALTWATER MURRIS.

“ Michael considers himself as a storyteller rather than an artist. ”

Michael considers himself as a storyteller rather than an artist. He has accepted that he is the channel for his old people's stories; and his purpose is to do justice to their stories, which are also his stories. He tries to be led by the work, not knowing what story his paintings will bring up, surrendering control and delighting in the epiphanies as he goes along. He embraces the healing he derives from this spiritually demanding practice, a process he describes as “beautiful, magical and hard work”.

Many of the SALTWATER MURRI paintings deal with nighttime fishing, Michael's relationship with his father, the sea, moon and stars. Dark nights pierced with a simple yet profound symbolism, the works capture quiet connections between family members, and with the greater world. The paintings contain complex and paradoxical narratives of personal reconciliation; darkness suffused with light, intensely private yet universal stories, nostalgia for a lost childhood facilitating mature healing, immediate yet meditative, and

Continued page 39

Equipping the Aboriginal health sector for the online world

A TEAM BASED AT THE University Centre for Rural Health (UCRH) in Lismore is two years into a three-year funded project and already their intensive community consultations have resulted in the creation of an Aboriginal specific e-wellbeing program that's changed the national online mental health landscape.

The aim of the national project is to develop skills and competency for primary health care practitioners to become familiar with e-mental health resources and be able to refer clients to these resources. It targets GPs, allied health professionals and Aboriginal health professionals.

The UCRH research team comprises three Indigenous and three non-Indigenous members directed by Associate Professor James Bennett-Levy with Research Officer Dr Judy Singer, Coordinator and PhD scholar Darlene Rotoumah, e-trainers Kelly Hyde and Simon DuBois and supervision coordinator Brenda Holt.

So far, the project has created and run the *R U Appy?* training program and the culturally appropriate e-wellbeing program which Mindspot.org.au developed.

"Mindspot taking up the suggestion was a tangible outcome from the community consultation process. The community reviewed about 30 e-mental health online programs and told us that none were appropriate for Aboriginal people.

"And the community's response has affected policy too. The Aboriginal specific e-wellbeing program has made a major impact at a national level in terms of creating a far more equitable e-mental health strategy for Aboriginal and Torres Strait Islander people," said Judy.

"Our favourite quote from one of our Advisory group members is 'You haven't done community engagement, you've done community involvement.' And I think that's absolutely the case and that was our aim," he said.

The community consultation included ongoing participation in the Ngayundi Aboriginal Health Council, quarterly Advi-



An *R U Appy?* training group in discussion at UCRH.



sory Gropu meetings in Lismore and Tweed and Learning Circles of Aboriginal health professionals and the community in Tweed and Lismore.

"I've come to really see that the focus of the project is entirely community consultation, it doesn't stop as we continue to report to Ngayundi, we continue to have advisory groups and continue to seek feedback from the training programs. We made quite significant changes to the project based on feedback, even to the point of going counter to the Commonwealth's language," Judy said.

Judy is referring to the re-badging of the local program. While the national project is 'e-mental health', she explained that it didn't make sense on the North Coast.

"There are very few Aboriginal mental health qualified workers here, instead we have a lot of community workers not trained in mental health. But by shifting the emphasis to e-social and emotional wellbeing it became more accessible to the community," Judy added.

Strong is only available on these devices, but Judy said nearly half the participants bring along their own iPads.

The training is also an important educational step for health professionals as the overall emphasis is on skills development.

"It's about bridging the era of the computer and mobile to the era of iPads and smartphones, participants come away with more knowledge and competence around new technologies generally which is really important," said Judy.

Another legacy of this project will be the development of peer supervision for Aboriginal workers. James said that the Advisory Groups told them that Aboriginal health professionals often did not have clinical supervision.

"In collaboration with the Aboriginal Health and Medical Research Council we're setting up a peer supervision process. So all the people doing the *R U Appy?* training will become part of supervision groups for the next six months.

"We are doing that not only for the project but to leave something behind which we hope will become a feature of North Coast Aboriginal services. That and the e-social emotional wellbeing skills will be a big legacy," he said.

The *R U Appy?* training program is three sessions over three successive weeks, a design that grew out of community consultation.

"The training over three weeks allows people to go away and practice and gives them time to consolidate the learning," said James.

Training participants include staff from Aboriginal Medical Services, NGOs such as Rekindling the Spirit, New Horizons etc, North Coast Medicare Local, Bugalwena Health Service and On Track community programs.

It was thought that the lack of ownership of and familiarity with iPads might be a barrier to the training as one popular app, Stay

Briefs

Facebook depression

UNIVERSITY OF Houston researchers have found that those spending a lot of time viewing Facebook and making social comparisons may experience depressive symptoms.

Ms Mai-Ly Steers' research is presented in the article *Seeing Everyone Else's Highlight Reels: How Facebook Usage is Linked to Depressive Symptoms*, published in the *Journal of Social and Clinical Psychology*.

"Although social comparison processes have

been examined at length in traditional contexts, the literature is only beginning to explore social comparisons in online social networking settings," said Ms Steers.

Steers conducted two studies to investigate how social comparison to peers on Facebook might impact users' psychological health. Both studies provide evidence that Facebook users felt depressed when comparing themselves to others.

"It doesn't mean Facebook causes depression, but that depressed feelings and lots of time on Facebook and comparing oneself to others tend to go hand in hand," she said.

How to integrate MTOP into your practice

FAMILY PLANNING NSW has confirmed that there are only two North Coast centres offering medical or surgical termination of pregnancies – the Options Clinic in Tweed Heads and the Bluewater Medical Centre in Coffs Harbour.

A number of North Coast women's health practitioners have expressed concern at the lack of GPs offering medical termination of pregnancy (MTOP) using the so-called 'abortion pill' RU486 in the region.

In April, Brisbane GP Dr Janet Fairweather presented a webinar on the topic. With her kind permission, *HealthSpeak* has edited Janet's presentation in order to provide GPs interested in incorporating MTOP into their practice with the information to do so successfully.

A Fellow of the RACGP with post graduate qualifications in child health and a special interest in family planning, Janet has for the past year been giving her patients the option of MTOP from her Brisbane clinic. Janet works at the Victoria Point Surgery which incorporates Redlands Family Planning Clinic. The clinic's website spells out the services offered, including abortion.

Janet began with an overview of medical abortion and how to integrate it into a practice. She introduced a support program by MS Health, MS-2step, a free online prescriber training for GPs which can be viewed here: http://www.mshealth.com.au/uploads/Product_Information_MS2Step_24Dec14_-_FINAL.pdf

Options & choices

Janet uses a slide to talk through options and choices with women. The slide can be viewed at <https://www.youtube.com/watch?v=sJmmqT6rixY> It is two minutes into the presentation.

"It helps me to discuss with people their choices. You can't really give informed consent for something unless you've been given all your options. In Australia the approved regimen is up to 63 days gestation and involves the use of two medications.

The first is mifepristone (RU496) 200 mg orally and the second, taken 36 to 48 hours later, is GyMiso (misoprostol) 800 mg buccally, four tablets in one intake."

Mechanism of Action

"As you would all be aware, progesterone is required for a pregnancy to continue. Mifepristone acts as a progesterone antagonist by blocking progesterone. With mifepristone decidual necrosis, occurs which is the equivalent of a miscarriage. I usually explain that about 20 minutes after a lady takes the tablet - from the time they leave me - they will be having a medically assisted miscarriage. Then we give their body 36 to 48 hours to recognise that it has an unviable pregnancy.

"Some women do bleed



Dr Janet Fairweather

experience some discomfort.

"The way I recommend is to take the buccal misoprostol in the morning. After a decent breakfast, I suggest a couple of Panadeine Forte, some Maxolon or another antiemetic to relieve nausea. Then, after taking food, I ask them to start dissolving the tablets between the cheek and the gum, after half an hour they are advised to wash down any residue with a drink. The

"Consent must be informed and voluntary and meet the legal requirements in each state or territory. On the MS website (<http://www.mshealth.com.au/>) there's a fantastic presentation by a legal professional," said Janet.

"Gestational age must be no more than 63 days. You need to assess that there are no medical contraindications. The training program gives you a good idea of contraindications. Be careful if someone has a tendency to bleed or if a patient comes in who's on steroids for asthma. In that case, I usually increase their dose of steroids for a couple of days around taking the medication."

