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CRANA *plus* magazine

the voice of remote health



educate 34
advocate 44
support 50

from the editor



Welcome to the June edition of the CRANApplus Magazine. It is with much pride that our front cover features CRANApplus member Noela Davies who is the recipient of the prestigious 43rd Florence Nightingale Award. This award recognises exceptional courage and devotion to victims of armed conflict or natural disaster.

A full interview with Noela is on page 9.

Plans for our Perth Conference are ramping up and there's excitement in the air as the conference program comes together. Watch our website for the full program.

Among the benefits offered by the range of CRANApplus courses, is their relevance to the remote environment. Our point of difference is the exceptional facilitators who offer their time to CRANApplus to deliver them. Inside you will meet one of these champions, Dr Minh Le Cong.

In 'Members Insights', you will be treated to a variety of stories from across the country. Members share the diversity of how, and where, they practise. If you have a story or photos you would like to share with our readers in future editions, please contact us.

This edition of the magazine will arrive in thousands of letterboxes across Australia and throughout New Zealand, introducing CRANApplus to a previously unreached audience. We trust readers will enjoy the wealth of information and stories within these pages, offering an insight into our organisation and the extraordinary professionals who make up our membership.

Anne-Marie Borchers
Business Manager, CRANApplus

About the Cover: Noela Davies in Northern Liberia in West Africa (near the border with Sierra Leone). It is at the opening of a remote health centre in Lukasu, Kolahun region in Lofa County. She is handing over the key to the clinic to a representative of the Lofa County Health Authority. All the women in the background now finally have access to a midwife, for antenatal care, postnatal care and for newborns and children. There had been no health facility in this region for about a decade and Liberians were slowly returning, post war, from neighbouring Sierra Leone and Guinea.



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from the ceo

And here we are – it's June, midpoint of 2011, and the end of the financial year.

Always an excellent time to take stock, reflect and readjust the sights on the horizon.

With our funding from DOHA secured for 3 years from July 2010, the usual frantic machinations with government have been missing from the past few months, I am relieved to say, allowing time and energy to get on with what CRANApplus does so well – delivering, responding, and being present, as the voice of remote health.

Reflecting on some of our achievements in this financial year, it is difficult to believe that it was June 2010, a short 12 months ago, that eRemote was launched. From small beginnings, a robust and highly regarded resource has been developed. You, the members, have demonstrated your faith in the product, and enrolments continue to grow. New modules are in the development stage.

There has been no rest for the dedicated Education staff who have been finessing split-second timing to deliver 50 FLEC courses in the past 12 months, with a further 30 to be offered before Christmas. And still the demand is for more, please!

In its understated way, Bush Support Services has stepped onto centre stage, quietly and effectively making its unique services known to those in need. From Mark Millard's Road Show through some of the most remote areas of Australia, to the engaging and fun Stress Buster competitions and the ever-available 1800 free call Bush Support Line, BSS has supported and encouraged those of you working and living in remote and rural health.

The appointment of Geri Malone as National Professional Co-ordinator, has given CRANApplus a powerful and respected voice to speak on professional developments at the national level, and brought to us a wealth of experience that is invaluable to informing our future priorities.

As our membership consolidates over the 1000 mark, and the breadth of our representation of allied health professions increases, we can look forward with confidence to speaking with even more authority as the voice of remote health.

It is timely that the Board of Directors is now reviewing the Key Issues that will be the main focus of this organisation's advocacy efforts for 2011, and will continue to be through 2012.

In the next few months you will see a new more engaging CRANApplus website, and we will meet, gather and share stories at the October Conference.

There is a lot to look forward to; it's never a dull moment in the health arena.

Stay with us, there is much to be done.

Carole Taylor
CEO, CRANApplus



Remote and isolated areas have some of the most innovative and comprehensive models of Primary Health Care...

Remote and isolated areas have some of the most innovative and comprehensive models of Primary Health Care; multi-disciplinary, community driven, meeting complex local needs within a fiscally responsible model. All of this achieved despite the enormous challenges of recruiting and retaining a health workforce, intense isolation, extreme environmental conditions, cultural and language misunderstandings, varying local priorities, political volatility and financial inequity/insecurity.



The burden of chronic disease and the challenges of maintaining a healthy culture and lifestyle in today's world both contribute hugely to the health of our consumers. So, despite the gains we are making, the counter forces detract from us seeing our successes.

I'm optimistic. If anyone can overcome these health inequities, the tough, spirited, dedicated rural and remote Aussie can. With the assistance of the remote and rural health workforce, we will make a big difference to the health of our future generations.

It's the distillation of this sentiment, through your support and membership of CRANAp/plus, that will ensure that the remote health workforce has the:

- Education they need to do what's required (regardless of their discipline)
- Support they need to flourish (regardless of how isolated they are from traditional support mechanisms)
- Advocacy they need on the issues that matter (regardless of political cycles of populous policies) ►►

engage

amazing advancements achieved

We all seem to have spent an inordinate amount of time looking forward and planning within the last few years: with the changes of governments, health reform, national registration and the spotlight on Indigenous health outcomes.

Well, I think it's time for us as an industry to take a breath and celebrate the amazing advancements we have achieved.

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Over a year ago I had the opportunity to work in Haiti following the devastating earthquake: on one particular day I had a 'moment' of déjà vu as a flaccid, emaciated infant was put into my arms.

The infant was tiny and her dark sunken eyes looked way too big for her skull. Her skin was wrinkled like she was 100, not 1. As she lay there quiet, too exhausted to cry, looking off into space, breathing so fast you couldn't count ...I was shocked into realising that it has been many years since I last faced such a sick kid in Australia. Previously this was not an

uncommon occurrence, working in remote regions. Thankfully, because of a dedicated, educated and culturally appropriate health workforce, this is a much less common occurrence: a workforce that uses all its skills in implementing improvements in clinical care, political activism, social mobilisation and compassion to achieve that end.



Photo: George Fort.

►► Your professional body, CRANApplus, and the wonderful staff who implement our vision have adapted and evolved magnificently over the past three decades: from our humble beginnings as a group of passionate volunteer remote area nurses, to now a major player in the national health arena with offices in three States and a large professional workforce. We have morphed from the Council of Remote Area Nurses of Australia to CRANApplus and broadened the Constitution to welcome all providers of health care in remote areas as full members.

The people involved in this transformation over the past 30 years are too many to mention, but I think, as an industry, we should be so proud that we have practised what we preach, taken ownership of our professional body and driven it to meet our needs. Having been your elected President for the past five years has been one of the greatest honours, and, along with the rest of the Board, we take the responsibility you have bestowed on us very seriously.

Looking forward...by the time this edition is in print the Board of CRANApplus along with the senior staff will be meeting in Cairns to review our strategic directions and ensure we are well positioned to deal with the challenges we encounter. Our challenge is to work out what our remote health workforce needs are now, as well as in 10 years' time!

CRANApplus needs to be in a strong financial/business position to be able to implement initiatives that are unique to the needs of the remote and isolated workforce. It's core to our organisation that we are clinically relevant and address the contemporary needs of our unique sphere of health.

Unlike my Haiti experience, babies dying of acute dehydration isn't the major challenge that the remote workforce faces anymore.

Today's remote health provider is much more likely to be managing the multiple complex chronic diseases of a client, responding to an industrial accident, facilitating a community development activity on safe parenting or assisting in the social and emotional wellbeing of troubled youth.

Tragically the infant in Haiti died within an hour of arriving at the first aid tent, another preventable death! It reminded me of how many people are alive and healthy today, thanks to the contribution each of you makes to the health of people who live, work and play in remote and isolated Australia.

Keep safe and keep in touch.

Christopher Cliffe
President, CRANApplus ●

making an impact



Dr Peter May presented this paper: "Overburden: The human impact of illness in Central Australia" at the 2010 CRANApplus Conference in Adelaide, pitching it to be "both an encouragement and a reality-grounding" for those working in remote Aboriginal communities.

The collision of cultures has brought with it a host of new illnesses and problems for aboriginal peoples in Australia and abroad.

By contrasting the diseases and health burdens experienced by original Australians living in Central Australia with those of citizens living in a regional, predominately white community, I seek to challenge any creeping acceptance within you that what you encounter on a daily basis is anything like normal.

The collision of cultures has brought with it a host of new illnesses and problems for Aboriginal peoples in Australia and abroad. Whilst struggling to meet these new challenges, these same people have had to contend with enormous individual and community losses,

which have undermined their capacity to absorb, respond and recover. Family and social disintegration in such circumstances has resulted in the collapse of law and, for many, a descent into alcohol and substance abuse, violence and neglect. Those who are holding things together under such circumstances are faced with ever-increasing challenges, ambiguities, contradictions and competing demands that result in choices that, at first glance, seem inexplicable but with closer examination seem almost inevitable.

I graduated from the University of Newcastle in 1985. I am now a qualified specialist in emergency and critical care. I was formerly a general practitioner. My work has always been in regional and remote areas including Tamworth (a regional service centre of 50,000 in NSW), Tom Price, Exmouth and Onslow in the Pilbara, Alice Springs, Bella Coola (a predominately native American community on the coast of British Columbia), Ba (an Indian Community in Fiji), and Nepal, where, with my wife Jenny, I undertook TB and leprosy control work as undergraduates.

I mention this only to underscore the fact that I am familiar with some of the hardships and difficulties experienced by people living in Indigenous, remote and poor communities. This is significant because when I commenced work in the Alice Springs Emergency Department at the beginning of 2010 I was far from naive and yet I was taken aback by the extent of hardship and by the burden of illness that I was encountering amongst the Aboriginal people I was meeting every day.

Two representative case examples paint a picture of individual burden:

Case one: A 46-year-old man with hypertension, chronic kidney disease (stage 3), hypothyroidism, obesity and obstructive sleep apnoea, who is also a carrier of hepatitis B. ►►



» He has already had 113 admissions and many more attendances as well as 2011 blood tests in 10 years. (I didn't record the number of imaging studies!)

Case two: An unfortunate 34-year-old man with bronchiectasis, diabetes and pancreatic failure. He would be admitted for weeks at a time and discharged for days only. At the age of 34 he had a NFR order and died earlier this year.

Such cases are all too common in Central Australia.

Reflecting on six years in general practice in Tamworth, I recall two deaths by suicide, about 10 deaths per year from cancers etc, three patients on dialysis, (all in their 60s or older), no patients on prophylaxis for rheumatic fever, one patient with an AMI under 35 years, nobody with a stroke under 50, and only one family devastated by the death of a teenager in a car crash. The only people who died from sepsis were old (although there were a couple of close calls), domestic violence was usually concealed and gonorrhea was exceedingly rare. Compare this with your experiences as remote area nurses. How many in your community have died violently from murder, crashes and suicide? How often do you treat for gonorrhea? How many have heart valves replaced? How young are your patients with heart failure and on dialysis? Do you have to dig to unearth domestic violence?



Some may wonder if, by comparing General Practice with remote area clinics, I am using a different sieve.

What about the EDs in Tamworth and Alice Springs? At any moment, Aboriginal patients would comprise about 90 per cent of the patients within the Alice Springs ED (we do see a greater percentage than that of non-aboriginals, but by and large their problems are less complex and quicker to resolve). For the majority of patients, English is their second language and miscommunication and misunderstanding are a significant risk. Many patients attend and then decide to leave without being assessed. Large numbers are re-attending for the same complaint, having decided for one reason or another not to undertake or to complete the treatment prescribed.

Occasionally, I will need an interpreter but never for an aboriginal language.

A lot present late in the course of their illness and miss out on time-critical interventions e.g. reperfusion therapies for myocardial infarction. Stabbings are common. Missed dialysis with fluid overload and life-threatening hyperkalaemia are commonplace. For women the chief reasons for attending the Alice Springs ED are assault, injury, missed dialysis, alcohol related illness (not including injury), and STIs and other infections.

In Tamworth, which is slightly larger, I have managed as many people with fractured neck of femurs in one shift as I have seen in Alice in 10 months! Most of the patients requiring admission are elderly and their co-morbidities are usually under good control. The majority attending with STEMIs do so within the time window for reperfusion treatment, whilst severe heart failure under 65 is rare – and those seen are usually not rheumatic. Missed dialysis is only occasionally encountered, severe bronchiectasis is rare, and stabbed chests are almost unheard of. Occasionally, I will need an interpreter but never for an Aboriginal language.

Domestic violence is probably missed more often than not because it is rarely overt. Sadly, we still see alcohol-fuelled violence, road trauma and suicide but nothing like to the same extent as in Alice Springs.

