

issue 81 | march 2011

# CRANA *plus* magazine

the voice of remote health



educate 30  
advocate 42  
support 48



# from the editor



The theme for our 2011 National Conference is 'CRAN*plus* – supporting the full spectrum of remote health practices'. We are now calling for abstracts, and we want your ideas. It's important that the conference, our 29th, covers the very broad cross-section of individuals and bodies that make up our organisation; the people who are providing and supporting health service delivery in remote and isolated areas.

We've gathered some great articles for you to read in this edition. You'll find an interview with Geri Malone, for example, who has recently taken up the new role of CRAN*plus* National Coordinator of Professional Services. Geri is based at our new Canberra office.

Members' stories about their day-to-day remote practice will inform and move you; and Education Manager Libby Bowell gives us an insight into her recent work in PNG with the Australian Red Cross during the cholera outbreak.

Lenny Cooper our Aboriginal Liaison Officer and Steve Batten FLEC Admin Officer, relate the story of their travels together through the Central Australian outback where they met with members and health workers to promote the varied range of CRAN*plus* products; among them the FLEC training programs and Bush Support Services, so relevant to them and their practice.

And there's more! We have contributions from student members and, from now on, the Executive Committee of the National Rural Students Health Network will have a feature article each edition.

That's just a sample of the reading you'll find inside these pages, which we hope you will enjoy. If you have a story or photos you want to share with our readers for future editions, don't hesitate to contact us.

**Anne-Marie Borchers**  
Business Manager, CRAN*plus*



**Australian Government**  
**Department of Health and Ageing**

Email: [publications@crana.org.au](mailto:publications@crana.org.au)  
Phone: (08) 8959 1111  
Fax: (08) 8959 1199  
CRAN*plus* Magazine  
PMB 203, Alice Springs, NT 0872  
Magazine circulation 3500.

CRAN*plus* graciously acknowledges the Australian Government Department of Health and Ageing for making this magazine possible through grant funding.

**About the Cover:** CRAN*plus* President Christopher Cliffe (left) in Canberra with newly appointed National Coordinator of Professional Services Geri Malone (right).

# from the ceo

I write this letter to members with mixed feelings of sorrow and pride.

I am, as are many people, extremely saddened by the recent events in Queensland, the fires in Western Australia and Victoria and the floods in New South Wales and northern Victoria. In the words of one of my staff "whoever has upset Mother Nature – could they please apologise and ask her to stop".

We have many members who have been affected by these events – some to a greater degree than others. And we all have friends that have had a very rough time. To all members and supporters who have suffered at the hands of Mother Nature – we offer our concern and our support.

In all of these trials, our Bush Support Services has been active. Calls and information have been going out to each area feeling the wrath of the elements.

In all of this sadness, however, I am filled with pride at the way the CRANAplus family responds to need.

Not 24 hours after the massive cyclone hit far north Queensland, Libby Bowell, our Education Manager, had suggested she put out a call for volunteer RAN's to work in the affected areas.

The President Christopher Cliffe also rang seeking advice on how quickly BSS could respond to need (they had already done so) and we had a teleconference to see how we could assist if needed.

And respond we did, with 27 RANs immediately offering their time and energy to be deployed at any time. How amazing is it that such a small and busy part of the profession could muster such expertise following one call to arms. I have never been so proud and so humbled.

In the wash up, they were not called, but they were there, ready to help colleagues, strangers and those who were sick and injured. The offer of assistance was made to the Federal Chief Nurse, the Queensland Chief Nursing Officer and the disaster management team who all remarked on our ability to pull such a group together at such short notice.

It's a great family to belong to.

It is caring, professional, well-trained and has a wonderful heart.

Thank you for allowing me to be a part of that family – I am so proud.

**Carole Taylor**  
CEO, CRANAplus





Photo: Libby Bowell

# engage

## from the president

What is it that Dorothy Mackellar says?

I love a sunburnt country,  
A land of sweeping plains,  
Of ragged mountain ranges,  
Of droughts and flooding rains

Never more accurate than reflected in the last few months and I hope, for those of you who have in any way been impacted by floods and cyclones, that you are on the road to recovery.

I was fortunate in that Cairns escaped relatively unscathed. However, in undertaking a site report for Royal Flying Doctor Service down the coast at Cardwell and Tully, the scene was not the same: the devastation and impact on those communities was extreme and they face a long road to recovery from all aspects, not least emotionally.

I was really pleased that CRAN*plus* was responsive in appropriate ways. Libby Bowell initiated a call to arms through a Friday Flyer which had a huge response, with many RANs offering to support communities in need

and their colleagues working in affected areas. Whilst, ultimately, our assistance was not called upon, the offer was well received and appreciated within QLD Health and acknowledged at the highest levels. It was truly reflective of the camaraderie and values that exists within our world.

### On other matters:

**Health reform:** I have written extensively in previous editions on the activity and CRAN*plus* perspectives around the area of Primary Health Care reform in particular. As you would have seen in media announcements, more is imminent and, as is oft the case, the devil will be in the detail. Watch this space for more...

**Scope of practice for Tasmanian RANs:** CRAN*plus* is developing a response to the issues raised as per our media release (featured opposite) for the Remote Area Nurses in Tasmania and has a meeting planned with the Tasmanian Minister for Health and other key players.



**MEDIA RELEASE : January 28 2011**

## **Tasmanian Remote Nurses hampered by bureaucracy**

Nurses and midwives working in remote and rural Tasmania are prevented from doing their jobs properly by outdated laws and departmental practices.

CRANAPlus has swung its support behind the Greens in Tasmania, who are pushing for changes to the Tasmanian healthcare system.

Aspects of the health system reflect the view of nursing and midwifery in the 1950s, not 2011, says Christopher Cliffe, President of CRANAPlus, the professional body for the Australian remote and isolated workforce.

The result is a 'brain drain' from Tasmania's rural and remote areas, as highly skilled and educated nurses and midwives leave because of the restrictions on their capacity to practice.

Mr Cliffe said that, despite a huge up take of CRANAPlus courses in Tasmania, these highly skilled and knowledgeable nurses are often prevented by local bureaucracy from undertaking their essential role. "I urge the Government and Health System in Tasmania to acknowledge and embrace their remote health professionals, support and facilitate this incredibly tough job and help them improve the wellbeing of Tasmanians, regardless of where they live," Mr Cliffe said.

### **National Registration:**

We have also commenced discussions around the Endorsement standard for RNs for scheduled medicines. This new standard for RNs in isolated and rural practice is a new endorsement for all, bar those in Queensland, and we are seeking clarity around the implementation of this.



I was pleased to be in Canberra last week for the very unofficial and informal opening of our Canberra office. Geri Malone has located there and is in the process of setting the physical space up, as well as making those important links and contacts. This will provide greater capacity for CRANAPlus to be responsive to a whole range of issues.

It is amazing to me that we are about to send out the call for abstracts for our 2011 Conference. The last one was only just a few weeks ago, or so it seems. We are seeking input from the entire, diverse range of health professionals who are out there in remote locations, to reflect the scope of CRANAPlus.

## **This year we want to encourage first-time presenters to be part of the conference presentations.**

There are always great stories to tell and lessons to learn across a whole range of topics and issues. This year we want to encourage first-time presenters to be part of the conference presentations.

As daunting as it may seem, we are a friendly lot and we are keen to hear from you.

**Christopher Cliffe**  
**President, CRANAPlus ●**

# CRAN*plus* goes to canberra

CRAN*plus* has established a base in Canberra in its bid to improve awareness of rural and remote health issues on national and political agendas.

Geri Malone, a Registered Nurse and Midwife with extensive experience in rural and remote area nursing, has been appointed National Coordinator of Professional Services.

Among her first challenges is dealing with the key issue of credentialling for remote area nurses and involvement in the National Health reform.

CRAN*plus* is increasingly recognised as the leading voice of Australia's remote and isolated workforce and this strategic move to Canberra

will see us working very closely alongside other key national professional bodies and NGOs.

**“We now have a permanent presence in Canberra to promptly liaise and respond to our stakeholders and ensure that the voice of the remote and isolated workforce is continued to be heard.”**



CRAN*plus* CEO Carole Taylor (left) and President Christopher Cliffe (middle) in Canberra with newly appointed National Coordinator of Professional Services Geri Malone (right).

A huge number of national organisations have a presence in Canberra including those representing nursing bodies, midwives, mental health nurses and numerous NGOs.

“I’m thrilled that CRANAplus after 28 years is at a point in its evolution where it is able to commit its own resources to this dedicated role,” said CRANAplus President Christopher Cliffe.

“We now have a permanent presence in Canberra to promptly liaise and respond to our stakeholders and ensure that the voice of the remote and isolated workforce is continued to be heard.”

Geri, who has served as the Director of Australian Rural Nurses and Midwives and most recently worked with the Royal Flying Doctor Service, considers the Canberra base to be a natural progression for CRANAplus.

**To be a remote area nurse you need a diverse range of knowledge and skills to work within a very broad scope of practice, often in professional as well as geographical isolation.**

She has had extensive involvement with national organisations, including NGOs, a crucial skill in this new position.

“As CRANAplus continues to expand it is an important step to have a dedicated resource that can respond in a timely manner to issues around the national workforce agenda and particularly Nursing and Midwifery professional issues, alongside other peak bodies,” she said.

Geri considers the new position of National Coordinator of Professional Services will add

impetus to the push by CRANAplus to have remote area nursing recognised as a specialist area of practice that requires specific skills, education and professional endorsement.

“CRANAplus has been involved for many years in the push to recognise that remote area nursing requires specific skills, training and experience,” Geri said. “To be a remote area nurse you need a diverse range of knowledge and skills to work within a very broad scope of practice, often in professional as well as geographical isolation.

“One of the key activities I will be involved with immediately is to be responsive to the Coalition of National Nursing Organisation’s (CoNNO) project to develop a National Nursing Credentialling Framework. Lyn Hinspeter has been representing CRANAplus on this coalition and I will be able to support Lyn in ensuring that remote health professional issues are addressed.”

Another area of interest to rural and remote registered nurses is that of the National Registration standard for endorsement for scheduled medicines. This has become a national standard alongside the implementation of National registration and is a new topic for many in this area. CRANAplus has commenced discussions with the relevant national bodies to gain some clarification around the requirements.

“I have no doubt there will be many initiatives that I will be able to get involved with including education issues in its broadest sense with the CRANAplus education team along with many other professional issues as they arise,” said Geri.