Janet said that the medications can be offered to women of any child bearing age who've had any number of pregnancies

“The meds can be used very early in pregnancy.”



between taking the first tablet and the next four tablets. It's important to emphasise the importance of taking the four misoprostol tablets regardless of any prior bleeding. Misoprostol is a prostaglandin analogue which causes the cervix to relax and causes the uterus to contract. This is very important to reduce the risk of retained products of conception and thus the complication of infection. It is usually between 30 minutes and four hours after taking the misoprostol the ladies will expe-

reason I like them to have pain relief before they start is because some women find that they are starting to cramp before the half hour, before they've washed down the buccal misoprostol. So, if they have pain relief on board they don't have to wait the extra 20 minutes for something to work. Also, a side effect of misoprostol is that a lot of women get quite nauseous and if they've already got something down to prevent that that."

Patient eligibility

including caesarians. It can be given very early in the pregnancy.

"That's important to note because sometimes surgical terminations are less reliable in very early pregnancy."

Informed consent

"We talk about how and where the meds are taken. I give them pain relief and advise them to take them in that order. The Mifepristone they take while with me and I watch them take

it because the medication will terminate a pregnancy at any gestational age and I don't want to be responsible for someone giving someone else the drug and terminating a different pregnancy."

Potential risks, side effects

"I run through these in great detail. The two main risks are bleeding too much or ongoing bleeding. And if you retain products of conception you can have a higher infection risk. But it's not a huge risk, one to two per cent of these patients require a surgical procedure and a 0.1 to 0.2 per cent risk of requiring a transfusion due to heavy blood loss. Potentially you are at a higher risk of continuing a pregnancy than having a medical termination, but nothing is risk free."

tinuing. You want to make sure the woman is well and not having fevers or abdominal pain. I get my RNs to give the ladies a call and confirm the history over the phone if necessary."

Janet said it's also necessary to be able to organise for the patient to have a surgical abortion where the MTOP has not completed.

Contraindications

These include a lack of access to emergency care. "You wouldn't want somebody heading out to the middle of nowhere two minutes after taking their pill."

Suspected or confirmed ectopic pregnancy – all of my patients have an ultrasound before they come to me and because some patients are very early in their pregnancy, I warn

on the process without warning them to take some oral iron for a week or two if they are low on iron stores."

To cover all of the above Janet has set up a template in her medical software and she makes sure she covers all these points at the beginning of the appointment.

Breastfeeding - "I have had patients who have used this treatment while breastfeeding and I say to them 'feed your baby before you start, put aside some of your milk and use it for the feed after next. That tends to solve any potential problems with diarrhoea.'"

Janet said there is a new precautionary warning about using this treatment on women over 35 who smoke.

Assessing gestational age

"I have an ultrasound scan done. I approached several local providers and have arranged a couple who bulk bill my patients. Otherwise you are relying on dates and most people will be fairly reliable with dates, but if you can palpate that uterus and it's well out of the pelvis and feels more like a 12 week gestation, I'd not be doing an MTOP for that particular lady."

Screening

Janet said it was important to detect all the RH negative patients.

"I do a full blood count, an HCG in case I need a long distance follow up, I do the iron studies and a group and antibody screen. So if ladies come through who are RH negative, they receive 250 iu of anti D which we keep in the practice.

24-hour hotline

"There's a 1300 number staffed 24/7 by caring RNs experienced with medical termination and I often encourage women to ring that number if they have the slightest concern. Many do call for reassurance that what they are experiencing is normal." This is a national number – 1300 515 883.

Pain management and anti-emetics

"When I first started I wasn't giving such structured medication advice. Now I say, 'don't wake up at 10 pm and take medication, wait until the following morning, have your breakfast and meds and then start the process.'"

"For a lot of women it's over and done within four hours. Without pain relief it becomes more unpleasant than is necessary. Around half of my



“Everyone leaves my first consultation with options for long acting reversible contraception”

Janet stressed that after hours access to medical care is extremely important.

"When I was planning to become a prescriber, I did arrange to inform my hospital ED and I've done a couple of medical information sessions up at the hospital so everyone knows there is a prescriber in the area."

Follow up is essential, with all patients advised to come back within two weeks.

"If they come from a long distance I do sometimes give them a form for a quantitative Beta HCG and do a telephone follow up. Depending on what source you read, if the reading has dropped by 80 to 85 per cent at the two week mark and the woman has a reasonable history you can be fairly well assured the pregnancy is not con-

tinuing. You want to make sure the woman is well and not having fevers or abdominal pain. I get my RNs to give the ladies a call and confirm the history over the phone if necessary."

If a woman has an IUD in place you need to take it out before treatment.

Uncertainty about gestational age, chronic adrenal failure, concurrent long term steroid therapy (here if you increase the dose they are pretty well covered).

Anticoagulants, hypersensitivity – an adverse reaction in the past, anaemia. "As part of my work up I do a full blood count and an iron study, because I don't want to start patients



patients will take a second dose of Panadeine Forte, I have never had a patient require more than two doses.”

Contraception advice

Janet always covers this topic during the first consultation. “We don’t want these patients back for another medical termination. Sometimes what happens is that clinics are not always as motivated to provide ongoing contraception as their GP would be. “Everyone leaves my first consultation with options for long acting reversible contraception, what’s available and information on options. If someone is interested in Implanon or Depo you can give that to them immediately after taking their mifepristone pill, during the first consultation, it does not interfere with the effectiveness of the termination process.

Follow up

“Follow up is essential. I do a urinary Beta HCG at the time and palp the tummy if I’m not sure of the history. I check their bleeding history. Most do know when they’ve passed products of conception.

“We like to have a support person with people but I’ve had people go through without for various reasons and the 24 hour phone nurse support is fantastic. There’s also a SMS offered by MS Health saying ‘We hope everything’s gone well for you. If you have any concerns, don’t forget to call us on 1300 515 883’...

“The majority of patients have two or three kids already, a stable partner and accidentally fell pregnant”

How have I done this?

With most GPs really busy, how does Janet manage a medical procedure when she’s very time limited?

“I freed up four or five appointments every morning and four or five every afternoon and called them ‘book on the day appointments’. So, unless an urgent thing comes up, those appointments are available. That’s allowed me to see a few more children and a few more quick and easy patients who would otherwise be going to registrars or doctors not as booked out as me.

GP concerns

“Some doctors become quite concerned about patients finding out that they are doing this work. If you are prescribing in a city or large metro area people probably would never know. Because for the most part if you are only looking after your patients with unwanted pregnancies, it’s exactly like any other medical consult.

The next patient doesn’t know what you were talking about with the previous patient.

If you are practising in a rural location there is more likelihood of someone finding out. But I’m not convinced this is a bad thing. It is a service for your patients. Studies where they’ve looked at the attitude of Australians to MTOP show overwhelming acceptance of this. In this day and age if you are pregnant and don’t want to be, there’s no reason why you should have to be.”

Janet said she’s trained her front office staff in how to deal with sensitive phone calls. With her approach being one of letting everyone know she’s engaged in MTOP, many people are ringing up for such appointments.

“We did set up a private place for our front office staff to speak to people if required. Some of these ladies have very sad stories, and our receptionists were becoming quite distressed by the patients’ distress. So they can pop into the PM’s office and talk to the patient. This is not required often but it is nice to be able to provide this privacy. I also have a checklist for staff so that all patients get the same message and this ensures that no pre-appointment medical tests are forgotten

Check list form includes:

- Date
- Caller
- Patient
- Medicare card?
- Regular GP?
- Cost
- Need for two appointments
- Medical tests required

“If a patient wants to book, we set them up as a patient and the receptionist sends a pop up message for me with a request for ultrasound and bloods for the patient We are then able to fax to the patient’s preferred provider or leave for collection with reception. We are able to recommend bulk billing providers if required.”

Appointment duration

“I usually give an hour to run through everything with most patients. The majority of patients have two or three kids already, a stable partner and accidentally fell pregnant. They don’t have enormous emotional trauma, for the most part they are very straight forward. You could probably get through in 45 minutes, but I don’t like to push time, I like them to be

well informed and comfortable with me and with the process, so they know they can come back to me with any concerns.