On commencing work in Alice Springs, I discovered myself adopting a self-protective mindset: I was working in another country with a people and a culture that were not my own, that didn't share the same standards and privileges that I enjoy as an Australian. To confront such disparity is hard, and harder still when it occurs in this country. For Aboriginal Australians, overall mortality rates are three times the Australian average, the median age at death is just over 50 years and life expectancy is 20 years less than the non-Aboriginal population. It is worse in Central Australia. To appreciate this, let's look at end-stage renal disease, diabetes, ischaemic heart disease and alcohol-related issues. These conditions are often interwoven.

End-stage renal disease (ESRD):

Table 1 shows the rate ratios between Indigenous and non-Indigenous populations in Australia: 2 per cent of the population carries 10 per cent of the dialysis burden. In addition, 48 per cent of these Australians are from communities without dialysis facilities. They and those they care for, and those who care for them, must uproot and move far from their homes, their people and their country. For the rest of their foreshortened lives, they are condemned to live on other people's country and amid strangers who often talk another language. (It is understandable that from time to time people vote with their feet and return home only to be flown back some days later in fluid overload and hyperkalaemic). And their lives are foreshortened with death rates 30–57 times higher compared with non-Indigenous Australians with ESRD (that's up to 5,700% greater).

Table 1: Aust. end-stage renal disease per 100,000 pop. and rate ratios 2001–2004

Age	Indigenous	Non-indigenous	Ratio
25–34	141	34	4.1
35–44	488	55	8.9
45–54	1603	90	17.8
55–64	2546	168	15.2

Figure 1: Death rates ESRD

Females

- 25–34yo x57 higher than non-indigenous
- 45–54yo x48 higher

Males

- 25–34yo x38 higher
- 45–54yo x31 higher

Diabetes:

For Aboriginal Australians, diabetes is four times more common and far more likely to prove lethal. There is a much higher likelihood of poor glycaemic control, hypertension and albuminuria. These lead on to ESRD.

Ischaemic heart disease:

Ischaemic heart disease complicates both diabetes and renal failure. Yet, for a number of reasons, Aboriginal patients are over-represented and »

► at a younger age (Aboriginals aged 12–25 are twelve times more likely to suffer IHD than non-Aboriginals), they are less likely to present early in AMI, and they endure a greater mortality.

Grog:

Problem drinking rates are high in remote Australia, both in aboriginal and non-Aboriginal populations. In Alice Springs it is very visible, often because of the added constraints on housing for people who are off their country. The burdens are great and include violence, road trauma, depression, suicide, gastritis, pancreatitis, cirrhosis, infection and a failure to manage other health problems. These burdens are further compounded by overcrowded or non-existent housing.

Serious infections:

All these burdens are inter-related and compound with one another. This is reflected in the outcomes for serious infections managed at Alice Springs Hospital between 2001–2005, as reported in the MJA in May 2010. (I understand that the situation has changed in recent years).

The data in Figure 2 records the much greater rates, greater mortality and the much younger age at death among Aboriginals. This is not to say that those with serious infections are not identified and treated aggressively; they are. However, as a group, Aboriginal patients are more likely to present with advanced infections and are more likely to have serious comorbidities that impact negatively on outcome.

Figure 2: Serious blood stream infections at Alice Springs Hospital – aboriginal vs non-aboriginal

- 26.5 vs 5.2 per 1,000 admissions
- 1,355 vs 70 per 100,000 pop.
- Risk of death 32% vs 13%
- Mean age at death 48.5 vs 75.1 years

I appreciate that none of this is new to any of you and I appreciate that I am new on the scene, but I am not trying to discover what is already so familiar to so many.

What I am saying is this: If you don't feel that you are working in some other country; if the illness patterns and severity, if the chronicity and under-treatment, if the sense of failure to make an impact, if the communication problems and the sense of frustration from the people you treat no longer cause you to pause and to ask how can this be happening to Australians then you have lost perspective and are out of touch with the mainstream.

...if you do feel that you are forever pushing uphill, or feel defeated, sad and tired there is good reason and it's not just you.

Or if you do feel that you are forever pushing uphill, or feel defeated, sad and tired there is good reason and it's not just you. For without this sense of disparity, empathy is lost. But to confront it day-by-day risks exhaustion. As both witnesses and workers in a flooded river of premature suffering, illness and death, it is hard to maintain a footing and to continue to stand firm for what is fair. It is hard to continue to believe that what you do matters and that you are making an impact for the better. It does and you do!

I will finish up with what I like to call the take-home messages:

- It is hard to hold back the tide.
- What you are dealing with is far, far from the Australian norm. It is unacceptable.
- Maintain perspective and compassion.
- Try and recognise the causes when you can and understand that the solutions may be different to what we usually do.
- Do everything to improve communication.
- And finally observe what is happening to you and be fair to yourselves and each other. ●

a rewarding experience

CRANApus member Noela Davies has been presented with the Florence Nightingale Medal from the International Committee of the Red Cross (ICRC): the highest international honour a nurse can receive, awarded for exceptional courage and devotion to the victims of armed conflict or natural disaster.

Australian aid workers overseas are highly regarded, says Noela Davies, a registered nurse and midwife, who has worked for Red Cross in conflict zones around the world. And Noela, currently working for the Royal Flying Doctor Service in Mount Isa, says that experience in rural and remote locations, is a perfect stepping stone to international aid work.

"You have to be flexible, adaptable, think out of the square."

"It's 12 years since my first mission, which I saw as an adventure," says Noela, who worked as a remote area nurse in the Northern Territory and undertook the Red Cross basic training course before applying for the work. That mission was to northern Kenya as a surgical ward nurse in a MASH hospital, treating wounded people from southern Sudan.

"I didn't see these overseas missions as a permanent professional career choice," she says. "But once I got a taste for it... I have found my passion." Noela has since been on Red Cross missions to countries such as Afghanistan, Ethiopia, Kyrgyzstan, Liberia and North Darfur in Sudan.

"Each mission, each job description has been different, and that can change and vary as the mission progresses," says Noela. "You have to be flexible, adaptable, think out of the square."

Aussies, says Noela, have a reputation for getting the job done.



"Australians are highly regarded in overseas aid work," says Noela. "It's recognised that we don't need all the creature comforts, that we are realistic, that we tend to step into a situation, sum it up and get on with it."

"I didn't see these overseas missions as a permanent professional career choice... But once I got a taste for it... I have found my passion."

Some friends and family members are not aware of exactly what Noela does and that she is part of a fairly select band of Australian aid workers deployed around the world. The Australian Red Cross (ARC) has about 50 aid workers in the field in countries including Afghanistan, Haiti, Sudan, Pakistan, Vietnam and East Timor and each year sends around 130 aid workers on assignment overseas.

Some are not even aware that she has received this award. "I think this award is really for everyone who does the kind of work I do," she says humbly. ►►



Lokichokio, Northern Kenya in 2001. Noela is sitting on the top of stairs to a plane waiting to load repatriated patients back to South Sudan. During this mission, she evacuated weapon wounded, surgical emergencies and obstructed labours from more than 150 very remote locations and grass strips across Sudan.

► Australian Red Cross' Head of International Programs Donna McSkimming has a different view: "Noela is a credit to Australian nursing, an ordinary Australian who has made an extraordinary contribution.

"Australians are highly regarded in overseas aid work...It's recognised that we don't need all the creature comforts, that we are realistic, that we tend to step into a situation, sum it up and get on with it."

"Noela Davies and her fellow Florence Nightingale Medal recipients are inspirations

to us all in their efforts to help Red Cross fulfill its lifesaving mission," she said.

"The recipients epitomise all that the Red Cross Movement stands for, principles such as humanity, impartiality, and neutrality. These awards – which were first given out in 1912 – honour nurses and nursing aides who show outstanding qualities, such as exceptional courage and commitment, and devotion to care."

What next for Noela? She has just turned down a mission in Lebanon. "That was quite difficult," she acknowledges. "I am now working for the Royal Flying Doctor Service, an iconic organisation in Australia. And I'm in Mount Isa, a very friendly town.

"But I'll be off again in the future. I guess it's just something in you.

"It's not about a lofty idea of saving the world. In fact, I think international aid workers get a lot more out of this work than we give to the people on the ground. It's hugely rewarding." ●



Photo: Donna Lamb

the tyranny of distance

Michael Lanagan tells a fascinating tale of how he came to be the St John Ambulance Officer for the remote community of Sandfire in Western Australia.

My first experience with the medical profession, as a little kid on Carnegie Station east of Wiluna in 1950, arrived in the form of a tiny Auster 2-seater aircraft. The pilot was the doctor: in fact, he was Dr Harold Dicks who went on to become the Royal Flying Doctor Service (RFDS) chairman in Western Australia. The RFDS had been called to help a stockman who had come off his horse and broken his leg. I vowed to myself there and then that I, too, would become a doctor and a pilot. I did learn to fly but never became a doctor. However being an Ambo suffices.

Today, I live and work in Sandfire, a little village of just six people sitting on the Great Northern Highway, midway between Port Hedland and Broome. If you're travelling to or from the Kimberley by road, chances are you've stopped or will stop at the Sandfire Roadhouse, the only fuel stop in 610 kilometres of road. An average 150,000 people pass here each year. As well as the roadhouse, we have a motel and caravan park and a workshop for minor vehicle repairs.

And I am the community's one and only St John Ambulance officer, clocking up 600 km for the average round trip to serve the "locals" in the vast surrounding area. We have no mobile service so I rely on a satellite phone in the ambulance.



I arrived here back in 1991. After many years on cattle stations, rising to become a manager, I left the job after being diagnosed with cancer (which I beat) and looked elsewhere for something to do. Ken Norton, who owns the Sandfire roadhouse offered me the job of running the powerhouse here, and I jumped at it. So I did a diesel engineers course and here I still am.

When I got here, I took over the somewhat neglected RFDS medical chest and started going to vehicle rollovers in my tow truck. I never once carted a car from one of those accidents, just the people. However, a truck is not an ideal ambulance so I joined St John Ambulance Service and started a subcentre here on my own.

The challenges are huge – the tyranny of distance and lack of communication are just two.

When you have up to 12 patients in one accident you are stretched to the limit, and triage can be a hard decision. My two main therapies would have to be oxygen and a good sense of humour. In amongst all the tragedy, there is sometimes a lighter side: that helps a lot.

...I am the community's one and only St John Ambulance officer, clocking up 600 km for the average round trip to serve the "locals"...

I run a clinic at the roadhouse as well, for those who maybe just need a patch-up or something from the RFDS chest. A great many elderly folks don't travel with enough of their medications, but press on regardless when they become ill – heaven forbid their trip should be disrupted by a detour to a doctor!! So speed is of the essence. Minimal treatment and a lead foot is the go. The sooner I can get these people to a hospital the better chance they have.

After working for many years, I decided I needed a little "company" so trawled around on the net and found CRANApus. I was a bit hesitant at first as I'm only an Ambo – no letters after my name except 40YE (forty years experience). CRANApus has been good to me – the magazine is great and seeing how others in the bush cope is really helpful. My next door neighbours live in Alice Springs and Adelaide. To me, CRANApus is bushies for bushies!!

I haven't done any courses, much as I'd like to, but distance and finance is a challenge. I really would like to do the MEC course as childbirth in a remote area can be tricky if something goes wrong. If it does, I basically have to stay put, handle things here, and wait until the RFDS arrives with a paediatric team.

I love doing what I do. I'm 65 now and pretty creaky with arthritis and Paget disease but people need help and I am here where it matters. ●

a true generalist

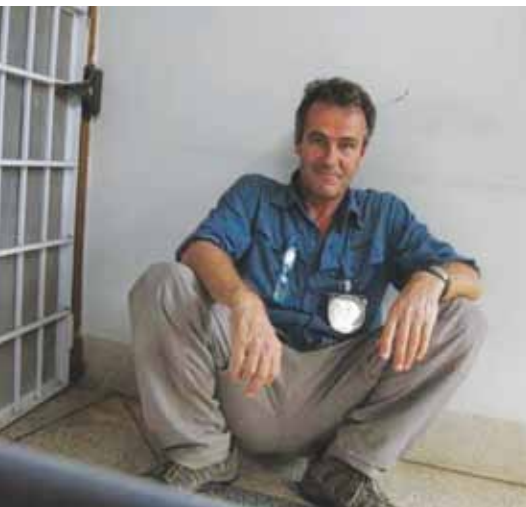
Dr Nick Williams has been a doctor for over 30 years and reckons almost everything useful he has learnt has been from nurses and community health workers.