**It is an exciting time to be with CRANAplus...**

“It is an exciting time to be with CRANAplus and I am looking forward to reacquainting with a lot of colleagues in remote health as well as forging new alliances and partnerships.” ●

# remarkable road trip

**For Lenny Cooper, Aboriginal Liaison Officer and Steve Batten, FLEC Administration Officer, their recent road trip to clinics in remote SA, WA and NT proved to be an experience involving spectacular scenery and adventure, as well as meeting amazing CRANAp<sup>lus</sup> members and their clients.**

On this trip, Lenny's main aim was to spread the word about Bush Support Services, promote membership and follow up outcomes of the Adelaide Conference – as well as catching up with people he had met on previous trips.

For Steve, whose role is to administrate our online training products, his focus was to promote the new eRemote on-line modules. It also proved a wonderful opportunity for Steve to

get exposure to the unique aspects that dominate the CRANAp<sup>lus</sup> remote workplace.

The destinations scattered throughout the vast Outback on Lenny and Steve's list varied from modern establishments with specialist services, to remote Aboriginal set-ups with minimal resources. The journeys between, of course, were equally eventful.

Here are the highlights of the trip:

## Day One

Heading for Coober Pedy along the Stuart Highway, Lenny and Steve quickly left the city sprawl and soon found themselves surveying the dry, open expanses of outback South Australia. Johnny Cash and friends kept them entertained along the way.



Photo: Steve Batten

Here, they came upon the first of many natural wonders on the trip: flooding rains from Queensland, combined with consistent rains across the Red Centre meant that the normally dry Salt Lakes were full and Lakes Gairdner and Hart shimmered in the bright sun and the bird life was everywhere.

Approaching Coober Pedy, they were welcomed by the unique conifer laden landscape of mine tailings and the even more unique warning signs including “Don’t Run”, “Don’t Run at Night” and, Steve’s favourite, “Don’t Walk Backwards”!

Their first night was spent at the Catacombe Motel where rooms are cut into the side of a hill, keeping temperatures at a consistently mild 22 degrees Celsius all year round. Even the cuts made in the walls to create this odd form of architecture were artistic and unique in their own right.



Photo: Steve Batten.

## Day Two

Heading north to Eralunda, then west along the Lassiter Highway, the first pit stop was at Mt Ebenezer Road House where Lenny and Steve had a look at original artworks from the Imanpa Community, before passing through Imanpa on the way to the community around Kings Canyon. While they naturally expected desert and dust, with the unusual amount of rain, they found the landscape becoming greener and greener as they headed further inland.

## Johnny Cash and friends kept them entertained along the way.

Here, still early in the trip, Lenny had some down time with Steve heading off to do the creek bed walk. Lenny had previously learnt the hard way that this was not for the faint hearted as he and Carole had done the same walk years earlier, but on a seriously hot summer’s day with not enough water and all the rules of desert movement ignored. He wasn’t about to do it again and left his younger and fitter colleague to his own adventure.

Steve’s report of this walk states that – “with water trickling slowly down the creek, the lush grasses and local wild flowers flourished. Evidence of ancient sea beds could be seen in the rock forms and the stark colours of deep blue, green and red made for an amazing walk – highly recommended.”

“with water trickling slowly down the creek, the lush grasses and local wild flowers flourished...”

At Kings Canyon they stayed at the resort, with Steve asking Lenny when they would start roughing it. This was about to begin and Steve would soon eat his words. ▶▶



### » Day Three

The next morning the pair called into the Canyon clinic where they were warmly welcomed by Katie and Jeremy, who explained that a lot of their clientele were tourists with sprains and cuts or suffering from dehydration.

Next stop, Uluru and Yulara. On the horizon loomed a large monolith which Steve naturally assumed was Uluru. Like many others he was confused by the magnificent Mt Conner. This table-top monolith rises 300 metres and dominates the landscape until Uluru takes over 100km down the road.

According to Steve (and many others who come to marvel at this phenomenon) seeing this magnificent rock on TV or in magazines does not do it any justice at all. It is like a magnet and draws you in with its magical spell.

They met the staff at the Yulara clinic and spoke to the Primary Health Care Manager Leith Aitchison, who explained how their population of around 800 rises to 3,000 with tourists.

This is quite a modern clinic with a GP, two RANs (Level 4), four ambulance auxiliaries, two specialist services and a 24-hour on-call service.

**On the horizon loomed a large monolith which Steve naturally assumed was Uluru. Like many others he was confused by the magnificent Mt Conner.**

Another clinic at nearby Mutitjulu handles most of the Aboriginal clients with much less in the way of resources. This was a clinic the guys were keen to visit (or revisit in Lenny's case) but they were advised to do this another time as there had been some trouble in the community.

The Rolling Stones was the music of choice as they passed Kata Tjuta and made tracks for Kaltjukutjara (Docker River), finally leaving the relative safety of the bitumen for the red, dusty



Photo: Steve Batten.

outback roads. Heavy rains had left roadside puddles everywhere but recent grading work gave them a surprisingly smooth stretch. As remarked by Steve who is clearly quite poetic, as well as, in Lenny's words "a mad keen photographer", the red dust was replaced by green shrubs and masses of wildflowers of every colour and description. "We passed a mob of camels who looked back at us with nothing but disdain" was his diary entry.

At Kaltjukutjara, as was becoming their luck, Lenny and Steve found the clinic was unmanned due to a call out. Kaltjukutjara is a fairly large community with diverse health needs and as in many a remote clinic with minimal resources, when there is a call out it means the clinic has to be shut for that period of time, impacting on community members and the health staff. It is reflective of the demands on staff in remote clinics, particularly in these places that are very isolated from peer and colleague support, a factor reflected in the report from the Centre for Remote Health, "Back from the edge".

Being a bit of a weather buff, Steve was excited to pass through Giles (Ngaanyatjarra) where the local weather station is part of the Bureau of Meteorology's national grid of stations.

They crossed the border into Western Australia, heading for Warburton, not to be confused with other towns of this name, this is one of the most isolated places in Australia, located at the junction of SA, WA and NT. Being a bit of a weather buff, Steve was excited to pass through Giles (Ngaanyatjarra) where the local weather station is part of the Bureau of Meteorology's national grid of stations.

#### Day Four

A very hot day saw Lenny and Steve arrive in Warburton where they stayed two nights. They paid a visit to the clinic where they met Mary O'Shaughnessy the clinic co-ordinator, RAN's Helen Merritt, Jacinta McCormack, Jane Truscott, Christine Hurwood and Brett Murphy the receptionist. They talked about the local health issues and the challenges they face with fluctuating staff levels. ▶▶



Photo: Steve Batten.

» Day Six

They back-tracked to Wannan, a single-nurse post, where they spoke to the clinic RAN Marg who was there on a locum contract. She'd been there 4 months and was getting ready to head home soon.

During this trip, the intrepid duo came across a car which had broken down and stopped to offer assistance to the local bush mechanics. There is no doubt that the locals had the expertise to get almost anything going, but they lacked the tools to do so.

Lenny and Steve soon discovered that "Sorry" and Ceremonial times were going through this district and talk of further traditional practices filtered through and, on advice, they cut short Warburton and its region and started heading back towards Alice Springs.

They headed back towards Yulara where another car was near death and, once again, offered an iron bar to assist in its revival.

Back on the road, they soon returned to near Kata Tjuta, where they stopped for a rest, and just a few more photographs. They then reached Yulara, where they were able to pitch their tents, with Steve finally getting some use out of his swag. Apparently for Steve this experience lost all of its charm when he found he could not sleep and made him question if he is not just a city boy at heart! This of course was made even more difficult with Lenny snoring peacefully beside him.

As the CD collection started running low, Shania Twain serenaded the pair back to Alice Springs.

Day Seven

They headed north-west out to the Papunya clinic along the Tanami 'highway'. This was described by Steve as the skinniest road you'll ever come across and quite scary when facing the oncoming trucks and monstrous road trains. While at Papunya, Lenny took the opportunity to catch up with some of his ex-students from Worawa college, following which the pair were invited by Ria Beatson from the clinic, to join her for a much welcome coffee at the Nurses' quarters. Lenny and Steve found Ria to be someone who loves her job, was keen to talk about it, and her enthusiasm was contagious.

**"Heading remote and meeting the magnificent nurses and health practitioners was an absolute pleasure..."**

Venturing outside again the guys handed out some netballs and backpacks, donated by Netball Australia as part of their NetSetGO program. The SA National Football League also donated footballs and motivational footy posters of Aboriginal players. As expected, once the local kids got word that these were going free, they came from everywhere. As fast as the portable car tyre compressor pumped up the balls, more kids arrived.



Photo: Steve Batten.

Happy that they had made some kids smile, even though they could have handed out many more footballs, Steve and Lenny headed back to Alice. Some 6,226 km later, the trip was over – Lenny was home in Alice Springs and Steve was headed back to Adelaide.

**Last words**

Steve: “Heading remote and meeting the magnificent nurses and health practitioners was an absolute pleasure. Despite working in such harsh conditions, their smiling faces and happy-go-lucky attitude was so welcoming. Thanks to Lenny for the great company.”

**“It was fantastic to get back out there..”**

Lenny: “It was fantastic to get back out there. I get to see some of the most beautiful country in the world; I meet local countrymen who have so little and are so welcoming; and I catch up with some of the most dedicated staff in the health system.” ●



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# complexities, contradictions and challenges: nursing in an immigration detention centre

**Nurses work in environments that are often politically and ethically contradictory and highly charged. In this article, Jeanne-Maree Auld RN, RM and Linda Hathaway RN, RM, give an insight into the unique set of challenges facing nurses working in Immigration Detention Centres, which are amongst the most intense and incongruous nursing environments in Australia and present nurses with a unique set of challenges.**

Nursing experience in the rural and remote area context is an invaluable pre-requisite to work effectively in an Immigration Detention Centre environment. By its very nature, remote area nursing requires a specific skill set and personal, professional and psychological resilience and vigour to handle the unmitigated responsibilities and multiple demands of the role. These same attributes are required if one is to manage the challenges of clinical nursing practice within an Immigration Detention Centre, which shares similar challenges, including geographical isolation and dislocation from the supports of more structured nursing environments.

However, even with considerable rural and remote area nursing experience, nothing can quite prepare you for the role. Nursing in Detention Centres is a whole new ball game.

We both found this experience to be one of the most challenging of our individual careers, which span 30 and 40 years in predominantly rural and remote environments. Upon reflection, our individual decisions to accept short term contracts to work in an immigration detention centre, were not formed on any comprehensive understanding, nor appreciation of what we were to face during the weeks we were there.