What to charge?

I asked what other providers were doing and picked a fee for an hour of my time. I bulk bill the follow up appointment and also bulk bill for insertion of long acting reversible contraception. However I appreciate this is more generous than many doctors will be able to afford and I am not sure for how long I will be able to continue to bulk bill the insertion of IUD or Implanon post MTOP.

Accessing medications

You need to deal with a pharmacy registered to dispense this medication. Fortunately, there is a pharmacy very close to me. I can walk across the corridor and pick up the medication. I keep the medication at our practice under lock and key because of the risk of terminating a pregnancy at any gestational age.

If I didn't have a pharmacy close by, I'd have a system where I write the script, fax it to the pharmacy and they fax back with the price to charge and dispense it and I give the original to the pharmacy at a later date.

Medical indemnity

This is an issue that is very much quicker and easier now. Originally insurers were wanting to charge a procedural fee, but now most are happy to continue to provide your indemnity with no additional fee. So you can operate as a non-procedural GP but they do like to be advised that you are becoming a prescriber. So email them and let them know you are doing this and confirm they are happy about it.

Medical & surgical backup

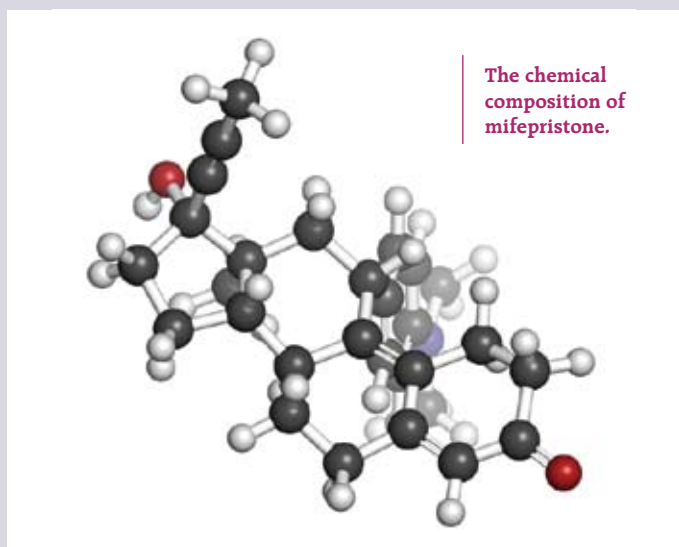
The follow up – local patients return two to three weeks later and I get their history. I do a urinary HCG, an exam and only if I am concerned will I send them for a follow up ultrasound.

If bleeding heavily I do an ultrasound. The vast majority have reasonably heavy bleeding for first few hours, then it settles down and two to three weeks later they are no longer bleeding. The other half have a bit of spotting going on, and extremely rarely significant bleeding. I have been doing this for over 12 months now, with 6 or 7 patients a week and only have had to investigate two for retained products. Neither patient had retained products nor have there been any infections. Remote follow up – the patient gets a telephone call from the RN. They go through history of what happened and the pathology request for their HCG. I like HCG to have dropped by at least 85 per cent, but the 80 to 85 per cent is an arbitrary figure.

“If you have an unintended pregnancy, you don't need an anaesthetic and a surgical termination”

back into you with a complication. So please do the free online training at: www.mshealth.com.au/uploads/Product_Information_MS2Step_24Dec14_-_FINAL.pdf
Checklist:

- If you go ahead let your medical insurer know.
- Have a good relationship with your pharmacy. Discuss with local hospital



Check list if not already prescribing

My goal is to encourage all GPs to do the free, online prescriber training and the reason for this is so important. Your patients will know about this, the first thing a woman with an unintended pregnancy does is go online and Google this stuff. So your patients are going to come in knowing about it. Even if you have no intention of ever writing a script, someone down the road probably is and if it's your patient they could walk

O&G and ED.

- Discuss with colleagues with whom you practice. If you want other doctors to know, then discuss it, otherwise don't tell them and just use it with your patients. It's a personal decision. Educate and discuss the topic with staff. Because I have actively promoted that I do this my staff have to know I am doing it. But if you're not actively promoting this, you don't need to.

A doctor's role is very much about education and we need to educate our patients that if you have an unintended pregnancy, you don't need an anaesthetic and a surgical termination, medical termination is a viable option for women.

Consultation snapshot

Medical points

- Do you have a heart condition etc?
- Are you at risk for STIs? Would you like screening? I check to see pap smear up to date and then we get into pregnancy history
- Are the dates consistent with the scan?
- Any signs of ectopic pregnancy, pain etc?
- Go through contraception options
- Provide the patient with the 1300 number and all leave with a letter of introduction to the emergency department

Key points

Medical abortion is now an effective alternative to a surgical abortion. It is TGA approved and PBS subsidised up to 63 days gestation.

It induces a miscarriage process within hours of the second medication. A patient will take it on a Saturday morning and will be watching their kids play cricket in the afternoon.

Women can complete the process in their own home, but it is important to recognise they are having a miscarriage and have access to medical care in case things don't go to plan.

MS Health has the MS-Step2 resources with additional research being added and now a linked in group for health professionals. The website is at: www.mshealth.com.au

Other Resources:

Dr Fairweather's Webinar is at: www.youtube.com/watch?v=sJmmqT6rixY
www.childrenbychoice.org.au
www.drmarie.org.au/
www.fpns.org.au/

A different approach: Central Pottsville Medical Centre

WHEN *HEALTHSPEAK* visited Central Pottsville Medical Centre, the friendly atmosphere was apparent upon walking in the door.

Situated near the beach, the centre is in a light-filled arcade and its furnishing and décor are smartly casual with clever use of colour to reflect the location.

Staff pride themselves on providing a warm welcome and 'going the extra mile' whenever they can. Practice Manager Annalea Patch said the centre wanted to provide a feeling of warmth and care, something that some medical clinics are too busy and too big to offer.

"A lot of the time you go to a medical centre and they don't greet you, they're not smiling. Our focus is to get to know the patients, we call them by name, I make ultrasound and x-ray appointments for them as well as appointments with our allied health practitioners. We do the complete job," she said.

The other main points of difference at Central Pottsville Medical Centre are the amount of time that doctors spend with patients and minimal waiting times.

"Our patients are not just a number. Our doctors are happy to be called by their first names and are keen to establish relationships with patients. Our doctors are interested in a patient's total wellbeing, incorporating preventative health measures.

Urgent appointments are always seen on the same day. Currently the centre has a speech pathologist, a psychologist and a physiotherapist and they are looking for an acupuncturist. The centre's Dr Aruni Abeywardena is a women's health specialist and other GPs have a special interest in sports medicine and skin cancer. A local doula is also available for expectant mothers.

"We want to provide broad allied health care so that patients can come to the one place for their care," Annalea added.

The centre's practice assistant and Healthy Lifestyle Coordinator Cathy Lee is happy to discuss specific needs with patients and as an accredited



Practice Manager Annalea Patch, Dr De Silva and Asitha Koralage.

Shared Medical Appointment facilitator, Cathy is working on setting up groups focussing on a particular health concern.

Cathy is planning on running a group Weight Loss Program for men and recently a Women's Health Clinic was held on a Saturday which was a big success.

Central Pottsville Medical Centre opened in July last year and bulk bills all general practice patients. It is the first of a number of medical centres that the group APR Holding are

planning to develop.

CEO Asitha Koralage said APR grew out of meetings between the Director of Cardiology at Gold Coast Hospital, Professor Rohan Jayasinghe and Dr Priyal De Silva Nanayakkara.

Asitha explained APR Holding's plans.

"We knew that the healthcare industry is booming in Australia, so we created a business that caters for a number of healthcare aspects that could expand from there.

"We want to set up specialist centres, 'one stop shops' with specialists and GPs in the one centre. At Pottsville we want to build up the specialist centre so patients who come here can be looked after in one single place," Professor Rohan Jayasinghe told *HealthSpeak*.

APR Holding is also keen to expand into rural areas of need, selecting overseas trained doctors with special skills to provide comprehensive medical care in regions currently without a medical clinic.

But its plans don't stop at medical centres.