In Australia, he has provided Royal Flying Doctor Service (RFDS) evacuations and community medical services to remote Aboriginal communities and currently works in a Community Health Service in a multi-disadvantaged area of Adelaide.

Dr Williams' work outside Australia has taken him to remote areas of Africa, a Cree Indian community in Canada and Pakistan's North West Frontier Province.

Here is his story.

Inspired to do medicine by the GP in my hometown of Jamestown in the mid north of South Australia, my future was set after a student elective in the highlands of PNG in 1978. The "see one-do one-teach one" school of remote medicine I experienced there shaped my future career.



I learnt how to cross-match blood under kerosene lamplight from a pidgin-speaking Clinical Health Worker; how to do a lumbar puncture from the local nurse; and how to resuscitate a flat neonate from the community midwife. I was strongly drawn to Third World Medicine.

With the goal of getting enough confidence with clinical skills to work in Africa, I completed a Diploma of Obstetrics in Australia and headed off to England to do anesthetics. Nine months later I was the only doctor in a remote hospital on the wild coast of Transkei, a homeland of South Africa. I was overwhelmed by the burden of illness the community faced. Cholera, malnutrition, tuberculosis, bilharzia, were all new to me. Measles was a killer disease with 40% mortality in children. I watched neonates with tetanus convulse with every sound or movement in the nursery until the sedatives mercifully relieved them of their pain. I will always remember the experience of putting in a spinal block before performing an emergency caesarian section and resuscitating the baby whilst a nurse assistant controlled the uterine bleeding. There was no knowledge or skill that was not taught and shared for purely pragmatic reasons. It was an experience. I moved on later to work in paediatrics in a large hospital in Bulawayo, Zimbabwe.

I learnt how to cross-match blood under kerosene lamplight from a pidgin-speaking Clinical Health Worker...

After four years in Africa I headed back to Australia to do paediatric training in Sydney. Working in a First World Tertiary hospital was a huge culture shock. I was doing emergency retrievals of 600gm neonates across the State with more equipment and technology than



I ever had at my disposal. My previous experience was that if a neonate could not survive with a bit of head-box oxygen (when there was oxygen) then it had no chance. I could not see my future in hospital medicine.

It was 1988 when I headed back to Africa to work in rural Zambia and in the three years I had been away AIDS had arrived. Many of the health advances of the previous decade were being lost. It was heartbreaking.

It was at this time that I finally realised that there was little point concentrating all my efforts in the hospital when the causes of all the health problems were in the community. I started to go "upstream" and try to stop people falling off the bridge rather than plucking them out downstream.

Left: Nick back from 5 days in the field in Pakistan.

Above: With ICRC in mountains of Pakistan.

We trained Community Health Workers and supplied them with ORS (oral rehydration salts) and chloroquine. We brought in Traditional Birth Attendants (TBAs) to spend two weeks in the maternity ward with the midwives. The amazed reaction of the TBAs when they saw a LSCS (caesarian section) is something that stays with me forever: they would be gowned and gloved and leaning over me almost pushing me aside to get a better look at 'this bag' the baby had been in. It was the best training I had ever been involved in. The incidence of women presenting with a ruptured uterus and babies with tetanus dropped dramatically over the next two years.

Being one of two doctors serving a population of 150,000 in rural Zambia was always going to be a hard act to follow, and perhaps it was inevitable that on returning to Australia in 1990 I ended up as a District Medical Officer in Alice Springs. ►►

► Working with remote area nurses and Aboriginal Health Workers was what I was accustomed to. Providing RFDS evacuations and community medical services to remote Aboriginal communities had its own challenges. These challenges were hugely supported by my involvement in the Central Australian Rural Practitioners Association (CARPA). I was and remain a passionate supporter of CARPA and was very involved in the first three editions of the Standard Treatment Manual, one finger typing most of the first edition. The 'bible' has gone on to become a fully entrenched part of health service delivery in remote Australia. During my time in Central Australia I consolidated my Public Health knowledge with a Masters, so finally I was a 'master' of something and not just 'a jack of all trades'.

After eight years in Central Australia, interrupted by a year in a remote Cree Indian community in northern Manitoba, we made the 'kids' education' decision and ended up in Adelaide for the high school years. Having seen the wheel re-invented two or three times by health service bureaucrats in Remote Health, it was time for a break anyway! Working in a Community Health Service in a multi-disadvantaged area of Adelaide has been a

change of pace. I have managed to keep in touch with remote area work with several locums in remote communities in the Northern Territory and through my involvement with the CRANAPlus Remote Emergency Care (REC) program. I am a proud member of CRANAPlus.

I have always wanted to remain a true generalist, combining clinical knowledge and skills with a public health passion. I work in an ED one night a week and teach a little at University.

Inspired by CRANAPlus members (Libby Bowell and Chris Cliffe) I became involved with Red Cross a couple of years ago. I subsequently spent three months in 2009 as an ICRC Health Delegate in the North West Frontier Province (NWFP) of Pakistan during the complex emergency created by military action against the Pakistani Taliban. I remain on-call for International emergencies.

CRANAPlus will remain part of my professional life into the future which will almost certainly involve more remote work with people I love and admire and in environmental settings that people normally pay to go to.

Dr Nick Williams
MB.BS, DRACOG, MScPHC, FAFPHM, FACRRM

... And one of our favourite REC facilitators!!!! ●

christmas every day

It's mid-December and a tropical low is developing offshore causing high winds and seas. The supply ship has left again after another unsuccessful attempt to offload essential supplies on Christmas Island. Plumes of sea spray shoot up into the air as waves hit the jetty and surrounding cliff face, roads are covered in wind-blown debris and trees groan and creak as a storm approaches.

Weather dominates conversation here on this tiny speck in the Indian Ocean; after all, weather does dictate much of the activity and movement on and off the island.

Christmas Island is one of Australia's most remote territories situated 2,600 kilometres north west of Perth and 350 kilometres south of Jakarta. It is a volcanic plug that soars thousands of metres out of the sea bed and is home to a permanent population of around 1500 people. Three quarters are of Malay, Chinese, Indian or Eurasian descent with Chinese dialects and Malay the primary languages spoken. The Island's cultural diversity is in part due to a long history of Chinese and Malaysian migration to service the phosphate mining industry over the last one hundred years.

Over the last two years the Island's population has swelled due to the influx of asylum seekers and the fly-in fly-out population employed at the detention centre and the associated service industries. This, along with a rapidly ageing permanent population with a high burden of chronic disease, has provided unique challenges to an isolated health service providing care to a widely disparate group of people.

The Island currently has two health services: The Indian Ocean Territories Health Service (IOTHS), which has an 8-bed inpatient facility, and a private health contractor providing initial health induction and ongoing Primary Health Care to detainees.

Registered Nurse Christine Folettin has been working on Christmas Island since 2009. Christine has extensive experience, including significant periods of time overseas working with the International Committee of the Red Cross (ICRC) in war-zone areas including Rwanda, Sierra Leone and Myanmar and in many Primary Health Care projects. In Australia she has a wide diversity of experiences including midwifery in urban and regional maternity units, with the Royal Flying Doctor Service (RFDS) as both a Flight Nurse and in a Primary Health Care role, and with new immigrants in new arrivals programmes.

The hospital provides inpatient care, A&E, PHC, dental, counselling, radiology, pathology and audiology services to the community and asylum seekers. It is staffed with 2 GPs, 7 RNs, 4 ENs, a dentist, 2 medical scientists and 4 counsellors. Visiting surgeons, specialists and allied health services also provide additional services to this remote community.

Christmas Island is one of Australia's most remote territories situated 2,600 kilometres north west of Perth and 350 kilometres south of Jakarta.

The following snapshots highlight just some of the challenges that we face in this far-flung part of Australia.

Whilst there has been a strong emphasis in the past on inpatient care, the reality is that the greatest challenges IOTHS now faces are ►►



Photo: Stephanie Jeremy.

►► Primary Health Care, the management of chronic diseases and a rapidly ageing permanent population. High rates of diabetes, asthma and hypertension are aided and abetted by the duty-free status of alcohol and cigarettes on the Island.

A packet of cigarettes costs \$2.50 and a bottle of gin costs \$10. In contrast, promoting healthy lifestyles and eating habits are a major source of frustration when one banana costs \$2.50 and a bunch of celery costs around \$11.

Aero-medical evacuation to a tertiary health care service in Perth may involve a 6-hour flight and extended delays due to adverse weather conditions, lack of available planes and one of the world's most dangerous airstrips. It is also expensive with an aero-medical retrieval costing between \$50,000–\$80,000 per evacuation.

Fly-in fly-out staff has swelled the Island population and these employees are often separated from their normal support networks for prolonged periods of time. Combined with long work hours, stress, poor lifestyle choices in terms of diet, exercise and a supply of cheap cigarettes and alcohol, this isolation exacerbates existing health problems and creates new ones.

Fly-in fly-out staff has swelled the island population and these employees are often separated from their normal support networks for prolonged periods of time.

Maintaining professional skills in isolated settings is an ongoing challenge. Weekly in-service and off-island professional development and mock disaster scenarios are all essential to retain staff and maintain skills. This became even more apparent in December last year as we updated our disaster plan and equipment, unaware of the events ahead.

It was really amazing to see the actual plan unfold and go into action and, whilst mock scenarios are not the 'real thing', they do have benefit.

CRANApus brought the REC course to Christmas Island in 2009, giving 20 of us the opportunity to be involved in the course. This was fantastic from a local perspective to having such a course delivered on site, and not having to travel.

CRANApus Education Manager Libby Bowell said the Christmas Island experience illustrated the benefits of being able to run a course for a team who will work together, with a focus on emergency roles and teamwork.

"Despite a pretty rough flight to get there we enjoyed the experience and are happy to go back anytime!" she said.

Other challenges include: vicious centipedes that lurk in linen, shoes, dive equipment and cause a painful bite that women often describe to be as bad as child birth; visitors to the island who run out of their heart transplant anti-rejection drugs and come to the hospital wanting replacement drugs! and raking red crabs off the road so you can get to work during crab migration season.

Anyway, life goes on and it's early April now. The Island children are still waiting for their Christmas presents to arrive by the supply ship and diesel is running low. Red crabs are crawling up the screen door and out my window. I can watch Christmas Island boobies doing aerial dances as they swoop and dive on the updrafts. Meanwhile the RNs and ENs on this tiny speck in the Indian Ocean are gearing up for one of our biggest challenges – to gain parity with our mainland colleagues in terms of wages and conditions.

**Christine Foletti
RN, RM Masters PH ●**

daydream dreamers



Sue...and Jenny...job share the position of Live-on Resort Nurse on Daydream Island off the Queensland coast. Well. Someone's got to do it!

Rewarding work combined with a tropical lifestyle in an idyllic island setting: Sue and Jenny recognise they indeed have a dream job on Daydream Island, which is just off the mainland of Queensland in the Whitsunday group of Islands.

Both RNs and RMs with many years' experience in acute, midwifery and general practice, they share a position that is a 24-hour 7 days a week job.

Jenny was attracted to the position of Resort Nurse for several reasons: the climate, the diversity of work within the resort, and utilising the skills, knowledge and experience that

she has gained over many years in acute care nursing, midwifery and senior management.

Sue spotted the job advertisement whilst sailing over from New Zealand and realised it was her ideal job: sun, sea and sand, naturally, but she also knew the varied and exciting aspects of the nursing involved would make it very rewarding.

"Our office/treatment room is approximately 5 metres by 3 metres: very intimate when there is more than one casualty from an incident or when stabilising a person prior to the Medivac arrival," says Jenny.

"The retrieval method is dependent on weather and availability: we mainly rely on CQ Rescue Helicopters but on occasions the resort fishing charter boat has been the only means of transporting casualties to the mainland. ►►

►► “Every day is different: we never know what we will encounter. It can be someone needing a bandaid or stabilising a critically ill patient following an encounter with a ‘Marine Stinger’.

“Both being mothers helps enormously with the many children we see,” Jenny added.

“And, whilst our role is to treat guests and staff from the island, we have been known to sail out to treat people on passing yachts.”

At any one time there can be up to 750 guests and staff on the island. The closest mainland contact is Airlie Beach.

“Every day is different: we never know what we will encounter. It can be someone needing a bandaid or stabilising a critically ill patient following an encounter with a ‘Marine Stinger’.”

Both agree that experience – experience – experience, both in acute care and life in general, are essential for this job – plus completing the REC for Remote Area nurse through CRANAp/plus.

“Working as the sole practitioners on an isolated island, we find the CRANAp/plus

Remote Emergency Care Course and the Clinical Procedures Manual invaluable,” says Sue.

