Bowel Cancer Screening
Jessica Alcorso, Health Promotion and Special Projects Officer
Cancer Council NT

Bowel cancer is the second most common form of cancer in Australia with around 14,000 cases diagnosed each year, and approximately 80 deaths each week. If detected early bowel cancer can be treated successfully, but currently less than 40% of bowel cancers are found at an early stage.

The National Bowel Cancer Screening Program is the result of recommendations from The National Health and Medical Research Council that faecal occult blood test (FOBT) screening of average risk people should begin at age 50 and continue every two years. It is encouraging that the Federal Government has announced it will be expanding the free screening program, initially only for people aged 50, 55 and 65, to include all Australians turning 50, 55 and 60 in 2013, and 65 and 70 in 2015. People are sent free FOBT kits by mail.

It is important to encourage participation in screening even for those who do not have any obvious symptoms, because it means bowel cancer can be caught in its early stages. Doing a FOBT every two years can reduce the risk of death from bowel cancer by up to one third. People who are not eligible for a free kit you can speak to their doctor about purchasing a kit. Kits are available from GPs, chemists and online through Bowel Cancer Australia.

For more information regarding screening for bowel cancer the Cancer Council suggest speaking to a GP or calling the Cancer Helpline on 13 11 20.

For information on the National Bowel Cancer Screening Program, visit: http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/bowel-about

Reference:
Indigenous comedian on-the-rise Sean Choolburra, Bangarra dance troupe performer Rarriwuy Hick, and hip hop singer Corey “Yung Nooky” Webster are just three of the prominent Aboriginal Australians featured on the new No Smokes website, which went live on World No Tobacco Day, 31st May 2012.

No Smokes is an anti-smoking initiative designed especially for use by young Indigenous people. It’s based on the understanding that social marketing is at its most effective when it speaks the language of its intended audience, when messages are delivered by people they look up to, and when they can see something of themselves in the faces and voices featured.

As Project Leader Dr Sheree Cairney explains:

“No Smokes is about providing positive role models for Indigenous young people and helping them understand the detrimental physical effects of tobacco.

Smoking causes one out of every five deaths among Australia’s Indigenous population. More than half of Australia’s Indigenous people smoke; compared to less than one fifth of non-Indigenous Australians. It stands to reason therefore, that if we’re serious about ‘closing the gap’ between the life expectancy of Indigenous and non-Indigenous Australians, addressing smoking rates is a high priority.”

No Smokes is a project that has been two years in the making by Dr Cairney and her team. Inspired by encouraging results from New Zealand – where quit rates of 60% were achieved using multimedia strategies – the researchers held extensive focus groups with young Indigenous people, teachers and youth workers to discover what would work best here.

Not surprisingly – and mirroring the New Zealand experience – the No Smokes team found that Aboriginal and Torres Strait Islander young people did not identify with most traditional anti-smoking campaigns and therefore easily dismissed the campaign’s message.

Those Cairney interviewed found a much stronger pull to multimedia, video, social networking, animation, music and mobile phones – media is especially useful in overcoming language and literacy barriers. As a result, No Smokes is rich with interactive content, including mobile phone apps, links with social networking sites and a YouTube channel ‘No Smokes TV’.

“Participants said they wanted to see Aboriginal faces and messages that mean something to them. We believe that with No Smokes we’ve created the most relevant and effective site possible,” she says.

“We’re aiming to empower young people with knowledge – with clear messages explaining the facts about smoking, and functions like an animated brain that shows how tobacco addiction works – as well as to entertain them with features like the hip hop dance-off that lets users upload their own photos.”

Dr Sheree Cairney, Project Leader talking about No Smokes: It’s Deadly

Continued on Page 3
The No Smokes website is now up and running and is well worth a look. It features numerous video clips, the aforementioned brain animation, interactive games and quizzes – all ‘on message’ about the dangers of smoking and with some great support for smokers to quit and stay quit. From a hilarious skit of comedian Sean Choolburra hamming it up in a version of Beyonce’s ‘All the Single Ladies’ where he substitutes ‘All the Cigarettes’ and concludes that ‘if you love it put a patch on it’ to a cheesy game show style quit quiz with a gold toothed Indigenous compere walking players through a successful quit journey, No Smokes is novel, fun and youth friendly.

No Smokes is also a great resource for teachers and health workers, providing educational material, downloadable tools and fun interactive activities. Designated teacher and health worker sections are going live in the coming weeks.

The No Smokes site was developed with the help of a $700,000 grant from the Australian Government Department of Health and Ageing.

Check out No Smokes at www.nosmokes.com.au It’s deadly!

The Groovy Grans
Dottie Daby, Coordinator
Groovy Grans

Groovy Grans is a Senior Line Dancing Troupe. I am the Co ordinator, organiser and teacher as well as a performer with the group comprising of seniors from 60 years of age to 80 years of age. I guess we are doing something right for each other and for ourselves.

We practise every Wednesday from 1pm-5pm; 1pm to 2.15pm is for those seniors interested in public performances and depending on the space at various venues the group could comprise of 6, 10 or 13 performers. Public performers must be 60 years and over. We allow ourselves a 15 minute break and hit the floor again. From 2.30pm to 5pm we open the class to anyone wishing to join us.

The Groovy Grans performing at the Firie’s 2011 Pensioners Christmas Party

Most of the Groovy Grans are chronic sufferers including myself; we suffer from diabetes, heart diseases, osteoporosis, blood pressure problems, blood disorders and epilepsy. We also have cancer survivors in our group - you name it we’ve got it, or had it!! The exercise through dancing helps our way of life, gives us something to look forward to doing and motivates us.

We dance for various senior groups and organisations and perform for most of the Nursing Homes in the Northern Territory, especially at Christmas time. We always endeavour to present a new act at the Firie’s Pensioners Christmas party each year; this event is enjoyed by approximately 600 people. We did 25 public performances in 2011 and some of our performances were:

- for “Around Palmerston” at the Casino
- the Royal Darwin Show for Darwin City Council
I find that dancing helps me think of other things instead of on my health problems. I would now like to share some of the other member’s reasons for being part of the Groovy Grans.

Maureen Thomas says:

“I joined the Seniors Linedancing Troupe at Palmerston when it first started approximately 8 years ago with Dottie Daby. My reason for joining was to keep fit and healthy in my later years while enjoying myself, and also to meet and socialise with other people. I had never done line dancing before; I am now 75 years young and it certainly keeps my mind active.

Pat Cook says:

“I have been a member of the Groovy Grans for 4 years and I enjoy the social aspect as well as the fact that I get to exercise and have company while doing so.”

Joan Carter says:

“I have been linedancing for a long time. It is so good that I can’t remember! It keeps my brain working, I love the social interaction and it is so much fun.”

Ruth Bishop says:

“I enjoyed 15 years of linedancing at Port Lincoln and since coming to Darwin have been with the Groovy Grans for 3 years. I love the exercise, the dancing and being part of the Groovy Grans which provides us the opportunity to make friends and we enjoy each other’s company.”

Marge Duminiski (Music Marge) says:

“I love the company and dancing but the best part is the “chardy afterwards”.

My interest in linedancing is to stay fit, active, and motivated and this interest in the Groovy Grans is keeping “my ladies” fit, active and motivated as well. Linedancing has given “my ladies” self esteem and confidence, and is a pleasurable way of exercising to music.

We have even done a football show at Kantilla’s and although some young footballers were present - we were a hit in our football Guernseys, football shorts and long club socks - it was a scream especially with the dances being performed to the football club songs!

All the shows we do are mostly on voluntary basis especially for the Nursing Homes (we are even happy to perform for bikkies and a cuppa). When we are presented with a donation, it is so exciting and eagerly accepted. The big organisations always have us for a luncheon or a dinner - we dance for our supper (as it were). We haunt the Op shops for most of our outfits and the sleepless nights of dreaming up the acts are worth every minute, especially to see the enjoyment on everyone’s faces with all the toe tapping, hand clapping, body swaying in seats and smiles all around! It is most rewarding and we love every minute of it.

My interest in linedancing is to stay fit, active, and motivated and this interest in the Groovy Grans is keeping “my ladies” fit, active and motivated as well. Linedancing has given “my ladies” self esteem and confidence, and is a pleasurable way of exercising to music.
The COTA NT Story
Robyn Lesley, Chief Executive Officer
COTA NT

Council on the Ageing (Northern Territory) Inc (COTA NT for short) is a not for profit organisation. It was established in the NT in 1969 to support and assist seniors in all aspects of life to live well, and advocate for services and their appropriate delivery. COTA NT works with its senior’s membership across the NT, organisations supporting seniors and non members in the age categories of over 45 years for Indigenous and over 50 years of non indigenous seniors.

Julie Colbert (Project Officer), Robyn Lesley (CEO), Afzala Awan (PICAC Officer), Leonie McNally (Volunteer), Bilawarra Lee (Operations) - Taken at Spillett House at the very successful Multicultural Lunch for Seniors

COTA’s Darwin office is located at Spillett House, 65 Smith Street where a variety of programs and projects are delivered including:

- the Partners in Culturally Appropriate Care (PICAC)
- Peer Education delivery of Beyond Maturity Blues and Quality Use of Medicines
- Computer Training Hub for seniors
- Seniors Month Activity Program
- Multicultural Affairs Sponsorship Program for Seniors
- Independent Seniors Round Table
- Policy Council
- Information and referral services for seniors
- Coordination of a wide range of information /workshop events targeting seniors
- Research and advocacy relevant to seniors as a method of supporting effective and relevant decisions by the different levels of government regarding seniors

COTA NT has two branches: Coomalie and Darwin – and links other seniors in Katherine, Tennant Creek and Alice Springs via members. These networks provide valuable resources for volunteers and social engagement.