"Another area we are looking at developing is the medical tourism industry. In Asia, there's a booming economy and a high number of people who are interested in coming to Australia, so with our Asian connections we thought of promoting Northern NSW as a place to come for procedures, surgery and a holiday," Asitha explained.

Another area APR is keen to move into is aged care. With its suite of ideas and plans, it will be interesting to watch how APR expands into health care over the next few years.

Congratulations, Teri

TERI RICHARDSON HAS been a valuable member of the Jullums Aboriginal Medical Service in Lismore for four years and she's become the first staff member to gain qualifications as an Aboriginal Health Worker.

Through determination and hard work, Teri studied while working as a receptionist at Jullums and will soon graduate with a Certificate Four in Aboriginal Primary Health Care.

With four kids aged 16 and under, Teri has a busy life, but grabbed the opportunity to study, completing the Certificate Three in Aboriginal Primary Health Care before committing to the further certificate.

"Certificate Four involved eight weeks of face to face



Dr Andrew Binns and Teri Richardson at Jullums.

teaching in Sydney which was a great experience. I really enjoyed the group work, bouncing ideas off other people and learning about how other people's ideas," she said.

Teri said she worked a lot at night to get through her courses and is pleased she now has her qualification. She now works two days at reception and three days assisting the GPs at the AMS.

Transforming disruptive students into listeners

AN ESTIMATED 60,000 Australian school children have Central Auditory Processing Disorder (CAPD), which means they will struggle to understand their teacher.

CAPD is an umbrella term for disorders that result in a breakdown in the hearing process. Instead of a child hearing their teacher at the front of a noisy classroom for example, they hear a jumble of sounds. Children with CAPD can get frustrated, their schoolwork can suffer and they get tired from trying to hear.

A breakthrough service from Australian Hearing has helped transform a significant number of students into attentive listeners. The CAPD service includes the LiSN-S test, which diagnoses a specific type of CAPD called Spatial Processing Disorder, and the innovative LiSN & Learn computer program, which retrains the brain.

Australian Hearing's specialist Audiologists are now offering the CAPD program in Coffs Harbour. It is suitable



Vienna Pisana on her home computer as part of the CAPD program.

for children from 6 years of age who do not have a hearing loss. The assessment fee is \$380, while the remediation fee will vary.

Vienna's Story

Belinda Pisana says her ten-year-old daughter Vienna was struggling in the classroom since kindergarten and was labelled as 'disruptive' by teachers. Vienna was assessed

by a paediatrician and a psychologist assessed her IQ with results in the superior range. But due to her lagging school results, she was diagnosed with ADHD and placed on a trial medication without any improvement. After further testing, weaknesses in auditory processing were identified and she was referred to Australian Hearing.

"I remember this date viv-

idly", said Belinda. "The Australian Hearing team gave us a diagnosis that made sense." Vienna had Spatial Processing Disorder, a type of CAPD.

"I think some of Vienna's teachers assumed she was a bit naughty and perhaps not too bright. It would have saved us so much time if parents and teachers were aware of the symptoms to look for in CAPD."

Vienna completed the LiSN & Learn program over three months, and returned for reassessment. Results were now within the normal range. Vienna could now use pitch and spatial cues to understand speech in background noise just as well as other children her age. Her ADHD medication was immediately stopped.

Today, Vienna's teachers report that she is now interacting socially with her peers, completing her work at the same pace as her classmates.

For more information, call Australian Hearing on 6652 0700 or visit www.hearing.com.au

Wanted: Psychologist patients for online study



By Arwyn Warner

LIFE IN RURAL Australia is very different to urban areas in many ways. I am a psychologist who has lived and worked in a rural town in southeast Queensland for the past 10 years.

Apart from the vast skies and rolling landscapes, the local community is very different from the area I left in Brisbane.

People seem to know each other better, have more connections within their community and have a greater sense of belonging. However, this closeness has implications for those who live and work in their rural community, and those who access services in the community.

How often have you seen your child's school teacher at the shops or seen a local business owner when you are out for dinner? At times these interactions foster a greater sense of community, but at other times they can be awkward or even prohibit people from accessing local services.

Psychologists call this "overlapping relationships" – when our personal and professional lives overlap. This overlap can also occur when a psychologist lives and works in the same area, and clients may see their

psychologist outside of appointments. Traditionally, psychologists have aimed to keep a clear separation between their personal and professional life, however, for rural psychologists this is often simply not possible.

Some rural clinicians argue that when these relationships are managed ethically and respectfully, some degree of outside contact can actually be beneficial in different ways for clients and that it is in keeping with local rural culture.

Much research has been conducted into rural health providers' experiences of overlapping relationships, but few studies have investigated the experiences of clients. This information is vital to know how to best manage these situations for rural people and improve access to psychology services.

If you are an adult over 18

years and have seen a psychologist in the past five years, I invite you to share your experiences for my Master of Psychology research project with Charles Sturt University. Participation involves accessing an online survey and answering some questions about yourself as well as completing three questionnaires. All information is anonymous and should take less than 20 minutes.

To participate, please go to <https://www.surveymonkey.com/r/GXY-H2M2> or scan the QR code to complete the survey. Thank you!



Risks are Rising

Economy
David
Tomlinson



INVESTING ETHICALLY is big business these days. Individuals and superannuation funds are now seeking out ethical investments as part of a move that seems to be recognising that fairness and sustainability are essential for our longer-term survival.

In response, companies and fund managers are offering a wide variety of ethical investments to meet demand. But what do we really mean by ethical?

In the old days ethical investors shunned investments involved with the evils of tobacco, alcohol and gambling. Dancing would probably have been included if you could invest in it. These days the term has broadened.

Now ethical investors can also screen out companies involved in animal cruelty or testing, that make munitions, that treat workers badly and companies involved in industries that harm the environment.

Some of these investment options are quite specific while others are broader ranging.

Many mainstream funds are also evolving following pressure on them to exclude certain types of investment.

One issue that tends to raise the passions is global warming. Many investors such as charities and universities are now being lobbied to boycott companies that either mine or use fossil fuels.

But ethical investment can also be positive.

Investors are seeking out companies and projects that have positive outcomes in the environmental (renewable energy) and social areas. Micro loans for example can assist people, often women, trapped in poverty simply because they have no access to finance. Even loans of \$100 to women in the third world have seen many establish small businesses that then grow.

The United Nations is now involved in the whole area of ethical and responsible invest-

ing. It has adopted a voluntary charter called the Principles for Responsible Investment (PRI).

The principles cover environmental, social and corporate governance issues.

Importantly, many large investors have signed up and now use these principles when deciding an investment. Worldwide the amount invested in these funds in 2013 amounted to more than \$45 trillion.

In Australia the amount is \$460 billion. Almost half of the 50 biggest fund managers in Australia have signed up to the PRIs.

A list is available on the web site of the Responsible Investment Association of Australia: http://www.responsibleinvestment.org/wp-content/uploads/2014/08/RIAABenchmark2013_v3b.pdf

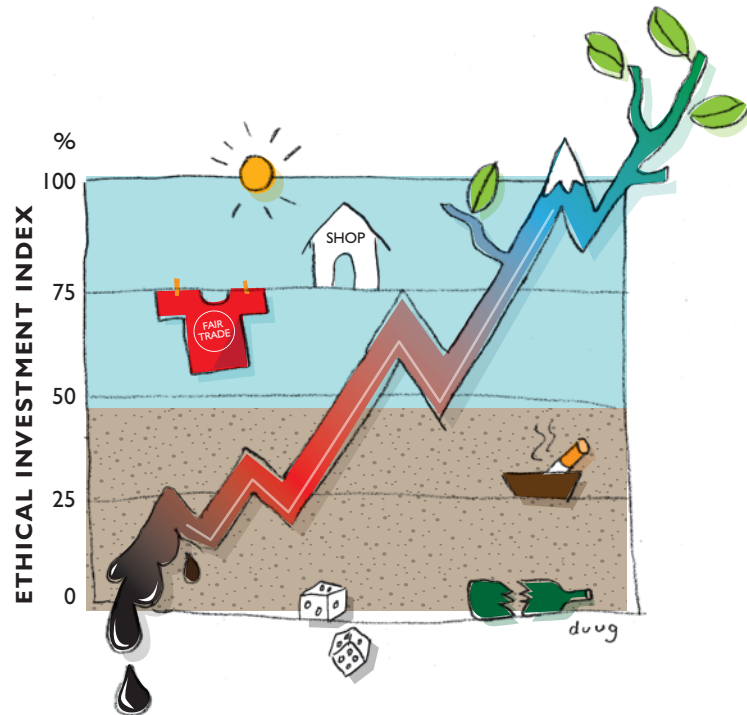
The good news is that ethical investment does not just make you feel better. The investment returns can be equal to and even better than that of traditional investments.