“If we are ever in doubt the doctors at Airlie Beach provide telephone consults as do the local hospital and CQ Rescue.”

Sue, who has initiated a Stop Smoking Program for the staff, said the pair had reviewed and updated some of their equipment and procedures since attending the CRANAp/plus REC education course.

“On occasion we have felt a little overwhelmed and isolated,” Sue conceded, “but this is usually due to a lack of sleep.

“Being called out several times a night can be hard, but humour, appreciation and thanks go a long way to dispelling these moments.”

And, their accommodation is in the resort, surrounded by beautiful gardens, with kangaroos, cockatiels and large monitor lizards roaming around.

They have access to beautiful beaches and pools, a gym overlooking the Coral Sea, the extreme fun activities on offer, such as parasailing, the health benefits of naturopathy, aromatherapy, hydrotherapy and massage at the rejuvenation spa, and the opportunity to explore and experience the wonders of the Great Barrier Reef.

Sue and Jenny would definitely recommend their job: but it would seem they aren’t about to create a vacancy just yet! ●

a passion ignited

Mature-age student nurse Nancy Weatherford explains how a short conversation has shaped her nursing career.

She was just another girl in the classroom: a nurse in training and a fellow student. Her name is Roshie and she changed my world. It was a short conversation with my new Nepali friend: but it started a thought process that would light a fire in my heart and begin shaping my nursing career.

Only a few short months later, I was on a plane and landing in Kathmandu, having signed up to do a volunteer stint with an NGO in Roshie’s native home. I always had a passion to work in such a country and, with the first year of my nursing degree completed, I was loaded with enthusiasm to learn more and experience what I had seen only in textbooks.

A major part of my experience was the immersion into the Nepali culture.

Kathmandu was nothing like I had ever experienced before. Having been to several developing countries, I thought I would be prepared for such a place. However, I was still shocked by the rubbish, pollution and random sights, such as a cow seated in the middle of a busy intersection. It’s important to mention that the concept of an organised intersection is completely foreign, as is the notion of road rules. A taxi driver told me that the one rule for the road is, there are no rules! Basic survival behind the wheel on these roads seems an art form known only to locals.

A major part of my experience was the immersion into the Nepali culture. Living in a homestay, we ate as they ate and lived as they lived. ►►

Nancy Weatherford

The career path for mature-age student nurse Nancy Weatherford has seen her pull on steel-cap boots for climbing ladders, slip into stockings and heels to serve airplane passengers – and then don sensible footwear for pacing hospital wards.



Nancy’s working life took its first major diversion in 2005 (after a part degree in Health Management and many years spent in administrative employment) when she found herself on remote Horn Island in the Torres Strait, population 400, working as an aircraft refueler.

She then moved to the USA, to take up the offer of a job as far removed from refueling as possible: she became a flight attendant for Continental Airlines, based in Houston, Texas. As she says: “Quite a change from the steel-cap boots and wife-beater singlet, I swapped into stockings with heels and makeup.” Her flying career continued when she moved back to Australia, flying for Jetstar International.

Far from settled, however, she found herself thirsting for the medical emergencies onboard. This led her to look into Paramedicine and eventually Nursing. “So here I am,” she says. “A mature-age student, second shot at university, now in my second year studying nursing at the Australian Catholic University (ACU) in Brisbane.

“And living the dream.” ●



► This of course included ice-cold showers, 14 hours of power cuts per day and sleeping on a low wooden bed. As one of eight volunteers at the homestay, I was blessed to experience the true life of my Nepali family. They welcomed us with open arms and taught us all we could learn in such a short time. Conveniently positioned, a 30-minute walk meant I was close to my placement and many shops along the way.

My commitment to the project included a two-week placement at Alka Hospital, a private facility in the city of Patan just outside of Kathmandu, and it could not have been farther from the private hospital you may be envisioning. Being a private hospital, patients pay for their consult, any tests and treatment provided and although the cost is generally well below what we would pay to visit the local GP in Australia, in comparison, the expense for people in Nepal can easily prove impossible to meet. The majority of my placement was in the Emergency Department, in which I was continuously surprised by the methods of testing and care used.

Emergency consisted of nine patient beds, barely spaced apart with curtains, which are occasionally drawn for privacy. A paramedic and a nurse greet each patient and within minutes of arrival the doctor is bedside to give a full examination. After the constant horror stories that occur in Australia, I was surprised to see such prompt examination. Following the doctor's assessment, the patient follows written instructions to gain blood tests, x-rays or medication from the various departments, also situated on the hospital premises. Nurses and paramedics are readily available for the family to consult during this process and, with the arrival of test or x-ray results, the doctor will continue to instruct and communicate with the patient and family as required.

The treatment of each patient is very much dependent on their family being bedside. All patients seem to have three or more family members that arrive with blankets, food and drink.

I was encouraged by the concern of the family members. However I was also shocked at the lack of emotional support during minor procedures in emergency, as all family vacate the space for any treatment or assessment.

I was amazed at the skill of the paramedics and nurses as they sutured wound after wound with exact precision. With little to no use of helmets or seatbelts, road accident victims are frequent in emergency, with a wide range of treatments needed. Fortunately for these patients, the doctors, nurses and paramedics are extremely well trained and experienced. They always maintain a cool head and steady hands and, with an amazing level of teamwork, all remain thorough with their duties even when the emergency room was what I would describe as hectic.

I was truly blessed to have this experience in Nepal where, even as a student, I was thanked by a local woman for 'helping her country'.

During my placement, I was invited to maternity, where there were two women in the later stages of labour. The rooms were small and heated, which only made it feel more claustrophobic. The pre-birth room, which was the size of your average bedroom, had two women in labour, four women awaiting various types of gynecological surgery including a woman awaiting a Dilation & Curettage (D&C). When the gynecologist arrived, it was as though a storm was whisking through the tiny maternity ward. As I struggled to stay out of the way, I witnessed two natural births and the scheduled D&C. The birthing suite, also the size of a bedroom, contained two stirrup beds with a workspace in between for the pediatrician to work on the neonate. To save time, there are always two women in the stirrup beds, so the gynecologist can simply step between the two patients.



If you are lucky, she may stop to change gloves in between the patients. Cleanliness is not a priority in any way and neither is emotional support. After a baby is delivered, it is wrapped and delivered by the pediatrician to the father, who is in the waiting room. The mother sits and waits until she is either cleaned up or moved to another room. Without even a second thought, or a cleaning cloth, the next woman is placed in the stirrups and on goes the day.

Of course, during my stay, I was also fortunate to have weekends that included travel to Chitwan National Park in the south and Pokhara in the west. Both being beautiful destinations,

they capture the splendor of Nepal with the gracefulness of its people.

I was truly blessed to have this experience in Nepal where, even as a student, I was thanked by a local woman for 'helping her country'. I saw it as a unique opportunity for us to serve others in a field we are distinctively versed in. My time in Nepal, although short, has ignited a passion not only for the country but also for nursing in the developing world. I am returning in November and, with another year of study under my belt, I look forward to working in a more isolated area, to again serve the friendliest and happiest people I have ever met. ●

The 29th CRANAplus Conference will be held at the Novotel Langley Hotel, Adelaide Terrace, Perth, Western Australia. Unlike previous years this Conference is to be held during the week, rather than over a weekend.

The opening function will take place on Tuesday 11 October and conclude with the official Conference Awards dinner on Friday 14 October.

This year our Conference theme is:

“supporting the full spectrum of remote health practices”

The diversity of remote health practice is akin to the diversity of this vast continent of Australia. At this Conference we will hear from the very broad section of individuals and organisations that are providing and supporting health service delivery in remote and isolated areas.

In October, Perth is to host the Commonwealth Heads of Government Meeting (CHOGM) with leaders from 54 nations and international delegates arriving in Perth throughout the month, and this has necessitated that this Conference be held during the week.

CRANAplus Conferences offer an environment that will foster new ideas, promote collegiate relationships, provide opportunities for professional development and celebrate remote area health practice.

We hope you will join us in Perth. ●

accommodation

CRANAplus has negotiated special conference rates at three hotels, starting at \$158.00 per night. The Conference will be held at the Novotel Langley Perth. We have provided options and price ranges below, all within walking distance of the Conference venue.

We have also engaged the assistance of Shortlead.com.au who will process your accommodation booking from the CRANAplus website, which means you do not have to go looking. Simply go to our website (www.crana.org.au) and fill in your request and you will be notified of availability and confirmation of your booking by email.

options:

Good Earth Hotel

195 Adelaide Terrace, Perth WA
Double or Twin Studio: \$158.00 per night

Ambassador Hotel

196 Adelaide Terrace, Perth WA
Double or Twin Room: \$175.00 per night
Executive Apartment: \$195.00 per night

Novotel Langley Perth

221 Adelaide Terrace, Perth WA
Superior Queen or Twin Room: \$270.00 per night (room only + \$30.00 breakfast)

Visit the conference area of the CRANAplus website for more details. ●



award nominations

The Aurora Award

The Aurora Award is an honour granted each year at the CRANAplus Annual Conference in which one person is recognised for his or her outstanding contribution to the delivery of remote health care.

Nominating a mentor, colleague, or co-worker is an excellent way to show your respect and admiration for their contributions to the industry.

The nomination form requires submitters to provide a short narrative extolling the achievements of the nominee. Nomination forms and details are available on the Conference section of the CRANAplus website.

CRANAplus Awards

The CRANAplus Awards recognise remote health professionals who have made a special contribution that improves health outcomes,

or have made a special contribution to their profession in general. Nominating a fellow practitioner is an excellent way to show your admiration and respect for their hard work.

Winners will be announced at the Conference dinner. There are a total of seven areas of recognition in the CRANAplus Awards:

- Clinical Excellence
- Research & Education
- Management
- Primary Health Care Champion
- Novice/Encouragement Award
- Collaborative Team Award
- Mentoring Award

The one-page nomination form must be accompanied by a short paragraph from you, describing their achievement and your reason for their nomination.

Nomination forms and details are available on the website in the conference section.

All nominations for all awards must be submitted to the Alice Springs Office by 1 September 2011.

Deadline: 1 September 2011

Forms available on the CRANAplus website: www.crana.org.au or by calling (08) 8408 8200

Winners will be announced at the 2011 CRANAplus Annual Conference in Perth, WA. ●

courses available!

Make the most of your trip to the 2011 CRANApus Conference by tying in one of the courses and workshops to be held in conjunction with the Conference.

Remote Emergency Care 8–10 October 2011 (Pre-conference)

The CRANApus Remote Emergency Care (REC) course helps health practitioners to develop knowledge and skills essential to providing emergency care and treatment in common emergency situations encountered in the remote setting. To provide the remote and rural practitioners with knowledge and to promote confidence to deliver safe and quality care to the patient. Register for this course in the education section of the CRANApus website.

Remote Area Nurse Practitioner Professional Development

A workshop open to Nurse Practitioners and Nurse Practitioner Candidates

Join us for a Nurse Practitioner professional development workshop prior to the CRANApus 29th National Conference in Perth, Western Australia.

Date: Tuesday 11 October 2011
Time: 1:30 pm – 4:30 pm
Venue: The Board Room
Novotel Langley, Perth

The final outline for the session will be available closer to the date and will include a case study and professional discussion.

The session is supported by the Centre for Remote Health and CRANApus and offered at no charge to registrants.

Enquire: Vokill Shiell (08) 8951 4700

Register: crh.shortcourse@flinders.edu.au

Introduction to Remote Area Nursing Workshop

11 October 2011, 9:00 am – 1:30 pm

This workshop is designed to give those people interested in remote area nursing as a career, some insight and information about that role and the context in which it is delivered. It will be delivered by a selection of remote area nurses with wide experience in this exciting and challenging work. Register for this course on the conference registration form.

Maternity Emergency Care 15–17 October 2010 (Post-conference)

The CRANApus Maternity Emergency Care (MEC) course teaches maternity emergency care to non-midwives working in a remote or isolated setting. Register for this course in the education section of the CRANApus website.

All courses will be held at the conference venue, the Hotel Novotel Langley in Perth ●

opening address

CRANApus is delighted that our invitation to Senator Judith Adams to open our conference has been accepted. She was very keen to make that time available to us. Many of you will remember she joined us at our Silver Jubilee Conference in Broken Hill in 2007. Holding the Conference this year in her state we feel it is particularly relevant to have Senator Adams as our invited speaker. She trained as a nurse and a midwife in New Zealand, worked in rural and remote areas in Western Australia before marrying and establishing a farm in the southern region of Western Australia. Judith knows well the challenges surrounding rural and remote health service delivery, and utilising her health background, experiences as a consumer, and a Member of Parliament, she has been proactive in many forums and a very strong advocate for rural health.