**We both found this experience to be one of the most challenging of our individual careers...**

The paradox begins with the fact that nursing is set within the alien context of detention, amongst people who have entered the country illegally, upon which is juxtaposed the expectation to provide high quality, humane health care. The key to dealing with



Photo: Stephanie Jeremy

these contradictions is to maintain the same commitment to the integrity of nursing practice and delivery of ethical and professional care, as one would in any setting.

The structure of the workforce delivering health care to people in detention, mirrors other settings, in that nurses form the critical core of health provision. Nurses are at the clinical frontline and accordingly in the firing line. It is a common experience for nurses to feel sandwiched between polarised societal attitudes, political pressures, expectations of the clients, government and the employing organisation. Fortunately for us, we had the benefit of excellent support from on-site nursing management, who provided strong advocacy and back-up. Nevertheless, nursing practice was difficult due to the politicisation of the clinical setting, with the presence of DIAC officials and a stream of scrutinising organisations and bureaucrats. Consequently, the normally natural flow of reflective practice and clinical problem solving was made arduous, due to the highly charged political context and the cultural and linguistic filters through which all communication passed. Furthermore, one functions in an unnatural state of constant self-awareness, in that any word, action or approach could be interpreted in the negative. The relentless nature of the clinical demands delivered within this perplexing milieu added an unexpected and often unnecessary layer of strain.

We soon recognised that the detainees were not a homogenous group and the recent experience and circumstances of individuals varied considerably. Many clients had evidence of having endured trauma, torture and experience of direct geo-political conflict. Others had frustratingly unrealistic expectations of what we could deliver e.g. requests to provide remedial or corrective interventions for acne scars; flat feet; infertility; rhinoplasty. Also, we were female health workers providing care to some men who culturally held women in low esteem, and this presented some additional but not insurmountable challenges. Considerable

diplomacy, resilience and focus were necessary in prioritising health issues and problem solving.

Immigration Detention Centre nursing is not for the faint hearted. Our experience in direct care delivery was, in hindsight, a mixture of positives and negatives. Our individual contracts were originally four and eight weeks respectively, but extended to six and 10 weeks due to the difficulty in replacing us.

**...we were fortunate to meet some exceptionally courageous people who have endured great suffering and hardship but remained optimistic and hopeful about their futures.**

To work in such a pressured environment for less than compensable remuneration is not something we would recommend on the basis of financial gain alone. The team of professionals who assisted us in our care of clients, including Mental Health Nurses, Psychologist, GP and the Health Service Coordinator, were highly professional, supportive and compassionate, and provided exemplary care. We considered ourselves fortunate to work with such a cohesive and pragmatic group.

Sometimes the most difficult experiences can be the most character-building and we were fortunate to meet some exceptionally courageous people, who have endured great suffering and hardship, but remained optimistic and hopeful about their futures. It is our hope that we did make a difference in the lives of these people and that they would be facilitated in finding meaningful and productive futures. Our experience of working in Detention Centres has left us exhausted, but unscathed, and with a fuller appreciation of the complexities, contradictions and challenges surrounding the issue of detention and peoples seeking asylum. ●

# red cross mission to png

**Libby Bowell, CRAN*plus* Education and Training Manager, recently returned from a short Australian Red Cross mission to Daru in PNG, during the cholera outbreak.**

Cholera is unfortunately a poor person's disease...or more specifically it occurs because of poor water and sanitation. It is absolutely tragic that people die of cholera.

There is nothing sexy about doing a cholera mission...it is quite simply about good hygiene and safe water and sanitation practices....easy to say when I have a tap that provides clean water and a flush toilet! Death is by dehydration and it is really horrible to see death after death from a treatable disease. It really amounts to a race against the clock to rehydrate quicker than the patient is losing fluid!

The first unconfirmed case of cholera in Daru was identified in mid October, and since then cases and deaths have increased and spread into many remote villages. ▶▶

## Cholera background

Cholera is a diarrhoeal disease caused by infection of the intestine with the bacterium *Vibrio cholerae*, either type O1 or O139. Both children and adults can be infected.

About 20% of those who are infected develop acute, watery diarrhoea – 10–20% of these individuals develop severe watery diarrhoea with vomiting. If these patients are not promptly and adequately treated, the loss of such large amounts of fluid and salts can lead to severe dehydration and death within hours. The case-fatality rate in untreated cases may reach 30–50%.

Treatment is straightforward (basically rehydration) and, if applied appropriately, should keep case-fatality rate below 1%. Cholera is usually transmitted through faecally-contaminated water or food and remains an ever-present risk in many countries. New outbreaks can occur sporadically in any part of the world where water supply, sanitation, food safety and hygiene are inadequate.

The greatest risk occurs in over-populated communities and refugee settings characterised by poor sanitation, unsafe drinking water, and increased person-to-person transmission. Because the incubation period is very short (2 hours to 5 days), the number of cases can rise extremely quickly. (WHO, 2004).



Photo: Libby Bowell.

Left: Team loading the boat to travel to the field.

Right: A larger community with a health post along Bamu river, this community understand and adhere to the health messages and are treating cases daily. In December they had buried 12 cholera patients who died despite coming for treatment.

# png background

Papua New Guinea (PNG), Australia's nearest neighbour, occupies the eastern part of the world's second largest island, and shares an 820 kilometre border with Indonesia. The capital is Port Moresby.

PNG is comprised of diverse communities or 'wantoks' that collectively speak over 800 languages. The majority of the population is ethnic Melanesian and 44% of the population is Christian.

PNG is the least developed country in the South Pacific and health and economic indicators have been steadily declining since independence in 1975.

The population has more than doubled since independence and continues to increase at a rate of 2.4% annually.

PNG's major industries are mining, petroleum, fishing, forestry and agriculture, and it exports coffee, copper, gold, silver, tea, copra, palm oil, and forest and marine products. International aid also plays an important part in the economy.

Approximately 86% of the population lives in rural areas where they depend on subsistence farming and operate in a traditional informal neo-monetary economy.



Population	6.4 million
Area (land)	452,860 sq km
Population density	10.8 per sq km
Rural population	86%

Inadequate road infrastructure isolates many PNG communities and results in expensive and logistically challenging service delivery.

PNG faces several social challenges including crime, corruption, and rising rates of HIV and AIDS.

There are a large number of political parties and a high degree of political instability.



Photo: Libby Bowell

▶ PNG Red Cross (PNGRCS) was deployed to Daru in November to work alongside the Department of Health Services. Red Cross is traditionally called upon to do what they do very well... disseminate public health awareness about how to prevent cholera and how to treat it. I was deployed as a public health delegate to work alongside the PNGRCS team to provide support and to gain a better understanding demographically of the extent of the outbreak and to try and contribute towards a more accurate picture of what was actually happening...this included visualising of gravesites to establish a more accurate case fatality rate (CFR).

## I was deployed as a public health delegate to work alongside the PNGRCS team to provide support and to gain a better understanding demographically of the extent of the outbreak...

My colleague, a water and sanitation expert, was deployed to provide assistance to the PNGRCS and to also assess the area for the need for safe water. Australian Red Cross has a water module that can provide safe drinking water to populations of up to 5000 people.

Daru is located in the South Western Province of PNG. It is isolated and remote, and has many complex issues: not the least being the cholera outbreak.

Daru is the access point to the mainland for many communities in the south Fly and Bamu river region. Demographically, Daru sits at the very southern tip of PNG across the Gulf of Papua from Port Moresby and just 3 kms from the Torres Strait. Access to and from Port Moresby is a very unreliable daily flight that boasts a slogan 'we'll fly our way'. I guess this can be interpreted as 'I'll take off if and when I want to.' Unfortunately



Photo: Libby Bowell.

this contributed to a very staggered response, as several team members were left stranded in Port Moresby for days at a time. By water, it is a two-day trip but even that is not without problems. Our Red Cross banana boats went via a barge that decided to offload what they decided was not essential...the outboard motors (OBMs) and lifejackets for the boats in our case!

The majority of villages affected with a high prevalence of cases are located on the islands and banks in the mouth of the Fly River, mouth and islands of the Bamu River, North Bamu and along the Dudi coastal areas. These areas are all tidal villages/islands and access is only via banana boat skippered by a knowledgeable local person as obstacles such as sand banks and rock shelves scatter the coastline. Populations vary from 200 to 1200 per village.

Above: Toilet over rainwater channel that runs into a tidal river used for bathing.

Above right: This house sits on the edge of the seaside and is affected by daily tides.



Photo: Libby Bowell.

Cholera treatment centres have been set up in bigger communities where case numbers were higher and can service up to 10 other villages. Most island communities report cases via HF radios and although this is happening regularly, it is somewhat unreliable and difficult to map as often the cases are only reported when a death occurs or sometimes cases/deaths can be reported more than once and often cases can be incorrectly diagnosed. The other big problem related to transport of sick people from outlying villages. Fuel is expensive and often difficult to get and big tidal swings meant sick people were stuck for hours in boats on sand banks in direct heat waiting for it to change...this unfortunately contributed to deaths.

The Government of PNG, with assistance from AusAID, established a cholera treatment unit at the Daru Hospital, which included a triage area, observation area and an isolation wing. The role of the Department of Health Services was to train Community Health Workers (CHWs) to enable

teams to be dispatched to affected communities to carry out Oral Rehydration Salts (ORS) treatment and mass awareness with PNGRCS.

**...big tidal swings meant sick people were stuck for hours in boats on sand banks in direct heat waiting for it to change...this unfortunately contributed to deaths.**

These areas are poor and living conditions vary from 'quite good' in bigger villages to 'really terrible' in other areas that sit lower in the water. Climate change and erosion is certainly making life harder for these people with some communities telling us that their whole village floods every month meaning that water sources are contaminated and sewerage runs freely. ▶▶



Photo: Libby Bowell.

Above: Map showing the Fly and Bamu river systems. The yellow dots were bases from which the four teams travelled. The distances travelled were from between 2–9 hours from Daru.

Below: PNGRCS team members doing dissemination to a group of 100 villagers.



Photo: Libby Bowell.

▶▶ Most of these communities either use a pit latrine system or practise open defaecation in the bush or along the seashore. In mainland Daru people use the ‘black bucket’ system but because of the increase in watery diarrhoea the pick up system is just not frequent enough resulting in buckets being emptied straight into the sea.

By mid December a second round of dissemination was underway and it is envisaged that another trip will occur from early January. The CFR was at 10% in December with deaths just under 400 and 4000 cases treated. There are certainly some good stories where bigger communities were embracing the knowledge and were determined to be able to supply a good service to outlying villages whilst maintaining good health themselves. However, a compounding factor was the Christmas season, with many people travelling to camps to hunt for deer.