According to the Responsible Investment Association of Aus-

“The (ethical) investment returns can be equal to and even better than that of traditional investments”

tralia the average return over five years from Australian share funds that invest responsibly averaged 15.8 per cent a year compared with the average return from the ASX 300 companies of 12.3 per cent.

Over a 12 month period the responsible funds returned a whopping 21.5 per cent compared with 17.6 per cent for the sector as a whole. This



is probably not too surprising given the way the world is changing. Smoking is on the decline in western countries so it would not take much effort to see tobacco companies as a risky investment.

Many superannuation funds have already dropped these companies from their portfolios. Per capita alcohol consumption in Australia is at 50 year lows. Maybe we are becoming more health conscious or maybe it just reflects the ageing of the population.

In any case the alcohol industry is not one you would target if you were a growth investor - even if you liked the odd shandy or two yourself.

The major retailers are being interrogated about the source of their products and they risk boycotts and embarrassment if they source from suppliers not acting in environmentally sustainable ways or who have dangerous and unfair working conditions for their workers.

The climate change debate is an interesting one. It is now being reframed in financial terms that focus on risk rather

than the environment. Many analysts from the big broking houses are warning investors that they are over-valuing fossil fuel companies such as coal mines and coal-fired electricity generators because they have not factored in the likely government response. For example many coal companies are priced on the value of the reserves they have in the ground.

If governments act to restrict global warming to a two degree centigrade increase as promised, then these reserves could well become worthless. The OECD, the World Bank, the UN, the International Energy Agency and a raft of private sector energy analysts are also warning investors about policy shifts that may see many fossil fuel assets stranded.

At the same time these companies are being squeezed by the rapidly falling cost of producing renewable energy. Change in this area could be rapid. The message from all this appears to be that the pot of gold at the end of the investment rainbow could well be stamped 'ethical'.

Coffs Shoulder and Hand Clinic

RECOGNISING THE LACK of Hand Therapy Services available across the Mid North Coast, and the long distances some patients were required to travel, Faye Wiffen opened Coffs Shoulder and Hand Clinic in 2006.

Five years and 4,000+ hours of direct practice in Hand Therapy later, Faye has completed all the requirements of proof of advanced skills and theory in upper limb rehabilitation, earning her credentials as a Certified Hand Therapist (CHT) [recognised specialist internationally]. She is the only qualified hand therapist between Newcastle and the Gold Coast.

A Certified Hand Therapist is an expert in upper limb rehabilitation, and working with a CHT assures patients of the



Hand therapist, Faye Wiffen

therapist's skill and knowledge.

Too often 'minor hand injuries' are overlooked until excessive scar deposition impacts on hand function - making rehab

and recovery unnecessarily delayed. Patients with CMC O-A of the thumb frequently suffer performing menial tasks while state of the art lightweight bracing and conservative functional intervention can make a real difference in their lives.

Nerve entrapments such as Cubital or Radial Tunnel syndromes or even Carpal Tunnel Syndrome can respond to conservative management if intervention is timely.

And just like proprioceptive retraining and strengthening are necessary after any ankle sprain, so it is after any wrist injury/trauma to avoid overload on tendons, ligaments etc.

Faye says her passion is always to prevent the next injury – and a thorough rehab program following any injury, but especially with the hands, is the best insurance.

Faye's services include examination, diagnosis and treatment protocol development of:

- Tendonopathies of wrist, hand, elbow, shoulder
- Nerve repairs, entrapments [Carpal Tunnel, Cubital or Radial Tunnel Syndromes]
- Arthritis – bracing, management and advice CMC, wrist, RA hands etc
- Customised splint fabrication
- Fractures – casting; management; EXOS braces
- Complex Regional Pain Syndrome
- Multi-traumatic and post-surgical care – tendon repairs, fractures, dislocations
- Elective surgery – joint replacements, corrective surgery, etc
- Wound care; scar management; oedema control

Faye's practice is at 175 Rose Avenue, Coffs Harbour. Contact her on 6651 1745, fax 6651 8029. Faye has a Masters of Health Science in Manipulative Therapy and a BSc in Physiotherapy.

Job at risk? CHES can help



injury or other health conditions such as asthma, epilepsy, chronic fatigue to name a few.

Participants can register directly with CHES by visiting one of our offices. Together the consultant will work with the participant to identify any issues and develop a plan based on their individual needs to overcome any obstacles and to support the participant to maintain their employment.

If you would like to know more about the program or have any queries, please feel free to contact one of our offices.

Coffs Harbour: 43 Gordon St
Ph 6691 9333

Woolgoolga: 47a River St
Ph 6654 0338

Bellingen: 15 William St
Ph 6655 1108

Nambucca Heads: 47b Bowra St
Ph 6568 5046

Grafton: 149 Prince St
Ph 6644 3222

Yamba: 2/32 Coldstream St
Ph 6646 8911

Maclean: 20a River St
Ph 6619 1940.

For more information, www.ches-employment.com.au

EMPLOYMENT HAS many added benefits apart from the obvious financial gain. It can give people confidence, a purpose, a social outlet and much more. What happens then when a person's employment is at risk due to the impact of injury, disability or a health condition?

This scenario could happen to any one of us and the risk of losing our employment can be added stress that we don't need.

Here at CHES we can assist through our Jobs in Jeopardy program. This is a free service where a skilled consultant works with a participant to address issues and maintain their employment. Issues can range from mental health, physical



Country Care Link: care for rural families

Image: www.nswforeveryone.com.au

RUN BY THE SISTERS of Charity, Country Care Link provides help for rural people coming to Sydney for medical reasons.

The service has around 40 volunteer drivers available to meet country people coming to Sydney for medical purposes. They can collect passengers from Mascot airport or a railway station and drive them to and from their accommodation or place of appointment. These are free services.

Drivers operate seven

days a week, including early morning and late at night to meet the country trains arriving into and departing from Sydney.

Country Care Link can also provide phone numbers for short term accommodation close to hospitals in Sydney and can organise for someone to visit a country person in hospital.

Country Care Link phone line operates Monday to Friday from 9.30am to 3pm. It's a free call – 1800 806 160 or 02 8382 6434.

Tangled webs in Memory Lane

Light Airs
David
Miller



A FUNNY THING happened yesterday on the way to the Tweed Regional Gallery. A group of about thirty people were outside the gallery on the grass, gazing at Mt Warning in the near distance. Was it about to erupt after 20 million years of sleep?

No, it was still in majestic dormancy but a persistent honking from inside the gallery supplied the clue. It was the fire alarm within.

While milling around this gathering, which resembled a badly organised cocktail party sans refreshments, a good looking woman warmly greeted me. It was an embarrassing moment because she had to remind me of her name. It had been quite a few years since we last met – during her labour.

Of course, it came back, that pivotal time of pregnancy and birth, so precious, sometimes scary, in the life of a woman, but one day in the life of a doctor.

Once the fire engine had come and gone and the alarm was off everybody trooped back into the exhibition. In the hallway enroute to the Margaret Olley home studio reconstruction was a series of paired photo portraits by Rod McNicol, taken many years apart. Life's experience was evident in the portrayals but it was the essential same person who still looked out of the time altered faces.

Because I still live in the same community, I am frequently treated to unexpected surprises when people remind me of our interactions going back 20 or 30 years. 'Do you want a labour or a live baby?' I'm told I said. I may well have. Some of those women were so strong willed about wanting to do it their own way - to the edge of brinkmanship.

Looking back on this time in my career, there is no doubt that I was led by the nose into a primitive, emotionally charged

world. 'Doing a delivery' was not what these women wanted from their doctor. Who were they and why were they so different to those more compliant ones I had encountered during early training?