We look forward to Senator Adams joining us in Perth this October. ●

senator judith adams



Senator Judith Adams was born in Picton, New Zealand.

After completing her secondary education she trained as a general nurse and midwife, and gained a Diploma in Operating Theatre Nursing.

In 1963 Judith joined the New Zealand Territorial Army as a Nursing Sister obtaining the rank of 1st Lieutenant and in 1967 was appointed to the NZ Surgical Team in Vietnam as a civilian nurse under the auspices of the Columbo Plan.

In 1968 Judith was employed by the Western Australian Medical Department as a member of the Emergency Nursing Service.

This involved relieving as a Director of Nursing and midwife in rural and remote WA. She met her husband Gordon, a RFDS pilot, while working at Meekatharra and married in 1970.

Judith and Gordon farmed in the Great Southern Region at Kojonup for 36 years with their two sons. The family was very involved in the community and Judith was recognised as the Kojonup Lions Citizen of the Year in 1995.

Judith has had a long involvement with the National Rural Health Alliance as a councillor and served as the rural member representing the Australian Healthcare Association for seven years.

Other community appointments included serving on the PMH/KEMH Board, the Metropolitan Health Services Board, Aged Care Planning Advisory Committee (WA), and as President of the Country Hospital Boards Council (WA).

Elected as a Liberal Senator for Western Australia in 2004, Judith was involved in securing changes to Government legislation in the areas of wheat legislation, the Australian Defence Force drug policy and the Patient Assisted Travel Scheme.

As well as being Deputy Opposition Whip in the Senate, Judith is a member of the Community Affairs: Legislation and References Committees, Selection of Bills Committee, Senators Interests Committee and the Joint Standing Committee on National Capital and External Territories.

Judith has worked and travelled extensively throughout WA and continues to be a strong advocate for those living in rural, regional and remote areas. ●



keynote speakers



Professor Colleen Hayward is a senior Noongar woman with extensive family links throughout the south-west of WA. She comes from a teaching family with both her parents and two siblings having been teachers. Her father was the first Aboriginal teacher, and Principal, in WA. She is currently Head of Kurungkurl Katitjin, ECU's Centre for Indigenous Education and Research.

For more than 30 years, Colleen has provided significant input to policies and programs on a wide range of issues, reflecting the needs of minority groups at community, state and national levels. She has an extensive background in a range of areas including health, education, training, employment, housing, child protection and law & justice as well as significant experience in policy and management. In much of this work, she draws on her qualifications including Bachelor of Education, Bachelor of Applied Science in Aboriginal Community Management and Development and a Post Graduate Certificate in Cross Sector Partnerships from Cambridge University.

Among her many achievements, she has been recognised for her long-standing work for and on behalf of Aboriginal and Torres Strait Islander communities across Australia by being named a finalist in the national Deadlys Awards in the category of Outstanding Achievement in Aboriginal & Torres Strait Islander Health (2008) and by winning the 2008 National NAIDOC Aboriginal Person of the Year Award. Colleen is also a recipient (2006) of the Premier of WA's prestigious Multicultural Ambassador's Award for advancing human rights and anti-racism in the community and is the 2009 inductee into the WA Department of Education's Hall of Fame for Achievement in Aboriginal Education. She is currently a member of the inaugural Board of the National Congress of Australia's First Peoples. ●

John Mofflin, Director and General Manager Jack Thompson Foundation Ltd.



In 2007, John Mofflin attended the Garma Festival in the North East Arnhem Land of the Northern Territory and was moved by the stories he heard of overcrowded homes and the ensuing social problems. Through his knowledge of timber milling and building, he realised how the timber growing in the area could be used to solve the chronic housing shortage in Arnhem Land. People living 'on country' could be taught to build their own houses out of the 'living ground'. He approached Jack Thompson, for his support and Jack, fully seeing the potential of the idea, offered his backing and the Jack Thompson Foundation was born.

John lived in Northeast Arnhem Land for 9 months in 2008, working with the Yolngu people, and teaching logging and milling techniques and facilitating instruction on how to build their own homes. It was a resounding success; this constituted the Jack Thompson Foundation pilot project.

Since then the Foundation has been spearheaded by John's continued voluntary commitment. John has become a Keynote speaker at conferences in the area of Indigenous issues and has gained respect in remote communities throughout Australia as an advocate and champion of Indigenous issues. John Mofflin is an ordinary bloke with an extraordinary vision. ●

conference 2011 principal partner



Australian Government Department of Health and Ageing

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

advertising rates

Standard rates		One issue	2 issues (- 10%)	3 Issues (- 15%)	4 Issues (- 20%)
Full page	Type: 128mm W x 183mm H Trim: 148mm W x 210mm H Bleed: 154mm W x 216mm H	1,600	2,880	4,080	5,120
Half page	Horizontal: 128mm W x 90mm H Vertical: 65mm W x 183mm H	880	1,584	2,244	2,816
Third page	Horizontal: 128mm W x 59mm H Vertical: 65mm W x 121mm H	600	1,080	1,530	1,920
Double page		3,040	5,472	7,752	9,728
Colour rates		One issue	2 issues (- 10%)	3 Issues (- 15%)	4 Issues (- 20%)
Full page	as above	2,240	4,032	5,712	7,168
Half page	as above	1,232	2,218	3,142	3,942
Third page	as above	840	1,512	2,142	2,688
Double page		4,256	7,661	10,853	13,619
Magazine insert				1000	2000
Full size	Trim: 148mm W x 210mm H Artwork must be supplied			450	900

Magazine is printed in A5 format. Other advertising sizes can be negotiated.
Note: Back cover and centre spread are unavailable until December 2011.

Publication Dates: March, June, September, and December
Submission Dates: First day of February, May, August and November

Rates are in AUD\$ and are inclusive of GST. All artwork to be submitted by close of business on the published deadline date. Full colour ads to be submitted in high resolution PDF format with all fonts embedded and all colours separated into CMYK. ●

NAHRLS

Nursing & Allied Health Rural Locum Scheme

Can't get away to do your
Continuing Professional
Development training?

**Apply to the Nursing & Allied
Health Rural Locum Scheme
for someone to fill in for you
while you are away...**

The Australian Government has established the Nursing & Allied Health Rural Locum Scheme (NAHRLS) to support nurses, midwives and allied health professionals in rural and regional Australia to get away to do the professional development training they need to continue their vital work.

NAHRLS will find you and your workplace a suitable locum for the period you are away. The scheme supports all locum recruitment, travel and accommodation costs. Applications for this scheme will be accepted four times a year. Organisations can also apply for locum support for their staff.

First round applications are now open and you can apply online.

For more information visit:

www.nahrls.com.au



CRANApus corporate members



Finding the right balance
Barkley Region Alcohol and Drug Abuse Advisory Group Inc.

Barkley Region Alcohol and Drug Abuse Advisory Group (BRADAAG) was established in 1982 as a community based group to address alcohol and other drug issues.



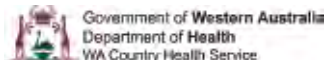
Cairns Nursing Agency is the employment gateway for Nurses and Healthcare professionals traveling to, around and through Northern Queensland and the Northern Territory



CQ Nurse is Australia's premier nursing agency, specialising in the placement of nursing and midwifery staff, in regional, rural and remote facilities.



Northern Territory Dept of Health & Families Remote Health Branch offer a career pathway in a variety of positions as part of a multi-disciplinary primary health care team.



Department of Health WA Country Health Service – working together for a healthier country WA.



Indigenous Allied Health Australia's vision is to achieve the same quality of health for Aboriginal and Torres Strait Islander peoples.



The Indian Ocean Territories Health Service manages the provision of health services on both the Cocos (Keeling) Islands and Christmas Island.



Katherine West Health Board provides a holistic clinical, preventative and public health service to clients in the Katherine West Region of the Northern Territory.



NASANSB The Best Place For Nurses. As South Australia's leading nursing agency we have the greatest choice of general, specialist and aged care shifts in all regions.



The cornerstone of the **NT Medic** workforce development strategy is the recruitment, retention and professional development of their NT workforce in support of the needs of the rural and remote regions.



NAA NSW provides a selection of staff for public and private hospitals, aged care and mental health facilities throughout metropolitan and regional New South Wales.



NAA QLD is located in the heart of Brisbane, and provides general, mental health and aged care staff to hospitals throughout metropolitan and regional Queensland.



WANA prides itself on offering the greatest choice of shifts and work opportunities – from the glitter of Perth, to rural towns and the red heart of the outback.



Since 1989 **Oxley Nursing Service** has based its service on what health clients and professionals would be seeking – ethical, professional, approachable and supportive.



The **Remote Area Health Corps (RAHC)** is a new and innovative approach to supporting workforce needs in remote health services, and provides the opportunity for health professionals to make a contribution to closing the gap.



Randstad's healthcare team has provided the best people, recruitment solutions and HR services to your industry for over 30 years.



Silver Chain provides primary health and emergency care to 11 remote communities throughout Western Australia where there is no resident doctor or hospital.



educate

point of difference

The calibre of CRANAp^{plus} facilitators, we believe, is our point of difference compared with the many organisations offering similar education courses.

We have a very diverse pool of knowledge, skills, experience and expertise.

All of our facilitators are currently practising practitioners in their specific areas, with knowledge of current trends and an understanding of the realities of working in difficult and/or resource-poor environments.

The Remote Emergency Care (REC), Aboriginal Health Worker REC and Advanced Remote Emergency Care courses are fortunate to have input from FACEMs (Fellows of the Australian College of Emergency Medicine) from all over the country, in addition to experienced RANs, educators from tertiary centres, nurses from various rural and metropolitan settings, and paramedics who work across the spectrum.

We have midwives contributing to the Maternity Emergency Care (MEC) and the Aboriginal Health Worker MEC courses, with the Midwifery Upskilling (MIDUS) course supported by a senior and experienced group of midwives from academia, metropolitan and rural and remote areas.

While expenses are covered for each facilitator they actually volunteer their time and energy. This ensures we attract and retain a group of enthusiastic and passionate people who do this work for the love of it. This passion and enthusiasm is evident in their presentations and participants respond to this.

We couldn't run courses without our very talented and passionate group of facilitators. We acknowledge their contribution to making all of the CRANAp^{plus} courses the popular success that they are. The facilitators help maintain the great reputation that CRANAp^{plus} courses continue to enjoy. ●



minh le cong

Minh Le Cong, MBBS (Adelaide), FRACGP, FACRRM, FARGP, GDRGP, GCMA, GEM, Dip Aero-Medical Retrieval & Transport (Otago), is currently the Medical Education Officer for RFDS Queensland, providing governance and coordination for teaching and training programs across the state.



He is also currently a Senior Lecturer in Aeromedical Retrieval at James Cook University, and holds current instructor certificates with EMST and ALS.

Minh's primary Fellowship training is in Rural General Practice medicine with advanced skills in emergency medicine, adult internal medicine and critical care.

His clinical interests are in emergency airway management, acute mental health care, retrieval medicine and prehospital ultrasound. He is an active GP registrar supervisor and mentor for both the RACGP, ACRRM and RVTS programs.

Minh has strong research interests. In 2010, he was the winner of Best Research Paper (Flying Doctor Emergency Airway Registry) and Best Conference Paper (Psychiatric Aeromedical Retrievals - Towards Best Practice) at the International Society of Aeromedical Services Annual Scientific Meeting in Christchurch. ●

a passion for helping

Minh Le Cong, a medical officer with the Royal Flying Doctor Service in Cairns, Queensland, is the first to admit his daily job is a heady combination of aeromedical retrieval duties, remote general practice and medical education. Here he outlines the path he travelled to finally arrive in Outback Australia to explain why he is so passionate about rural and remote medicine and helping others.

My story begins way down south in Adelaide where I grew up and did my medical training. Even as a child growing up in urban surrounds, my father exposed me to rural Australian health care, as he was an overseas trained doctor from Vietnam and required, for his medical registration, to work in a remote South Australian town (Wudinna) for two years.

I remember vividly the trips to visit my father in Wudinna, as my brothers and I lived with my mother in Adelaide. I recall my first rodeo experience on the back of a horse and falling off! I recall my father being asked to go and help a farmer suture a wound on a cow's lip!

And I will never forget the trauma of being involved in a car accident on a remote highway when my mother was driving us to Wudinna and a stone, thrown up from a passing road train, smashed the car windscreen. My mother, despite having sustained multiple lacerations to her arms and hands, completed the rest of the journey in the night, whilst my siblings and I sheltered behind the car seats from the cold night air rushing in from the gaping hole in the front windscreen.