Most of these camps were not even on our radar so we had no way of finding them.

We also ventured towards areas where we were told that bows and arrows would be used to kill if necessary. I can't say I felt comfortable about that at all!

**So this is what is happening just north of us, it is rarely picked up by the world news because population-wise it isn't really significant on the world stage.**

Cholera has also been reported in Port Moresby, with 4000 cases identified since April last year and recent reports indicating more than 100 deaths in January 2011.

So this is what is happening just north of us, it is rarely picked up by the world news because population-wise it isn't really significant on the world stage. But spare a thought for them. They are doing it tough and it really doesn't look like going away in a hurry.

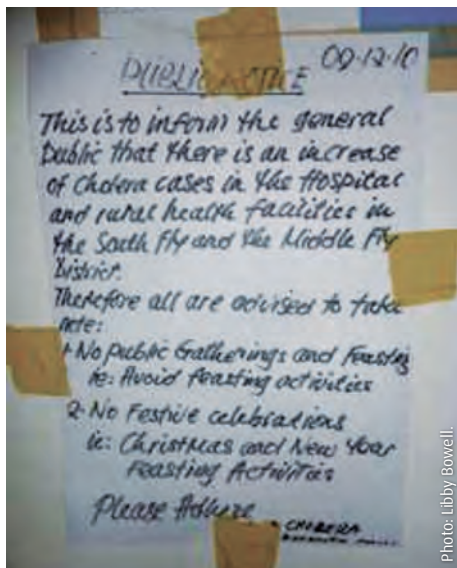


Photo: Libby Bowell.

This was one of the most challenging missions I have been on! ●

Libby has spoken about the cholera outbreak on both ABC Radio National and 2SER as a Red Cross delegate to help raise the profile of the outbreak.



Photo: Libby Bowell.

Above: A cholera bed in the cholera treatment unit at the hospital, note the cover in the middle is actually a hole designed to catch the diarrhoea in the bucket underneath the bed. The bucket sits in the wooden box underneath the bed.

Top right: Typical NDoH awareness poster scattered around Daru townsite.

# a dream come true



Left to right: Jonathan Hardwick with newly appointed National Coordinator of Professional Services Geri Malone.

**When Peri-operative Nurse Jonathan Hardwick attended his first CRAN*plus* Conference last year, little did he know the exciting opportunity that would arise.**

After winning first prize in one of the conference competitions, he is off to Alice Springs very soon to spend a day with the Royal Flying Doctor Service (RFDS).

"This is a dream come true," he says, "to see and experience first hand for myself what it is like to work for Australia's oldest Aeromedical Service."

Jonathan, who has worked in the health sector for more than 16 years and is currently working in Urology and General at The Alfred Hospital in Melbourne, is keen to find out who uses the RFDS service, the extent of the demographic area the Alice Springs team covers – and how one becomes a flight nurse.

"I have a keen interest in remote nursing," Jonathan says. "I had a first taste of this in my last year at Charles Darwin University where I did my Bachelor of Nursing Degree. I spent six weeks out in the community at Hermannsburg, working in the Health Centre with the team led by John Wright."

**"I have a keen interest in remote nursing..."**

Jonathan plans to begin his Masters in Peri Operative Care this year at La Trobe University, leading to a post graduate course in Remote Health in 2012. He recently completed the Maternity Emergency Course (MEC) through CRAN*plus* in Scottsdale, Tasmania.

Look out for Jonathan's report on his day with the RFDS team in Alice Springs in a future edition of the magazine. ●

# network of support

**Nurse Practitioners working in remote parts of Australia are building a unique network to help and support each other through the “growing pains” of this new job classification.**

Donna Simmonds, among Australia’s first remote area Nurse Practitioners when she graduated in 2004, says professional support, mainly through online contact, as well as professional development opportunities, are the main benefits of the network.

“We created the network in 2007 as a discussion group to provide professional support and to help drive the development of Nurse Practitioner positions in remote areas of Australia,” she said.

“Members can email and share documents and photos through the moderated Yahoo Groups webpage, which is free and open only to approved network members.”

A special professional development session is also planned to coincide with this year’s CRANAP*plus* conference in Perth.

As moderator of the Network’s website, Donna is keen to promote its services to remote area

Nurse Practitioners who often have to cope, not only with the isolation that comes with their job, but also legislative and other issues surrounding this new clinical role for nurses in Australia.

**Nurse Practitioners have a Masters qualification and provide wholistic nursing care...**

Nurse Practitioners have a Masters qualification and provide wholistic nursing care which may include extended responsibilities such as prescribing medications. With legislation slow to change and employers still learning about the role Nurse Practitioners can play in a team of professionals, the Network is an ideal forum, said Donna, to assist and support.

## How to join

Go to: <http://au.groups.yahoo.com/group/RANP/>

Request to Join the RANP Group

You will be prompted to enter your Yahoo ID and password or to create a Yahoo account. ●



Left to right: Desree Sowers (NP), Doune Heppner (RANP – Torres Strait), Donna Simmonds (RANP) and Natasha Bertschi (RANP – Gove, NT) at the the International Nurse Practitioner Conference, Brisbane 2010.

# challenges and colourful characters

**CRANApus member RAN Donna Lamb extols the benefits of working rural and remote.**

I commenced working in rural and remote seven years ago and what an adventure it has proved to be.

Through my employment I have been fortunate enough to travel throughout Australia and experience some of the most amazing places, people and events. I have lived in a dug-out in Coober Pedy, spent the winter overlooking the snow capped Great Western Tiers in Tasmania, completed a Triathlon at the Ceduna Oyster Fest, attended an Anzac Day Dawn Service on Kangaroo Island, spent Christmas in a remote Aboriginal Community in South Australia, shopped the Eumundi Markets in Queensland and spotted crocodiles in the Northern Territory.

Not only has the travel been extensive, but I have gained valuable knowledge and skills from the varied situations I have experienced. Working in rural and remote has brought scenarios that have proved to be very

challenging. I have attended motor vehicle accidents (MVA's) in the middle of nowhere, delivered premature babies in remote clinics, sutured wounds, worked 24-hour shifts waiting for medical help to arrive, learnt to speak Pitjantjatjara, 'contact traced' Meningococcal outbreaks, gathered bush tucker and learnt how to cook a kangaroo.

**I have forged long-lasting friendships from all over Australia, met some very colourful characters and experienced plenty of laughs along the way.**

I have forged long-lasting friendships from all over Australia, met some very colourful characters and experienced plenty of laughs along the way. The work is unpredictable and exhilarating.

And, to top it all, I take over 14 weeks holiday each year. I love the lifestyle. All I can say is... Get out there and give it a go! ●



Photo: Donna Lamb

# 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
<b>Magazine insert</b>				<b>1000</b>	<b>2000</b>
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 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. ●

## 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. ●

# 2011 CRANApplus C



The 29th CRANApplus 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.

The theme for this conference is:

## **CRANApplus – supporting the full spectrum of remote health practices.**

Abstracts are now being accepted and the closing date for abstracts is 15 May.

### **The Venue**

The 4.5 star Novotel Langley Hotel Perth is located in the central business district of Perth, which is the capital city of Western Australia and is often acclaimed as one of the most friendly and attractive cities in Australia.

The hotel is situated only 12km and 19km from the domestic and international airports respectively, making it easily accessible from anywhere in the world.

The Novotel Langley Hotel is within walking distance of shopping malls, restaurants, pubs, the beautiful Swan River and many other tourist attractions with further available within a short bus, car or ferry ride.

Perth's lifestyle is easy-going with a number of inner-city parks and the beautiful Swan River

adding to the relaxed, nature-based feel. Kings Park has sweeping views of the city skyline, the Swan River and the Swan Bells. Go shopping, enjoy local seafood, laze on a beach, enjoy a river cruise or try your hand at surfcat sailing or parasailing which is available right on the city's doorstep.

CRANApplus has block-booked rooms at the Novotel Langley Hotel and at other nearby accommodations in a variety of price ranges.

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

## **call for abstracts**

In this 2011 Conference we would like to hear from the very broad cross section of individuals and organisations that are providing and supporting health service delivery in remote & isolated areas. See page 26 for the full outline.

We encourage first time presenters to submit an abstract. This year an Encouragement Award will be offered to the best 'first time presentation' given during the conference.

If you think you might have a presentation but are not sure, please contact us ([geri@crana.org.au](mailto:geri@crana.org.au)) to discuss your ideas.

Contact information including name, title, organisation, phone and email address are required in the online submission process that can be accessed at the CRANApplus website.

Abstracts should address the conference theme and contain the following:

- statement of purpose for the presentation; and
- three main objectives to be presented.

### **Closing date for abstracts is 15 May 2011.**

Abstracts must be submitted electronically in order to accommodate the review process.

# onference

Faxed submissions will not be accepted.

Abstracts must be in English and should not exceed 300 words. They should be typed in Times font, 12 point, single line spacing.

Graphs, tables and references cannot be included as part of the abstract.

The entire title should be spelled out avoiding abbreviations.

The maximum presentation time is 15 minutes with a further 5 minutes allocated for questions and discussion. No extension of time can be allowed due to constraints of the program.

All abstracts will be reviewed by the CRAN*plus* abstract selection panel, and their decision will be final.

A copy of your full presentation including any handouts, notes or PowerPoint presentation is to be submitted upon your arrival at the conference venue in Perth. ●

## award nominations

### The Aurora Award

The Aurora Award is an honour granted each year at the CRAN*plus* 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 CRAN*plus* website.

### CRAN*plus* Awards

The CRAN*plus* 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 CRAN*plus* 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 CRAN*plus* website: [www.crana.org.au](http://www.crana.org.au) or by calling (08) 8408 8200

Winners will be announced at the 2011 CRAN*plus* Annual Conference in Perth, WA. ●

# CRANAplus 2011 conference

novotel langley | perth  
tuesday 11 – friday 14 october 2011

supporting the full spectrum of remote health practices.



nursing | midwifery | medicine | mental health | oral health | aboriginal health workers | allied health

## call for abstracts

The diversity of remote health practice is akin to the diversity of this vast continent of Australia.

For the 2011 Conference we would like to hear from the very broad cross section of individuals and organisations that are providing and supporting health service delivery in remote & isolated areas.

We would like to hear your stories: about your type of practice setting, specific clinical scenarios, and/or patterns of disease.