This was the Byron shire during the 70's and 80's. It was a living laboratory in lifestyle with experiments in housing, relationships, macrobiotics. I was a kind of hamster running on the wheel in the childbirth section.

More is forgotten than is ever remembered and it is only by belonging to a community for such a long time that these reminders occur. For example I saw an old mate chatting to someone in the beer garden of the Brunz. I went over, sat down and introduced myself to the stranger.

'I know you alright,' he replied. 'You ran over my dog'. I was taken aback. That could not be right. He must be confusing me with another.

'No, it was you. 25 years ago you came hurtling around the corner in Main Arm in your

“ ‘Do you want a labour or a live baby?’ I'm told I said. ”

yellow mini-moke where I was walking with my dog and you knocked him over.'

The description of my car of the time was consistent enough but still....

'You said you were hurrying to a homebirth and could not stick around so you gave the dog a shot of morphine for his dying pain.' The memory seeped back in an unwelcome rising tide. The dog had a clinical traumatic pneumothorax and was unable to breathe and a small dose of morphine



from my bag settled its distress. So I was able to continue to the house close by, where there seemed to be something wrong. From the kitchen a trail of upturned cleaning products led me to the bathroom where, crouched in the corner, amongst the blood and mess, was a woman clutching a newborn. Both were shivering, so I was busy until the midwife thankfully arrived a few minutes later and all thoughts of the dying dog were erased forever.

'I'm very sorry about your dog,' a belated apology, 'but you still seem annoyed.'

'It was all very well to give the dog morphine,' he said, 'but I was suffering too. Where was my morphine?'

I'm happy to report that these days natural birth in all its forms is much better managed by the team of midwives from the Mullumbimby birth unit. Homebirth and water-birth, now it's all normal.

Portion control: why clients don't do as they're told

PEOPLE GENERALLY have a better memory for pictures than for words which makes us all visual learners to some degree.

It's a sad fact that our clients retain only 10% of the precious information we impart to them verbally and 20% of the content of the handouts we give them. When we take the step of showing them images and get them doing something physically, that retention rate reaches a staggering 80%.

Advanced accredited practising dietitian Amanda Clark has been practising for over 25 years and has applied this knowledge effectively

Amanda has created a perfect example through Portion Perfection by smoothly incorporating both seeing and doing into all the portion control education tools.

Clients are shown how much to eat pictorially, and then have the opportunity to use the portion plates and bowls they see in the pictures so that they can



The Portion Perfection plate

follow on to do what they saw and concrete the learning. Even the recipe book shows portion accurate photos for everyone in the family. The plate also works as a visual cue to remind them of the message when the consultation is long over.

Health professionals can start the conversation with patients by identifying the health risks associated with their weight and asking them if they'd like you to get them started on a simple strategy that can help them feel satisfied on less food.

If they appear open, then hand them an education page which gives them the first step of modifying how they make up their own dinner plate that night and guides them to further information and tools to take the process further.

This strategy can be shared by all members of the health team. Download a copy of the education pages for

1. Men, women and children and
2. Bariatric surgery patients from: www.greatideas.net.au/aboutportionperfection

Or request more information or assistance from info@greatideas.net.au

The full Portion Perfection kit includes the portion plate, a portion bowl, a full pictorial eating plan with clear and simple portion guides for all family members, and a four-week menu plan with recipes that guide the correct portion sizing.

See www.greatideas.net.au

Data on very high and frequent GP visits

MORE THAN ONE-THIRD of Australians (35.3%) went to a GP six or more times in 2012-13, and those who went most tended to be older and less wealthy, and more likely to have several long-term health conditions and to be seeing several GPs.

The report, Healthy Communities: Frequent GP attenders and their use of health services in 2012-13, shows that one in eight Australians (12.5%) saw a GP at least 12 times in 2012-13, accounting for 41% of the \$16 billion Medicare paid in out-of-hospital benefits. About one-third of this group saw five GPs or more in that year, although some of these GPs may have been the same doctor practising in a different location.

Australians visit a GP 5.6 times per year on average, but until now there has been little publicly available information about the patients who see GPs much more often.



The report divides the Australian population into six groups based on the number of times people visited a GP in 2012-13. The focus is on the two highest groups: people who visited a GP between 12 and 19 times in the year ('frequent GP attenders'), and those who went 20 or more times ('very high

attenders').

The findings show that in 2012-13:

- Among very high GP attenders (20+ visits), three-quarters (75%) were aged 45 or above, and 57% were aged 60 or above. In contrast, 45% of frequent GP attenders (12-19 visits) and 18% of occasional attenders (4-5 visits) were aged 60 or above. Very high GP attenders were almost twice as likely as low attenders (1-3 visits) to live in areas of low socioeconomic status (29% compared to 16%)
- Among very high attenders (20+ visits), more than one-third (36%) reported having three or more long-term health conditions, compared to 29% of frequent attenders (12-19 visits). The figure for all Australians was 7%

- Very high and frequent GP attenders (12+ visits) accounted for about 60% of the people who reported being admitted to hospital four or more times in that year. Just over 40% of very high attenders (20+ visits) and 30% of frequent attenders (12-19 visits) reported visiting an emergency department, compared to 10% of low attenders (1-3 visits).

The report does not suggest any number of GP visits is either too many or too few. Nor does it assess the extent to which patient needs are being met in any of the attender groups.

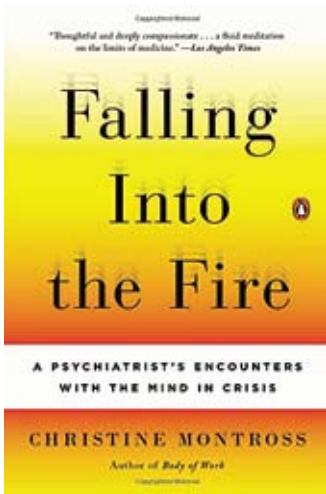
More information on the percentage of high and frequent GP attenders in each of 330 local areas, the report and downloadable spread sheets is available at (www.myhealthycommunities.gov.au).

Robin Osborne



Falling Into the Fire

CHRISTINE MONTROSS
ONE WORLD



TAKING HER TITLE from Matthew 17:14-16 - "Lord have mercy on my son: for he is a lunatick and sore vexed: for oftentimes he falleth into the fire" - US psychiatrist Christine Montross has shared with intimacy and professional rigour her encounters with some of the most extreme maladies of the mind.

Largely, although not exclusively, the patients whose conditions she discusses are self-harmers, not always with suicidal intentions, although the outcome of ingesting foreign bodies such as batteries and knife blades, or of self-amputation, is likely to lead to death without prompt intervention.

In summary, the five chapters about "the mind and its mysteries" cover patients who intentionally injure themselves, undermining the work their doctors do to help them; patients "relentlessly tormented" by mostly illusory ideas about their bodies; the legal ability of doctors to hospitalise and/or medicate patients against their will; the perils faced by patients whose illnesses are not correctly defined; and the implications for patients whose bodies are overtaken by illnesses of their minds.

Woven through these categories, illustrated by case histories so extreme it is often hard to believe they have been de-identified, are tales from the author's personal life, notably her determination to balance work and family life.

It seems incidental that she is lesbian, with two young children, although she makes several mentions of her partner, clearly a supportive helper.

Long hours as a psychiatric resident in various settings, including prisons, and more recently supervising the locked wards of a major hospital, make for a challenging high-wire act: at times one wonders how close is the author herself from falling into the fire.

"I treat people who are in moments of profound crisis," she explains.

"The majority of them are hospitalised because they might not be safe otherwise. I do not lose sight of the fact that my patients come to me in these precarious states.

"I encounter people who are despondent, or terrified, or raving mad. I see people's lives that have been ruined by addiction. I hear unfathomable things that people have done to others, from familial betrayals to brutal attacks. I talk with people who, more than they have ever wanted anything, want to die.

"It is not a dull job."

And this is anything but a dull book, not least because of the complexity, mostly good natured, of her interactions with those medical colleagues called upon to perform life-saving procedures on patients often viewed as being 'at fault', and likely to 're-offend' soon after being released back into society.

Perhaps the most extreme example, and the one that most enrages the ED doctors, is Lauren, 'the woman who needed a zipper', which would enable much easier extractions of the harmful objects she habitually swallows.