Perhaps these early memories of rural life, trauma and health care shaped my future medical career. Certainly as a medical student I became involved in the university rural student club and spent several summers in rural towns in the Riverland region of South Australia on the Murray River.

I met my future wife at university where we were fellow medical students, and we eventually started our general practice careers in her hometown of Loxton on the Murray River, three hours from Adelaide. Four years in Loxton as rural general practitioners, providing anaesthetic, emergency medicine and obstetric services to the local hospital was an extremely valuable part of my formative years as a rural doctor. It was here that I started to appreciate and yearn for a greater understanding of the role of retrieval medicine in remote Australian health care. I remember many nights waiting for the retrieval team from Adelaide, either coming in the Westpac helicopter or on a RFDS aircraft. Little did I know that in the years to come I would have those roles reversed!

What we learn in urban hospitals just does not cut it all the time out in the middle of nowhere.

During those years I also became heavily involved in hosting and teaching medical students from the Flinders University rural school. This sparked my ongoing passion for rural and remote health education.

It was clear to me then and now that providing quality training for a rural and remote context is vital to the future health workforce for Outback Australia.

After our daughter Ebony was born, my wife, Shelley, and I saw a recruiting advertisement for the RFDS in Queensland. We both enthusiastically applied and were accepted as medical officers for the Mt Isa RFDS base. We spent two summers in Mt Isa and I fell in love with the country around that region. It is rich in Australian and RFDS legend and history.



Photo: Libby Howell.

Moreover, I found a keen interest and yearning to gain more knowledge in Indigenous Health Care from my time in Mt Isa. We had our second child, Joshua, whilst we were there and I was granted a medical education part-time role for RFDS Queensland. This necessitated a move to Cairns base, which is where I have been for the last four years.

How did I get involved in the AREC courses? I had started to lecture and run RFDS workshops on retrieval medicine and received an invitation from the Rural Health Education Foundation to participate in a satellite education broadcast on trauma, triage and retrieval. Libby Howell, the education manager for CRANAp^{plus} and one of the founders of the REC and AREC courses, was a co-participant. We got talking about rural and remote work and she mentioned these courses. I had never heard of them but the concept struck at the heart of what I believe in: that quality training in emergencies for rural and remote providers is instrumental. What we learn in urban hospitals just does not cut it all the time out in the middle of nowhere.

In my time with RFDS I have worked with and learnt from a number of experienced rural nurses, paramedics and health workers. It is these professionals who constitute the rural emergency department! A lot of emergency courses are designed for urban hospitals and the difference with the REC and AREC workshops is that they are specifically tailored to rural and remote providers in Outback Australia. The courses are very practical and borrow from the vast emergency experience of the faculty, like Libby. The members of the faculty have all worked extensively in remote areas and rural Australia and know what works and what does not in these settings.

Whilst my career also involves running courses in retrieval medicine for hospital specialists, my heart lies in courses like AREC/REC where helping rural and remote providers develop confidence in common emergencies will derive the most benefit for the communities we serve, because all Australians deserve the best emergency care we can offer as professionals. ●

why we do what we do

The MEC course has been supporting RANs for more than eight years now with the MIDUS course into its first year post pilot. The MIDUS course has recently received Australian College of Midwives (ACM) MidPLUS endorsement, which ensures that high-quality, relevant education activities meet the ongoing educational needs of Australian midwives. Both the MEC and MIDUS courses provide participants with 20 CNE points.

For CRANApus MEC Coordinator Katie Sullivan, her knowledge of, and exposure to, remote nursing has been limited to the stories of Remote Area Nurses (RANs) and Remote Area Midwives (RAMs) who attend the Maternity Emergency Care (MEC) and Midwifery Upskilling (MIDUS) courses. Katie set out to gain first-hand understanding of the remote setting and here is her own story.

Here I am in Mililingimbi on a three-week casual contract with Top End Remote Health Service. My program is woman's health but, as there is no designated midwife here, I am counted in the numbers as one of the RANs. This is extremely challenging and outside my comfort zone. And it's exactly what I need.

My midwifery background has been in outer metropolitan Sydney maternity units. I didn't know what it was like 'out there', and I really wanted to appreciate the breadth of the role of people working in remote locations.

Milingimbi is the third and biggest step in that process. The first step I took to get experience was to spend a day with Cheryl, the Royal Flying Doctor Service (RFDS) outreach midwife in Pt Augusta, South Australia.



Milingimbi Clinic.

Then I organised to spend a week in Nguui, on Bathurst Island in the Northern Territory, with Di Griffin, a midwife who is also a MEC facilitator. I can say I was completely overwhelmed from the minute we arrived at Nguui airport. But my anxieties were quickly relieved by the incredible staff I met during my week there. The RANs and Di are very well supported by a large group of Aboriginal Health Workers (AHWs), GPs and other local staff. On one occasion, I was able to accompany Di to Milikapiti with the doctor's charter to provide some on-going support to the staff at the health centre as well as the new midwife working there. For me this brought lots of experiences: flying in the small charter plane was great as was seeing another remote



Walking in Milingimbi on International Midwives' Day.

community and seeing how another remote health centre works. Back in Nguui the week progressed really quickly with Di doing both the RAM job and trying to fulfil the manager's role that week as well. Of course with 28 antenatal women in Nguui, we were also kept busy with seeing these women as well. Working with Di reminded me of the components of antenatal care that are different for women in remote areas. At the beginning of the week I was not good at remembering to do urine analysis and weights on the women we were seeing, but I soon got used to it and was attending them on all women!

While the week in Nguui was great and I was sad to leave at the end, it became obvious to me that I needed more than one week to give me a real idea of what working remote is like.

Which has brought me to Milingimbi. Milingimbi is a community on an island 50km off the coast of East Arnhem in the Northern Territory. The RN staffing is supposed to be six registered staff and the manager, but the manager is currently the only permanent staff member.

This is extremely challenging and outside my comfort zone. And it's exactly what I need.

However there are some RANs who come back here regularly and a couple who are about to commence long-term contracts. There are two Aboriginal Health Workers (AHWs) and 2 'strong woman workers', and four trainee AHWs ►►



Me helping in the kids' room.

►► have just started. There is no permanent doctor here at the moment but tomorrow one is coming in for two weeks, which will be great for the health centre and the community.

The health centre is small and old which makes it extremely difficult to work in, especially when there is a lot of visiting staff around. But despite all of this, it is a great environment and a lovely community. I have been in the 'woman's room' most days. There are seven antenatal women on the books at the moment and I have been upskilling on all my woman's health knowledge.



The beach behind Milingimbi Clinic.



Apsley Strait, Nguu.

I have not been restricted to this room though and have done some chronic disease checks, assisted with the assessment and care of both young children and adults, and generally been a member of the current team. Today I did my first ever chest pain call out and ECG assessment. The woman was well in the end, but I was pleased to have been involved in her care.

I want to thank everyone that has supported me here in Milingimbi and in Nguu and during the MEC and MIDUS courses with CRANAp_{plus}. The opportunities I have had have reminded me of the reason I went into nursing in the first place and the reason we do the work we do. ●

MidPLUS

Endorsed by the Australian College of Midwives.
Approved for 20 CPD points in the MidPLUS Program.



We are excited and proud to announce the accreditation of our Advanced REC course and ALS on line program by the Australian College of Rural & Remote Medicine. The course had been approved with ACRRM for 20 PDP points for doctors upon completion of the course or program.



This Activity has been endorsed by APEC number: 050620121 as authorised by Royal College of Nursing, Australia according to approved criteria.
Contact hours: 20 CNE points.

FLEC courses for 2011

Location	Dates	Remote Emergency Care (REC)	Maternity Emergency Care (MEC)	MIDUS	Advanced REC	Aboriginal Health Workers
Darwin NT MEC ○	31 May-2 June					●
Tennant Creek NT ■	3-5 June			●		
Broken Hill NSW	17-19 June				●	
CRANC ACT ■	24-26 June	●				
Rockhampton QLD	24-26 June			●		
Darwin NT ○	30 June- 2 July	●				
Longreach QLD	8-10 July		●			
Alice Springs NT	8-10 July	●				
Tennant Creek NT ■	15-17 July		●			
Alice Springs DHF NT ○	19-21 July					●
Cowra NSW	29-31 July		●			
Port Lincoln SA MEC	2-4 August					●
Thursday Island	2-4 August					●
Laynhupuy NT REC ■	10-11 August					●
Ceduna SA	12-14 August		●			
Darwin NT	19-21 August				●	
Alice Springs NT	19-21 August			●		
Port Augusta	26-28 August	●				
Alice Springs DHF NT ○	1-3 Sept	●				
Darwin NT MEDIC ■	9-11 Sept	●				
Cairns QLD	16-18 Sept		●			
Kalgoorlie WA	23-25 Sept				●	
CRANC ACT ■	23-25 Sept		●			
Mt Isa QLD	30 Sept-2 Oct	●				
Perth Pre-conference	8-10 Oct	●				
Perth Conference	12-14 Oct	Conference				
Perth Post-conference	15-17 Oct		●			
Broome (following pharmacotherapeutics)	28-30 Oct		●			
Oatlands TAS	11-13 Nov	●				
Alice Springs DHF NT ○	7-9 Nov		●			
Darwin DHF NT ○	22-24 Nov	●				
Swansea TAS	25-27 Nov			●		
Darwin NT	28-30 Nov	●				
Walgett NSW ■	10-24 Dec		●			

■ Private funded course ○ DHF funded course
Please keep checking our website as details subject to change.

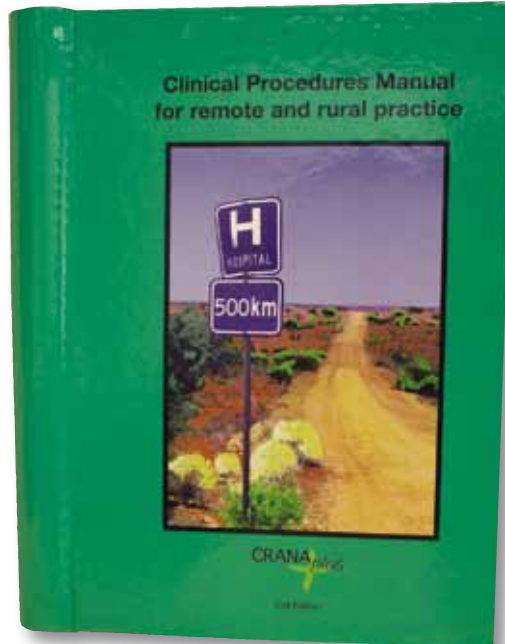


clinical procedures manual (2nd edition) \$70 incl. postage and handling

Remote areas are characterised by dispersed populations and predominantly high health need. The people who live in remote, rural and isolated areas experience higher levels of trauma, and delays to treatment associated with location and geography – often vast distances, but sometimes water, weather or transport. Remote health professionals not only provide the emergency care, but as part of the primary health care service, perform a wide range of clinical procedures on site. This resource is designed to support this practice.

As with the first edition of the manual, this edition has been written by remote practitioners, for their remote and rural colleagues. The aim is to incorporate the practice, wisdom and experience of these practitioners into a practical, best-practice guide to the many routine emergency procedures carried out in the bush, often in isolation.

Order online www.crana.org.au
or phone (08) 8959 1111 ●



eRemote overview

Introduction

To meet the challenges in remote health practices the CRANAplus eRemote e-learning program provides access to a dynamic and innovative educational resource that complements the First Line Emergency Courses. The eRemote program assists in maintaining lifelong learning, with links to current remote best practice. This program empowers the health professional by creating learning modules that are engaging, interactive and focus on remote and rural practice, while ensuring a positive outcome on the skills, knowledge and capacity of the remote health workforce.

Learning opportunities

The Online Program Coordinator offers unique clinical educational support to the end user via phone, e-mail and/or Skype, to encourage the remote practitioner to reflect upon their learning and develop their knowledge and skills in the remote clinical setting.

To meet the Online Program Coordinator, click on the link: <http://courses.crana.org.au/30-page-about-online-education-crana.html>

The program is flexible in its delivery modes and self-paced to allow the individual health professional to complete modules in their own time frame.

Modes of delivery to support the online learner are:

- Powerpoints
- Cases studies
- Assessments
- Text/handouts/checklist charts – downloadable
- Videos

The e-learning programs on offer will continue to grow to support the health practitioner in maintaining skills and knowledge relevant to remote and rural practice.