If you are involved in something new and innovative we would like to hear about it: the successes, challenges and frustrations. If you are engaged in study or research we would like to hear about what it is you are doing. If you have completed a course or program that has delivered something special and relevant to your practice, we would like to hear more.

**Who:** All disciplines – Nurses, Midwives, Aboriginal and Torres Strait Islander Health Workers, Doctors, Oral Health, Mental Health and Allied Health professionals.

**In all areas of professional practice:** Clinical, Management, Education & Research, Policy development, Administration/support services

We encourage first time presenters to submit an abstract. This year an Encouragement Award will be offered to the best 'first time presentation' *given during the conference*.

If you think you might have a presentation but are not sure, please contact us ([geri@crana.org.au](mailto:geri@crana.org.au)) to discuss your ideas. Full details are available on our website [www.crana.org.au](http://www.crana.org.au)

## Closing date for abstracts: 15 May 2011

# Calling all AHWs, Allied Health, RANs, Doctors, Dentists, Pharmacists, Nutritionists, remote practitioners (new, past and present)...

The success of past editions of the *CRANAPLUS Clinical Procedures Manual* and the *CARPA Standard Treatment Manual* have been dependent on input from health professionals such as yourself.

Many generous remote practitioners have already signed up to contribute to the new editions of the **Remote Primary Health Care Manuals** (*CARPA STM*, *CRANAPLUS Clinical Procedure Manual*, *Women's Business Manual* and *Medicines Book for AHW*)... but more are needed...

## You can contribute by:

- Joining a working group to review protocols and procedures across the 5 manuals
- Becoming a secondary reviewer and evaluating any changes initiated by the Working Groups – review as little or as much as suits you, **any** contribution is appreciated

Note that whilst all protocols and procedures will be reviewed, changes made only if evidence dictates. We then need practitioners and experts such as you to let us know if the changes are clear, helpful and realistic in the remote context.

Evidence based guidelines are integral to remote health care, and making sure they work in your practice and setting is the secret to making them relevant and helpful.

## Please contact me if you can help:

Stephanie.mackie-schneider@flinders.edu.au  
0417 804 764



# CRANaplus corporate members



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

**Barkly Region Alcohol and Drug 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.



Government of Western Australia  
Department of Health  
WA Country Health Service

**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.

Photo: Libby Bowell

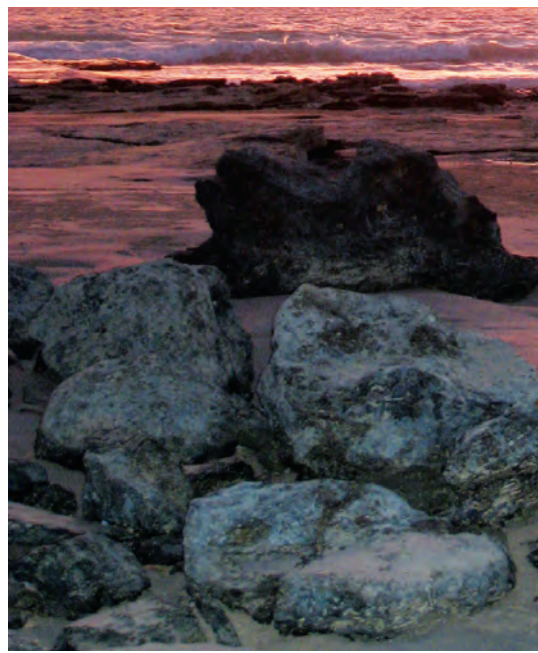
# educate

## an eRemote update

It has been a very busy time for the eRemote online program, one of the new programs in the FLEC suite of courses – well not so new now. At the beginning of February, we recorded 372 people undertaking the various modules on offer.

We have users from all over Australia with a couple from Indonesia, Lombok, Bali and Napier in New Zealand: so we have gone international. Staff from Christmas and Cocos Island have registered for the “Core Mandatory” modules and Kangaroo Island staff have registered for the “Clinical Upskilling in the Bush” modules.

The First Aid program for Aboriginal Health Workers was trialled in Darwin in December 2010, with good feedback helping in the revision of the program for future use. One comment made by an AHW – *“Good learning. First time at using this type of program – would recommend it to others. Pictures were good and the answers voice-over was good.”*





The first aid program has also gone international using Skype to support the end user, with the Solomon Islands "together for healthy community' (THK) program logistics officer and senior first aid instructor utilising this platform to assist in his knowledge of first aid principles to adapt to their working environment.



*"I have learnt more than I've been thought at first, from these modules I learn things I know but more detail so it opens up my knowledge to any different stage, which I believe this year 2011 all of my participants will be satisfied when they complete their first aid course which I teach them. thanks."* (This quote was taken from the evaluation of the program.)

A further three more participants have enrolled in the program.

First aid in the Solomon Islands is taught at a village level, and involves community members learning about community based first aid i.e. health and hygiene and basic first aid. The communities do not live with a health service on the doorstep and often have to walk or paddle a canoe more than an hour to seek help, so basic first aid training can save a life.

Solomon Island Red Cross (SIRC) has a big role in teaching first aid to inmates in jail, security officers and guards and at the local mines. CRANaplus is supporting their role by providing this training online.

The online modules have continued to grow to support the remote practitioner. Module development occurs in conjunction with discussion from the national eRemote advisory group and end user evaluations. The current modules available are outlined overleaf. ▶▶



Photo: Libby Bowell.

## ► We have 12 Core Mandatory Modules

**Basic Life Support:** has been revised with the 2010/11 ARC changes.

**Advanced Life Support Program:** has nine modules that have been revised with the 2010/2011 ARC guidelines. This program is available as part of the Advanced REC course or as a stand-alone program with the practical component completed by local assessors or via Skype with the online program coordinator.

**First Aid Program for Remote Health Workers (HLTFA201A and HLTFA301B):** has 4 modules to be completed on line with the practical component completed as part of a REC course. Each module has a power point presentation (a voice-over accompanies the presentation slides with extra script from the manual) and text/ notes from a manual.

**Clinical Upskilling in the Bush:** has 11 modules. These modules have been developed to prevent "skill rusting" by providing clinical education for those remote, rural and isolated health professionals who require clinical knowledge and support. They include: 12 Lead EC, Airway Management, Defibrillation, Interpretation of Arrhythmias. IV cannulation, Non-Invasive Positive Pressure Ventilation (NIPPV), Chest Pain Assessment, Intravenous Narcotic Pain Relief, Suturing, Plastering and Interpretation of Blood Results including ABG's.

**Case studies for REC and MEC:** Various case studies based on the topics from the First Line Emergency Courses.

Every user of eRemote receives free access to various websites relevant to remote practice. They include: external education links, relevant clinical guidelines, Journals of Interest and the new online professional portfolio.

A fantastic 98.7% of the users who have filled in the evaluation survey would recommend us. Here is what they are saying.

- *"Once again many thanks. The online education is a terrific resource and I have found it more useful than attending 'compulsory' in-service as the workbooks are excellent resources and I can study at a time and pace that suits me."*
- *"I finished the 'Core Mandatory' course today...many thanks for such a great course. I didn't know how I'd ever get my education up-to-date working in remote areas until I found your course..."*
- *"I am very impressed with the courses. As a 'mature-age' RN and second year out...these courses have offered me an opportunity to review areas I felt were not covered fully in my degree, to upskill and for on-going education. My nemesis is ECGs and cardiac related events...CRANAplus has given me the chance to really get to grips with this... and have the material at my fingertips for future reference. So hearty thanks to all at CRANAplus."*

For any further information please contact Julia Stewart, Online Program Coordinator  
e-mail: [Julia@crana.org.au](mailto:Julia@crana.org.au) ,  
phone: 0407 658 209  
website: [www.course.crana.org.au](http://www.course.crana.org.au) ●



Photo: Libby Bowell



Photo: Libby-Bowell.

## coursing along

FLEC is back into swing for 2011 and many courses are already full! The number of courses is at an all time high, with 55 already confirmed and several more under negotiation.

As a result, we have taken the unprecedented action to show **ALL** course locations (including private) so far for this year.

Private courses are the result of a direct request from an organisation or agency to run a course specifically for a designated group. Normally these courses are full but on occasions we know that there may be several vacant spots.

We cannot automatically allow extra registrations into these courses but if you see a private course in a location you are working in then you may contact your local hospital, agency or AMS to find out whether you are eligible to attend.

DHF courses are specifically requested by the Northern Territory for NT Dept of Health & Families

employees, but often there are vacancies in these courses also. DHF has kindly often allowed for a participant outside of the organisation to register in these courses if they have a vacancy.

The requesting organisation will always have the right of refusal for additional participants into a private course.

**CRANApus administration staff are not responsible for, and will not take**, individual registrations for private courses. Please always look at our website for the process to enrol in a course.

If you have enquiries concerning your eligibility to enrol in a private course please email the Education Manager on [flec@crana.org.au](mailto:flec@crana.org.au)

Thanks to all our facilitators who have risen to the challenge ensuring we continue to meet our high standard in delivering a record number of courses this year. ●

# FLEC courses for 2011

Location	Dates	Remote Emergency Care (REC)	Maternity Emergency Care (MEC)	MIDUS	Advanced REC	Aboriginal Health Workers
Melbourne RAHC VIC ■	11-13 Feb	●				
Scottsdale TAS	11-13 Feb		●			
Portland VIC	25-27 Feb	●				
Broome WA ■	25-27 Feb	●				
Mansfield VIC	4-6 March		●			
Darwin NT MEC (for Males)	9-11 March					●
Karratha WA	25-27 March	●				
Darwin NT	25-27 March			●		
Alice Springs DHF NT ○	7-9 April	●				
Alice Springs NT REC	12-14 April					●
Alice Springs DHF NT ○	15-17 April		●			
Orroroo SA	15-17 April	●				
Kununurra WA	29 Apr-1 May			●		
Mackay QLD	29 Apr-1 May				●	
Alice Springs NT	13-15 May				●	
Carnarvon WA	13-15 May		●			
Darwin DHF NT ○	17-19 May					●
Cairns QLD	20-22 May	●				
Cairns QLD REC	24-26 May					●
Darwin NT	27-29 May		●			
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			●		



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.

Location	Dates	Remote Emergency Care (REC)	Maternity Emergency Care (MEC)	MIDUS	Advanced REC	Aboriginal Health Workers
Darwin NT ○	30 June– 2 July	●				
Longreach QLD	8–10 July		●			
Tennant Creek NT ■	15–17 July		●			
Cowra NSW	29–31 July		●			
Port Lincoln SA MEC	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			●		
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 ( <i>following pharmacotherapeutics</i> )	28–30 Oct		●			
Oatlands TAS	11–13 Nov	●				
Alice Springs DHF NT ○	7–9 Nov		●			
Darwin DHF NT ○	23–25 Nov	●				
Swansea TAS	25–27 Nov			●		
Darwin NT	28–30 Nov	●				
Walgett NSW ■	10–24 Dec		●			

■ Private funded course ○ DHF funded course



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.