The five top priorities for NT Government action developed by COTA and endorsed by the Independent Seniors Round Table during 2012 are:

- Access to and design of housing for different cohorts of seniors across the NT
- Employment opportunities for seniors and how to address ageism in the workplace
- Appropriately designed public and private infrastructure which is access friendly for all but considers the particular needs of seniors, the disabled and mothers with young children
- Consumer friendly service delivery
- An integrated Transport service for vulnerable seniors within the greater Darwin region (extending to other centres as the model is developed and tested)

COTA NT has worked effectively with its State/ Territory partners through COTA Australia on the aged care reform agenda over the past three years. As the Commonwealth rolls out the decisions arising from the Productivity Commission’s report ‘Caring for Older Australians’, the NT will be faced with the challenges of the fastest growing population group being the over 50 years and the implementation of seniors’ wishes aligned with Commonwealth policy to support “ageing in place”. This means that service delivery methods will change. COTA NT looks forward to working with service providers, governments and volunteers to ensure we cope with the challenge of growth in the numbers of seniors in the NT and quality in design and service delivery to the home.

COTA NT can be contacted on Phone 08 89 411004, Monday to Friday between 10am to 4pm.
Implications of an ageing population on health services in the Northern Territory

Bhanu Bhatia, Research Assistant
Karen Dempsey, Senior Epidemiologist
Steven Guthridge, Director
Health Gains Planning, Health Protection Division

Australia’s population is ageing. This means that the proportion of people in the 65 years and over age group is increasing. This group comprised 13% of the Australian population in 2006,1 13.5% in 20102 and is likely to increase to 22.6% of the population by 2050.3 This poses significant social and economic challenges including increasing burden of disease and health care expenditure.4

In the Northern Territory (NT), the population has been comparatively younger than in other States and Territories and consequently issues related to population ageing have not been prominent. However, the impact of ageing in the NT is changing. In 2006 only 4.6% of Territorians were aged 65 years and over.5 Over the following four years this proportion increased to 5.5% in 2010.6 Even though the proportion of older residents in the NT population is lower than the national average, the rate of growth among this age group has been higher.5 The ageing of the NT population is expected to continue well into the future as illustrated in Figure 1, which shows that while the projected proportions of children (0–14 years) and working age persons (15–64 years) are set to decline; the proportion of older persons (65 years and over) is expected to increase. By 2036, the proportion of the NT Indigenous population in this older age group is projected to be 8% and for the non-Indigenous 11.4%, which together will be 10.3% of the total population.7

Figure 1- Projected change in proportion (%) of working and non-working Indigenous and non-Indigenous people, Northern Territory, selected years, 2006–2036

Making this demographic transition more challenging for the NT is the relatively large Indigenous population, who have a much earlier onset of disease and disability.8,9 The disease profile of middle-aged Indigenous Territorians aged 50 to 64 years is similar to that of non-Indigenous Territorians aged 65 years and over. An example of this health differential is demonstrated by NT hospital admission rates. The results in Table 1 display public hospital admission rates per 1,000 population for all-causes of disease and injury across four-periods, spanning from 1992 to 2010. In each period the admission rate of middle-aged Indigenous people (50–64 year olds) was marginally lower than older non-Indigenous people (65 years and over) and the growth in admission rates was similar. Admission rates doubled over time for middle-aged Indigenous Territorians and almost doubled for older non-Indigenous Territorians. Mortality rates are also presented in the table and, for most groups, declined in each of the four 5-year periods between 1986 and 2005.

Table 1- All-causes: trends in public hospital admission rates and death rates, by age group and Indigenous status, Northern Territory and Australia, 1986–2010

<table>
<thead>
<tr>
<th>Year</th>
<th>NT Indigenous Rate</th>
<th>NT Non-Indigenous Rate</th>
<th>Australia Indigenous Rate</th>
<th>Australia Non-Indigenous Rate</th>
<th>All causes</th>
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<tbody>
<tr>
<td>1986–1990</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths</td>
<td>5.6</td>
<td>1.7</td>
<td>1.2</td>
<td>34.2</td>
<td>84.9</td>
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<td>1991–1995</td>
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<tr>
<td>(deaths)</td>
<td>5.6</td>
<td>1.3</td>
<td>1.1</td>
<td>30.1</td>
<td>79.2</td>
</tr>
<tr>
<td>(admissions)</td>
<td>247.6</td>
<td>130.7</td>
<td>300.1</td>
<td>168.1</td>
<td>344.7</td>
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<td>1996–2000</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Admissions</td>
<td>284.6</td>
<td>133.6</td>
<td>382.0</td>
<td>175.3</td>
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</tr>
<tr>
<td>Deaths</td>
<td>5.7</td>
<td>1.3</td>
<td>1.1</td>
<td>26.9</td>
<td>74.6</td>
</tr>
<tr>
<td>2001–2005</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>351.8</td>
<td>133.4</td>
<td>494.7</td>
<td>182.3</td>
<td>555.1</td>
</tr>
<tr>
<td>Deaths</td>
<td>6.2</td>
<td>1.1</td>
<td>1.0</td>
<td>22.2</td>
<td>66.6</td>
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<tr>
<td>2006–2010</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admissions</td>
<td>395.5</td>
<td>138.8</td>
<td>604.2</td>
<td>181.6</td>
<td>616.2</td>
</tr>
</tbody>
</table>

Source: The health and wellbeing of older Territorians (unpublished report), Health Gains Planning Branch, NT Department of Health.

Notes:
(1) All-causes include all diagnoses and underlying causes of death.
(2) Rates are expressed as number of cases per 1,000 population.
(3) More recent data on deaths was not available at the time of the study.

While the ageing NT population signifies tremendous achievements in improved life expectancy and a stabilisation of the outmigration of older residents, it also raises challenges for the future. Ageing of the population implies considerable growth in future health care needs, in the face of already existing labour shortages in the health care industry and an anticipated decline in the proportion of the working-age population in the NT.7,10

There is, therefore, an urgent need to moderate future health care demand, including through investment in preventative health care measures that mitigate the risk of diseases.10-11

References:


Darwin Region Urban Indigenous Diabetes (DRUID): follow-up study

On behalf of the DRUID study investigators

Prof Joan Cunningham, Epidemiologist and Principal Research Fellow
Menzies School of Health Research

Dr Louise Maple-Brown, Endocrinologist and Senior Research Fellow
Menzies School of Health Research

Dr Elizabeth Barr, Research Fellow
Menzies School of Health Research

Mr Shaun Tatipata, Senior Program Officer
Fred Hollows Foundation

Associate Professor Terry Dunbar, Director
Australian Centre for Indigenous Knowledge and Education, Charles Darwin University

Corresponding author

Dr Elizabeth Barr MPH PhD, Research Fellow
Menzies School of Health Research

Diabetes significantly increases the risk of cardiovascular disease (CVD: disease of the heart and blood vessels)\(^1\), and both diseases represent a serious public health problem in Aboriginal & Torres Strait Islander Australians, and are major causes of death and disability for Indigenous people aged 45 years and over.\(^2\) Two-thirds of all deaths among Indigenous Australians occur before the age of 65 years which is vastly greater than the 20% of deaths experienced by non-Indigenous Australians at the same age.\(^2\)

Therefore, the prevention of diabetes and CVD is important to reduce the discrepancies in health status between Indigenous and non-Indigenous Australians.

The Darwin Region Urban Indigenous Diabetes (DRUID) study was started nine years ago to assess the burden of diabetes, kidney disease, heart disease and other health problems in Aboriginal & Torres Strait Islander people in and around Darwin. DRUID included 1004 Indigenous men and women volunteers aged \(\geq 15\) years (42% aged over 40 years), and was conducted from September 2003 to March 2005. Details on the study have been published\(^3\).

Briefly, participants underwent a health examination which involved blood and urine tests (including an oral glucose tolerance test), clinical and anthropometric measurements, and administration of questionnaires. Of those aged \(\geq 55\) years, half were found to have diabetes. Even among younger people aged \(<35\) years without diabetes, 45% had at least two CVD risk factors, and very few people had no risk factors.\(^4\) Thus, the future burden of CVD in this population is great, and follow-up data on premature mortality, fatal and non-fatal CVD and related conditions is now required.

In 2012, with funding from the Diabetes Australia Research Trust and NHMRC program grant (#631947), the next phase -- the DRUID Follow-up Study -- will look at how people’s health changes over time, and what factors are important in predicting who gets diabetes, heart disease, and other health problems, and who stays well. The study investigators will work with the Indigenous Steering Group who will provide guidance on the conduct of the study and dissemination of the study’s findings. To capture as many outcomes as possible, both passive and active follow-up methods will be undertaken. Passive follow-up will involve data linkage of consenting participants (~90%) to the National Death Index, Northern Territory and South Australian hospital databases, and Northern Territory pathology laboratories. Active follow-up will entail inviting participants who consented to be contacted again (~90%) to answer a short questionnaire, and with permission, participant’s medical records will be reviewed to verify self-reported events.

The DRUID Follow-up Study aims to improve diabetes and CVD risk assessment and advance our understanding on the links between diabetes and chronic conditions in Indigenous Australians.
and related metabolic disorders, and CVD and mortality in urban Indigenous Australians. Additionally, the influence of other factors such as poverty and poor educational outcomes on these relationships will be explored. We hope that this new information will assist health workers to find and treat risk factors for diabetes and heart disease much earlier and help keep people healthy and strong into middle age and beyond.

References:


“Dry Mouth”: an often overlooked condition of the wise years

Dr Chris Handbury, Principal Dental Officer Oral Health Services, NT Department of Health

One and a half litres of saliva: that’s how much the average healthy person makes daily!!