Upon successful completion of the program, participants will be able to print off a certificate of completion. To review eRemote please go to <http://courses.crana.org.au/>

On the right hand side is the eRemote log in. A visitor access has been set up: username – cranavisitor, password – welcome123

Online program and modules

Core Mandatory

Basic Life Support
Cultural Awareness
Drug calculations for Remote Practitioners:

- Adults
- Paediatrics
- Mental Health

Fire
Infection Control
Managing Difficult Behaviours
Manual Handling including Ergonomics for Office and Clinical Use
Medico-legal Documentation
Natural Disasters
Professional Development
Respectful Workplace

Advance Remote Emergency Care (AREC)

ALS – 9 modules

Aboriginal Health Workers

First Aid Program – 4 modules
Case studies

Clinical Upskilling in the Bush (REC)

12 Lead ECG
Airway Management
Defibrillation
Interpretation of Arrhythmias
IV cannulation
Non-Invasive Positive Pressure Ventilation (NIPPV)
Chest Pain
Intravenous Narcotic Pain Relief
Suturing
Plastering

Case Studies for REC and MEC

Various case studies based on the topics from the First Line Emergency Courses

All modules are available on CD as well as online. For further information and costs on the eRemote programs please go to: <http://courses.crana.org.au/83-page-modules-explained-crana.html> or contact Julia Stewart, Online Program Coordinator, phone: 0407 658 209 or e-mail: julia@crana.org.au ●



advocate

advancing the cause

The advocacy role of CRANApus is evident every day of the year: with staff promoting the role of the organisation at every opportunity, supporting the remote sector, assisting all those who work in it and advancing major initiatives.

Some of the more direct actions in recent months include:

- Meeting in Tasmania and ongoing contact with the Minister for Health, the Greens and the Office of the Chief Nurse concerning the role and scope of Remote Area Nurses. It is our view that any one profession should not govern or have control over another and this principle was understood and accepted by the decision makers in Tasmania.
- As reported in the March edition of the magazine, we are advocating the development of a Nursing Governance Model, which will clarify the circumstances and conditions under which Nurses, in specified rural and community health facilities, respond to emergencies outside the health facility.



Photo: Steve Batten.

This involves a review of legislation, determination of mandatory education and the endorsement of Guidelines to clearly identify the scope of practice of nurses undertaking this role.

- Making a submission to the Senate Enquiry on the Australian Health Practitioner Regulation Agency (APHRA).
- Lobbying the Controlled Substances Branch of SA Health on behalf of members in SA who are experiencing some interesting challenges in relation to their role in the remote mining context.

We continue to have representation at many forums through Board members, staff and other CRANApus members.

Geri Malone's appointment as National Coordinator of Professional Services, based in Canberra, has enabled us to be more responsive to requests and invitations to attend activities and Geri has been very active in attending a variety, including:

- Representing CRANApus on the Scholarship

Advisory Group for the Nursing & Allied Health Scholarship Support Scheme (NAHSSS) and the Aged Care Scholarship selection & advisory committee – both of these are administered by Royal College of Nursing Australia (RCNA)

- Attendance at the Personal E Health record forum
- Telehealth Advisory Group (on behalf of President)
- Attended with Anne-Marie, the National Rural Health Student Network (NRHSN) forum 'RAW Surf' held on the NSW south coast, hosted by students from the Canberra University Rural Allied Health Collective (CRANC)
- Attending pre budget & post budget forums on behalf of the CEO



In addition, our efforts are ongoing in regard to:

- The expanded role in regard to the MBS and the PBS
- Credentialling and the Coalition of National Nursing Organisations (CoNNO) project
- Endorsement on Registration for scheduled medicines
- Medicare Locals, Local Hospital Networks

Our participation on numerous committees, roundtables, expert reference groups and the like will continue and CRANApus will continue to be the major advocate for the remote sector and all those who work in it.

Advocacy is an area of work that is ongoing and vital to the health work being carried out by our members. It very often goes unnoticed and that is the way it should be. As long as we can continue to advance the cause and assist the main players in remote health – we are doing our job.

Carole Taylor
CEO, CRANApus ●

raising awareness about climate and health

CRAN*plus* is a founding member of the Climate and Health Alliance – a national coalition of health care stakeholders advocating for action on climate change to protect and promote public health. Fiona Armstrong, Convenor and President of the Climate and Health Alliance, provides an overview of CAHA activities and the organisation's aims and objectives.

The Climate and Health Alliance was founded in August 2010 when representatives from over 40 major health sector stakeholders met in Melbourne to discuss establishing what was then being described as a "green health alliance". There was a unanimous decision at that meeting to establish the alliance, with agreement to adopt the title of 'climate and health', with the understanding that while there was a broader remit of advocacy for environmental health issues, climate was the most urgent symptom of humanity's adverse environmental impacts.

...climate change poses a serious and increasing threat to human health...

The members of the Climate and Health Alliance acknowledge that climate change poses a serious and increasing threat to human health, and take the position that health care stakeholders have an important contribution to make in advocating for policy action on climate change and environmental issues.

The membership of the Alliance is a broad cross section of the sector, and includes health care professionals, health care service providers, institutions, academics, researchers, and health care consumers. The Alliance is composed of and represents stakeholders in the health care sector who wish to address the adverse environmental impact of the health care sector and see the health implications of climate change addressed through prompt policy action.

...there are significant environmental consequences associated with the delivery of health care and profound human health and ecological impacts associated with unmitigated climate change.

This is based on a collective understanding that there are significant environmental consequences associated with the delivery of health care and profound human health and ecological impacts associated with unmitigated climate change.

The purpose of this alliance is to raise awareness among policy makers and the wider community of the health implications of climate change and the associated challenges of resource

depletion, increasing population and food and water insecurity. The establishment of the Alliance demonstrates the public interest concern of health care sector and its members' commitment to contribute to the development of sound evidence based public policy that protects the community.

CAHA's advocacy spans a broad range of issues – from calling for policy to deliver strong emissions reductions to advocacy on issues such as a sustainable population, healthy power generation, healthy transport and urban planning, sustainable healthy agricultural

systems, improvements to land use, protecting and conserving our water supply, and improving climate literacy in the community.

CAHA also hopes to assist people and organisations in the health sector reduce their impact on the environment, and encourages all health care facilities to establish environmental committees, monitor and reduce their use of energy and water, and minimise production of waste.

For further information, to donate to CAHA's work or volunteer, visit www.caha.org.au ●

membership

CRAN*plus* now has more than 1000 members and the numbers continue to rise.

This growing membership gives our organisation an ever stronger voice with decision makers, providing us with the strength to advocate with greater authority on your behalf, and that of the remote health sector.

Our members are the backbone of this organisation. In the three years since membership opened up to all health disciplines, 15% of our members are from outside the nursing profession: social workers, doctors, paramedics, Aboriginal Health Workers and ambulance officers are among the growing range of disciplines featured among our membership today.

Almost 62% of those joining us are first time members of our organisation. Queensland and the Northern Territory are the states where we continue to enjoy the greatest proportional membership.

We believe our increasing membership is an acknowledgement of the value of CRAN*plus* expertise in the areas of remote education, support and advocacy for all remote health professionals.

CRAN*plus* membership offers a range of benefits including substantial discounts on

courses and the suite of eRemote online training products.

Growth among our corporate membership now sees us with 16 corporate members. We are proud that these organisations value our relationship with them, and pass the benefits of this membership on to their employees.

If you are the employee of a corporate member, you are entitled to receive concessional discount on your membership cost, whilst still receiving those benefits of full membership. You need only identify yourself as an employee of that organisation when joining, or renewing your membership.

Concessional membership categories, of \$50 annually, are available for those commencing their career, and those no longer actively involved, in the rural and remote health workforce.

We actively support students, who we see as the remote health professionals of the future.

Likewise, we have created a category for those who have retired from the remote workforce, among them past members, many of whom have been with the organisation from its inception.

CRAN*plus* grassroots members are indeed our organisation's strength – and one of the principal reasons this organisation was formed over a quarter of a century ago. ●

The health of the planet is our future

The Climate and Health Alliance is an alliance of stakeholders in the health sector who wish to see the threat of climate change addressed through prompt policy action.



report for RAW surf

Former world champion, Pam Burrridge, provided surfing lessons for students and coached many in their first waves.



What do surfboards, Pam Burrridge and karaoke have to do with improving mental health?

Well, not much really... but when you put them together in a jam packed weekend, grab some fantastic speakers on mental health and round up 150 university students from across Australia you have RAW SURF 2011!

What is RAW Surf?

RAW (Rural Appreciation Weekend) Surf is a two day conference focused on rural mental health for Rural Health Club student members from all across Australia. Held in April this year, the weekend aimed to inspire health students towards rural health careers, while they learned about mental health.

RAW Surf was set in the beautiful seaside surrounds of South Durras and Mill Beach, which provided the perfect setting for two intense days of learning and fun.

The weekend offered a full day of talks by fantastic speakers, with topics ranging from mental health first aid training, to accounts of personal stories of struggles with mental health, and the importance of inspiring the youth of today towards education and opportunities. Speakers included Stephanie Fraser (Physiotherapy student from Charles Sturt University), Paul Chandler (Australia's first Indigenous University Dean), and Pam Burrridge (Former World Champion surfer and Rural Advocate).



As part of the weekend, students were offered the opportunity to share 'high tea' with local carers of those with mental illness. Over cups of tea, the carers shared their personal experiences and offered insight on how to be better health practitioners for this population.

Keeping with the theme of the weekend, good mental health was promoted by a wealth of social activity over the weekend including a karaoke night, group yoga, and a morning of surfing. Former world champion, Pam Burrridge, provided surfing lessons for students and coached many in their first waves.

The success of the weekend was clearly evident in the number of new friendships

formed, meaningful conversations had, and the increased awareness of mental health from both the individual and carers perspective.

RAW Surf is part of a broader network of events organised by Rural Health Clubs across Australia to provide rural and remote experiences and educational and social networking opportunities for health students. Rural Health Club members are also part of the National Rural Health Students' Network and more information can be found at www.nrhn.org.au.

Samantha Johnson
Physiotherapy student,
Charles Sturt University, Albury
MARHS Rural Health Club member ●

support

good timing

by Mark Millard, BSS Psychologist

Corrigin, a farming community about 230km south-east of WA's capital, holds the world record of 'the most dogs in a ute', with a statue to commemorate the achievement. But it doesn't have a doctor. And that's where CRANApus Remote Emergency Care training comes to the rescue!

Mark Millard outlines here the last leg of his 2011 Bush Support Services CRANApus Roadshow – including the tale of his visit to the small township of Corrigin, population of less than 1000.

Registered Nurse Ruth Davis was having a relatively quiet Sunday afternoon shift at Corrigin Hospital, surfing the Net, when a surprise visitor carrying a box of Bush Support Services information kits walked up to her asking if she had some time spare for a chat.



Mark Millard outlines here for CRANApus Magazine the last leg of his 2011 Bush Support Services CRANApus Roadshow.



It was me, heading east toward Hyden and then north through Southern Cross to the Goldfields area of south-eastern inland WA. I thought I'd pay a visit to the local hospital on my way.

Ruth almost fell off her chair: I had arrived just at the moment she had been checking the CRANApus website for training courses...

Ruth almost fell off her chair: I had arrived just at the moment she had been checking the CRANApus website for training courses, and was particularly interested in the Remote Emergency Care training. She couldn't believe that on this sleepy Sunday in Corrigin someone from CRANApus would walk in the door just as she was cruising around the website! The Internet hadn't come this far, had it? ►►

►► We talked for a while about just why nurses in a town not too far from Perth in WA would be really keen on this training. It wasn't because they were planning a sojourn in a more far-flung place, but to be better skilled for their work at Corrigin.

...there was no doctor based at Corrigin, and the town relied on visiting locums or telephone contact with doctors 116km away at Narragin...

Ruth explained that the problem was there was no doctor based at Corrigin, and the town relied on visiting locums or telephone contact with doctors 116km away at Narragin, the nearest regional hospital. Further, it was often

hard to obtain these. So RNs in Corrigin had good grounds to be doing the REC Courses, since they were often the ones, just as in more 'remote' places, who had to provide the first line emergency care.

Ironically, this exact situation was underlined for a much larger audience at the National Rural Health Conference in Perth (March 2011), which I attended immediately after this part of the Roadshow, when the WA Minister for Regional Development, Brendon Grylls, spoke about Corrigin Hospital and its struggle to attract doctors to a large conference audience. Mr Grylls grew up in the Corrigin District, and his grandmother is a user of the Hospital.

Another highlight of this last leg of the Roadshow was a brief visit to Silver Chain's Hyden service centre, which covers the communities of Hyden, Karlgarin, Varley, Pingaring and Mt Walker. Families from Newdegate also regularly access Hyden's



facilities as the Hyden Primary School is the education provider for this town. Wave Rock, the popular tourist site nearby, attracts between 120-125,000 visitors per year, which means that things can get pretty busy in the tourist season.

Silver Chain plans and co-ordinates a range of services including emergency services, prevention and health promotion, disease control, maternal/school/child health and development screening. Primary health and chronic disease management are important service provision areas also.

Just up the road is Southern Cross, the town that provides care and services to the people of the Yilgarn Shire area. Southern Cross Hospital is part of the regional Multi-Purpose Service

and provides a variety of services including emergency, home and community care, acute medical, paediatric, geriatric (hostel and nursing home), respite and palliative care.

Southern Cross is one of many Hospitals in this area struggling to survive a drive for rationalisation and struggling to attract sufficient medical staff. It provides a wide range of community health services as well as traditional small hospital services.

WA Health has a creative response to the staffing challenges in this region by diversifying the service model of small hospitals and networking them in a kind of linked hierarchy to maintain skilled service staff and range of service. ●

share it don't wear it

by Annmaree Wilson, Senior Psychologist for the Bush Support Service, BSS Psychologist

The power of confession has long been known to be good for the soul! It makes sense, then, that talking about your problems is also good for your physical and mental health.

...many people avoid talking to others when they are troubled because the process can actually be quite painful.

However, many people avoid talking to others when they are troubled because the process can actually be quite painful. But, painful as it may be, it is really important to keep in mind the long-term health benefits of talking about your problems.

Research has shown that confiding in other people really is physically good for you. Keeping troubles, difficult feelings or traumatic events bottled up can make you physically ill because unspoken feelings, such as grief or remorse, create internal stresses. People whose coping strategies exclude them from confiding in others actually have compromised immune systems.

Research has also shown that confiding does not necessarily have to be spoken: it can be written as well. Keeping a journal or a diary, even if you are the only person who ever reads it, allows you to externalise your feelings and also helps you to work through the issue.

The same can be said of painting or drawing. Any activity that helps you get your thoughts out of your head serves the same function.

It is important to remember that not all confidantes are the same. For example, talking to one of the psychologists at the Bush Support Services is different to talking to a friend or your partner.

With people you know, you may withhold information because you might want to protect them or you are worried that information might be misused. In many instances, talking to someone who is not involved at all in your day to day life is much more helpful.

However, it is not always possible to find someone neutral to talk to. Or perhaps you may need to disclose information that you have been carrying around in your head to someone in particular. It is important to remember that, when you are talking to friends and family, it is not wise at times to self-disclose without some sort of internal gate-keeping. Self-disclosures about romantic fantasies or past indiscretions, for example, can have negative consequences.

You need to explore your motives for self-disclosure. The very best reason to self-disclose is in order to improve a relationship. Self-disclosure also needs to occur in the right context. There needs to be an opportunity for the person you are talking to to respond openly and honestly. Remember, if you have kept something secret for a long time there is usually a reason. It is important not to disclose too much too soon.

It is important not to make judgements.

On the other hand, if someone discloses a burden to you, it is important to hold that information and that person with care. Make sure that you let the person know that you hear and understand what they are saying. It is important not to make judgements. Keep the information you have heard confidential and do not use it against them in any way.

Don't forget that Bush Support Services is available on 1800805391, 24 hours, seven days per week. ●

overcoming the tyranny of distance

The telephone counselling service provided by Bush Support Services (BSS) not only overcomes the tyranny of distance for health workers in rural and remote areas; research increasingly shows the specific benefits of the phone-counselling model.

"There is an increasing amount of research that looks at how beneficial telephone counselling is, compared to face-to-face counselling and to no treatment," said Dr Annmaree Wilson, Senior Clinical Psychologist at BSS.

"A recent study found that more than half of clients (58%) who had experienced both face-to-face and phone counselling preferred phone counselling.

"Similarly, a 2002 study found that phone counselling clients rate their counselling relationship similarly to in-person clients," she said.

"Also, phone counselling has been established as an effective treatment for diagnoses ranging from depression to agoraphobia."

Dr Wilson said a key understanding of the Bush Support Service was that both Indigenous and non-Indigenous health workers comprised a particular group of people living in remote areas who have particular mental health needs.

"In short, due to isolation, remote area health workers chronically face high levels of occupational stress," she said. "These same workers also face increased chances of experiencing discreet traumatic events."

The Bush Support Line is a toll-free twenty four hour, seven day per week telephone counselling service, staffed by psychologists with rural and remote experience. Bush Support Services, a program of CRANAp^{plus}, provides a telephone counselling, debriefing and support service to

remote area health workers and their families. It also provides educational packages focussing on managing stress. In addition, BSS provides an on-line counselling service, case management and the provision of professional supervision. BSS also outreaches to remote area workers by running fun activities such as the Stress Buster Competition and a knitting project. (See the BSS website www.bss.crana.org.au for further information.)

What is telephone counselling?

Telephone counselling refers to psychological services that occur on the telephone. Psychologists working with clients face to sometimes advise them to make use of telephone crisis counselling to obtain support outside of therapy, if they need it.

The advantage of the telephone counselling service provided by Bush Support Services is that it is overcomes the tyranny of distance often encountered when working remote. It is free, confidential, anonymous and can be tailored to suit individual needs of callers.

So, if you feeling like a chat or there is something on your mind call Bush Support Services.

Contact details:

Telephone counselling: 1800 805391

Website: www.bss.crana.org.au

Email: counselling: scp@crana.org.au

Administration Office (Alice Springs)

Phone: 08 8959 1110 ●

learn something new

Bush Support Services is once again calling for entries for their Stress Buster Competition.

After the huge success of their inaugural competition last year, staff at BSS are once again eagerly planning for a deluge of fabulous and fun ideas from CRANAplus members across the country.

The theme this year is "Learn Something New" and you have until the end of September to get your entries in. The idea is for individuals or teams to learn something new: from belly dancing to skydiving. Whatever works for you as a stress buster. The 2011 Stress Buster Competition entry form is the loose-leaf insert in this edition of the magazine.

When they launched the competition last year, the BSS staff wasn't sure if anyone out in the rural/remote health workforce would respond to their competition. But respond they did. The competition generated great excitement throughout the CRANAplus organisation.

The idea is for individuals or teams to learn something new: from belly dancing to skydiving.

When the entries started arriving at the Alice Springs office, the competition became a source of fun and enjoyment for the staff, just reading about what people were doing in their downtime in the bush. When photos started arriving, things got even more interesting and, as the competition closure date loomed closer, staff could not get to the office early enough to open entry emails.



Amazing ideas and team spirit emerged from this competition and single-post nurses discovered ways to beat the loneliness blues.

Amazing ideas and team spirit emerged from this competition and single-post nurses discovered ways to beat the loneliness blues.

After the success of the 2010 competition, Bush Support Services is delighted to announce the 2011 Stress Buster Competition. The competition remains the same but focuses on the theme "Learn Something New".

Now's your chance to enter once again: learn something new and be in with a chance

for your ideas to make you richer (as well as enriching the lives of others with your ideas for managing stress).

Entries need to include a brief description of your activity, how often you have done it during 2011 and photos of you engaging in the activity. As usual there will be some fabulous generous prizes.

Entries should be emailed to:
bss@crana.org.au
or posted to:
Bush Support Services
PMB 203, Alice Springs, NT 0872
by Friday 30th September 2011

Winners will be announced at the 2011 CRANAplus Conference in Perth. ●

BSS cosy blanket project

Bush Support Services and all the 'knitters' who have taken part in the BSS Cosy Blanket Project have received a huge thank you, from Queensland.

"We are very touched to receive this kind offer from you and the people involved in this project," says Peter Conaghan, Community Services Manager of Blue Care in the Lowood/Rosewood and Brisbane Valley region.

BSS donated a large quantity of hand knitted blankets to mates in need through Blue Care. The Cosy Blanket Project saw health professionals working in remote communities use their spare time to knit woollen squares with volunteers in Alice Springs sewing the squares into warm blankets.

The Lockyer Valley region is just one of many where flood waters wreaked havoc resulting in loss of property, material possessions of every description, livelihood and sadly, loss of lives.

"The recovery from the floods has been long and very emotional for all of us and we are very honoured to have this kind gift from you and the project."

Thousands of people had to be evacuated including elderly residents of nursing homes



BSS volunteer Jacky and Colleen display a blanket destined for flood victims in Queensland.



BSS Manager Colleen Niedermeyer (centre) with Blue Care staff Sharyn Sallawaye and Peter Conaghan admiring blankets destined for the Queensland Lockyer Valley region.

who were housed in the local town hall for two days while the deluge continued. Some towns were cut off without basic essentials such as drinking water as emergency services worked around the clock to restore vital services.

BSS donated a large quantity of hand knitted blankets to mates in need through Blue Care...

"We still have many clients throughout the Lowood/Rosewood and Brisbane Valley Areas that have been significantly affected by the floods," Peter said.

"The recovery from the floods has been long and very emotional for all of us and we are very honoured to have this kind gift from you and the project." ●

generating interest

The word is now spreading afresh around New South Wales and Victoria about the fantastic counselling opportunities provided by Bush Support Services (BSS).

BSS has generated this interest after being invited in March to develop and facilitate workshops in Sydney for the Rural and Remote Area Psychologists (RRAP).

RRAP is a project initiated by the NSW Psychologists Registration Board, with 12 months funding to provide supervision, mentoring and support to psychologists working in rural and remote areas of NSW. There are approximately 80 psychologists registered with RRAP.

BSS provided two one-day workshops on Ethics and Supervision. BSS had the opportunity to work with experienced and senior psychologists and less experienced people, all working in a variety of settings including health, prisons and education.

The participants came from a large cross-section of NSW and Victoria: a number were from the Hunter New England Area Health Service, including Moree, Barraba and Narrabri; quite a few were from the far South and North Coasts of NSW and inland from Deniliquin; and the Victorian participants came from Wodonga.

Participating in this project gave BSS a great opportunity to further promote services to these states. There was a great deal of interest from the participants in regard to the supervision and personal counselling opportunities provided by BSS.

With the transition of state psychological registration boards to a national body in 2010, it is hoped that the new national psychological board will consider funding a similar nation-wide project. ●

Dear Colleen,

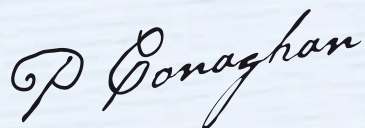
I just wanted to write to you and express the very sincere and heartfelt (and very warm heartfelt at that) thanks for the blankets that you recently delivered to our centre. In the past few weeks the nights in our area has become very cool and I have been very pleased to have the supply of blankets on hand to be able to provide to staff and clients who have been effected by the flooding in our area earlier in the year. It is a very moving experience to be able to hand someone some blankets, after they have just told you the story of how they have no warm clothing or blankets in their home following the floods. As the flooding in our area occurred in January, many people did not think of the winter and cold weather that would come, blankets and warmer clothing was hard to clean after being underwater so was disposed of, particularly woollens. One family I provided blankets to lost everything in the flood and are living in their home with no walls and cement floors, their children were complaining of a night time of being cold. I was very happy to be able to provide these blankets to them.

I would like to convey my personal thanks and the thanks from the staff in our area for this kind gift that we have received from you, it is making a difference in our area right now. As a survivor of the floods in January I can tell you that every day lives are changed for us because of those events but kindnesses such as yours are enormous in assisting us to recover.

I have also sent some blankets to Roma in South West Queensland who over Easter experienced their second flood in 18 months, a staff member who I know well has his home flood for the second time after only being back in the home for a few weeks.

Thank you for the gift and I ask that you convey my personal thanks to the remote health people who have knitted these squares. THANK YOU.

Regards,



Peter Conaghan
Community Services Manager,
Blue Care Lowood/Rosewood and Brisbane Valley

BUSH SUPPORT SERVICES

CRANA *plus*
bush support
services

1800 805 391

Toll-free Support line

a confidential telephone support and debriefing service

available 24 hours every day of the year

**for multi-disciplinary remote health practitioners and
their families**

**staffed by registered psychologists with remote and
cross-cultural experience**

available from anywhere in Australia

Resources also available
SELF-CARE BOOKS • SELF-CARE WORKSHOPS

Phone: (08) 8959 1110 **Email:** bss@crana.org.au **Web:** www.bss.crana.org.au



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Be part of the effort to improve Indigenous health

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Get involved.

Call 1300 MYRAHC

or apply online at rahc.com.au

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