# too hard to handle: indigenous victims of violence with disabilities<sup>1</sup>

By Kyllie Cripps, Leanne Miller & Jody Saxton-Barney

## Introduction

Nationally and internationally there is a consensus among researchers that women identified as having a 'disability' experience violence and abuse at a much greater rate than the rest of the population. Compounding the problem, women with disabilities who are victims of violence have traditionally been disbelieved and/or disregarded by those in positions to assist them to escape and/or heal from the violence inflicted upon them. It is widely recognised that Indigenous women with disabilities face additional barriers to disclosure and to seeking help.

...women with disabilities who are victims of violence have traditionally been disbelieved and/or disregarded by those in positions to assist them to escape...

But little is known about their experiences of violence and of their access to services. UN protocols for the Rights of Indigenous people, people with disabilities, women and children clearly support equitable access to safety and to services, but the reality often is that governments and service providers find Indigenous victims of violence with disabilities as a group *"too hard to handle"*. Partnerships between the disability, family violence and Indigenous community sectors are obviously needed to better assist our most vulnerable victims. This paper explores these issues in

the context of a research project funded by the Australian Research Council, "Building and supporting community led partnerships initiatives responding to family violence in Indigenous communities in Victoria". Four communities in Victoria were chosen to be part of this study – one of these 'communities' was Indigenous people living with disabilities and violence. This paper details the specific findings relating to this community, while analysing the practice and functionality of partnerships in responding to Indigenous family violence for people with disabilities. It will be particularly focused on Indigenous perspectives of the meanings associated with the term 'partnership', and the most appropriate processes needed to make 'partnerships' functional and sustainable for better service delivery for Indigenous people with disabilities who are also victims of violence.

## Background

Disability is recognised as a condition that affects most people in the population – to varying degrees and at different stages across their life courses. Like family violence, there is no one singular definition of disability used. It is however, often understood in the context of impairment, such as sight and hearing impairments, difficulties with mobility, or in the interaction between one's health condition and their environment. The Australian Bureau of Statistics refers to disability as a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities<sup>2</sup>. In this context, the 2008 National Aboriginal & Torres Strait Islander Social Survey estimates that 26,000 or 7.9 percent of the Indigenous population aged 15 years and over has a profound disability. Also, 137,000 or 41.9 percent of Indigenous people reported having limitations as a consequence of their impairments and/or



Photo: Libby Bowell.

ill health. The burden of disability is carried slightly higher by females (52.7 percent vs 47.3 percent for males)<sup>3</sup>. However, little information is available to identify when and how the disabilities are acquired, e.g. are they as a consequence of exposure to violence?

The latter question is important in the context of mainstream literature that clearly identifies disability as a recognised risk factor for family violence; and women with physical and cognitive disabilities in particular, are reported to experience higher rates of family violence than those without disabilities<sup>4,5,6</sup>. The violence is often perpetrated by family members and carers<sup>7</sup>. And in some instances existing disabilities are exacerbated or new disabilities/limitations are acquired as a result of the violence<sup>8</sup>.

Detailed statistical information about the prevalence and incidence of such violence in mainstream communities and/or Indigenous communities is problematic as the collection of such information is very limited. Largely because

women with disabilities are less likely than other women to report family violence, and less likely to receive services that meet their needs. The literature also tells us that police, courts and support services generally do not collect data on disability.

For Indigenous women recognising the increased burden of disability, there is little information available detailing their experiences of violence, and the success or otherwise of their engagement in the service sector. Our study sought to explore what family violence services existed in Victoria and how they engaged with the disability sector to best support the unique and varied circumstances experienced by this population group. We were particularly interested in how Aboriginal women and children with disabilities and experiencing violence got their 'voices' heard? How could they make services understand their experiences and their needs as being different in many instances to that of non-Indigenous women? And what happens when the services just don't get it? ►►



Photo: Donna Lamb.

▶▶ To answer the above questions our study, involved conducting 1:1 interviews and focus groups with Indigenous and mainstream service providers. The research was grounded in the lived experience of Indigenous people in Victoria: from the project idea, to the practice of doing the research and analysing its results, via an Indigenous research steering group.

...the research process was designed to engage communities and service providers in developing new ways of seeing and doing practices and processes.

Together we were seeking to bring better service delivery to the area through partnerships, and the research process was designed to engage communities and service

providers in developing new ways of seeing and doing practices and processes. The hope was that through this engagement we would leave working partnerships in its wake, or at the very least Indigenous community members with sufficient awareness and capacity about partnerships to negotiate better services in the spirit of partnerships on their terms. The research with ethical clearance, took place in four sites in Victoria determined by the steering group. Some 60 individuals across the sites participated. The sites included: the Hume; East Gippsland; Southern Metropolitan; and the Victorian Disability sector, the latter being the focus of this article.

### Multiple disadvantage and choice

Experiences of Indigenous women and children with disabilities experiencing violence were described by research participants as complex situations. These are people who experience disadvantage on the basis of their disability, their gender and/or status within the

community, and also as Indigenous community members. This multi-layered approach to disadvantage increases risk factors for exposure to violence and can make access to services difficult. Research participants described to us that often “people are just ignorant, and think that the disability [our] women have is being black and that their ...disability isn’t even seen”. Few services are knowledgeable and/or experienced in meeting the needs of such women and children, particularly when it requires straddling multiple services and institutional sectors that have not traditionally worked together. In this quagmire victims often get the bureaucratic-run-around, shuttled from Indigenous services, to family violence services and to disability services without any one service taking responsibility for coordinating the care and support the victim(s) may need. In this space and in sheer frustration, women typically return home to be taken care of by family and will continue to live with violence because “it’s just too hard ...”.

### Partnerships for change

Research participants in this study identified that Indigenous women and children with disabilities experiencing violence were a hard to reach population who deserved increased support and attention. They recognised that partnerships were essential if the needs of this population group were to be met, but that partnerships to date were largely tokenistic. It was consistently reported “partnerships that work in family violence do not work with disabilities”, and that services typically “opt out” of their duty of care to clients through referrals to other organisations and/or sectors. Follow up to ensure that a victim through this referral process has received some form of care/service is non-existent, and these women and children often fall between the cracks continuing to experience violence because there is no other alternative.

Research participants reported that they knew government policies attempting to integrate and improve family violence service delivery

existed in Victoria. These are documents that clearly articulate the rights of victims to expect specific services to be available and for appropriate standards of care. In workers experiences however, they were just glossy pieces of paper that typically rested on the desks or bookshelves of managers.

## Research participants in this study identified that Indigenous women and children with disabilities experiencing violence were a hard to reach population who deserved increased support and attention.

The translation of those documents into practice, that would change the circumstances of Indigenous women and children with disabilities experiencing violence, failed to filter down to grass roots interventions despite the best of intentions. Consequently delivery of services is often “hit and miss” and they fail to engage with the experiences and circumstances of women in difficult situations asking for help.

### Workforce issues

Across both the family violence and disability sectors we heard many reports of workers feeling over-worked, overwhelmed and under-paid. Training for workers was hit and miss and often limited to training for family violence related issues that did not engage in complex situations, where disability and/or culture and/or sexism intersected with violence. Workers described feeling as if they had little information to guide their practice and articulated that opportunities were needed to network in and between the sectors, to define roles and responsibilities in particular contexts, in order to provide more effective care and support to Indigenous women and children with disabilities experiencing violence. ►►

▶ Workers felt that partnerships were important, however, partnerships don't change the mindset of workers.

One participant stated: "if a worker is racist, a piece of paper between managers is not going to change that", reinforcing the importance of training, supports and monitoring of workers to work effectively in this space. It was also brought to our attention that in the day to day running of services formal partnerships had little effect on service delivery, rather, it was the networks and personal contacts of individual workers that made all the difference; many stated that it's often "who you know, not what you know".

## "If a worker is racist, a piece of paper between managers is not going to change that."

Workers indicated that more effective approaches to working in this space would involve case conferencing or case management, with lines of responsibility being clearly itemised between organisations. There was also a consensus that the importance of providing adequate time for this work was essential. The availability and access to resources was a further issue raised particularly in the context of providing supports outside of metropolitan areas. It was suggested that, for services to understand and to act appropriately and supportively to Indigenous women and children with disabilities experiencing violence "services [should] step into the world of these women and children, walk in their shoes, to learn how to do this [work] the right way".

### Funding

One of the principle frustrations that research participants commonly reported as undermining partnerships and good practice in the space of Indigenous violence and disability was the issue of funding. We were told that having a disability is expensive and "our budgets don't cater for

disabilities". Participants reported that finding funds to cover the cost of an interpreter for an interview with a victim was prohibitive; for a refuge in these circumstances the costs of an interpreter could be put towards other costs. In these circumstances, they would attempt other forms of communication to facilitate access, for example, writing things down for someone who is hearing impaired assuming they have sufficient literacy, as opposed to spending the funds needed to secure an interpreter qualified in Auslan.

We were also told of circumstances in which Indigenous women with hearing impairments were denied access to parenting programs because the service provider was unable and/or unwilling to provide an interpreter. The consequence for the mum was that she was not compliant with a child protection order, and was then denied the opportunity to get her child back – a circumstance that was wholly preventable.

### Moving forward

Our study clearly found that help in Victoria is often unavailable or inappropriate in meeting the needs of Indigenous women and children with disabilities experiencing violence, as those providing the services understand little of the context and/or experiences of Indigenous peoples in these circumstances. The typical 'one size fits all' approach that is so often used in mainstream service delivery has proven to be ineffective in Indigenous contexts, but even more so when we add disability as a further layer of complexity in the Indigenous violence space. Many organisations and services we know continue to operate as silos to the detriment of clients, particularly those who are the most disadvantaged and indeed the most vulnerable. The system needs to change, all women and children under international human rights standards<sup>9</sup> are entitled to live free from violence. It is unfortunate that, as we have found in this study, for Indigenous women and children with disabilities experiencing violence, getting help is "just too hard..."



Photo: Donna Lamb.

Key priorities for future research and service planning needs to include: listening to the women and children in such situations – what do they need/want/when and where? We need to build knowledge and capacity in the community about these issues both in the Indigenous and non-Indigenous context; help needs to be available and we need to carefully consider how we reduce violence for this vulnerable group by being proactive in prevention; we also need data, how many of our mob are suffering in these circumstances?