"Lauren's back again," the gastroenterologist groans, "lightbulbs this time."

Dr Montross recounts the difficulty of forging a connection with a person so buffeted by life that the self-destructive impulse seems the sole resort.

"Let me guess, you're the shrink right?" Lauren begins, "I can always tell you guys

- you're all nicey-nice handshakes and dipshit smiles."

The author does not say whether diplomacy is a key component of a psychiatry degree, but if not, she has clearly done a cram course.

Along with the bizarre behaviours, and some harmless black humour, there are useful clinical reminders, including the influence of early life trauma, abuse and neglect on subsequent self-harm.

Addressing an area that is receiving increasing attention, she cites trauma expert Dr Bessel van der Kolk about the brain being structurally and chemically altered by severe trauma, which may be permanent if it happens early enough.

This memoir is a valuable contribution to the popular psychiatry canon, and not surprisingly the author seeks to defend the oft-misunderstood, or maligned, reputation of her colleagues: "It's easy to regard the institution of psychiatry as the authoritarian legacy of One Flew Over the Cuckoo's Nest, to think of psychiatrists as cartoonish egomaniacs who thrive on their ability to take away the agency of others or who leave no room for divinity, for difference..."

"Yet in reality, psychiatrists, like their colleagues who go into various other medical specialties, have a specific desire to help people heal and to treat them humanely in that pursuit... [there is] the hope that we really are honing our diagnostic abilities and, in doing so, might be able to lead a patient out of the throes of depression or the haunted hallways of psychosis."

Unlike her medical colleagues, however, "Visions and voices and fear and despair cannot be captured by CT scan or measures in the amplitude of ECG waves. Try as we might, we simply cannot predict which of our patients will kill themselves, which will murder their children, and which will leave the hospital healed, never to return."

“I encounter people who are despondent, terrified or raving mad”

The FRS can help GPs

THE FAMILY REFERRAL Service (FRS) is a free State Government funded program delivered throughout the Far North Coast by the Northern Rivers Social Development Council in partnership with Interrelate. It links families with young children (0-18 years old) to support services and community resources to ensure that children and young people are safe and well.

“We work with all services to find out what best supports young people and families,” said Family Outreach Worker, Sharron Eyears.

“While we are a short term-service, usually around six weeks, we can facilitate referrals for longer term support if there are issues we were unable to address in that time.”

“People talk to their GPs about all sorts of issues which might be impacting on their health – things like homelessness, financial difficulties, domestic violence or other traumas. Many of these issues are outside a GP’s jurisdiction and this is where we can help. The FRS can link patients into social supports and long-term services that specialise in helping people with a range of different issues,” said Sharron.

“There are a myriad of different programs and services available which can sometimes be overwhelming to navigate. So, GPs can also call the free 1300 number for information about relevant services,” Sharron added.

The Family Referral Service came into operation two years ago after the Wood Commission into child abuse and operates from Tweed Heads to Grafton. It can help children, young people and families with issues relating to: domestic violence experiences; housing access; counselling and mediation; drug and alcohol concerns; parenting struggles; mental health concerns or finding culturally appropriate support.



However, if other services are needed, the FRS can help to find them.

“I worked with a family recently. There were five children with varying disabilities and the mum was suffering mental health issues. There were financial issues, social isolation and employment issues and problems with school attendance. The mum said they’d never received support in the past. We were able to facilitate longer term support which helped to address all of the issues this family was facing – the mother just cried, because all of those pressures were alleviated.

“Now she’s linked in, and she’s getting respite for her children, which also enables quality time for herself. She’s enrolled in TAFE and is pursuing one of her dreams. Even her physical presentation from when I first met her, to now, six weeks later, has altered dramatically.

“When I first met her she was crying, deflated, head down. But now, she walks with so much more confidence, there’s a remarkable, noticeable change. It’s really rewarding – hard work at times but we’ve got a great team”, Sharron said.

Contact the Family Referral Service on 1300 338 774 or email support@familiesnorth.org.au



Speech path practice offers mobile visits

SPEAK VOLUMES SPEECH pathology, run by speech pathologist Amber Allen offers in-clinic and mobile speech pathology services for adults and children across Northern NSW.

The practice can help clients with

- Pronunciation, stuttering and voice problems
- Developing, understanding and using language
- Verbal and nonverbal social communication (body language, eye contact, facial expression)
- Cognitive communication including executive functioning skills such as organising thoughts, paying attention, remembering, planning and/or problem solving.
- Paediatric feeding difficulties, eg due to prematurity, sensory processing difficulties, tongue tie, ‘fussy eating’ and/or developmental disabilities
- Reading assessments to determine the reason behind why a person is struggling to read, followed by evidence-based intervention. Remedial reading groups available.

Bulk billing is available for clients with a valid concession card and Medicare referral. Phone Speak Volumes on 6676 0854.

New BreastScreen mobile unit ‘vital’ to saving lives

IN EARLY MARCH, THE new mobile North Coast BreastScreen unit hit the road to help the early detection of cancer in the one in eight women affected by breast cancer.

Offering up to 100 appointments per week, the bus features upgraded digital mammography equipment, a wireless communication system for instant transfer of images to radiologists and wheelchair accessibility.

It will visit Ballina, Bonalbo, Bowraville, Byron Bay, Casino, Dorrigo, Evans Head, Grafton, Iluka, Kempsey, Kyogle, Ma-

clean, South West Rocks, Uki, Urbenville and Yamba.

At the launch the Chair of the Northern NSW Local Health District Dr Brian Pezzutti said the unit complemented the fabulous cancer care available on the North Coast where women could be treated locally with good results.

“We are offering world class care, safety and accuracy,” he said, launching the bus on its first journey.

The Director of BreastScreen NSW North Coast Jane Walsh said mamograms could detect



NNSWLHD Chair Dr Brian Pezzutti speaking at the launch.

cancers before they could be seen or felt.

“If detected early, survival from breast cancer can be as high as 97 per cent,” she said.

Jane said it was vital for all women aged between 50 and 74 to have a mammogram every two years.

“We’d appreciate GPs reminding women in this age group to have regular mamograms,” she said.

“It’s a free service that could save a life. No doctor’s referral is necessary. Simply call 13 20 50 to make an appointment.”

Think of wine like a rose

ALL WINES HAVE A 'drinking window', a magical stretch where they are most delicious. For some wines this is all too brief, a 'blink and you'll miss it' moment between tartness and vinegar. For others, like Penfolds Grange, it can stretch for decades. In general, you get what you pay for, with the more expensive also offering a measure of resilience, so a hot spell in the cellar won't necessarily mean disaster. In general, you can count on three years good drinking for each \$10 spent for most reds, up to say \$60.

Certain grapes give longer windows – cabernet sauvignon, shiraz, riesling, semillon and chenin blanc. Think of wine as a rose, with firm petals and little scent at the outset. As the rose opens, the perfumes appear as the petals soften. Over time, the lovely aromas fade, and the petals fall away. So it is with the acids and tannins in a wine. They are the structure which hold the fruit flavours in place, and ensure the wine is not merely a one-nighter. If these elements are present in good measure, the wine will 'hold its fruit' and stay delicious for much longer. Lovely soft, silky tannins and delicious acids mean the wine will be enjoyed over a much longer period of time (you will pay for these).

At the start of its life in the bottle, most wines have firm acids and tannins, not much aroma, and are termed 'closed'.



Chris Ingaal

“ Different wines have different shapes in your mouth and the glass shape complements this ”

We can decant the wine, exposing it to oxygen, and hastening its development, or have a glass and come back to it over a few nights, seeing how it develops. Having the wine in a broad glass helps us appreciate any aromas and fruit flavours present, and throws back the harder elements. As it develops in the bottle (faster under cork) the softer elements come to the fore, and the same glass may make the wine seem too soft, so a narrower necked glass would help the wine maintain its 'balance' in our mouths. We appreciate the aromas chiefly through our sense of smell, while the acids and tannins are a 'mouth-feel' experience.

You know about certain glass shapes for certain grapes? A lovely flute or thin glass for champagne (although this is changing, watch this space!),

a goldfish bowl for pinot noir. Why? Different wines have different shapes in your mouth and the glass shape complements this. So a riesling has beautiful lime acids, and a wide glass would see these diminished, bringing other elements of the wine to the fore, making it arguably less enjoyable. Similarly the beautiful aromas of pinot noir are hidden by a narrow-necked glass, making the wine seem 'flat'.