One of the major oral problems encountered in the “wise years” is dry mouth or xerostomia. The condition is unpleasant and often a major complaint of older citizens. It can have the following complications:

- Difficulty in swallowing
- Difficulty with speech
- A higher susceptibility to dental decay at the necks of teeth. This is because saliva contains a number of antibodies, enzymes and fluoride ions that assist in a constant battle against demineralisation of the enamel and reducing the pH of the oral environment
- It also changes dietary preferences: who wants to eat peanut butter or vegemite with a dry mouth? It may alter the sufferer’s nutritional status, causing vitamin deficiencies and caloric insufficiency

A number of factors contribute to this condition:

**Sjögrens Syndrome**

Sjögrens syndrome is a relatively common autoimmune disease that mainly affects the eyes and salivary glands, but can also affect different parts of the body. Immune system cells called lymphocytes and auto antibodies attack the body’s moisture-producing glands. This results in abnormal dryness of the mouth, eyes or other tissues.

The disorder may progress slowly, so the typical symptoms of dry eyes and mouth may take years to show. However, rapid onset can also occur with mild, moderate or severe symptoms, with progression often unpredictable.

**Drug induced xerostomia**

Several hundred medications can cause or exacerbate xerostomia, including antihypertensives, antidepressants, analgesics, tranquilizers, diuretics, and antihistamines. These drugs affect the saliva’s quantity and possibly quality, but usually the problem is temporary or reversible.
Radiation

Irradiating to kill cancer cells in the treatment of oral carcinomas requires dosages of between 40-60 Gy. Very significant permanent damage can be done to both major and minor salivary glands. People undergoing radiation need constant dental care prior, during and after these treatments. There are a number of regimes that can assist with their oral care.

What can be done to help reduce the symptoms of Xerostomia?

Sipping water or sucking on ice chips throughout the day may moisturize the mucosa and possibly alleviate symptoms. If this is not effective, artificially moisturizing the mucosa is a possible next step. There are numerous types of saliva substitutes available including; toothpastes, mouthwashes, chewing gum, spray and gels. They are available in the oral care section of any pharmacy. They are best used at bedtime and periodically throughout the day; their relief is temporary and efficacy varies.

Oral pilocarpine, also a cholinergic agonist, is approved for salivary gland hypofunction caused by radiotherapy for cancer of the head and neck or in patients with Sjögren’s syndrome in the absence of ophthalmologic and cardiorespiratory contraindications. It, too, stimulates exocrine function. Side effects include sweating, nausea, rhinitis, diarrhoea, flushing, and polyuria. Dose-related hypotension, hypertension, bradycardia, and tachycardia can occur, as can blurred vision. Patients must be able to increase fluid intake.

Conclusion

Dry mouth, especially when it is chronic, drastically alters patients’ lives. They will find that the sore mucous membranes and gums, cracked lips and split corners of the mouth and a rough, painful tongue make eating impossible. When teeth feel like razors, spicy foods set off alarms, and sleep eludes them because they wake to sip water. Xerostomia needs to be recognised and appropriate treatment options commenced, as it significantly improves quality of life.

Rheumatic Heart Disease Guideline Phone App
Victoria Close, Marketing and Communications Unit
RHD Australia

An app for iPhone, Android and iPad is now available to assist with improving clinical practice and reduce death and disability from acute rheumatic fever (ARF) and rheumatic heart disease (RHD) throughout Australia.

ARF is a significant cause of disease among Indigenous children, often leading to RHD, a chronic heart condition in which the heart valves are damaged, which can lead to heart failure, strokes and premature death. Australia has amongst the highest recorded rates of RHD despite the disease being almost eradicated in most developed countries during the second half of the 20th century.

The app is based on a new guideline; The Australian guideline for prevention, diagnosis and management of acute rheumatic fever and rheumatic heart disease (2nd edition).

Dale Thompson, Senior Manager of RHD Australia said the app is a significant source of easily accessible information to doctors, nurses, health workers and other clinicians working at the front line of primary health care.

“Most doctors and nurses in Australia are trained in places where rheumatic fever is rare, so when they come to rural and remote settings where these diseases are common, they need easy ways to find out about diagnosis and treatment. The app makes that information easily accessible and should help ensure we deliver high quality care,” Dale Thompson said.

“The app is particularly important for improving the quality of health care for Aboriginal people and Torres Strait Islanders, who bear the brunt of this disease in Australia.”

Using the latest available evidence, RHD Australia (an initiative led by the Menzies School for Health Research, University of Melbourne) has created a guide for identifying and managing acute rheumatic fever and rheumatic heart disease among Indigenous children, and this new app makes the latest information available for free in a mobile format.

The Rheumatic Heart Disease (RHD) guideline app can be downloaded from the Apple App Store, Google Play or the RHD Australia website.
Continued from Page 10

of Health Research) undertook a comprehensive update of the original 2006 guideline.

The revised guideline has expanded on the first edition to help clinicians with additional information on preventative action, diagnosis and management of ARF and RHD.

The evidence based guideline and information about the app is available online from www.rhdaustralia.org.au

Background

Rheumatic heart disease (RHD) is caused by one or more episodes of acute rheumatic fever (ARF). These repeated episodes leave the heart valves damaged so that they can no longer function adequately, leading to heart failure and sometimes cardiac surgery or even death. ARF is caused by the body’s autoimmune response to an infection by the Group A streptococcus germ, and is commonly seen in children from Indigenous communities across northern and central Australia. ARF occurs mainly in children aged between 5 and 14, and affects a number of areas of the body, including the joints, brain, skin, and heart.

RHD Australia is Australia’s national rheumatic heart disease coordination unit and aims to reduce death and disability from acute rheumatic fever and rheumatic heart disease. Funded by the Australian Government Department of Health and Ageing RHD Australia is an initiative of Menzies School of Health Research in partnership with Baker IDI and James Cook University. The unit was established in 2009 as part of the National Rheumatic Fever Strategy.

Menzies School of Health Research is the national leader in Indigenous and tropical health. The independent medical research institute aims to improve and advance health; to break the cycle of disease and to reduce the health inequities in Australia and the Asia Pacific region, particularly for disadvantaged populations. Menzies sets its sights on fostering excellence and leadership in scientific research and education. The organisation has more than 300 staff working in over 60 communities in Central and Northern Australia, as well as the Asia Pacific region.

Heartmoves has come to Alice Springs and it’s FREE!
Jess Karlsson, Director of Health and Wellness
YMCA of Central Australia
Lucinda Coobs, Healthy Communities Coordinator
Alice Springs Town Council

The National Heart Foundation’s Heartmoves is a gentle physical activity program suitable for adults of all ages and is designed to be safe for people with stable long term health conditions.

Five local health professionals have recently participated in Heartmoves training to become accredited instructors. These instructors are:

- Pippa Tessmann, Physiotherapist, Alice Springs Physiotherapy & Sports Injury Clinic
- Jess Karlsson, Director, YMCA Health & Wellness
- Jo Black, Registered Fitness Professional, YMCA Health & Wellness
- Mitch Cameron, Development Officer, Alice Springs Town Council Community
- Lucinda Coobs, Healthy Communities Coordinator, Alice Springs Town Council Community

Heartmoves is suitable for people with conditions such as asthma, osteoporosis, arthritis, obesity, angina, lung conditions, cardiovascular disease, chronic pain and muscle/joint problems.

Alice Springs Town Council’s Healthy Communities Coordinator, Lucinda Coobs says:

‘Heartmoves is a fantastic low to medium intensity physical activity program and is available FREE of charge to all adults in Alice Springs for the duration of the ‘Active in Alice’ program. If you have suffered a stroke, heart attack or heart surgery, Heartmoves is a terrific follow on program after cardiac rehabilitation is completed’.

The benefits of participating in a Heartmoves program include:

- maintaining a healthy lifestyle
- social interaction and FUN
- continued exercise after rehabilitation
- lower blood pressure and improved cholesterol
Heartmoves participant, 81 year old Ron Wallace of Alice Springs was rushed to Adelaide with the Royal Flying Doctors Service suffering tachycardia and returned with a pacemaker. Ron is now a regular member of Heartmoves and the Heart Foundation Walking Group. Ron says:

‘The Heartmoves instructors are exceptional in their delivery of the program, inspiring those within the class to work at their own fitness levels’.

Ron believes the Heartmoves Program has provided him with numerous benefits including ‘companionship, a feeling of wellbeing and having a regular exercise regime’.

To register your interest please contact Lucinda Coobs, Healthy Communities Coordinator on (08) 8950 0533 or email: lcoobs@astc.nt.gov.au OR you can start as early as today by arriving at the YMCA ten minutes prior to class times to complete a Pre-Exercise Questionnaire.

A Heartmoves Session

Heartmoves sessions include:

- warm up, cool down and stretching
- aerobic and resistance training
- balance, coordination and flexibility

Sessions are conducted by our accredited Heartmoves leaders and you can attend one or all sessions currently being held at YMCA, Sadadeen Road on:

- Mondays 4:30pm
- Wednesdays 12:00pm
- Thursdays 10:15am

The Heart Foundation website at [www.heartfoundation.org.au/heartmoves](http://www.heartfoundation.org.au/heartmoves) is an excellent resource for further information on the history of the Heart Foundation’s Heartmoves program.

### Challenging Pain: a self-management course

**Hilary Fowler, Secretary to the Arthritis & Osteoporosis Board**

Arthritis & Osteoporosis NT

Pain is a factor of life for people with many different chronic diseases. It can be very debilitating, both physically and mentally.

There are many conditions for which pain treatment is only partially successful. In these cases the best alternative is learning to cope with the pain so that life can continue as normally as possible. ‘Challenging Pain’ is a self-management course which aims to assist pain sufferers in coping better with their pain. It is conducted over two sessions of 2 ½ hours each one week apart. In both sessions participants are asked to contribute both in pairs and in the general group, and contributions are built on to develop techniques which can be applied in everyday life.