These are basic system requirements that need careful consideration if we are serious about upholding human rights and delivering dignity to all women and children in these circumstances.

Our study indicated that there is a willingness to improve access to services for Indigenous people with disabilities but it's not automatic, it has to be raised and pressured by champions in the community and in the workforce.

We encourage others to join us in this work. ●

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- <sup>7</sup> S Salthouse & C Frohmader, 'Real trouble in the home: the domestic violence reality for women with disabilities' (2005) *Domestic Violence & Incest Resource Centre Newsletter*, No 4, Summer, 11.
- <sup>8</sup> Above note 4.
- <sup>9</sup> United Nations General Assembly, *Convention on the Rights of the Child* (1989); United Nations *Convention of the Elimination of All Forms of Discrimination Against Women* (1979); United Nations *Declaration on the Rights of Indigenous Peoples* (2007).

Dr Kyllie Cripps is an Indigenous academic in the Indigenous Law Centre at the University of New South Wales. Leanne Miller is the Executive Director of Koorie Women Mean Business. Jody Saxton-Barney is the director of Deaf Indigenous Community Consultancy.



Photo: Donna Lamb.

# advocate

## advocacy affairs

Do you ever get the feeling that you are banging your head against a brick wall? They say it's great when you stop. But sometimes I think that stopping is not going to happen any time soon.

In 2010, most of our work was focused on the Health Reforms negotiated by Kevin Rudd, as Prime Minister, and supported by the work of the National Health and Hospitals Reform Commission.

Towards the end of the year, we were talking about the implementation phase of the program and we spent many hours working with Government to ensure that the Primary Health Care aspects were to be implemented in an equitable manner. After all, this was the only tangible part that the remote sector could hope to see achieved. That and the patient controlled records, which we felt would probably assist in the bush. There were all the discussions around Medicare Locals and their structure and Governance; Local Hospital Networks which have already been rolled out in some States (albeit

renamed in NSW as Local Health Networks); and a single funder of health over a period of time.

Well, here we are in 2011, another COAG meeting later and the State GST percentage hand-back, which was to fund certain aspects of health reform (mainly those around Primary Health Care) has been compromised.

**Our next efforts will be to ensure...health delivery that works in the remote context is not disregarded in favour of something new and 'better'.**

So all we have now in terms of reform is the move towards the Federal Government gaining greater control over hospitals (over time); another layer of bureaucracy to administer the pooling of hospital funds; and the doubling



of Medicare locals (without the process and outcomes being evaluated). And that's about it.

I certainly recognise that the political landscape has changed in the past few months. The Federal Government has a reduced mandate and State Governments have changed hands. And I also understand that politics is the art of the possible. But it is so disappointing.

We have moved in terms of reform: but not in a way that remote health will gain much of the benefits.

Our next efforts will be to ensure that the Medicare Locals are not just a case of Divisions rebranding and that health delivery that works in the remote context is not disregarded in favour of something new and 'better'.

Oh well, we push on. It is wonderful to now have Geri Malone on board (see article page 4) who will be assisting us on a number of fronts including credentialing framework with the Coalition of National Nursing Organisations (CoNNO). This goes

hand in hand with our push for protection of title, the MBS and PBS rollout and the Registration Standard for endorsement for scheduled medicines for registered nurses (rural and isolated).

The above endorsement, with the implementation of national Registration, has been adopted across Australia by Australian Health Practitioner Regulation Agency (AHPRA). This endorsement previously existed in Queensland and the National Board was asked to maintain it. In Queensland, nurses gained this endorsement through undertaking the Rural & Isolated Practice Registered Nurse program.



## It is wonderful to now have Geri Malone on board...

Currently, as a national endorsement, the standard states that to be eligible for this endorsement to "obtain, supply and administer limited schedule 2, 3, 4 or 8 medicines appropriate to the nurse's scope of practice..." the registered nurse must have completed an approved program of study determined by the board.

Currently the only approved programs are the RIPRN program and University of Southern Queensland Postgraduate Certificate in Advanced Nursing Practice (rural and remote).

CRAN*plus* has initiated discussions with the Nursing & Midwifery Board Australia (NMBA) around this issue in regard to clarification of the requirements and process of adding further appropriate courses to the list that are more widely accessible.

Welcome, Geri. You certainly have your work cut out.

**Carole Taylor**  
CEO, CRAN*plus* ●

# unforgettable foster

Second-year nursing student Emma-Jane Lush reckons she could write her own magazine, describing all the positive moments she experienced during her placement at South Gippsland Hospital in Foster, Victoria. Here she summarises her "adventure".

On my first day I met with my clinical educator, who I can't thank enough for organising such a wonderful placement. She had prepared a flexible roster for me that covered so many different areas of community nursing practice including district nursing, midwifery clinic, time with a diabetes educator and a session with the practice nurses in the local medical centre.

The majority of my two weeks was spent with the District Nursing Service, where each day was unlike the one before. For example, in one day we travelled almost 120km. Another, we were

at a client's home tending to a dressing and the air ambulance helicopter landed out the front.

Through the unwavering support of the district nurses I finished the two weeks with a much improved nursing skill base particularly with regards to wound care, medication administration and patient education. Each nurse was incredibly knowledgeable, passionate, kind, hard-working and humorous and the patients adored and respected them. They were a delight to work with.

Special thanks to CRANAplus for allowing me to undertake such a fantastic placement. Thanks also to all the people of Foster, particularly the staff at the South Gippsland Hospital, for making me feel very much at home despite the distance. Each of my preceptors allowed me to practise in an autonomous fashion when appropriate but allowed just the right amount of support.

## Special thanks to CRANAplus for allowing me to undertake such a fantastic placement.

What a sensational way to finish up the year. I am now walking away from second year and on into third year with knowledge and confidence I wouldn't have had without this experience. I would put my hand up for another placement in Foster in a heartbeat, and I would encourage any nursing students with the opportunity to do the same. ●

For her two-week community placement to end her second year in nursing at Latrobe University, Bendigo, Emma chose to go to Foster, a long way from home: 328.7km to be exact. Her "adventure" was supported by a CRANAplus scholarship.





## individual journeys

**The chance to be a part of the pregnancy and motherhood journeys of the women of Palm Island in Queensland is what midwifery student Nikki Carlos values from her recent placement, which was financially supported by a CRANApus scholarship. Here is her report:**

The Indigenous community of Palm Island faces considerable health and social challenges. Birthing services are currently not available to the residents and pregnant women are required to relocate to nearby Townsville, away from family and community support, for birthing. Furthermore, although Palm Island is geographically close to Townsville, the Palm Island community places great value on their community's individual identity. One pregnant Palm Island woman reflected how important it is that the place of birth is recorded as Palm Island. Returning birthing to Palm Island is a health priority.

Currently, the community's maternity services consist of a visiting midwifery Nurse Practitioner who conducts antenatal clinics during the week. As a midwifery student, to have the opportunity to participate in the provision of culturally appropriate maternity care in a community like Palm Island, was a rare and valuable experience in the development of my midwifery skills and

philosophy of care. Witnessing the impact of maternity services on the whole community identity was also a very rare and powerful experience.

Of particular value to me was the privilege of observing the individual pregnancy and motherhood journeys of the women of Palm Island. The insight gained from their experiences, the impact of the midwife, and the acceptance of the community will undoubtedly provide an added dimension to my future midwifery practice, especially in relation to Indigenous birthing values, beliefs and rituals.

I remain extremely grateful to CRANApus for the placement scholarship that facilitated this experience, thank you. It was a tremendous financial help. ●

Nikki started her Bachelor of Nursing Science Bachelor of Midwifery course in the inaugural intake at Queensland's James Cook University in February 2010. Regular travel to and from Palm Island is only available by plane and accommodation in the community is limited. Hence the cost of travel to and from Palm Island during the course of the two-week clinical placement was considerable.

# students set sights on healthy change for rural australia

**Students are the future of rural health... that's why the National Rural Health Students Network (NRHSN) exists.**

Since 1996, the NRHSN has been bringing together people studying nursing, allied health and medicine – with the aim of encouraging them to pursue careers in the bush.

It is Australia's only multi-disciplinary student health organisation, reflecting the nature of health work in rural areas where teamwork is a necessity. As a result, many of the network's activities have a multi-disciplinary focus to better equip members for life in the field once they graduate.

**Since 1996, the NRHSN has been bringing together people studying nursing, allied health and medicine...**

The network spans 29 university Rural Health Clubs from Hobart to Broome, representing more than 9000 members.



Indigenous Festival.

In 2011, a new executive team has taken the reins for what promises to be a busy year of networking, professional development and activities such as rural high school visits.

Student leaders Francesca Garnett, Jacinta O'Neill and Catherine Ryan have been joined by Executive Officer Helen Murray, the Director of Future Workforce Programs at Rural Health Workforce Australia (RHWA).

Each of the students brings a particular strength and focus to the NRHSN.

Francesca, the daughter of two Ballarat-based psychologists, is studying medicine at the University of New South Wales and has a passion for Indigenous health.

Jacinta, a former PE teacher, is keen to drive the Rural High School Visits program as a way of inspiring secondary students to consider tertiary studies in health. An active patrol member of the Torquay Surf Life Saving Club, she is studying medicine at Deakin University.

Catherine, a former jillaroo, wants to round up more nurses for careers in the bush. Raised in Baynton, Victoria, she is a second year nursing student.

Helen, who has extensive experience in advocacy, business management and policy development in the agribusiness sector will provide assistance and mentoring.

Together they are building a jam-packed calendar that includes the National Rural Leadership Development Seminar in partnership with the Australian Medical Students Association, club participation in high school visits and Indigenous festivals, and professional development opportunities such as mental health first aid.



2011 NRHSN Exec Team. Left to right: Francesca Garnett, Jacinta O'Neill and Catherine Ryan.



Rural High School Visit.

The network remains committed to Closing the Gap on Indigenous health and partners with Indigenous festivals to deliver programs on healthy eating, diabetes and general wellness.

Another core activity is the Rural High School Visits program, where club members speak to young students about healthy habits and the career opportunities that exist in health. In 2009, 400 Rural Health Club members volunteered for this program and 300 schools were visited.

The importance of Rural High School Visits is underlined by research showing that university students from rural backgrounds are more likely to return to their home communities to live and work when they finish their studies.

Intertwined with the above, the new executive has also set itself three key goals for 2011:

- Increasing membership and involvement among allied health and nursing students;
- Promoting greater collaboration between clubs; and
- Encouraging continuity of activity through the club and executive handover process.