If I want to know where a wine is along its life, I'll first chug-a-lug a small(ish) mouthful straight from the bottle to appreciate its tannins and acids alone, then pour it into three glasses, usually a riesling, chardonnay and pinot noir, and compare the balance of the wine in each. The riesling glass will make an old wine seem younger, while the rounder pinot glass may give it a blowsy quality, and vice versa for a young wine. The best glass gets all the wine poured in, and is ceremoniously emptied. (I wouldn't let your guests see the chug-a-lug bit).

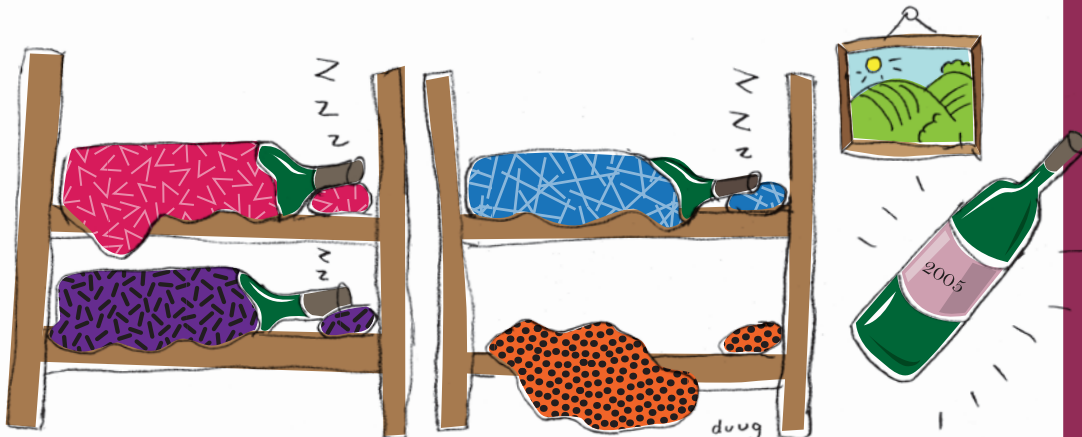
So to close the logic circle, if a wine is opened too early, decant it and pour it into a lovely big glass. The same wine at the end of its vinous existence would taste better undecanted and in a less expansive tumbler, so by choosing your glass wisely you can extend the wine's drinking window considerably. You can use Riedel glasses if you have the cash, their thin lips always showing the wine at its best, but makers such as Spiegelau are also good.

Wine Tip

The hotter the terroir, the cooler the wine should be drunk. In general, wines grown in regions enjoying hotter summers (think McLaren Vale reds) tend to be higher in alcohol. The converse is Alsatian rieslings, with a low alcohol content. Alcohol will jump out of the glass at what passes for room temperature in Australia, so if you want your wine to be balanced, chill it for half an hour. Have a look at the label when buying, and if the alcohol content is over 13.5%, make sure it is cool to drink.

Cellar Tip

You will discover over time when you most enjoy drinking certain wines. If you like your reds young and firm, you'll be drinking them when they are just a few years old, but if (like me) you prefer them a little softer and more approachable then they may wait seven or more years. Similarly with your whites, with riesling and semillon in particular going through an awkward adolescence from four to seven years. Plan your cellar around these habits, and multiply by the number of bottles you drink each week. Happy buying (and drinking) dear reader.



By Alex Lewers

FOR MOST PEOPLE, going overseas and working four to five hours a day isn't their idea of the perfect holiday, yet when you've been living the life of a backpacker for a few months, volunteering can be a godsend.

I never would have said it before going travelling and can almost hear the scoffing as I type, but, constant travel can be exhausting (I know first world problems huh!).

Fortunately, help exchange websites have paved the way for weary travellers of all ages to seek the little luxuries of a regular shower, home-cooked meals, and a comfy bed in exchange for a day's work.

Yet, it's also so much more than just a place to recharge your batteries. Help exchange allows travelers to meet local people and have experiences that are otherwise impossible to get as a tourist.

Unlike the often criticised 'voluntourism', help exchange is focused on achieving mutual benefit with work length and type dependent on the host's needs and the volunteer's skills.

We pruned olive trees and sold craft beer to locals at a food festival in Italy (mainly by sign language), minded Russian children in Turkey (again, mainly by sign language), weeded a kilometre of fence line at a chateau in the famous Loire Valley and played with day-old lambs and brushed donkeys while house/pet sitting in the south of France.

In nine months on the road we've stayed with five different hosts in three different countries, made countless new friends and had many new experiences.

In Turkey, one of our favourite experiences was working at a wildlife rehabilitation centre caring for sick and injured animals.

Working with between 10 to 20 volunteers from all over the world, we prepared food for the injured animals, trained puppies, assisted the owner on his



New friends are just some of the benefits of help exchange



Hard at work at a beer and food festival in Italy



Feeding Miss Piggy at a help exchange in Turkey

local vet visits and weeded vast fields of roses.

We made meals for each other, shared games and taught each other about our own culture and language (I am now proficient at swearing in Spanish, while several workers tried their hand at Australian slang like 'ya flamin' drongo' or 'she'll be right mate').

Through this help exchange we also got to see what 'real'

rural Turkey is like.

We crammed into buses surrounded by locals with their produce for market, sipped tea with local families (for readers of my last article you'll know this was begrudgingly) and ate regional delicacies (which turned out to be sheep intestine, but was surprisingly tasty).

Although the facilities were very basic, (squat toilets, solar showers, which I'm now convinced is just code for cold showers, and a communal kitchen built for dwarves) the experiences we had and the people we shared them with made it a highlight of our entire trip.

However, sometimes learning new customs was not so enjoyable.

At our first help exchange in France, I found out that older French men REALLY like their midday nap and REALLY don't like having their naps disturbed.

One day after eating lunch, I

went outside to split some wood at our host's request. Unfortunately, as I later discovered, their neighbour was attempting to take a nap.

After several heated words, of which I had no idea of the meaning, and some angry looking charades, I figured out that between noon and 2pm is a no noise time zone... lesson learnt.

Despite my run in with a grumpy Frenchman, our experience of help exchange was overwhelmingly positive. The people we met were all very generous and it was nice to be able to repay their generosity through work.

Help exchange allowed us experiences that money couldn't buy and helped create some of the most lasting memories of our journey and is something I would recommend for travellers of all ages.

For anyone interested in help exchange, there are numerous websites available. We recommend www.helpx.net and www.workaway.info.



Petting day old lambs at a help exchange in France

From page 23

seemingly ancient yet ultra-contemporary at the same time.

The COSMOLOGY IN ME series of prints is taken from Michael's first doodling sketch pads, digitally reversed so that they are white on a black ground rather than pencil on white. These works shimmer and pulsate like phosphorescence or starlight scattered on a dark sea.

These linked exhibitions of Michael Philp's individual practice and personal stories are further evidence of how art expression may help individuals to reconnect their thinking and feeling, bridging personal histories to memories. Doodling or painting or making things are whole brain activities, spontaneous, at times unconscious, exploratory, calming and satisfying. They are means by which we may become captains of our souls, exercising self-mastery as well as providing a pleasurable roadmap of thoughts, memories, feelings and ideas.

Michael Philp has learned through experience and his art that for him, "Being creative is an ongoing journey, artistically and therapeutically."

Art is a revolt against fate

Andre Malraux

Briefs

Single flu shot?

AUSTRALIAN RESEARCHERS have been part of a discovery that could lead to a single-shot flu vaccine offering protection for life.

The University of Melbourne-led team says 'killer' CD8+T cells have the job of taking out new viruses and are able to memorise distinct strains. Samples from patients infected with that flu showed those who could not make the T cells were dying.

The University's A/Prof Katharine Kedzierska said the research could lead to a vaccine component that would protect against all new influenza strains. It could also help clinicians make early predictions about how well a patient's immune system will handle a virus.

The research paper has been published in *Nature Communications*.

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- Sports & Orthopaedic Conditions
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- Acupuncture for myofascial pain/muscle spasm
- Gym & Pool rehabilitation
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