In the first session pain is discussed and participants are asked to assess the level of their pain. Reasons for challenging pain are discussed, including the effect on activities and the negative thoughts it generates. Conscious breathing techniques are practised and gentle exercises introduced. Participants are asked to set reasonable goals and ways of achieving them. Recognising and coping with stress is addressed. Relaxation exercises are practised.

In the second session feedback from the goal setting of the previous week is considered. The concept of diversion is discussed. The use and side effects of medicines are considered. Positive and effective communication is practised. The exercises and relaxation techniques from the first session are practised and built on.

While some of this can be achieved by self-teaching with online assistance, it has been found that the interactive group sessions are very valuable for the participants. Meeting other
people with similar problems and discussing how they are coping and what they find helpful can be of great assistance in managing the mental and emotional aspects of pain.

A sufferer from osteoarthritis who attended the Challenging Pain Course wrote 12 months later:

“Thanks to the management techniques I learned at the workshops I now feel so much more in control. I can’t say I have no pain, however, by following the guidelines I learnt, regarding exercise, diet and attitude, my quality of life is much better and I am able to feel confident that the crippling effects of the condition are significantly reduced. I also use minimal pain killers as a result and have an all-round healthy and pro-active approach. The best part is that I am smiling and enjoying life again.”

In other states Challenging Pain has been offered to people waiting for hip and knee replacement surgery. They have found that patients who have completed the course recover more quickly from their surgery.

Challenging Pain is licensed from Arthritis Care UK and is currently run by Arthritis & Osteoporosis NT (AONT) who will be conducting training for presenters of Challenging Pain later this year. If you are interested in doing the course please contact 89485232 or email: development@aont.org.au

If you would like to participate in Challenging Pain contact AONT as a group of at least eight people is necessary to be viable.

Asthma and Seniors
Jan Saunders, Executive Officer
Asthma Foundation NT

Asthma in older people is more common than previously understood. The prevalence of asthma among middle-aged and older Australians is approximately 15% as compared to the general adult population which is estimated at approximately 10-12%. Emerging international evidence suggests that the prevalence of both asthma and chronic obstructive pulmonary disease (COPD) is increasing.

Asthma in seniors is often under-diagnosed due to:

- lack of awareness of the possibility of new-onset asthma in seniors
- respiratory symptoms being attributed to ageing or common diseases of seniors
- poor recognition of asthma symptoms by older people
- associated co-morbidity which makes diagnosis difficult

Asthma is associated with significant disability, depression and impairment of mobility in older people. The risk of dying from asthma increases with age, with the majority of deaths occurring in people aged 65 and over.

The diagnosis of asthma in seniors is based on:

- history
- physical examination
- supportive diagnostic testing e.g. spirometry

Spirometry is an effective tool in the accurate diagnosis of asthma and helps distinguish between asthma and COPD.

Managing asthma in seniors is similar to that in all age groups. However, co-morbidities will influence the choice of delivery devices. People who are frail, weak or have arthritis affecting their hands may need to use additional aids or
undergo a trial of various devices to determine the best delivery method. Some people may require a carer to help them use their puffers and spacers while others may require use of a nebuliser. Some points to consider in determining a delivery system for seniors with asthma are outlined in the table below:

<table>
<thead>
<tr>
<th>Aspects to consider</th>
<th>Delivery System notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength to operate the device</td>
<td>Inhalers versus breath-activated devices</td>
</tr>
<tr>
<td>Inspiratory flow rate</td>
<td>Spacers</td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
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<tr>
<td>Agility</td>
<td></td>
</tr>
<tr>
<td>Visual acuity</td>
<td>Dose counters require good eyesight</td>
</tr>
<tr>
<td>Strength and function of hands</td>
<td>Haleraids for people with arthritis and disability</td>
</tr>
<tr>
<td>Cognitive status</td>
<td>Try not to mix inhaler types within a treatment regime</td>
</tr>
<tr>
<td>Understanding of the role of each medication</td>
<td>Reinforce when medication should be taken</td>
</tr>
<tr>
<td></td>
<td>Reinforce role of nebulisers</td>
</tr>
</tbody>
</table>

Older people with multiple co-morbidities may also experience difficulties taking complex medication regimes correctly, so it is important that administration of medications is kept as simple as possible and reviewed each time they visit their doctor. Asthma medications should also be monitored by the doctor for adverse effects and potential interactions with drugs taken for other conditions.

It is important that asthma self-management not only includes education to seniors with asthma, but also to family members/carers and a personalised Asthma Action Plan is provided. An Asthma Action Plan is a written set of instructions prepared by the doctor that assists asthma management; providing clear information on how to administer Asthma First Aid and when to call emergency services.

All people aged over 65 years, particularly those with asthma should have regular reviews with their doctor to ensure that they receive annual influenza re-vaccinations and that initial pneumococcal vaccination and subsequent re-vaccination occurs in line with current recommendations. Vaccinations are important as elderly people with asthma are at higher risk of complications if they get the flu.

The Journey May Be Longer Than You Think
Beth Amega, Renal Team Coordinator
Danila Dilba Health Service
Background

End Stage Renal Disease (ESRD), diagnosed when the kidney function drops below a glomerular filtration rate of 15mls/min, has two management pathways:

- Renal replacement therapy (renal dialysis or kidney transplant)
- Conservative management

There is little evidence documenting ESRD conservative management. General practice has often not referred clients to a nephrologist when they are not seeking renal replacement therapy. Renal teams also have not traditionally been actively involved in the conservative pathway for end stage clients.

A renal case management program providing primary care for chronic kidney disease (CKD) has provided the opportunity for the trajectory of the disease to be mapped in an urban Aboriginal & Torres Strait Islander population. As the program entered its third year a longer survival time was noted amongst this distinct population.

Conservative management and the associated shared care between renal and palliative care specialties has only been a recent development in nephrology management in Australia and also around the world. In 2007 the Northern Territory renal services undertook a specific program to look at this area of renal client care (Devitt, 2010).

In looking at survival times for persons managed conservatively with ESRD there are two studies of relevance to this discussion. A UK study on 69 ESRD patients who opted for conservative management rather than dialysis was carried out and published in 2009 (Ellam et al, 2009). It concentrated on the bio-physical factors of co-morbidity and laboratory parameters. They showed there was a median patient survival of 21 months and that early referral to a nephrologist and maintaining serum albumin >35 were predicting factors for even longer survival times. Their study concluded comorbidity and age did not predict survival. Risk factors in the dialysis population such as cardiovascular disease may not necessarily predict survival among those conservatively managed.

Murtagh and others undertook a study (Murtagh et al, 2008) in the USA of 74 persons with ESRD (mean age 81 ± 6.8 years); its objectives were to determine trajectories of symptoms and wider health-related concerns in the last year of life in people with ESRD, managed without dialysis. They found that it was in the last two months of life that patients had increasing symptoms. Their recommendations were that healthcare professionals should be alert for this change in condition which may indicate the patients are approaching death.

A retrospective analysis of all stage 5 clients managed conservatively at a single Aboriginal medical service over a four year period (31 May 2008 – 31 May 2012).

- 18 clients mean age of 56.2 ± 24 years (range 32-76) at the medical service were diagnosed with ESRD over the four year period.
- 10 clients commenced renal replacement therapy, mean age of 51 ± 19 years
- 8 clients have been managed conservatively, mean age 63 ± 12 years
- 4 actively chose the conservative management pathway in consultation with family and carers prior to reaching stage 5
- 2 clients were prepared for dialysis in stage 5 but then their condition changed and they were recommended to take a conservative approach
- 2 are undecided – not yet prepared for dialysis but also not actively engaging in conservative management

![Graph of months of survival post ESRD diagnosis](image-url)
The effect of case management

At the commencement of the case management approach, ESRD clients’ survival time post diagnosis appeared to be less than 12 months. Referrals to palliative care were being initiated at eGFR 20 prior to reaching ESRD if they were identified early. With the survival time of 3-9 months, this appeared to be appropriate. During 2009 the clinic had no CKD clients progressing to ESRD following a conservative pathway. It was late 2011 when a couple of clients survived well into their second year - this early referral to palliative care needed to be reassessed and this retrospective analysis was undertaken. It was found that those clients case managed with early referral to nephrologist, survival rate without renal replacement therapy was now well into their second year and some may even go into their third year. This is comparable to the UK study even though the mean age studied is some 18 yrs different.

Social determinants as factors

Accessing services was sometimes a problem. In the initial phase of the renal care coordination program many clients were very hesitant to access the services of the “kidney doctor”. Not only was it scary, but it often meant sitting in cold waiting rooms. The re-establishment of onsite nephrology clinic at the local AMS by 2009 resulted in 75-80% completion of referrals (Amega, 2009). This allowed clients and families to meet the multi-disciplinary renal team made up of Aboriginal Health Workers, nurses, GPs and nephrologists to make informed choices in a culturally safe environment, which can lead to increased quality of life.

In the earlier case managed clients social determinates such a safety, housing and family support were sometimes lacking and not enough time was left to work with them through these issues to enhance their quality of life. By initiating a case management approach some of these social factors can be worked through and appropriate support structures can be introduced early in the client’s journey. With secure housing, food security and being allowed to remain within their family and community it is being shown that conservatively managed urban Aboriginal & Torres Strait Islander clients with ESRD may have a comparable survival to those in other populations. Social determinants were not discussed in either of the studies cited although low serum albumin can be due to malnutrition and may indicate less than optimal care.