The NRHSN is managed by RHWA with funding from the Federal Department of Health and Ageing. ●



Photo: Donna Lamb.

# support

## 2011: year of change

Making resolutions is one of the traditions that appears to be part and parcel of the start of a New Year. I was curious to know more about the idea of New Year resolutions because an important part of the work that BSS psychologists do is to help people make the sort of lifestyle changes, such as losing weight or giving up smoking, that are popular choices as New Year resolutions. As well, everyone I know seems to make (and break) them.

Wikipedia defines a New Year resolution as a “commitment that an individual makes to a project or the reforming of a habit, often a lifestyle change, that is generally interpreted as advantageous”.

New Year seems to be as good a time as any to make changes...a new year, a new start! Historically, the idea of an annual tradition of self-improvement has been important. However, it appears that resolutions to change have not necessarily happened at New Year.

In the Christian tradition, for example, Lent, just before Easter, has been a period of sacrifice followed by renewal. During Judaism’s New Year, Rosh Hashanah, culminating in Yom Kippur (the Day of Atonement), around September/October, the task is to reflect upon one’s wrongdoings over the year and both seek and offer forgiveness.

...a commitment that an individual makes to a project or the reforming of a habit, often a lifestyle change, that is generally interpreted as advantageous.

I wonder how many of us made New Year’s resolutions at the start of 2011? What resolutions did you make? Have you kept them?



The sorts of resolutions that people make at New Year do very much reflect current health and lifestyle concerns. The areas that callers to the Bush Support Service often discuss on the telephone include:

- Looking after self better
- Paying off credit card
- Losing weight
- Exercising more
- Eating more fruit and vegies
- Drinking less
- Quitting smoking
- Doing some more study
- Changing job or career
- Travelling
- Being more organised ►►



**A RESOLVE**  
For Every Morning of the New Year

**I** will this day try to live a simple & sincere and serene life & repelling promptly every thought of discontent, anxiety, discouragement, impurity and self-seeking & cultivating cheerfulness & magnanimity, charity, and the habit of holy silence & exercising economy in expenditure. carefulness in conversation diligence in appointed service, fidelity to every trust and a child-like trust in God

From a Calendar by Bishop John H. Vincent  
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**YOUR NEW YEARS RESOLUTION**

Resolve to renew all your old resolves. And add a few that are new.

Resolve to keep them as long as you can.

What more can a poor man do.

» There seems to be a couple of factors that affect whether or not any change, including New Year resolutions, can be maintained. The first of these is to be realistic. There is no point, for example, setting a goal for 2011 to travel to Europe if you are having financial difficulties. A trip to Byron Bay may be far more achievable and therefore less likely to make you feel like you have failed.

The second factor to think about when making a resolution is to make sure it is not too huge or too vague. That is, it needs to be manageable, specific and not overwhelming. Instead of saying, for example, "I want to look after myself" say "I want to go to belly dancing every week and spend some time each day reading". Another trap people fall into is making resolutions to change a behaviour but not thinking it through to come up with a plan to do so. For example, deciding to exercise more is a great resolution. But what exercise activities are options for you? Remember walking or swimming is as good as any other activity but you need to do an exercise that you actually enjoy as you are more likely to continue it.

## Remember walking or swimming is as good as any other activity but you need to do an exercise that you actually enjoy...

Finally, research seems to indicate that there is something about making your goal public and getting support from friends and family to achieve it that contributes to success. We at Bush Support Services think that any day of the year is a good day to make healthy lifestyle changes. We are available 24 hours a day seven days per week if you would like to hatch a plot for 2011 and discuss strategies to keep you on track.

**Annmaree Wilson**  
Senior Clinical Psychologist for the  
Bush Support Services team ●

## winning ways

**Blackall Hospital in Blackall, Queensland, group winner of our Stress Buster Competition at the end of 2010, has written to us to let us know what they've done with their winnings.**

Frances Calleja, Director of Nursing, says: "Just following up to let you know what we have chosen to do with the \$1000 we gratefully received.

We have purchased an 81 cm flat screen TV with DVD and a wall mount for the staff dining room, 2 small AM/FM radio and CD players – one for the kitchen and one for the ward – and a couple of CDs for patients and staff to listen to (one being a Christmas CD).

I am also going to purchase a couple of nice table cloths for the dining room table and some more wool so we can keep on knitting.

Thanks again from the Blackall Hospital Team."

Congratulations. And lucky for us. Looks like the team at Blackall Hospital will continue to contribute to the BSS Cosy Blanket Project, just one of the stress-buster techniques that won them the prize. ●



# psychological preparations can help those facing cyclone threat

(Media Release: 1 February 2011)

The Australian Psychological Society (APS) has urged those facing cyclone threats not to neglect psychological preparations when taking safety measures to ready themselves for the threat of natural disaster.

Professor Kevin Ronan, chair of the APS Disaster Reference Group, said that adequate physical and psychological preparation was crucial if those exposed to cyclones were to protect themselves and other family members, especially children.

**“Being psychologically prepared helps us to make practical arrangements because we are able to deal with the anxiety that those preparations can bring and remain effective.”**

“Being psychologically prepared helps us to make practical arrangements because we are able to deal with the anxiety that those preparations can bring and remain effective,” he said.

“It also helps us cope better when disaster strikes, because, when the time comes, we have strategies to manage our feelings of fear or anxiety and unhelpful thoughts, which will ensure we can stay calm and focus on our disaster plan.”

He said psychological preparation involved people running through likely disaster scenarios, imagining how they might feel and developing strategies to calm themselves down and talk themselves through a disaster event.

The APS has released a set of tips on psychological preparation for those in cyclone-prone communities, which illustrates how three simple steps could help those facing an emergency situation to remain focused and confident so that they can take the necessary practical tasks to protect themselves and others.

The acronym ‘AIM’ incorporates the three steps for being psychologically prepared:

**ANTICIPATE** that the situation will be stressful – reflect on how you might feel facing a cyclone (for instance, the sounds of the wind, the sight of flying debris, the potential terror of this unknown situation). Think about how this will make you feel and the strategies you might need to move through fear and anxiety to enact your disaster plan.

**IDENTIFY** physical changes related to anxiety (upset stomach, shortness of breath, fast heart beat) and any frightening thoughts (I can’t cope, I am scared, I don’t know what to do, I am not going to make it).

**MANAGE** your responses using controlled breathing (breathe consciously and slowly to help yourself relax) and ‘self-talk’ involving reassuring thoughts (I can do this, I know what to do, I have a disaster plan).

“We urge communities vulnerable to cyclones to make adequate psychological preparations, and especially to help their children prepare psychologically, and we urge the media and local government to support communities to do this by providing adequate information and assistance,” Professor Ronan said.

The APS has a wide range of resources available on its website – [www.psychology.org.au/community/topics/disasters/](http://www.psychology.org.au/community/topics/disasters/) – for communities preparing for, or recovering from, a natural disaster including a new brochure, *Preparing children for the threat of cyclones*. ●

# investing in yourself

**In my encounters with people every day, I am constantly surprised by the fact that many people just don't have the time to think about how they are feeling, emotionally.**

The stresses of working remote, for example, such as attending to patients, the endless paperwork, dealing with colleagues and so on, often mean that people just don't get to invest in themselves. Part of the difficulty in living in this constant state of "busy-ness" is that emotions tend to "sneak up" and you end up feeling like you are running on empty. This can get tricky as it is our emotions that determine our motivations: why we do the things that we do; why we choose the friends that we do; in short, why we make the choices that we do. This is true even if you are able to give rational, logical reasons for decisions. For this reason, making the time to tune into your feelings and to do things that will make you feel good is really important for your overall well-being.

There are a number of actions that we can take to make ourselves feel better about ourselves.

**1. "You" time.** The first of these is to actually set aside some regular time to think about how you are feeling. Ask yourself, for example, why you made a certain decision recently and separate the rational reason from the emotional. Perhaps use a journal and write down your thoughts. One of the things that you are actually doing by thinking about yourself is you are investing in yourself. Other ways of investing in yourself is to read personal development articles and books, talk to a counsellor and even taking the time out to watch a DVD. All of these things help you to recharge your batteries and ultimately feel better about yourself.

**2. Relationships.** The second thing you can do to feel better about yourself is to invest in the relationships that you have. We all have a need to connect with other people, no matter

how much we enjoy working remote! We need to have friends and be loved. We need to share our experiences and to have others share theirs. Make the time to invest in others, either in person, telephone or email. Next time you are in town have coffee with that friend you have been meaning to catch up with.

**3. Values.** The third step that allows us to invest in ourselves is working out what our values are. It is crucial to feeling good about yourself that your actions are in harmony with your beliefs. This is a difficult thing to achieve if you are not sure or have not articulated what it is that is important to you. One of the ways of achieving this is again to give yourself the time to ask the question. *What is important to me? How do I like to be treated? What am I not willing to compromise on?*

**4. Celebrate.** The fourth action for self-investment is about celebrating what you are and what you have. This idea is really about being in the present and not spending too much time thinking about what is up ahead and what you could achieve in the future. By celebrating what you have already, you stop yourself from comparing yourself with others.

**5. Seize the day.** The fifth self-investment step is to seize the day. So many people let the daily grind wear them down. The important thing to remember here is that we are all in the same boat. We all have family problems, financial struggles and heavy workloads. How we think about these things really determines how happy we are with our life. By taking the attitude that life is a challenge rather than a drudge you really are investing in yourself and it will pay off in terms of how you feel about every aspect of your life.

**Annmaree Wilson**  
Senior Clinical Psychologist for the  
Bush Support Services team ●

# BUSH SUPPORT SERVICES



# 1800 805 391

**Toll-free Support line**

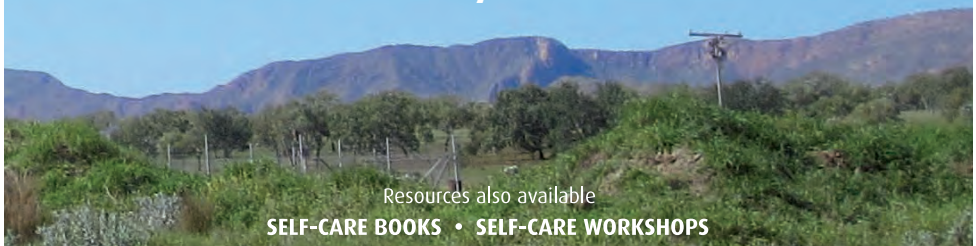
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