Conclusion

The journey may be longer than you think. Initiating a palliative care referral has often been done too early for those with ESRD in a stable environment. Family meetings are an important factor in conservative management:

A home medicine review is beneficial in conservative management
Nephrologist and multidisciplinary renal team input is important
A care co ordinated approach such as case management can ensure a holistic approach to health to optimize outcomes.
Continued from Page 16

References:

Devitt, J 2010, An evaluation report of the palliative care for renal clients living at home initiative, Department Of Health and Aging, Darwin


Amega, B & McGinness, P 2009, ‘Building a CKD program from the ground up’, paper presented to Chronic Disease Network, Darwin, Sept 2009

Physical Activity Recommendations for Older Australians

It’s never too late to start becoming physically active, and to feel the associated benefits.

“Too old” or “too frail” are not in themselves reasons for an older person not to undertake physical activity. Most physical activities can be adjusted to accommodate older people with a range of abilities and health problems, including those living in residential care facilities.

Many improved health and well-being outcomes have been shown to occur with regular physical activity. These include helping to:

- maintain or improve physical function and independent living
- improve social interactions, quality of life, and reduce depression
- build and maintain healthy bones, muscles and joints, reducing the risk of injuries from falls
- reduce the risk of heart disease, stroke, high blood pressure, type II diabetes, and some cancers

There are five physical activity recommendations for older Australians:

1. older people should do some form of physical activity, no matter what their age, weight, health problems or abilities
2. older people should be active every day in as many ways as possible, doing a range of physical activities that incorporate fitness, strength, balance and flexibility
3. older people should accumulate at least 30 minutes of moderate intensity physical activity on most, preferably all, days
4. older people who have stopped physical activity, or who are starting a new physical activity, should start at a level that is easily manageable and gradually build up the recommended amount, type and frequency of activity
5. older people who continue to enjoy a lifetime of vigorous physical activity should carry on doing so in a manner suited to their capability into later life, provided recommended safety procedures and guidelines are adhered to.


Renal Artery
The EYEINFONET: An Indigenous Eye Health Resource

Avinna Trzesinski, Research Officer
Australian Indigenous HealthInfoNet

The EyeInfoNet (http://www.healthinfonet.ecu.edu.au/other-health-conditions/eye) is a comprehensive web resource offering information and resources on Indigenous’s eye health located on the Australian Indigenous HealthInfoNet website.

Good vision and good eye health is important for a person’s physical wellbeing and social and emotional health during all stages of life, including the older years. Vision loss and blindness can have significant negative impacts for individuals, families and communities. Poor vision can increase the risk of injury and limit opportunities in education, employment and social engagement, and also be a reason for dependence on services and on other people [1].

Eye health problems can increase as we age. The number of Australians over the age of 50 years is increasing, and it is estimated that the number of people with visual impairment will double by the year 2030 [2]. Evidence suggests that even mild vision loss can increase the risk of mortality by 2.6 times for Australians [3].

Although ageing is a risk factor for many eye conditions, it need not lead to vision loss as it is almost entirely preventable, especially if detected early [4, 5]. Regular eye checks can ensure good eye health into the older years and current treatments - including visual aids and surgery - are very successful and cost effective [3]. Other risk factors for eye conditions include genetics, premature birth, type 2 diabetes, smoking, injuries, ultra violet (UV) exposure, and poor nutrition [5].

Box 1. Common eye conditions include: [6]

- refractive error (long or short-sighted vision)
- cataract (the lens of the eye becomes cloudy)
- macular degeneration (eye damage caused by ageing)
- diabetic retinopathy (eye damage caused by diabetes)
- glaucoma (disease which causes damage to eye nerve cells)
- trachoma (an infectious eye disease)

Indigenous people have poorer eye health outcomes than non-Indigenous people. The frequency of eye diseases (with the exception of trachoma) is similar between Indigenous and non-Indigenous people, but rates of vision loss are three times higher, and rates of blindness are six times higher for Indigenous people [3]. Indigenous people are more than three times more likely to report having type 2 diabetes [7]; a contributing factor to diabetic retinopathy and cataract [8]. Poor hygiene and living conditions (which increases the risk of the infectious eye disease, trachoma), is still found among some Indigenous communities in Australia [9].

Another major factor for Indigenous people is access to eye health services. More than one third of Indigenous people have never had an eye exam, and are less likely to access eye health services [3]. This can be due to difficulty in accessing optometry or specialist ophthalmology services locally that are affordable, coordinated and culturally appropriate, living in a rural or remote area, or having a lack of transport [10]. Providing quality eye services will be essential to improving the health of Indigenous Australians in the future [3].

The term Indigenous is used to refer generally to the two Indigenous populations of Australia, Australian Aboriginal people and Torres Strait Islanders.

Many health practitioners and organisations around Australia are working to close the gap in eye health between Indigenous and non-Indigenous people by providing quality eye
health care service delivery to Indigenous people, with the aim of reducing the prevalence of eye conditions particularly cataract, diabetic retinopathy, and trachoma.

The EyeInfoNet web resource can inform the health and policy workforce of programs or projects, latest research, and health promotion campaigns in Indigenous eye health. The EyeInfoNet provides information and resources on the following areas:

- policies and strategies – national and state-based, Indigenous and mainstream
- organisations – Australian organisations relevant to the eye health of Indigenous people
- health promotion resources – flipcharts, posters, pamphlets, DVDs, online resources and practice resources for health professionals such as clinical guidelines and toolkits
- publications – details of journal articles, reports, books and book chapters within a searchable bibliography
- workforce – details of job vacancies, courses, conferences and funding opportunities (such as scholarships or grant funding)

Contributions to the EyeInfoNet web resource are always welcome. Feedback from our users helps to keep the EyeInfoNet web resource relevant and current. Feedback is encouraged through an online form (http://www.healthinfonet.ecu.edu.au/contact).

Information-sharing is also supported through our free online yarning place (electronic networks), the EyeInfoNetwork, which allows people to share information, knowledge and practical experiences about Indigenous eye health with other people from across the country (http://yarning.org.au/).

For more information, contact:
Australian Indigenous HealthInfoNet
Kurongkurl Katitjin: Centre for Indigenous Australian Education and Research
Edith Cowan University
Phone (08) 9370 6336 / Email healthinfonet@ecu.edu.au / Website www.healthinfonet.ecu.edu.au

References:

10. Taylor, V., et al., Review of the implementation of the National Aboriginal and Torres Strait Islander Eye Health program. 2004, Centre for Remote Health: Canberra.
It is no secret that renal disease is an important health issue in the Northern Territory. Australian and New Zealand data reports for 2010 and 2011 show that the majority of new patients commencing dialysis are between 45 to 74 years old. This is an age bracket that includes the "wise generation" – those elders and leaders in the community whose loss to the community when they relocate to main centres for dialysis is significant.

Home dialysis offers an alternative; enabling people with renal failure to return to their community and perform self care dialysis treatment closer to home. Northern Territory Renal Services is committed to promoting self care dialysis.

Peritoneal Dialysis

Peritoneal dialysis is a gentle dialysis particularly suitable for those patients who still have some renal function and are small in body frame. Peritoneal dialysis aids in preserving residual renal function; has a shorter training time (2-4 weeks) and gives greater flexibility for travel. With time, the effectiveness of peritoneal dialysis may be reduced and a patient may need to commence haemodialysis. This is not to been seen as a failure but a progression of needs. Peritoneal Dialysis uses the person’s own peritoneal membrane (lining of the abdominal cavity and contents) as the filter to remove unwanted fluid, electrolytes and toxins. In this treatment, a specially formulated strength of dialysis fluid is drained into the abdominal cavity through a surgically implanted catheter. The extra fluid, electrolytes and toxins travel across the peritoneal membrane from the person’s blood stream into the dialysis fluid and can then be drained out. This treatment is conducted at home, every day, at least four times a day and is known as Continuous Ambulatory Peritoneal Dialysis (CAPD).

Another method of Peritoneal Dialysis is performed overnight using a “cycler” machine that pumps dialysis fluid in and out of the person’s abdomen numerous times while the person is asleep leaving their days free for employment or other activities. This is known as Automated Peritoneal Dialysis (APD).

Haemodialysis

Haemodialysis occurs by pumping the person’s blood through tiny filaments in an “artificial kidney” (dialyser) which is bathed with a specially formulated dialysis fluid. The filaments provide the semi-permeable membrane that allows the unwanted fluid, electrolytes and toxins to pass through to the dialysate side of the membrane but does not allow blood to escape. Two needles are inserted into a surgically made arterio-venous fistula, usually in the persons arm, and blood is pumped from one needle through attached tubing to the dialyser. The filtered blood is then returned through tubing and into the patient’s body via the second needle. At the end of the treatment the blood is flushed back using a saline solution, the needles are removed and the blood lines and dialyser are discarded.

This treatment process continues for about five hours at a time and must be performed at least three times a week for the person to stay well. Dialysis following missed dialysis can be dangerous due to rapid shifts in electrolytes. Home dialysis patients however do have some flexibility to alter their dialysis days and times of treatment to suit their activities.
Training time for self care haemodialysis varies with each patient but usually takes about three to four months. Patients learn how to set up the machine, work out how much fluid they need to take off each treatment, monitor their blood pressure throughout the treatment, give intravenous medication and take blood samples while on dialysis. In addition, they learn how to “troubleshoot” when the dialysis machine alarms.

Self care dialysis patients may have a machine in their own home if there is suitable room space, giving them the opportunity to perform nocturnal dialysis, a longer, slower dialysis that reduces the risk of a sudden drop in blood pressure that conventional dialysis has. Alternatively, they may share a machine in a multi-user facility or renal ready room.

Home dialysis therapies not only benefit the patient with renal failure but also gives them the opportunity to share their acquired renal health knowledge with the younger generation and to be an influence for change within their community.

Reference:
McDonald S. et al, Annual report 2010, 2011, Australian and New Zealand Dialysis and Transplant Registry
Continued from Page 21

The Elderly

Age greater than 60 years increases the risk of developing kidney disease. It is now known that an eGFR <60 mL/min/1.73 m² is very common in older people, but it is nevertheless predictive of significantly increased risk of adverse clinical outcomes, and should not be considered physiological or age appropriate.

Controlling Hypertension

Patients with CKD should be treated with medication that consistently lowers blood pressure to or below 140/90 mmHg. If albuminuria is present or the patient has diabetes, the target should be below 130/80 mmHg.

Detecting Albuminuria/Proteinuria

The preferred method of detecting albuminuria/proteinuria in patients with or without diabetes is urinary albumin:creatinine ratio (ACR) as it accurately predicts renal and cardiovascular risk. Dipstick for protein in urine is no longer recommended.

Following diagnosis, most patients with an eGFR of between 30 and 60 can be effectively managed by their GP. However, referral to a nephrologist is recommended when kidney function deteriorates rapidly or eGFR levels fall to less than 30mL/min/1.73m².

The revised guidelines have been endorsed by The Royal Australian College of General Practitioners, The Australian College of Rural and Remote Medicine, and the Australian and New Zealand Society of Nephrology. Kidney Health Australia also provides accredited education for health professionals through the Kidney Check Australia Taskforce (KCAT) program. For further information please visit www.KCAT.org.au

Reference:

Central Inner West Regional Profile

Liza Shaw, CDN Coordinator
NT Department of Health

Location - Travelling west from Alice Springs, Ikuntji (Haasts Bluff) is reached via the Namatjira Drive past Glen Helen Gorge, travelling through the West MacDonnell National Park. From there a track leads to Papunya and then Mount Liebig, where a small Aboriginal community sits below a 1524 m high mountain with the same name. All this land is part of Haasts Bluff Aboriginal Land Trust and permits are required to visit.

A little south is the following communities, also in the Central Inner West region:
- Wallace Rockhole
- Watarrka (King’s Canyon)
- Haasts Bluff (Ikuntji)

Health - Each of the above communities has a Health Centre, and the West MacDonnell Shire Council also provides services in many of these communities. Other small communities without a health centre are also scattered throughout this area.

Languages spoken in this region include Western Arrernte, Southern Arrernte and Luritja

Photo © Ludo Kuipers, OzOutback.com.au
Reducing Tobacco-Related Harm in the Alice Springs Region

John Bosco Odongo, Aboriginal Community Support and Education Officer
NT Department of Health

Tobacco use is the most common preventable cause of morbidity and mortality throughout the world, especially among disadvantaged populations. In Australia, tobacco use is the major risk factor for cardiovascular disease and in 2003 was responsible for 15,511 related deaths. In addition, the Northern Territory has the highest smoking rate in Australia with the prevalence of tobacco consumption amongst its non-Indigenous population at approximately 25% and rates for the Indigenous population at approximately 55%. This compares to a national prevalence rate of approximately 17%.

Both the Australian and State and Territory Governments have realised the economic and health impact of tobacco use on the population and have taken steps to address this problem head on.

The Northern Territory Government is tackling tobacco harm through its 2010 - 2013 Tobacco Action Plan which has been built on the National Tobacco Strategy of 2004 - 2009 and the World Health Organisation’s Framework Convention on Tobacco Control. The aim of the NT Tobacco Action Plan is to provide an effective, equitable and comprehensive approach to tobacco in all areas of the Northern Territory. However the main target of the initiative remains the disadvantaged population groups such as the Aboriginal and Torres Strait Islander peoples.

In addition the NT Government’s tobacco strategy has three clear priority activity areas, namely, community interventions, health care interventions and policy and legislation interventions. The aim of the health care interventions is to improve access to tobacco prevention and cessation treatment and services. At a community level the aim is to improve awareness of the harm caused by tobacco use and increase community action and local capacity to manage tobacco policy and control measures. Meanwhile the third action area, policy and legislation intervention aims at strengthening tobacco control legislation.

In the Alice Springs region the Government has recruited Tobacco Community Support and Education Officers who are based within the Department of Health’s Alcohol and Other Drug Services Central Australia (ADSCA).

These workers focus their attention in remote Aboriginal communities in the south and north of Alice Springs. Since the start of their tobacco campaigns in Central Australia in September 2011 over 200 tobacco education activities have been completed, all with the aim of minimising harms caused by tobacco use. This is being achieved through raising awareness on the health risks and identifying and supporting people who voluntarily agree to join a process of quitting tobacco.

In the three months since commencing the implementation of the NT Action Plans on tobacco in Ntaria and Papunya Aboriginal communities, the focus has been on raising community awareness on the harm caused by direct and passive tobacco smoke especially to pregnant women, children, breast feeding mothers and their babies, and to those people with lung and heart conditions.

In addition, continuous support and information has been provided to community leaders to assist them in working towards achieving their community’s identified goals and objectives around tobacco.

There has also been a concerted effort to provide assistance and support to both individuals and groups of people who wish to quit using tobacco. This has come in the form of offering advice; information and personal support to assist potential quitters to attend their community clinic.

Clients are medically assessed and offered counselling and prescribed an appropriate nicotine replacement therapy (NRT) such as nicotine patches or a pharmacotherapy such as Champix medication to suppress the nicotine cravings. Those people in the process of quitting tobacco have been encouraged to join the 100 Quit Club which gives them the opportunity to interact with and receive support from their peers. In addition the Tobacco Community Support and Education Officer continues to personally monitor and provide advice, support and encouragement to the 100 Quit Club members until they feel they’re in control of and managing their tobacco withdrawal symptoms and have ceased smoking completely.

The outcome of the tobacco control activities from January to end of March 2012 indicates...
that when the harm reduction activities are effectively carried out with the involvement of the target community it can result in people making positive decisions about quitting smoking tobacco. While some people are now on nicotine replacement therapy the majority are still at the pre contemplation or contemplation phase and will need comprehensive support, including motivation, to move to their next phase of quitting.

A significant factor in decreasing rate of smoking in remote communities is the development of community driven and managed tobacco policy. The cornerstone of good social policy is the provision of accurate information on prevalence, attitudes and understanding of tobacco consumption.

ADSCA, in collaboration with Ntaria Community and Ninti One, the Central Australian Research Centre are embarking upon a research project that will provide that information to the community.

Ninti One employs local Ntaria residents who are trained researchers and who will be active participants in the research design, conduct and analysis of surveys.

Information on the prevalence of tobacco consumption and the attitudes of tobacco users in Ntaria will provide the community with the tools to make informed decisions about local tobacco policy.

In addition to prevalence rates, the research findings will also provide an evidence-base that the community can use to better understand the behaviour and attitude of tobacco users, to identify high risk groups and to help with targeting of health promotion programs.

There is reason for optimism regarding the challenge to close the gap in the rate of tobacco use between the mainstream Australian population and the Indigenous population as with continued effort, culturally appropriate intervention methods, financial and material resources, community involvement and participation, improved outcomes will be realised.

References:


Creating Local Heroes at Ntaria Aged Care Centre
Nina Bullock, Service Development Officer
Ntaria Aged Care Centre, Central Australia

Hermannsburg, or Ntaria, is a semi-remote central desert community. Sweeping transformation in the past (Prime Minister’s Report, 2011) has left Ntaria with a piecemeal understanding of Western concepts such as ‘organisation’ and ‘health’ (Hagan, 2008). Equally, Westerners often only have a superficial understanding of Indigenous cultural and health practices (Dodson, 2010). The aim then, is to create an organisational culture that enables the service to address chronic conditions in a culturally appropriate and meaningful manner.

Ntaria Aged Care Centre (“the Centre”) is managed by MacDonnell Shire and funded by the Northern Territory Government, Department of Health to deliver Home and Community Care (HACC) services to twenty five clients and by the Federal Government, Department of Health and Ageing to deliver Community Aged Care Package (CACP) services to seven higher-needs clients. A non-Indigenous Service Development Officer supports four, soon to be eight, Indigenous staff to deliver these services. 96% of clients and 80% of staff of the Centre live with at least one chronic condition.

A typical day might proceed as follows:

8am - cook a nutritionist-approved meal
9am - transport interested clients to the Centre for breakfast, shower, social interaction, craft, line dancing or respite
10am - advocate on behalf of client needs, for instance disability access in a park project
11am - deliver meals-on-wheels to all clients, collate follow up activities such as enquiries to Centrelink
1pm - staff meeting to provide input into the Ntaria Alcohol Management Plan
2pm - staff mentoring: guide key staff through decision-making models
3pm - meet with Clinic staff to track client progress and needs
4pm - staff training; update client and service records

This timetable demonstrates the holistic nature of the Centre’s work: education; networking; advocacy; role-modelling; reporting; evaluating; and planning ways to achieve equity in health for our clients. However, a large body of literature (Waddell, Cummings, Worley, 2011) suggests that communities are much more likely to achieve positive outcomes if strategies are driven from within or ‘below’. With this in mind, the emphasis at the Centre is on staff empowerment, and the vision is towards self-management. That is, a key strategy at the Centre to achieve equity in health is supporting local staff to not only understand chronic conditions and the experience of ageing, but to actively drive change to prevent and manage chronic conditions.

Staff are thus being trained to create modified care plans for clients. Creating a care plan is an extended conversation that allows both client and service provider to share their story - an important part of local culture. These care plans are conducted in the local language, Arrernte where possible and incorporate images to ensure shared meaning. Recently, with the assistance of the Dementia Behaviour Management Advisory Service, the care plans integrated a family tree and a strengths-based approach; that is, the plans identify the skills and interests clients might be willing to share with others and the attendant benefits of this process such as building a positive sense of client capacity and the opportunity to facilitate meaningful social interaction. The care plans also enable staff with minimal literacy to contribute to the collective memory, and the Centre is in discussion with the local Chronic Diseases Nurse to share the care plans with the allied health community who already provide indirect input to care plans via the Northern Territory Remote Aged Care Assessment Teams.

Symbol-making is a consistent part of the Centre’s internal life - language referring to our collaborative vision is used almost daily and is supported with action:

- staff are involved in human resource and leadership decisions where possible;
- menu suggestions are incorporated where feasible;
- Key staff are mentored in models of decision making and engage in a daily ‘handover’ which has more in common with storytelling than traditional Western ‘action’ lists.

‘Two-ways learning’ (Harris, 1990 cited in Living Knowledge, 2012) or learning both Indigenous and Non-Indigenous ways of doing things, is also integral to creating local heroes and an outward-looking organisation. For instance, after some negotiation, the Centre supports flexible work arrangements balanced with consistent expectations around communication and forward planning. Creating a learning organisation also keeps us visible, and helps information to flow more readily between client, staff, and allied health services.

Of course, community Aged Care is not for everyone, and recruiting appropriate people is a challenge across Australia. However, creating a body of shared meanings, personalising staff development, engaging staff in Centre processes and promoting our stories throughout the community not only assists to build knowledge about chronic conditions management and prevention but also serves to attract a sustainable, talented workforce.

References:

**FREQUENTLY ASKED QUESTION**

Dorothy Brown, Renal Services Development Officer
Policy & Service Development Branch
NT Department of Health

**QUESTION:**

“I am working in a health clinic on a remote community with an elderly client who has Chronic Kidney Disease. She is not keen to leave her community for dialysis. Should I try to convince her to get dialysis? What are her other options?”

**ANSWER:**

**A Matter of Choice**

I don’t believe that you should try to convince this lady to “get dialysis” but rather ensure that she has the information required and a clear understanding of her options, in order to make a calculated decision based on that knowledge. Her decision will also be influenced by her goals and core values in life and by any co-morbid conditions that may already compromise her quality of life.

The options for this lady are dialysis, renal transplantation or conservative treatment and palliation. There is no cure for this lady’s kidney disease. What a huge decision for this elderly lady to make at a time in her life when she would be hoping to take life a little easier.

The shock of finding out that to survive, she will need to have dialysis and the implications of potentially having to relocate to a city centre for dialysis treatment are enormous, not only for herself but for her family and, if she is a significant community elder, for community life as well.

The confusion caused by the need for these decisions and change may be compounded by fear, her age and the uraemia (chemical waste in her blood) due to her kidney disease. It is for these reasons that any decision to commence dialysis should not be made hastily and education about her treatment options should be commenced at an early stage and progressively built onto as she moves towards the need for dialysis.

Though her decision should not be made under duress, after thorough education and an understanding of her options is achieved, there is a place for encouragement and guidance towards a particular mode of dialysis based on her clinical suitability. Besides educational input from chronic disease nurses in the community, attendance at a renal outreach clinic will provide an opportunity for the lady to meet with a renal physician, renal nurse and members of the renal allied health team such as the renal social worker and dietician. The use of the “Kidney Stories” DVD* and flip charts will provide further opportunities for education and guidance to both the lady and her family. It may also be helpful to have her talk with someone who has already commenced dialysis especially if they perform self care dialysis in the community. It would be negligent I believe, not to give this advice however the treatment option chosen ultimately must be what she decides is best for her and her family and she needs to be supported in this decision.

The choice to commence dialysis does hold many positive possibilities for this lady as

- Dialysis will keep her alive and possibly provide the opportunity to live many more years, thus giving her the opportunity to pass on the wisdom and knowledge accumulated over the years to the next generation of family
- Lifestyle changes (e.g. diet, exercise, cessation of smoking) and management of diabetes and hypertension may result in a delay in the progression of her chronic kidney disease and the need for dialysis

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The two types of dialysis, haemodialysis and peritoneal dialysis (into the abdomen) both give options for self care dialysis in the community.

With good planning, e.g. with AV fistula formation and buried Tenckhoff catheter insertion ahead of time, a relatively smooth transition to dialysis can be achieved.

Peritoneal dialysis, though often having a limited time of effectiveness, provides a much gentler dialysis; has shorter training times and requires less technological knowledge than haemodialysis. Peritoneal dialysis also gives greater flexibility for travel as it does not require electricity or a large machine.

Many communities have shared haemodialysis transportable or renal ready rooms to enable self care dialysis within the community if the patient is not able to accommodate a machine in their own home.

Northern Territory Renal Services is committed to providing treatment closer to home in line with national trends, and is endeavouring to promote home dialysis therapies over dialysis in a satellite unit.

Though it may be necessary to move to a city centre to commence dialysis, this lady can be confident that endeavours will be made to train her for self care dialysis as soon as possible enabling her to return to her community. Training time for peritoneal dialysis usually takes from two to four weeks and for haemodialysis one to six months.

If home dialysis is not an option, there are increasing opportunities e.g. through the mobile dialysis bus, for dialysis patients who have relocated to cities to dialyse to return home for a week of nurse assisted dialysis within their community.

Many patients already have family members who are dialysing in city centres so they are not necessarily without family support. In fact some patients grow to like city life and its conveniences and grow to enjoy the life style.

In summary, dialysis offers the elderly lady an opportunity to extend her life and does not necessarily exclude the possibility of her living in her home community, especially if peritoneal dialysis is used. To make an informed choice a thorough understanding of her options is needed and clinical advice and guidance and encouragement constitutes part of this. The choice to commence dialysis or not however, must be ultimately hers and she should be supported in her choice.

* DVD on the Kidney Stories is available at: www.chronicdiseasesnetwork.nt.gov.au

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**Combined Network Update**

Liza Shaw, Chronic Diseases Network Coordinator
NT Department of Health

There is only one remaining Combined Network Meeting for 2012. This meeting will be in Tennant Creek on the 13th of November, and more details will be provided through the e-CDNews.

Professor Victor Nossar will be a guest speaker at the Tennant Creek meeting which will continue to feature speakers related to the conference theme: ‘Promoting Healthy Childhood – Preventing Chronic Conditions’.

The Combined Network Committee is currently looking for organisations to join the committee. The purpose of the Combined Network Meetings is to:

- work in collaboration with other organisations to provide professional development to the regional health workforce
- support and facilitate networking across the regional workforce in a geographical area

Anybody wishing to discuss this further should call 08 89228280 or email: liza.shaw@nt.gov.au

**Networking at the 14 August 2012 Katherine Combined Network Meeting**
The Chronic Conditions Prevention and Management Strategy Current Update: Sneak Preview to our progress
Dr Laura Edwards and Dr Jacqueline Boyd, Public Health Registrars
Chronic Conditions Strategy Unit
NT Department of Health

The Chronic Conditions Prevention and Management Strategy (CCPMS) is the current evidence-based framework to address Chronic Conditions in the Northern Territory. It aims to use a systems-wide approach to target chronic conditions, with an initial implementation plan for the first 3 years. This plan is for a wide range of people working with Chronic Conditions, including policy makers, primary health care services, researchers and educators, Non-governmental services and communities. The Implementation plan can be found on the internet at http://www.health.nt.gov.au/Chronic_Conditions/NT_CCPMS/index.aspx

The annual report for 2011 is currently in draft form, being produced by the Chronic Conditions Strategy Unit (CCSU). It will report on the “Year 2 indicators” of the CCPMS Implementation Plan. The annual report will be presented at the Chronic Diseases Network (CDN) conference in September and is planned to be published around the same time.

Of the 8 Key Action Areas (KAA), we have given a sneak peek into what is currently happening under a selection of the year 2 indicators.

KAA 1: Social Determinants of Health
- Awareness of the importance of the Social Determinants of Health is increasing. The NT Early Childhood plan, developed in partnership with a range of governmental and non-governmental organisations and in consultation with communities across the NT in 2011, will soon be released.

KAA 2: Primary prevention
- NT Department of Health (DoH) has entered into a partnership agreement with DoH South Australia to implement the Childhood Obesity and Lifestyle (COPAL) Program, in the Palmerston community.
- Talking About the Smokes, based at Menzies School of Health Research was developed in 2011. It aims to understand which tobacco control policies and programs are successful in reducing Indigenous smoking.

KAA 3: Early detection and Secondary Prevention
- A number of three-day Preventable Chronic Disease short courses were well attended by health care professionals, including Aboriginal Health Practitioners, across the NT.

KAA 4: Self Management
- The Chronic Conditions Self Management framework 2012-2020 has been finalised and a detailed Implementation Plan being developed.
- An NT Self Management network is being formed as a subgroup of the CDN.

KAA 5: Care for people with Chronic Conditions
- Many new positions have been created under the ‘Closing the Gap’ funding for Indigenous Care Coordinators across the Territory. Some of these positions have enabled disease-specific care coordinators to be appointed in Aboriginal Medical Services.
- A framework describing Cardiac Rehabilitation Services in the Northern Territory is currently being developed. There are many exciting changes happening in this area, and it’s certainly a space to watch.

KAA 6: Workforce planning and development
- A number of people took up new roles related to Chronic Conditions in 2011. This increase was most evident in the Aboriginal Community Controlled Health Sector, where a team of dedicated Tobacco Action Workers, Healthy Lifestyle Workers and Chronic Disease Care Coordinators were employed throughout the Territory.

KAA 7: Information, communication and disease management systems
- An area with many exciting changes happening, including the rollout of the MyeHR (My Electronic Health record), aligning with the National eHealth record system. This enables greater sharing of information between health professionals, improving communication and patient care.
- Telehealth is in the process of being rolled out, enabling video and expanded teleconferencing, improving access for those living in rural and remote areas across the Northern Territory.

KAA 8: Continuous Quality Improvement (CQI)
- With an increased focus on CQI activities, there are now approximately 16 dedicated CQI facilitators in Aboriginal Primary Health Care Services working with both the DoH and ACCHOs to audit practices

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through a combination of NT AHKPIs and one21seventy processes.

If you feel that you have something to add to the Year 2 indicators for the report and haven’t as yet been contacted by CCSU, please email Jacqueline.boyd@nt.gov.au

<table>
<thead>
<tr>
<th>Cardiovascular diseases</th>
<th>Ischaemic heart disease, heart failure, hypertension, stroke</th>
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</thead>
<tbody>
<tr>
<td>Rheumatic heart disease</td>
<td>Chickary obstructive pulmonary disease, asthma</td>
</tr>
<tr>
<td>Type 2 diabetes</td>
<td>Micro/macro albuminuria, decreased GFR</td>
</tr>
<tr>
<td>Chronic airways disease</td>
<td>Depression anxiety, psychoses</td>
</tr>
<tr>
<td>Cancer</td>
<td>Those cancers associated with the common risk factors for other chronic conditions</td>
</tr>
</tbody>
</table>

The seven priority conditions addressed within the CCPMS

### Chronic Diseases Network Conference aims to improve Aboriginal health

**Liza Shaw, CDN Coordinator**
**Department of Health**

Rates of chronic conditions in the Aboriginal and Torres Strait Islander population are high, and one of the aims of the conference is to increase the capacity of the Aboriginal and Torres Strait Islander workforce to improve the health of their own people.

The other aim of the conference is to be relevant to Aboriginal and/or Torres Strait Islander staff, partly by ensuring a good proportion of presenters are Aboriginal and Torres Strait Islander people working in the field of chronic conditions. This year’s annual CDN conference will take place on 20th and 21st September and hopes to deliver information that Aboriginal and Torres Strait people working in the area around chronic conditions can take away and use.

So far for this year’s conference, about one third of presentations include speakers who have identified as either Aboriginal and/or Torres Strait Islander. The program also includes plenary sessions, workshops and concurrent sessions that address Aboriginal and Torres Strait Islander health issues. A discussion forum is planned, where a panel of experts in the field will discuss the topic “Promoting Healthy Childhood – Achieving Aboriginal Health Equality”. The role that child health promotion plays in closing the gap between Aboriginal and non-Aboriginal health outcomes will be discussed, and the audience will be encouraged to contribute to this discussion.

This year, the Office of Aboriginal and Torres Strait Islander Health has generously granted $70,000 to sponsor Aboriginal and/or Torres Strait Islander delegates to attend the conference, which has traditionally had a high attendance rate by Aboriginal and/or Torres Strait Islander delegates. Forty-six percent of delegates in 2011 identified as either Aboriginal and/or Torres Strait Islander, and this year’s increased funding will continue to support Aboriginal and/or Torres Strait Islander attendance. Evaluation forms from previous years have shown that the conference is a valuable and much appreciated professional development opportunity for Aboriginal and/or Torres Strait Islander staff.

An Aboriginal and Torres Strait Islander reference group has been meeting throughout the year to provide advice on conference plans, and ensure relevance to the professional development and cultural needs of Aboriginal and/or Torres Strait Islander delegates. The role of this group also includes supporting Aboriginal and/or Torres Strait Islander workers to present, by providing face to face support in completing and submitting abstracts, co-presenting or supporting people to present at the conference and “buddying” people attending the conference.

The full conference program and registration details are available on the conference website at: [www.cdnconference.com.au](http://www.cdnconference.com.au)
BreastscreenNT is a free cancer screening program that targets well women aged 50-69 years to participate in breast screening every two years. As 75% of breast cancers occur in women over 50, the main aim of the program is to detect early breast cancer among the most at-risk group (Cancer Australia, 2011). General Practitioners strongly recommend women aged 50-69 years have a screening mammogram every two years. With a current participation rate of 56% of Australian women aged 50-69 years, a mortality reduction of 21-28% has been achieved (Zorbas, 2011).

Cancer screening programs have played an integral role in rising survival rates. Breast cancer now has a five year survival rate of 88% with the greatest impact in the 50-69 age range. This has been attributed to breast cancer screening programs (AIHW 2008).

BreastscreenNT has a permanent service located at the Casuarina Health Services Centre, 9 Scaturchio Street, Casuarina, and Darwin. The service also travels to other parts of the Northern Territory each year. BreastscreenNT works closely with Women’s Health Educators, Remote Outreach Midwives, Aboriginal Medical Services and health personnel in each screening area to encourage women to commence screening upon turning 50 and continue their participation in the program.

Increasing equity of access for Indigenous and remote women

In October 2011, BreastscreenNT commenced screening at the Central Australian Aboriginal Congress (CAAC) Alukura clinic. The service was promoted by Alukura staff, in particular, Aboriginal Liaison Officers, who used a grassroots campaign, paired with Aboriginal radio and culturally suitable flyers. The five day service was delivered in an all-female, culturally appropriate environment. The trial was deemed successful with 105 women screened over five days; 87% of screened women were Indigenous and 67% were new women to the program (internal breastscreenNT data 2011).

BreastscreenNT looks forward to further expansion of the service to several additional sites this year. Although Indigenous participation has been rising in recent years, it is still much lower in the Northern Territory at 26%, when compared with the national average of approximately 38% (AIHW, 2009). This expansion of the screening service into additional remote areas will enable more equitable access for remote and Indigenous women to the program; a rise in the rate of Indigenous participation is an expected outcome.

### 2012 Screening Calendar

<table>
<thead>
<tr>
<th>Area</th>
<th>Dates</th>
<th>Location</th>
</tr>
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<tbody>
<tr>
<td>Palmerston</td>
<td>2nd–20th April 2012</td>
<td>Palmerston Community Care Centre</td>
</tr>
<tr>
<td>Alice Springs</td>
<td>8th May–15th June and 15th October–16th November 2012</td>
<td>Eurlipa House, Todd Mall</td>
</tr>
<tr>
<td>Katherine</td>
<td>2nd–27th July 2012</td>
<td>Katherine District Hospital</td>
</tr>
<tr>
<td>Nhulunbuy</td>
<td>13th–24th August 2012</td>
<td>Miwatj Health Aboriginal Corporation</td>
</tr>
<tr>
<td>Tennant Creek</td>
<td>1st–5th October 2012</td>
<td>Tennant Creek Hospital</td>
</tr>
<tr>
<td>Congress Alukura</td>
<td>8th–12th October 2012</td>
<td>Central Australian Aboriginal Congress (CAAC) Alukura Clinic, Alice Springs</td>
</tr>
</tbody>
</table>

### References:


Library Resources and Mobile Apps: helping you keep up to date
Marg Purnell, Clinical Librarian
NT Department of Health Library Services

Keeping up to date with the latest health/medical research in your specialty area is an important component of best practice. This can be a challenge when there are large amounts of research published every year in a variety of journals. These journals are stored in searchable health databases such as Medline. There are also summaries of this research created for use at the point of care and compiled within searchable tools such as DynaMed.

A key for busy health professionals is to be able to access this stored information quickly and easily. There is a variety of ways to access this information depending on your needs. This can be where the NT Department of Health (DoH) Library Service can help.

If you have a favourite journal that you would like to receive the table of contents of the latest issue into your email inbox, then you can set up an email alert for that journal. This feature is available on most health/medical databases and journal websites. If you would prefer not to have this come to your inbox, you can choose to receive these latest articles as an RSS feed, but you will need to set up a free tool such as Google Reader.

A number of these alerts can be set up through EBSCO, a large host database that the Health Library subscribes to. Many journals such as The Lancet, Australian and New Zealand Journal of Public Health and Health Promotion Journal of Australia are indexed within EBSCO. You can also search for a specific topic across Medline, CINAHL and other health databases. You can then save this search and create a search alert for when new information is published on that topic. For both search alerts and journal alerts, you need to create a free account within EBSCO that takes only a few minutes.

Librarians are aware of the growing importance of technology and the huge growth in the mobile health field (O’Hagan, 2012). We are continually investigating ways to keep up to date with the latest technology to be able to pass this on to make your life easier.

The last year has seen a huge rise in the number of DoH staff using smartphones, iPads or tablet PCs. The development of Library Services is evolving as the number of users with mobile devices increase (Cummings, Merrill and Borrelli, 2012). A number of the Health Library’s resources are available either with a mobile-friendly interface or can be installed on your device as an app: DynaMed is one such example. It is a point of care tool that can be used on a mobile device. You can search for a symptom or condition and the results are displayed as a summary about the topic. This tool is especially useful if you are working in a remote location, as once downloaded you do not need to be connected to the Internet to search it. A serial number is required from the Library for initial installation. Check out the Health Library’s website (www.health.nt.gov.au/Library/eLibrary) for other resources available in mobile format.

As well as the resources the Health Library subscribes to, there are a large number of free health/medical resources and apps available via the Internet through the App Store (for Apple) or Google Play (for Android). Some are aimed at health professionals, others at consumers. These include NEJM This Week, PubMed on Tap Lite, Medscape, Human Anatomy!, Eye Chart Pro and Skyscape Medical Resources. If you want to know more about the latest in medical apps there is a website you can subscribe to called iMedicalApps (www.imedicalapps.com) where the latest apps are reviewed and rated.

Accessing resources that the Health Library subscribes to requires you to be working for the NT DoH, the NT Department of Children and Families or be a member of one of our Memorandum of Understanding organisations, such as GPNNT. If you need further assistance with accessing the latest information give the Health Library a call on 08 89228961.

References:
The Chronic Diseases Network acknowledges the participation and support of the CDN Steering Committee members from the following organisations: