

GPSpeak

Spring 2019



Flying doctors travel inland

| What's App, Doc?

| Reducing sedative use in aged care

| Quality in General Practice

| North Coast GP Training sails on



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Pictured at [William Creek airfield](#) before flying over Kati Thander-Lake Eyre, now in a dramatic flood phase, are (l-r) Seair Pacific pilot and guide Kirk Campbell, Ruth Tinker, Susan Brown, Jane Griffin, John Haggerty, Andrew Binns, Jeni Binns, Emily Yorston, Mark Hartcher, Maree Beek, Jurriaan Beek, and pilot and GP Isaac Flanagan.

Dr Andrew Binns describes their inland aerial journey on page 7 of this issue. Cover photo by Ruth Tinker.

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Editorial

My first 45 rpm record was The Beatles' **Eleanor Rigby** in retrospect an odd choice for a child, being written in a mixture of minor keys that go back to the ancient Greeks and with lyrics of loss and death that still evoke sadness. On the flip side was the distinctly more cheery Yellow Submarine.

I soon moved on to a reel-to-reel recorder with which I did much more listening than recording. With headphones on and volume up, it was pure magic. The sound quality was so much better as the Dolby audio compression got rid of the hiss. You could easily get **lost in the sound** and "picture yourself in a boat on a river with tangerine trees and marmalade skies ..." But that was another Beatles hit, about a Lucy not an Eleanor.

Next came the Sony Walkman. Its name said it all. You clipped it on your belt, plugged in the headphones and set off. I got a lot of satisfaction listening to the Stones but found it was best to only **sing and dance** in the privacy of your own home.

The technology moved on. Next came mp3 players and iPods. You could fit your entire CD and record collection on the one device. Mind you, if I still had that original vinyl 45 I could buy a whole new sound system. Moreover you could share it with your friends. Napster revolutionised music sharing much to the chagrin of the music industry. Record companies with the help of Metallica and Dr Dre shutdown Napster and then played whack-

a-mole with derivatives like Gnutella, Freenet, Limewire and Grokster. They sound like movie monsters!

These days we're in thrall to streaming services. You can find almost any song from any genre, with playlists on tap for every taste. The industry is much happier with this arrangement since some of your monthly fee will go to the record companies and some - a small sum - even gets to the artists.

The service cost is reasonable for the Spotify, Google, Apple and Amazon but starts to mount up if you subscribe to them all, not unlike Netflix et al. It's hard to choose the best and asking Cortana, Siri and Alexa does not help. They're all a little biased, but don't ask them, "What is your bias?" and expect a truthful answer, or any answer.

Change is a constant. New approaches and technologies supersede old ones. The new ones are better, cheaper or faster and often all three... until the next new ones. Records, reel-to-reel, cassettes, MP3 then streaming... each had advantages over its predecessor. As these advantages become apparent the new extinguishes the old. Only steampunks can be bothered with records, but don't dare challenge them unless you want a long, long diatribe.

The market advances through the process of **creative destruction** as first defined by Joseph Schumpeter in the 1940s. New companies profit and grow while the old whither and die.

The North Coast Primary Health Network is catching the next wave with its own internal IT structure. It is moving its computer systems to the "cloud", which is "up there" somewhere. It's not just pie in the sky... or Lucy in the sky with diamonds. This should offer improvements in accessibility, safety and efficiency. There will also be significant savings in hardware and maintenance costs.

Many patients are already in the cloud and are disappointed when

Dr David Guest

Clinical Editor



their doctors are not. There are literally tens of thousands of medical apps for mobile phones. Patients may enquire which ones their GP recommends. It is a daunting task to evaluate them. The NCPHN, in conjunction with HealthCare Software, is making the Australian Digital Health guide available on request to North Coast GPs to help address this issue.

The NCPHN is also pursuing Innovations in service delivery. Through commissioning it can extract maximum value from its contractors while avoiding the associated costs of long term relationships.

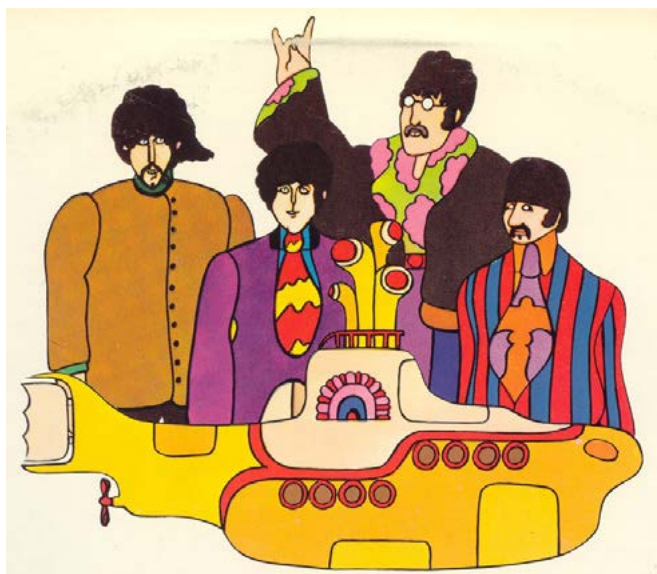
In August it was announced that North Coast GP Training had won the contract for medical education delivery across the PHN footprint. On page 19 the new CEO, Sharyn White, outlines the framework for the next nine months - an appropriate gestation period. NCGPT's relationship with the existing medical education groups is unclear as their membership and areas of interest fall outside the contract's restrictions.

Previous NCGPT CEO, John Langill, is leaving the organisation and the area. On page 5 he bids the future Ahoy! and reflects on what made the NCGPT a successful organisation and wishes Sharyn well for the future.

Also sailing over the horizon is the Hastings Macleay General Practice Network. On page 30 the last chairman of the Board, John Vaughan, pays tribute to the work done by the GPs and staff through the good times and the bad (I feel a song coming on!) of the organisation's 25 years' existence.

New approaches and technologies are constantly being trialled and the successful ones eventually replace the old.

Eleanor Rigby was the 'B' side, whatever that really meant. Thinking back, it was probably the much cheerier **Yellow Submarine** on the 'A' side that attracted this nine-year-old. That was a much better vessel for a magical mystery tour.



Beatles-yellow-submarine-characters; Anatheia Utley; CC by 2.0



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The good ship North Coast GP Training

John Langill, CEO, North Coast GP Training (2006 – 2019), looks back on his time skippering the iconic regional organisation.

As I sat down to write about my time with North Coast GP Training, I couldn't decide whether to take you on a nostalgic journey back to when the company was just starting out, or concentrate on the wonderful GPs-in-training with whom we worked over the years or perhaps focus on new beginnings, fresh starts and a continuation of the story.

Let's go with the last, the future is always more interesting, and if things change then I can't be held to account!

By now, I hope that many of GPSpeak's readers have heard the news that North Coast GP Training has been contracted by the North Coast PHN to deliver a range of education and professional development opportunities for GPs, practice nurses, allied health professionals and others supporting primary care in our region. Perhaps many of you might have thought that we were long gone and had long since sailed over the horizon, which would be understandable.

We did go quiet after we finished delivering the GP training program at the end of 2015, but we never went away. Over the last three years the Board, myself and a few hearty souls managed to keep the trusty vessel afloat. Although heavily reefed, we kept her ship-shape while keeping our eyes on the horizon for new opportunities.

In last year we came upon our chance when the PHN put their Health Workforce Professional Development project out to tender. With support from some of our closest and wisest colleagues we put together a submission that drew on the values at the core of our organisation from the very beginning. Through the project, we felt we had the opportunity to not only provide much needed professional development events but also to help bring people together by providing networking opportunities that would build important bridges across specialties and professions.

Relationships were always at the heart



of the work we did. Call me biased but I like to think that relationships are actually what we did best. Indeed we had a big hand in training over 750 new GP registrars, overseas trained doctors and junior doctors. More than that though we cared about and invested in our relationships with each and every one of those doctors, their supervisors and their training practices, and this is what made us so successful.

Moving forward we will carry on that tradition and seek to re-establish many of our old friendships as well as forging many new ones. That's where the rich rewards of this work come from.

Looking back I can only call it a stroke of good fortune that in 2005 I somehow found my way to North Coast GP Training. Without knowing it at the time, I had fallen into a cause that I would happily commit to for the next 14 years. I had also joined a team that would quickly become like family. When, a year later, the opportunity came to lead that team I knew I could not have asked for a finer, more loyal and talented crew to accompany me on the journey.

I would love to name and acknowledge them all, but alas, there's not enough room, but they know who they are.

Now, as we embark on the next leg of our journey, we will be casting a wider net and reaching out to our colleagues in the allied health professions, practice nurses

and others working hard to improve the quality and efficiency of the primary care services available to the communities of the NSW North Coast. Yes, we are funded to provide educational opportunities, but we know that our success will continue to rely on building relationships and, dare we be ambitious, to play a small role in fostering a well-connected and integrated community of medical professionals.

That's the ultimate destination and I hope all GPs and other healthcare professionals will join us.

As we set our course for that destination we encourage you to get involved by keeping a watch out for news about how to join your local clinical society or nurse network. In the next few months we will begin publishing a calendar of education events that will be held throughout the region, so stay tuned.

It is now time for me to step back and let someone new take the helm. In early July, under a happy and fortunate set of circumstances, the NCGPT board appointed Sharyn White as our new CEO. Over the last few weeks I have watched Sharyn breathe new energy and life into the organisation while she busily recruits her team to deliver the next phase of the project.

I am hopeful, that over time, some of the old hands will climb back aboard to help Sharyn and the rest of the crew. Already, one has. I know the ship is in good hands and that feels pretty good.

As for me, I'm going to take some time to travel back to the little town where I grew up in upstate New York, there to spend some quality time with my family and to consider what's next. I suspect the siren song of the beautiful North Coast will call me back before too long and when that happens I look forward to seeing old friends again. Until then, I wish fair winds and sunshine to Sharyn and her new crew. Adventures await!



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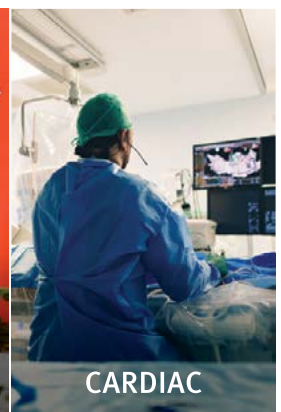
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PAEDIATRICS



24/7



CARDIAC

Feast or famine at Kati Thander-Lake Eyre

by Andrew Binns

Named for an English audience after the explorer Edward John Eyre, who first sighted it in 1840, Australia's Lake Eyre is still one of the natural wonders of the world. Not for thirty years would the lake's expanse be determined, and was 113 years before the site would be renamed Kati Thander, the sacred Aboriginal name for its more common characteristic, a flat saltpan. Showing how dry and hard it can be, it was chosen in 1964 as the site for Donald Campbell's successful world land-speed record (of 403mph) in his wheel-driven Bluebird.

The traditional name refers to "how the lake was formed after the skin of a kangaroo was spread over the ground".

When full, it is one of the largest inland seas in the world as well as being the lowest natural point in Australia at 15 metres below sea level. On the rare occasion when totally full - a major flood may occur about every eight years - it covers 9,500 square kilometers. The feeder rivers such as Warburton Creek, Cooper Creek and the Diamantina River from Queensland's Channel Country turn the whole basin into a vast wetland.

Thousands of pelicans, silver gulls, banded stilts and other water birds seem to know where the fish are in abundance and flock to the lake. No doubt some come from the shores of our own region. Freshwater fish are carried in with the flood, while brine shrimp hatch and vegetation sprouts.

Like the migratory birds, we flew in to find the lake about two-thirds full, although the water flowing in is about equal to the evaporation rate, so it won't fill further until there is more heavy rain.

In late January and early February this year an intense and slow moving monsoonal low over north Queensland caused record breaking rain and **disastrous flooding**. This was Cyclone Trevor and in March there was further rain over a broad region of central and southwestern Qld and adjacent areas of the NT.

To see what all this may look like from the air a group of ten of us from the Northern Rivers set off from Lismore on an excursion to Kati Thander-Lake Eyre. The pilot and



Lake Eyre salt flats - photos above and below by Emily Yorston

guide was Kirk Campbell and co-pilot Lismore GP cum aviator Izaak Flanagan.

From Lismore Airport we flew low over the Great Divide then over some of the bare drought stricken land of the Darling Basin. We finally landed on a dirt airstrip at a large sheep and cattle property called **Charlotte Plains Station**. Here we were met by the delightful owner Robyn Russell, aged 74, who had many outback stories to tell. Lunch was served on the homestead verandah.



She gave us startling statistics of the fraction of the number of sheep and cattle now on the property in these times of drought. However tourism is helping to fill the gap in revenue and more people venture to this great station attracted by the woolshed, landscape, outback culture and the artesian basin with open-air hot baths.

We went on to the famous Dig tree of Burke and Wills before a night at the Innamincka Hotel. The visit next morning to Burke's grave was very informative. There are a few varied stories about the timing of his death on the banks of Cooper Creek, but it seems he may have survived if he'd had a better relationship with the local Aboriginal people and their knowledge of bush tucker.

Then it was a low-level flight from south to north over Kati Thander-Lake Eyre. This was an amazing sight of the vast sea, with flocks of pelicans. The colour of the water varied with the depth and wind factors. The shores were varying colours alongside the vast carpet of green landscape with capillary-like creeks.

Cattle were abundant and well fed. One couldn't help feeling for the Queenslanders who lost all their stock in the severe flooding. And then there were those further south who have lost out with the drought of the Darling Basin.

Before a final night at the famous Birdsville pub, we went to the Big Red at sunset, red sand hills popular with 4WD drivers in their attempts to drive up. Nearby there is a valley that is the site of the Big Red Bash Music Festival, which this year featured Midnight Oil. This and the annual race day swell the population of Birdsville from 120 to tens of thousands.

The trip back home included a stop for lunch at Charleville's classic Hotel Coronas with its art deco features, and a visit to the Royal Flying Doctor base, with jokes that is where Dr Izaak Flanagan belongs.

The water will remain in Kati Thander-Lake Eyre until about September before the long process of evaporation takes it back to being a dry salt lake again, until the next phase in the cycle of this extraordinary place.

We need to talk about quality in general practice

This article is the latest in a monthly series from members of the GPs Down Under (GPDU) Facebook group, a not-for-profit GP community-led group with over 6000 members, which is based on GP-led learning, peer support and GP advocacy.

We are a mix of academic and full time clinical GPs. Along with our practice colleagues, we are enthusiastic about delivering high quality care. We teach medical students and registrars, meet regularly in our practice teams to discuss challenging clinical scenarios, undertake in-practice small group learning, and bicker over our patient recall systems with a fervour usually reserved for debating who will win the State of Origin.

We hoped that perhaps the Australian Government was interested in quality general practice too when they announced the Practice Incentive Payment Quality Improvement (PIP QI), which begins on 1 August 2019. So why were we left feeling puzzled and somewhat disempowered?

General practice care is a complex system. Even something notionally simple such as antihypertensive therapy is actually a complicated balancing act. We consider not only the blood pressure reading but also the patient's cardiovascular risk factors, medication tolerability, cost, and the patient's lifestyle. We think about what is behind the readings (the second cup of coffee after a sleepless night, the argument with their spouse). We think about whether starting a new medication is the most important thing we can do for this person today, and whether we need to explore and manage what is really going on with them (the hidden agenda behind presenting for a blood pressure check). And we understand that how we interact with this patient, and the choices we make in designing our clinical practice workflows, feeds back and influences the running of the practice in ways that can be unexpected.

Defining general practice quality is not as simple as comparing numbers, as Mary

Beth MacIsaac has written before. Naively, we could do trivial comparisons of, say, diabetes control in one practice to the next. But without deeply understanding the local contexts, the mechanisms, the why, we are likely just measuring bias rather than quality.

At the heart of any high quality practice, there are committed and energetic people who really care about what they are doing. Getting those people engaged in driving quality improvement benefits not only practices but entire communities. We must empower these people; they need to feel that they have a role in driving the improvement.

Implementing quality improvement in our own practices has been a challenge. We care about our patients and take pride in our outcomes. But working as a full-time clinical GP, quality improvement projects are essentially a hobby. Not only is there no funding, it takes time away from direct patient care, which is the only income stream for a non-owner GP. We have been told by my senior GP colleagues that this wasn't always the case.

The Australian Primary Care Collaboratives Program, which started in 2005, invested in GP ability, capacity, and leadership. This program upskilled GPs in quality improvement methodology, including change management and data use. There was evidence of clinical benefit – the Collaboratives demonstrated improvement in diabetes care and cardiovascular outcomes. Reduction in funding to this program meant a gradual decline in its impact.

Other countries have seen the value in a return to a Collaboratives-type approach. In Scotland, where the Quality and Outcomes Framework pay for performance scheme was withdrawn in 2016, a Collaboratives-type approach was implemented as GP Clusters. Key recommendations in the implementation have been local autonomy in the clinical area of focus, local GP

leadership, and administrative support.

In contrast, PIP QI is a top-down quality improvement strategy. Funding is based on data extraction for 10 quantitative measures that are shared with the local Primary Health Networks (PHNs). The practice then must engage in a quality improvement project, with vague descriptors of qualifying activities. The secretive nature of negotiations about the content of PIP QI has excluded the medical profession and the people we are trying to treat. The 10 measures are relatively crude, including percentage of patients who smoke, patients with diabetes with recent glycated haemoglobin recording, and patient weight recordings.

These limited measures are far too narrow to assess a complex system such as general practice. Rather than driving quality improvement, the focus becomes one of coding for the purposes of data extraction.

We need to be careful of what we are incentivising. Pay-for-data is a small step from pay-for-performance and public benchmarking, with all the unintended consequences of distorted clinical decision making and reduced patient autonomy. Even if the PIP QI remains pay-for-data, with these defined measures already being extracted, what incentive exists for practices to engage in a more challenging and important project such as promoting a culture of safety, communicating with hard to reach groups, or rethinking chronic pain management?

Quality improvement in these areas remains a hobby, something that is nice to do, potentially undertaken in spite of PIP QI, rather than supported by a cohesive policy. The rationale and purpose for a top-down PIP QI needs to be defined; it's not acceptable to simply say it seems like a good idea.

As we prepare to embark towards a top-down data driven quality improvement framework there are some gaping holes in



the path ahead. Practice-based electronic records need to be repurposed to become high quality, trusted data collection tools. GPs must be comfortable with the governance in place for their individual and practice data; this topic alone sparks frequent discussions within the GPDU forum. In negotiating agreements with PHNs, the power differential is significant. GP clinics need to be supported to move towards financially viable models in which non-clinical time to focus on learning and reflective practice is valued.

An alternative is a bottom-up strategy. Inspired by the idea that grassroots GPs can design projects that will benefit their practices and communities, we ran a workshop at the WONCA (World Organisation of Family Doctors) Asia Pacific Conference in May 2019. Although the participant GPs came from many different countries, they raised common themes – the burden of health costs on their patients, the need for system reform, and bureaucratic inertia. We were amazed by the passion and enthusiasm of the participants. These GPs were motivated to change not only their own practices but entire health care systems. Bottom-up strategies have the advantage of engagement – they involve empowering those at the grassroots level to make changes.

The PIP QI could be reimagined as a bottom-up strategy; it could fund a collaborative process that involved practices identifying their own areas for change, based on their community needs. The activity of collaboration, rather than the data, is the basis for the funding. The participants themselves are funded for the activity. The collaborative activity, with its results, are reported and submitted for review to the Colleges, much in the same way that independent activities are submitted for continuing professional development. The emphasis is changed from simply measuring “quality” to supporting localised, contextually appropriate quality improvement. In essence, for the activity to be meaningful, invest and support the people who need to actually do and lead the improvement.

We need to talk about quality.

The statements or opinions expressed in this article reflect the views of the authors and do not represent the official policy of the AMA, the MJA or InSight+ unless so stated.



Dr Mary Beth MacIsaac is a GP in south east Sydney. She has also worked as a locum in the Northern Territory and Tasmania. Before coming to Australia, she trained and worked as a GP in rural Canada. She is involved in GP registrar supervision and training. She is passionate about the vital role of general practice in the community, having been inspired by her supervisors while working as a medical student on a rural placement. She is a member of the Royal Australian College of General Practitioners Expert Committee – Quality Care.



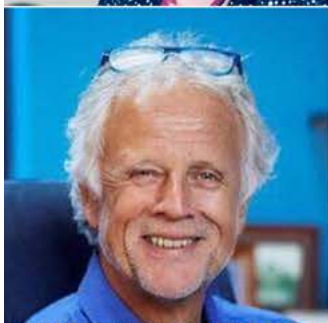
Dr Michael Tam is a GP staff specialist at the Academic Primary and Integrated Care Unit (APICU) of the South Western Sydney Local Health District and the Ingham Institute. He is a conjoint senior lecturer in the School of Public Health and Community Medicine, UNSW Sydney.



Dr Mark Morgan is a senior RACGP representative. He is Chair of RACGP's Expert Committee – Quality Care. His RACGP representative roles have included Primary Health Care Homes Implementation Advisory Group and the Medical Benefits Schedule Review, General Practice. He is an Associate Professor at Bond University, leading the clinical part of Bond's Medical Program. His research interests include multimorbidity and patient safety. He is a GP with 20 years' experience working in rural, regional and urban general practice.



Dr Katrina McLean is a Gold Coast-based GP, Assistant Professor in the School of Medicine and Health Sciences at Bond University, and a GPDU administrator.



Associate Professor Frank Jones is Immediate Past President of the RACGP. He has been a full-time GP in Mandurah, WA for over 30 years. He was previously Senior Medical Officer with the Royal Flying Doctor Service, Australia. He is a passionate advocate for quality patient care at the community level, with general practice being its most critical determinant.



Dr Manabu Saito is a rural doctor in Japan, developing “Rural Generalist Program Japan”.

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Sedative reduction improves resident care and staff satisfaction

Residential aged care facilities in Australia have long faced criticism – inadequate medical supervision, insufficient numbers of nursing and care staff, poorly trained and lowly paid workers... no one talks of an easy fix, but few argue that changes aren't needed.

Although the number of elderly residents exceeds 200,000 (in 2672 'nursing homes', as they were once called) the volume of concerns made public seemed relatively low... until recently when mounting complaints and media coverage prompted the Federal Government to call a **Royal Commission into Aged Care Quality and Safety**.

Hearings are well under way, as most Australians would know, and often harrowing evidence is being tendered. The Royal Commissioners are required to provide an interim report by 31 October this year, and a final report by 30 April 2020.

Among the key topics raised in the Royal Commission has been the inappropriate use of psychotropic or sedative medications, particularly in residents with dementia. From 2013-17 an innovative project known as Reducing Use of Sedatives – '**RedUSE**' for short – was funded by the Department of Health through the 'Dementia and Aged Care Service Fund'.

Program Research Lead Dr Juanita Breen (previously Westbury), Wicking Dementia Research and Education Centre, and Distinguished Professor Gregory Peterson Pharmacy, School of Medicine, University of Tasmania discuss the background and the significant outcomes...

One of the topics of discussion at the current hearings of the Royal Commission into Aged Care Quality and Safety has been the appropriate use of psychotropic or sedative medications, particularly in aged care residents with dementia. While there are no individual or quick fixes to the high use of these medications in aged care, a national interdisciplinary program, recently published in the Medical Journal of Australia,¹ was very successful.

Antipsychotics were developed to treat serious mental health conditions, such as schizophrenia. We know that in older people these medications are prescribed mostly to manage behavioural



Dr Juanita Breen

and psychological symptoms of dementia (BPSD), a term that describes symptoms of disturbed perception, thought content, mood, and behaviour that frequently occur in patients with dementia. While their effectiveness to treat these symptoms is modest, the risks associated with use can be severe, ranging from confusion and falls, to stroke and death.

Similarly, benzodiazepines are prescribed in older people to treat sleep disturbance, anxiety and agitation. These can be effective in the short-term but in time tolerance develops, and their continued use is frequently associated with over-sedation and confusion, falls, and the risk of dependency.

Given the modest benefits and the attendant risks, which are not insignificant, national and international guidelines recommend that both medication classes should be prescribed carefully when anxiety, sleep disturbance and/or behavioural symptoms cause significant distress, or pose a safety risk. When prescribed, they should be monitored regularly for effect and adverse effects, whilst using the lowest effective dose for the shortest period of time.

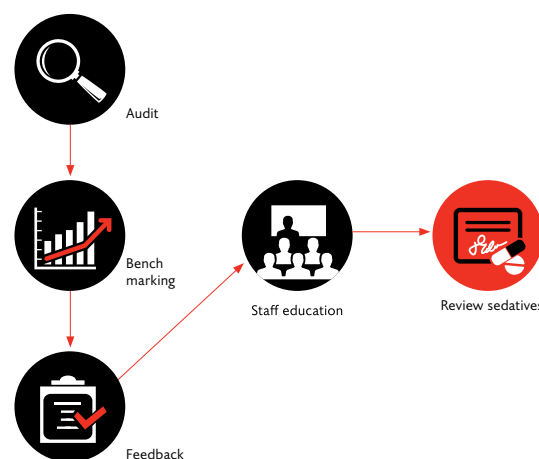
Inappropriate use of antipsychotic and benzodiazepine agents has been recognised as an issue in Residential Aged Care Facilities (RACFs) in Australia for several decades, resulting in Federal and State government inquiries, media attention and the release of a succession of professional guidelines. However, antipsychotic

and benzodiazepine use continues to be high in this setting, with many residents often taking these medications inappropriately, for extended periods.

The RedUSE (Reducing Use of Sedatives) project expansion was funded in 2013 by the Department of Health through the 'Dementia and Aged Care Service Fund'. The overarching aim of RedUSE is to promote the appropriate use of antipsychotics and benzodiazepines

(collectively termed 'sedatives') in RACFs. The project was first trialled successfully in a 2008 study involving 25 Tasmanian RACFs. The federally-funded expansion involved 150 RACFs across Australia during 2014-16.

RedUSE is a multi-strategic, interdisciplinary, structured initiative, which employs several approaches targeted to improve sedative use. During the 6-month project, each RACF's sedative medication use is audited at baseline, 3 months and 6 months, using a customised computer program. The audit results are then presented to nursing staff and carers during two educational sessions. Following this education, all residents taking sedative medication are reviewed in an interdisciplinary process involving a pharmacist, a 'champion nurse' at each facility and the resident's GP or nurse prescriber. The diagram below illustrates the main RedUSE strategies:





Review sedatives

The RedUSE project was enhanced before expansion by developing an interactive training program for nursing staff, which was designed to challenge their positive beliefs around sedative use. Training was also delivered on the risks and benefits associated with sedative use in older people, and concise guidelines provided. The sedative review process was refined and automated. Nurse input was crucial and professional roles clearly defined. The 'champion nurse' role was created for an expert peer to promote and model 'good practice'. Finally, academic detailing was delivered externally, by trained detailers, to inform and engage GPs.

prevalence from baseline to 6 months was higher, at 21%). Almost 40% of residents taking these agents at baseline had their psychotropics ceased completely or their dosage reduced. The reduction was also sustained over time.

The education provided to the aged care sector as a result of this project was substantial. Over 2500 nursing staff and carers attended RACF RedUSE educational sessions. Using a validated quiz, we found that the psychotropic knowledge of all levels of nursing and care staff significantly improved. Participants reported particularly valuing the opportunity to discuss the use of sedative medications for their residents and many wanted to learn more about medications and their side effects, along with non-pharmacological approaches.

Although several interventions have been designed and trialled to reduce sedative medication use in RACFs, few



Distinguished Professor Gregory Peterson

“Reducing benzodiazepine use was shown to increase the residents’ ability to perform activities of daily living... [while] participating in the RedUSE project... did not adversely affect job satisfaction of nursing staff”.

Strong demand to participate in RedUSE was generated after the two Australian peak aged care organisations, LASA and ACSA, promoted the project in their newsletters (print and on-line), resulting in expression of interest forms from over 300 RACFs.

Throughout the RedUSE intervention, antipsychotic and benzodiazepine use in each of the 150 RACFs was measured at baseline and then re-measured at 3 and 6 months, with 12,165 residents, on average, included at each time point. At baseline we found that over one-third of residents (37%) were taking a daily sedative medication. Specifically, 22% of residents were taking an antipsychotic and 22% were taking a benzodiazepine. With 'prn' or 'as required' prescriptions included, over half of all RACF residents (54%) were prescribed a sedative.²

Overall, a significant reduction was found in antipsychotic and benzodiazepine use. A 13% relative reduction was observed in the use of antipsychotics from baseline to 6 months (The reduction in benzodiazepine

have evaluated the clinical impact of such a program on the residents themselves. The expansion of the RedUSE project offered an ideal opportunity to do this and also establish if the project impacted upon staff satisfaction.

Using a sample of over 200 sedative users from 27 participant RACFs, we found there were no significant increases in behavioural symptoms for sedative reducers, contrary to expectations. In fact, antipsychotic reducers saw improvements in some behaviours, specifically agitation, whilst the non-reducers had worsening behaviour. Reducing benzodiazepine use was shown to increase the residents' ability to perform activities of daily living. Finally, participating in the RedUSE project, with ensuing sedative reduction, did not adversely affect job satisfaction of nursing staff.

In conclusion, the national expansion of RedUSE proved an effective intervention to significantly reduce RACF antipsychotic and benzodiazepine use, with high degrees

of staff, pharmacist and GP satisfaction. A multi-strategic, interdisciplinary intervention can significantly reduce potentially inappropriate psychotropic use.

- The RedUSE project and researchers involved have been recognised by two international research awards, the 2018 Tasmanian Community outstanding achievement award and a 2018 Mental Health Services award. It has also received over \$3.4M worth of research funding to date.

1. Westbury JL, Gee P, Ling T, Brown DT, Franks KH, Bindoff I, Bindoff A, Peterson GM. RedUSE: reducing antipsychotic and benzodiazepine prescribing in residential aged care facilities. *Med J Aust* 2018;208(9):398-403.

2. Westbury J, Gee P, Ling T, Kitsos A, Peterson G. More action needed: Psychotropic prescribing in Australian residential aged care. *Aust NZ J Psychiatry* 2019;53(2):136-47.

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The later phase of life

These days most Australians are fortunate enough to retire in reasonable health, and to access the appropriate care to keep them as well as can be expected. After a lifetime of making critical decisions day in and year out, with others supposedly heeding our advice, the shift to retirement can be a shock. Some come to suffer what politicians archly describe as “relevance deprivation syndrome”.

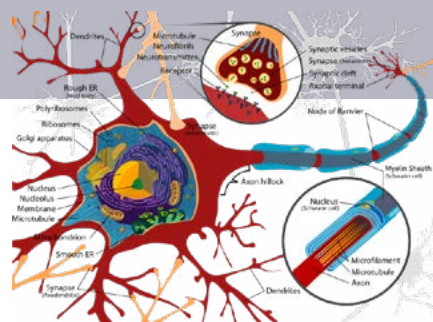
Keeping active in mind and body is the key to warding off the vicissitudes of old age, or at least delaying them.

Some research in this area is being undertaken by the Maintain Your Brain study, funded by the Australian National Health and Medical Research Council. The study is a randomised controlled trial of multiple online interventions designed to target modifiable risk factors for Alzheimer’s disease and dementia. Risk factors to be addressed are physical inactivity, cognitive

inactivity, depression/anxiety, overweight and obesity, and poor dietary habits.

Up to four intervention modules (physical activity, nutrition, brain training, and peace of mind) will be administered based on individual risk profiles. Each will run one at a time for 10 weeks with booster sessions (specific to each module) and ongoing monitoring to continue until the end of the trial.

All activities and assessments will be conducted on a computer with internet access via the Maintain Your Brain eHealth system. It has invited over 8,000 individuals through the 45 and Up Study to participate in the trial. These participants are aged 55-77 years and will not have been diagnosed with dementia, Parkinson’s disease or multiple sclerosis.



Complete Neuron diagram - LadyofHats [Public domain]

The study runs for three years with annual assessments measuring risk factors and cognition. The main trial recruitment began in May 2018 and is expected to finish in September 2021.

Former mayor of Lismore, Jenny Dowell, is part of the study. Retirement has allowed her to return to a long term passion, acting! The challenges facing an ageing novice are many but Jenny has successfully made the transition.

In the following article, which first appeared in [From the Bower](#), the magazine of Northern Rivers Arts, Health and Wellbeing, she describes this part of the next phase of her life.



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Getting into theatre



LISMORE THEATRE CO.

by Dr Jenny Dowell OAM JP

(Honorary Doctor of Southern Cross University), Mayoral Mentor LGNSW

Perhaps all of us hold a secret wish that we have never shared even with our nearest and dearest. I did and it was to act on a stage.

I've been a lover of theatre since my days as a new parent in Melbourne when Ron and I took advantage of the Melbourne Theatre Company's Young Parent preview nights - we could not only access discounted tickets but a baby sitter was provided in our home!

When we moved to Lismore, we subscribed to NORPA and also attended regular theatre nights at our local Rochdale Theatre that is within walking distance of our home. While I was Mayor, I took a keener interest in both NORPA and Lismore Theatre Company as both are in Council owned buildings.

After retirement, I joined the Board of NORPA and became a member of LTC in 2017. It was at LTC that I finally disclosed my deeply held dream of seeing if I could act. I was therefore thrilled when David Addenbrook offered me the role of Aunt Julia in Hedda Gabler. This was the start of a whirlwind of learning a whole new language and process of theatre and the roles of the vital back and off stage technical support crews for a production. The process towards production is quite intense with three rehearsals per week for two months as well as the private time learning lines so the commitment from everyone is significant.

At my age, I was concerned about my ability to learn my lines and was very pleased (and relieved) that I could do so!

Coincidentally, I'm part of a long term **Maintain Your Brain** study on memory and while some of the tests had me doubting my ability to remember some things, my acting roles have reassured me that I'm doing ok.

After the very successful season of Hedda Gabler, I set my goal of securing one LTC role per year and to audition for a role in Cagebirds in 2018. I had no idea of what was required in an audition but the director and producer were very patient. They asked for a couple of brief impromptu pieces and asked me to read for two roles. I was over the moon when the phone call came offering me the role of Thump. Again learning the



Jenny Dowell (right, as Clairee) and Elyse Knowles (left, as Annelle) in Steel Magnolias

lines was a challenge as was working with a director with a very different style. Andrew (Duckie) Silcock's vision for this 1971 play was brilliant and his style in directing was quite different so again, I learned a great deal. Duckie broke the whole play into more than 60 'blocks' of dialogue and although this play was just over one hour in length it was very intense.

This year I again auditioned and was thrilled to be cast as Clairee in Steel Magnolias under the direction of Sylvia Clarke. Like Cagebirds, the cast was all women. The intensity of over two months working together brought the six of us very close. Two of the women had been in my other two plays and I know how wonderful Sharon Brodie and Elyse Knowles are as actors and as women.

Clairee gave me the opportunity of playing a comedic role, something I'd wanted to do for many years. Clairee had lots of lines in this fabulous play so again, I had the challenge of learning hundreds of lines and movements- and was thrilled to be able to achieve it and to develop the necessary comedic timing. Steel Magnolias runs for 2.5 hours so it was also the longest play I've done to date.

All performances rely heavily on the relationship between the performers. At the start of the process, some cast members

are unknown to each other so there is a need to quickly develop trust in each other to ensure good timing in the dialogue and authenticity in the interactions, both verbal and non-verbal.

Fortunately all three shows I've been in so far have had great audiences so the positive reactions we get provide the reinforcement actors need to rise to be the best we can be.

In addition to acting, I'm the Publicity Officer for LTC and when not involved in a performance, I'm regularly on box office for the other 4-5 show seasons that the company stages each year.

I'm thrilled that I do seem to have some ability to act and I look forward to more opportunities in the future. Each is a learning experience that involves stepping inside a character who might be very different to one's own. That's a bit scary but also very exciting.

I'm now looking forward to another new challenge - performing an Eve Ensler Vagina Monologue in late November. The one I've been asked to perform is approximately six minutes and now I feel confident that I can indeed learn about two pages of solo dialogue!

As to 2020 and beyond, who knows but I look forward to more time with Lismore Theatre Company- on and off stage.



“I’m honoured to join Gold Coast Spine. It’s an internationally-renowned practice with a proud record of evidence-based medicine and patient-centred care.”

Asst Prof. Mario Zotti
Orthopaedic surgeon (spine)

Assistant Professor Mario Zotti MBBS, MS (Orth), FRACS, FAOrthA is now welcoming outpatient appointments at the **John Flynn Medical Centre**.

Asst Prof. Zotti is an orthopaedic surgeon specialising in the treatment of spinal disorders. He joined Gold Coast Spine following completion of his PFET accredited fellowship in spine surgery under Assoc Prof. Matthew Scott-Young in 2018.

Asst Prof. Zotti has clinical interests in:

- neck and back conditions (degenerate & deformity)
- radiculopathy/sciatica (arm & leg pain)
- sacroiliac joint dysfunction
- urgent spinal conditions (trauma, tumour, infection).

Also an honorary adjunct professor at Bond University, Asst Prof. Zotti visits Pindara Private Hospital, Gold Coast Private Hospital and John Flynn Private Hospital.

Please direct all enquiries to our Southport clinic.



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Get cracking on 'Ice' findings – Premier

by Robin Osborne

Despite taking seven weeks to reply to the Commissioner's request for a six-month extended deadline for the NSW Government's inquiry into the drug 'Ice' Premier Gladys Berejiklian has agreed to only half that time.

This is despite a two-page written request by Commissioner Dan Howard SC arguing that the original deadline of 28 October 2019 "allows insufficient time for the Commission to adequately address the many important matters raised by the terms of reference."

Mr Howard contacted the Premier on 21 May seeking a new reporting date of on or before 30 April 2020, expressing his belief that the Commission's report "has the potential to be a key resource for informing amphetamine type stimulants (ATS) policy in particular, and drug policy more generally, in NSW long into the future."

NSW is currently embroiled in a heated drug policy debate, both on 'ice' and the way that party-drug usage should be monitored and policed at music festivals. Overdoses and even deaths at recent festivals, along with allegedly heavy-handed policing, have alarmed and angered parents, drug experts, festival goers and authorities. At July's Splendour festival in Byron Shire the issue received close attention, with observers at the drug testing tent including the mother of one young woman who died in Sydney, and the NSW Deputy Coroner.

At the time of the Commissioner's writing his team was still engaged in a roadshow of country hearings, the last concluding in Broken Hill on 18 July. There, as in Lismore (14-15 May) and other centres, harrowing evidence was given by police, welfare workers, drug (and alcohol) treatment services and former 'ice' users themselves. If any consensus might have emerged it was that the 'ice' epidemic – and indeed the misuse of other illicit drugs and alcohol – should be regarded as a health issue rather than simply a legal one.

Various legal bodies have now weighed in. In a [thoughtful submission](#) the NSW Bar Association said criminalising personal drug use "may result in greater harm to the individual, and to society more broadly", than the harm caused by the use of illicit drugs:

"Many people who use drugs are rational consumers insofar as

they make a deliberate choice to take a drug or drugs to achieve a desired effect. Importantly, there are considerable harms associated with the criminalisation of personal drug use.

The legacy of involvement in the criminal justice system can be far-reaching and long-lasting. It can affect a person's ability to obtain and maintain employment, housing and education. Those who are incarcerated are exposed to more serious offenders.

Incarceration substantially increases the risk of mortality. The criminalisation of personal drug use affects personal wellbeing and relationships. Social stigma and the activities of law enforcement can also undermine the implementation of harm reduction measures."

It added,

"The current policy has not proved effective at minimising the harms associated with drug use. As the predominant tool, it may cause harm to personal drug users and to the community more generally.

"Decriminalisation of personal acquisition, possession and use of illicit drugs would allow the implementation of a comprehensive public health approach. This would be complemented by the use of civil orders, the expansion of harm reduction measures and drug treatment services with the continuing application of criminal sanctions for drug suppliers, producers and traffickers."

The [Public Defenders Office](#) voiced similar concerns, endorsing "the observations of the former law enforcement officials and agencies that "Australia cannot arrest its way out of the methamphetamine problem" and supporting the adoption of a suite of alternative, diversionary and harm minimisation approaches".

The [Office of the Director of Public Prosecutions](#) called for a specialist court [now operating in parts of Sydney and the Hunter] that takes referrals from some Local and District courts and tackles the issues underpinning drug dependency with tailored treatment and diversionary programs.

"While people in remote and very remote areas are 2.5 times as likely to use meth and amphetamines as those in major cities, the DPP noted that "many persons living in urban areas and almost all persons living in rural and regional areas of NSW are

excluded" from the court's geographical reach."

Legal Aid NSW said there was a "need for a cultural shift, greater community awareness and systemic decriminalisation so that drug usage can be addressed as a health issue rather than with the blunt instrument of the criminal justice system".

In a [lengthy submission](#) it said "the intervention of the criminal law is a significant barrier to access to treatment for many people... Defendants seeking treatment are frequently placed on unrealistic bail conditions to completely abstain from drug use, and being detected in possession or under the influence of drugs leads to frequent arrests and incarceration, which interrupts treatment."

In his letter seeking a six-month extension the Commissioner noted that from the submissions received from "many important stakeholders", a key issue to inquire into is "the question of the removal of criminal sanctions for the 'use' and 'possession' of ATS and other drugs... an issue that requires great care and thoroughness of approach by this Commission, if it is to make appropriate recommendations on this important question affecting the Justice sector and NSW's drug laws."

Seven weeks later the Premier said she appreciated the important work of the Commission and acknowledged the "complexity of the matters before the inquiry."

However, she was also "mindful of the importance of delivering outcomes for the people of New South Wales in a timely manner to combat the evolving threat of this dangerous drug."

Ms Berejiklian agreed to extend the reporting timeframe only to 28 January 2020. Coming two days after Australia Day, it is a document that may well have national resonance.

Commenting on the new timeframe to GP Speak, the State Member for Lismore Janelle Saffin said the Commissioner would have been overwhelmed with people and communities reaching out to tell their stories and seeking help.

"I have more people contacting me, saying they want to send their letters, their pleas for help to him. So many parents feel

cont on P16

Cloudy days on the horizon

*The North Coast Primary Health Network is currently transitioning to a cloud computing environment, as **David Guest** explains.*

These days, wherever you go, those not looking at a smart phone are the ones who stand out.

It's almost 13 years since **Steve Jobs popularised the internet** communicator. It's a phone, an internet browser and an iPod but these days it's all this and so much more. These devices, along with tablets and laptops, have changed the way we live and work. Keeping in touch with family and friends, shopping, education and entertainment have changed immeasurably in just over a decade.

Some even rely on their phone for medical care.

While these devices are a million times more powerful than the computer in **Apollo 11**, their main function is to connect to even more powerful, remote "cloud" computers.

In the last five years the familiar desktops of the early 2000s are being replaced by these lightweight devices. No longer is data stored in onsite computers but is increasingly being moved to platforms provided by cloud server companies.

The advantages for organisations both large and small are several. Using products like **Google's G Suite** and **Amazon's AWS**

gives companies a competitive advantage over their rivals.

Cloud services are usually purchased on a subscription basis. Depending on the product software updates can be installed automatically and backups occur in real time without local IT support staff intervention. Technical staff no longer need to worry about the vagaries of maintaining server hardware.

Data security can be improved by forcing users to use **two factor authentication**. Staying current is also much easier since users can share the latest versions of their files. This makes collaboration much simpler. Versioning systems even allow effortless rollback to a previous point in time if errors are made or changes are not accepted on review.

Since many of the IT tasks - formerly the responsibility of onsite staff - shift to the cloud provider, **IT support costs can shrink** by between 15% and 20%.

Adding and removing a user's cloud "virtual machine" is an easy task for the local IT administrator. This is ideal for companies where employees or outside contractors come and go frequently. The

virtual machine can have all the required software for each type of user pre-installed and the virtual machines can be activated within a few minutes.

The North Coast Primary Health Network is currently transitioning to a cloud computing environment using **Microsoft's Azure suite**. The process is expected to be completed by late October 2019.

The new approach is a much better fit for the NCPHN. External contractors and staff can be engaged on short term contracts and their access can be restricted to only those features and files they need to complete their work.

It also gives the PHN the ability to extract the best performance and value from its staff and contractors as it commissions organisations to address the Department's and local area's shifting health priorities.

Our lives have changed significantly in the 12 years since Steve Jobs first peaked into the future. Technology has once again allowed us to do more for less. In the new competitive world of health service delivery the successful organisation will reach for the cloud.

Get cracking on 'Ice'

cont from P15

desperate with the onslaught of this Ice problem. Its impact is harsh on all."

Noting that, "Police have been saying we cannot arrest our way out of this problem for some time and they want new approaches," Ms Saffin said. "We desperately need a Drug Court to sit in rural and regional areas, starting here locally. People should not be condemned because of their postcode.

"If you are an addict in Sydney you go to the Drug Court and get better treatment. You live in rural and regional NSW you get denied that service. We already miss out on so many services and do not get our promised share of the 30 per cent of Restart NSW funding. That could be fixed now."

She said, "Given there has been a Commonwealth Inquiry that did not seem to bring any discernible action [reported in GP Speak Winter 2019], a NSW Legislative Council Inquiry into rehabilitation services in regional and rural health that told us what we know: none or negligible rehabilitation services with long waiting times for rehab

services, and parents and people addicted crying out for help, we need action for more services. That could be fixed now."

However, Ms Saffin felt, "It is understandable that the Premier has given the Commissioner more time but not the six months he sought. The sooner he reports the better. It will arm her with the evidence.

"I look forward to working in a collaborative way so that we no longer bury our heads in the sand and continue to respond only that "drugs are bad". That needs to be fixed and hopefully the Commissioner will lay out the evidence for the Premier and her Cabinet that gives them the courage to make the changes."

Ms Saffin said there is a growing consensus across the board to decriminalise personal use of drugs. "Even Alan Jones is saying that "anything we have tried to date has failed", she said.

While all of society, not only the Premier, might want a quick fix to the inordinate



Janelle Saffin, State Member for Lismore

challenge of 'ice' - as the USA yearns for on the opiates plague - there is slight chance this will occur, but having more facts about why so many people take such a drug and how they might be helped can only be beneficial.

What's App, Doc?

Or, should the secrets of the smart watch be unlocked?

by David Guest

Atrial fibrillation (AF) is an increasingly common phenomenon amongst elderly patients, particularly those with diabetes, heart disease and hypertension. It increases the risk of stroke and other embolic phenomenon significantly but with modern anticoagulants its management has become much easier.

Intermittent AF is also common when infection or other illness strikes the patient. It can also occur randomly in many people. Such paroxysmal atrial fibrillation (PAF) is less likely to cause embolic disease but remains a significant risk for some patients.

Tremendous advances in medical technology are occurring on many fronts. For consumers smart devices are increasingly common and best represented by the newest generation of the Apple watch which can monitor pulse rate and rhythm with high degree of accuracy.

Many patients with AF are unaware of their condition. Alerted by these new

monitoring devices many will be presenting to their GPs for professional advice. While managing this three-way interface is a new challenge the best guide for treatment at this time is the **CHA2DS2-VASc score**.

The algorithm for the smart watch is proprietary, meaning nobody outside the company knows how it works. This is a common feature for most medical devices, including personal implantable devices like pacemakers/defibrillators and insulin pumps. They are tested in clinical trials, as is the **Apple watch**, but the underlying mechanisms are unknown.

Medical authorities are apparently not concerned by this approach but some computer enthusiasts familiar with the failure of proprietary software applications in other areas prefer to trust their own expertise and **advocate for the algorithms to be open** and subject to peer review.

Some enthusiasts have **built their own artificial pancreases**. These reportedly give better glucose control than the commercial offerings but most have not undergone scientific trials.

For those who do not need implantable devices there are literally tens of thousands of medical applications available for the smartphone. Many patients are keen on these apps and may seek advice from their GPs. Unfortunately, few GPs have the time or the expertise to make their own assessments.

In an effort to help, the North Coast Primary Health Network has teamed up with Healthcare Software to collect, evaluate and publish these evaluations. Healthcare Software's **Digital Health Guide** is a subscription service giving users information about an application, its intended audience, its pricing and which mobile platforms are supported.

Most importantly it is building up a database of the evidence behind each of the apps and how both users and health providers rate the application. The value of this data will increase over time.

In our data intense world it could prove an invaluable resource for the modern day **cyborg**.

NCPHN gets \$720,000 for development and training

The North Coast Primary Health Network (NCPHN) has announced it will receive \$720,000 in federal funding for a new funding partnership with North Coast GP Training, which will be a range of local networking and education events.

Investment in building the skills and capacity of primary health care workers is a proven strategy to ensuring a healthy community, according to the PHN, the coordinating body of an estimated 6,200 primary health care professionals working within its Tweed Heads to Port Macquarie footprint.

NCGPT will work closely with this network to identify and deliver education opportunities that will be most valuable, said the PHN's Director for Wellness, Monika Wheeler, who added that the scope of the funding includes the establishment of an advisory group to oversee the development of a 12-month local continuing professional development (CPD) plan.



"North Coast GP Training is well placed to build on the successes of previous years' local CPD events. These events support health care professionals in providing their patients with the most up-to-date, evidence-based care, with a particular focus on improving care for those most at risk of poor health outcomes."

Ms Wheeler said events will be delivered throughout the region, some hosted through the established local Nurse Networks and Clinical Societies.

"Additional Clinical Societies are being

planned, and cultural awareness training will also continue in collaboration with NCPHN's Aboriginal Health Team.

"Building health workforce capacity is investing in better health outcomes for the North Coast. Clinicians who are connected to their peers and up-to-date with the latest evidence help to ensure our communities receive coordinated and best-practice care."

Dr Chris Jambor, NCGPT Board Chair, said that since 2002 the organisation has had a commitment to providing quality general practice education and training across the North Coast region.

"It is our intention to continue this tradition by delivering a range of high quality, locally relevant, education opportunities to allow continuous upskilling of general practitioners, practice staff and allied health professionals," he said.

Is household debt consuming you?

By the end of 2018 Australia had, relative to the size of its overall economy, one of the highest levels of household debt in the world. At 127% of gross domestic product (GDP), our household debt, as a percentage of GDP, had nearly doubled over the last 20 years.

Are Australian households groaning under the weight of oppressive levels of debt? The short answer is no. A major reason for the increase in household debt is that interest rates are much lower than they were 20 years ago, so it's easier to service larger loans. Over 90% of our household debt is owner-occupied home loans and investment loans.



Good debt, bad debt

Home loans and investment property loans are often referred to as 'good' debt, when used responsibly, they can improve wellbeing and build wealth over the long term. That said, poor choices or unfortunate changes in circumstances, like borrowing too much, loss of a job or an increase in interest rates, can see 'good' debt turn 'bad'. Another type of 'bad' debt is lifestyle debt, which has a negative impact on wealth because the debt is being used to buy things like cars, clothes, holidays, groceries etc. that lose value rather than gaining it. It's easy to accumulate 'bad' debt.

Temptation galore

Credit cards, digital wallets on phones, payday loans and buy-now-pay-later options all make it easier to spend money, even if it's money we don't have. Relentless, targeted advertising, the fear of missing out, the increasing level of peer pressure enabled by social media or just paying for daily essentials are all capable of leading us into spiralling debt.

Is debt consuming you?

Some warning signs that you have a debt problem include:

- Not paying off your credit card in full each month, resulting in paying high rates of interest on the carryover balance.
- Your total debt is increasing, along with your interest payments.
- You're experiencing housing stress. Rent or mortgage repayments consume more than 30% of your pre-tax household income.
- You're using debt to fund basic living costs.

Taking control

How to deal with your particular debt problem depends very much on personal circumstances:

- Track your spending. Australians buy huge amounts of clothes they don't wear, food they don't eat and gadgets they don't use. For every purchase ask yourself, "do I really need this?"
- Take out a lower interest rate personal loan to pay off high interest debts, like credit cards. Repay the loan as quickly as possible.
- If you have a home loan, make sure it has a linked offset account that you use for everyday banking. You only pay interest on the difference between your loan balance and offset account balance so all of your money is working to pay down your loan.
- Review your home loan regularly. You may be able to refinance at a lower interest rate. Check all the fees.
- Talk to your financial adviser. They can look at your specific situation and recommend strategies that will put you in control of your debt rather than having debt consume you.

Please contact TNR if you have any queries from the above information or if you have other queries regarding your financial affairs.



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NCPHN Commissions NCGPT for local Professional Development

The North Coast Primary Health Network (NCPHN) has recently commissioned North Coast GP Training to deliver a range of professional development and networking events across the North Coast over the next 12 months.

Sharyn White, the new CEO of NCGPT, outlines their plans.

NCGPT is excited at the prospect of being able to facilitate educational events for the NCPHN. We have made a commitment to deliver educational opportunities that are high quality, locally clinically relevant and that will build strong local clinical neighbourhoods.

Under the contract NCGPT will deliver a range of CPD events and support local clinical societies and nurse networks across the region.

Clinical education groups (referred to as "Clinical Societies") that are supported by NCGPT can expect administrative support and assistance with obtaining professional development points for the meetings. This will be welcomed by local educational groups which have struggled with this administrative burden in the past.

The program will provide funding for venue and catering costs for four meetings a year and can pay up to eight hours per month for a clinical lead within the group to help with planning content and liaising with speakers. There is a small fund available to support travel and accommodation costs for speakers outside the area but the preference is to build local connections.

Under the contract there are several requirements that have to be met.

The first is that the topics need to meet a local clinical need and/or a PHN priority. The current PHN priorities are Mental Health, Drug and Alcohol, Aboriginal Health, being Digital Healthy, Population Health and the Health of Older People. These are broad categories, so there is lots of scope for topic choice, albeit through a lens of local clinical relevance.

As part of the contract, Clinical Societies supported under the program must have stated learning outcomes and content designed to meet these outcomes. This is a requirement of obtaining CPD points from the relevant colleges.

The third caveat is that meetings are open to all local health professionals, which will help build better relationships, an essential building block to delivering better care.



CEO of NCGPT, Sharyn White

The NCGPT is keen to work with the Clinical Societies and Nurse Networks that are aware of their local problems and are best placed to find the solutions that work in their communities.

NCGPT undertakes to have five Clinical Societies in the NCPHN footprint running by the end of 2019.

Additional resources will be available for smaller locations that may want to establish a Clinical Society, but are not quite ready to commit to four meetings a year. This will help smaller towns like Casino, Grafton, Kempsey and Nambucca to access quality education.

NCGPT will also support the four existing Nursing Networks and will continue the previous NCPHN programs in immunisation and cultural awareness training.

In addition to the local Clinical Societies and Nurse Networks, another component of the contract is the delivery of Multidisciplinary CPD events. It is likely these will be clearly aligned to NCPHN priorities and will be repeated in locations across the region.

An educational advisory committee will

soon be established and a key role of the committee is to help prioritise topics and assist in their design.

Expressions of interest from groups interested in being supported as a Clinical Society under the program will soon be open and announced in the NCPHN practitioner newsletter.

At this time support for those existing organisations who are unable or do not wish to meet the specified restrictions will fall outside this contract.

Under the contract NCGPT will deliver on all components of the contract and provide around 50 individual meetings and events by June 2020. The events are scheduled to commence in October 2019.

The contract runs until June 2020 and the NCPHN will evaluate uptake by local clinicians before commissioning further educational activities.

It is now time for those who have been advocating for more investment in clinical education to get involved so that we can have a secure provider of high quality, locally focussed education for clinicians in our region.

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The eyes have it

Dr Andrea Zarkovic shares valuable tips on maintaining vision in AMD patients in the primary care setting.

Patients with age-related macular degeneration (AMD) and those at high risk of developing the disease make up a large proportion of patients attending general practice. GPs can play an important role in the diagnosis and management of patients with macular degeneration.

Who should be checked for wet AMD?

Prevalence of AMD-related blindness in Australia has declined in recent years. While this is largely due to successful treatment, the key to success has been early diagnosis prompted by awareness of AMD in the general population and medical community.

The recent National Eye Health Survey showed AMD is found in more than 25% of Australians over the age of 50. While the majority will have a mild form of AMD, the risk of vision-threatening late stage AMD increases exponentially with age: 7% prevalence of late AMD is found in those over 80 years. Therefore, even asymptomatic patients over the age of 60 years should be encouraged to see an eye specialist on a regular basis, at least every few years.

Early detection is the one of the most important prognostic factors for wet age-related macular degeneration (wAMD). Any symptoms of distortion, sudden or rapid onset of blurry vision or dark patches in a patient's central vision could signify development of choroidal neovascularization and should prompt urgent referral to an ophthalmologist. Patients whose wAMD is picked up early, i.e. before significant visual loss occurs, have a much better response to treatment and a better long term prognosis.

At least 70% of AMD cases have a genetic link, with 50% of patients whose first-degree relative is affected can be expected to develop AMD. Therefore, it is crucial to advise parents, siblings and children of those affected by AMD to get their eyes tested at regular intervals.

Risk factors

Smoking is the most important modifiable risk factor for AMD and is directly linked to vascular inflammation and endothelial

AMD is found in more than 25% of Australians over the age of 50 [but] the prevalence of AMD-related blindness has declined.

damage found in neovascular AMD. smokers have a four-fold increased risk of development of AMD compared to non-smokers and the onset of their disease tends to be much earlier. In addition, some studies have found that smokers have a poorer response to therapy than non-smokers. Smokers with a diagnosis of wAMD or those with a genetic predisposition need to be made aware of the importance of quitting and supported in their efforts as much as possible. Obesity and high cholesterol may also increase the risk of AMD and there may need to be a lower threshold for treatment in predisposed individuals.

Diet and vitamin supplements

The role of diet and vitamin supplements in AMD has been extensively studied. A healthy diet high in antioxidants, green leafy vegetables and Omega 3 is beneficial for good macular health. Those with inadequate dietary vitamin intake and patients with moderate macular degeneration or late macular degeneration in one eye can potentially reduce their risk of AMD progression by 20% with the use of specific dietary supplements.

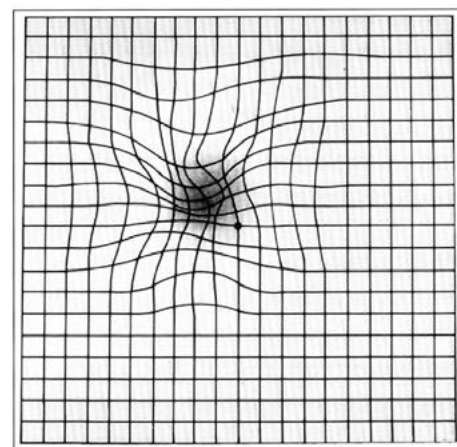
The recommended supplements are formulated according to the Age-Related Eye Disease Study 2 (AREDS 2) formula and contain vitamins C and E, zinc, copper, lutein and zeaxanthin. Beta-carotene has been removed from the formula due to increased risk of lung cancer in smokers. Ophthalmologists usually advise patients who are considering vitamin supplements to check with their GP to ensure that the supplements will not interact with other medicines or supplements.

Diagnosis

Asymptomatic patients should have their macula checked as part of their routine eye health check with their optometrist. Symptomatic patients should be referred straight to an ophthalmologist in order to ensure prompt diagnosis and minimal inconvenience to the patient.

Diagnostic tools used by ophthalmologists to diagnose and monitor wAMD include ocular coherence tomography (OCT), fluorescein angiography (FFA) and OCT angiography (OCTA). OCTA is the latest advance in retinal imaging and because it is non-invasive, is particularly useful in patients with poor venous access, allergy to fluorescein or the frail elderly.

Patients with AMD and those at high risk of developing the disease should use an Amsler grid for self-monitoring at home.



Distorted Amsler Grid

Amsler grid as it might appear to someone with age-related macular degeneration

Courtesy of National Eye Institute, National Institutes of Health

Amsler grid: first described in 1947 by Marc Amsler, this chart consists of a 10 cm square with a grid and a central spot for fixation.

Treatment

The mainstay of treatment of wAMD is intravitreal anti-VEGF injections. There are two anti-VEGF drugs, Lucentis and Eylea that are PBS listed and readily available. The injections are usually given as an induction of monthly treatments for three months and the treatment is then tailored according to the response. The treatment is given either in the sterile environment of a day surgery setting, in which case the cost is often covered by the health fund, or in the clinic rooms. The patients can be reassured that the eye will be numb and the



Dr Andrea Zarkovic MBChB, PGDipOphthBS, Ophthalmologist with *myEyeSpecialist*, Ballina and Robina.

injection is often less uncomfortable than having a blood test.

If a patient has had a recent stroke, a heart attack or any infections, the ophthalmologist needs to be informed as this will influence the timing of the anti-VEGF treatment.

Support for AMD patients

GPs, ophthalmologists and optometrists provide a vital support structure for patients with declining vision. Ophthalmologists refer patients to providers of low vision aids such as Vision Australia and Quantum Vision while GPs can help with extra support in the community such as home

Tips for GPs

- Patients with relatives who have been diagnosed with wAMD should be referred for an assessment
- Advise the ophthalmologist if a patient is unwell and unable to attend their injection appointments
- GP notifies a patient's ophthalmologist of any changes to their health and medication, in particular cardiovascular events
- GP ensures any AMD vitamin supplements are suitable for use in conjunction with any medication they might have already prescribed to the patient

help and transport. It is important that patients with AMD have regular checks with their eye specialist to ensure their glasses are as up to date as possible to maximize their vision. Macular Disease Foundation Australia provides information and support for people with macular conditions.

A Conversation with a Doctor In Training

by Dr David Glendinning

David Glendinning is an advanced trainee studying for his fellowship in general practice.

"Hi mate, haven't seen you for a while," says David's mate.

"Yeah, sorry mate, I've been studying."

"Studying? What I thought you were all done?"

"Not quite. I've been studying for my Fellowship."

"Oh yeah, what uni is that course through?"

"No, it's not through a uni, it's through my College".

"College? But I thought you had already done a uni degree. Why are you studying at a College?"

"It's the final exams for my speciality training. I'll then be accredited as a specialist through my College."

"But I thought you were already a doctor".

"I am."

"Oh yeah. So, you're just studying full time now?"

"No, not quite. I'm working at least 40-50hrs per week as a Doctor In Training, then doing a few extra shifts each month at a smaller hospital as a locum. Then every other moment I have, I'm studying.

"I have study group once to twice per week and have paid several thousand dollars to sign up for an online exam prep course. On top of that I've paid several more thousand dollars for the privilege of sitting the written exams. If I pass those then a few months later, I'll be able to pay even more thousands of dollars to sit the oral or practical exam. If I pass all that, then I'll get my Fellowship".

"Wow. Sounds full on. Well I have a practical case here to help with your study. Can you have a look at this rash for me?"



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AND/OR SELF HARMING
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Our program combines standard cognitive behavioural techniques for emotional regulation and reality testing with concepts of mindful awareness, distress tolerance and acceptance. It can be used to help people experiencing symptoms of impulsivity, frequent interpersonal conflict and difficulty with emotional regulation, anger and poor coping in stressful situations.

How to join

A referral to a psychiatrist with admission rights to Currumbin Clinic is required.

How much does it cost?

Participants are admitted as a day patient and as such, can claim their attendance via their health fund.

Further information

For information regarding this program, including start dates and how to register, please contact Currumbin Clinic Day Programs on 07 5525 9682.



Meet Dr Basem Dall

MBBS, FRANZCP

Dr Basem Dall is a general adult psychiatrist. His areas of interest include mood disorders, psychosis, addiction medicine and psychoeducation.

Dr Dall is proficient in treating mental illnesses using psychological approaches, pharmacotherapies and neurostimulation (rTMS and ECT).

Dr Dall graduated from Monash University before working at the Austin Hospital in Melbourne. He progressed through his psychiatry training in Sydney and has worked in several centres of excellence, including the Professorial Mood Disorders unit at The Prince of Wales Hospital and the Black Dog Institute.

After gaining fellowship in 2014 he worked in the public health sector in both NSW and QLD.

He relocated to the Gold Coast in 2016 and was the director of psychiatry services at The Southport Private Hospital before joining Currumbin Clinic.

Throughout his career, Dr Dall has been extensively involved in the education, training and mentorship of medical students and trainee psychiatrists. He supervises and teaches students from Bond and Griffith Universities.

Dr Dall is a visiting medical officer at the Tweed Hospital where he is actively involved in the redevelopment and expansion of mental health services in Northern NSW.

To arrange an appointment or referral, please contact Dr Dall's consulting suite on 07 5525 9606 or fax 07 5525 9686.

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Is the largest tendon in the body your Achilles Heel?

by Dr Richard Freihaut

Orthopaedic Surgeon, Surgery of the Hip,
Knee, Foot and Ankle

Images reproduced from 'Ankle Arthroscopy' by C. Niek van Dijk, published by Springer Publishers.

We all know the Achilles tendon. Most of us will also know the tendon is named after the ancient Greek mythological figure Achilles because it lies at the only part of his body that was still vulnerable after his mother had dipped him (holding him by the heel) into the River Styx.

Even for mere mortals the tendon remains a vulnerable part of our body, especially as we get older, and its chronic conditions can be difficult to treat. Understanding each particular condition can make our job easier and allow us to give informed advice to our patients, ensuring they recover faster and avoid unnecessary treatment and expense.

Chronic conditions of the Achilles can be broken up broadly into "insertional" and "non-insertional" problems based on the location of pathology.

- Insertional problems make up around 25% of these and include three distinct entities:

- o Insertional Achilles tendonopathy (IAT)
- o Retrocalcaneal bursitis (RB)
- o Subcutaneous bursitis (SB).

- Non-insertional Achilles tendonopathy (NIT) accounts for around 65% of chronic conditions. The remaining 10% can be attributed to chronic rupture.

Anatomically, three muscles contribute to the Achilles tendon and they cross up to three joints. Soleus crosses the ankle and subtalar joints, whereas gastrocnemius and plantaris cross the knee as well. Plantaris is a small vestigial muscle which contributes little to function but can play a part in Achilles tendon pathology.

The Achilles (Figure 1) inserts into the inferior half of the posterior surface of the calcaneus. Between the tendon and the superior half of this surface lies the retrocalcaneal bursa. A prominent posterosuperior process may contribute to the development of bursitis as the Achilles wraps around it with dorsiflexion. The retrotendonous or superficial bursa, when present, is an acquired structure.

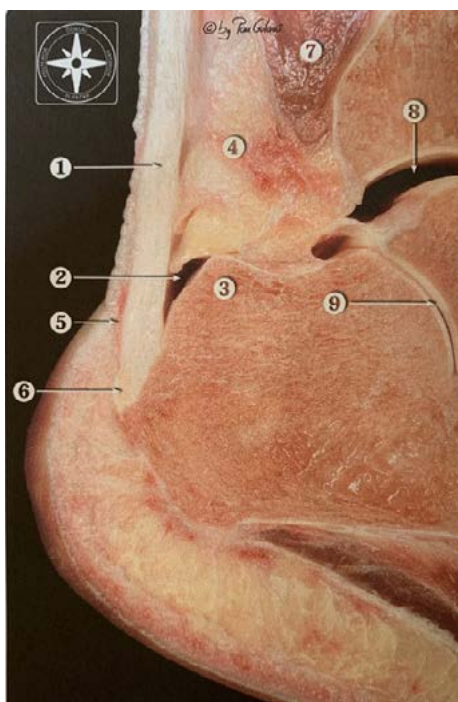


Figure 1. Cross section of the Achilles Tendon Insertion. 1: Achilles tendon, 2: Retrocalcaneal bursa, 3: Posterosuperior process of calcaneus, 4: Kager's fat pad, 5: Subcutaneous bursa, 6: Achilles tendon insertion, 7: Flexor hallucis longus muscle.

The Achilles itself is composed of collagen fibril bundles surrounded by a peritendineum (endotenon, epitenon and paratenon) over the top of which is the deep fascia.

Diagnosis can be made in most cases with history and examination but x-ray provides additional useful information. Ultrasound adds nothing.

Factors predisposing to pathology vary according to the specific condition. Age, obesity, new or unaccustomed activity, abnormal limb biomechanics (such as a cavovarus foot), inflammatory arthropathy or gout may contribute to insertional Achilles tendonopathy or retrocalcaneal bursitis.

Subcutaneous bursitis, known to Americans as the "pump bump" is classically caused by friction from the hard heel counter of a pump style shoe.

Non-insertional Achilles tendonopathy has been described as a condition associated with long distance running but in 30% of cases patients are sedentary. Half of the population at age 66 show changes of tendonosis however the majority are asymptomatic.

Clinically, patients will complain of pain, worse with activity. As the condition progresses pain can be present at rest and at night especially with IAT and NIT. RB may be worse immediately on walking after rest. Discomfort in shoes can be common to all but especially SB. Some patients may be able to accurately localise the pain.

These conditions may of course co-exist so I find the single most useful part of the examination is location of tenderness:

- IAT: central at insertion
- RB: medial and lateral to Achilles at insertion
- SB: posterolateral insertion
- NIT: 2-6 cm proximal to insertion (often but not always associated with a swelling of the Achilles).

The diagnosis can be made in most cases with history and examination but x-ray provides additional useful information. Ultrasound adds nothing. I generally reserve MRI for those considering surgery AND where the primary pathology remains unclear.

Insertional conditions display distinctive findings on x-ray. A typical posterior heel spur will be seen with IAT.

The findings of RB are more subtle but look for a prominent posterosuperior calcaneal process and Kager's Fat Pad Sign (Figure 2). Kager's fat pad is seen as a black soft tissue triangle on a lateral x-ray bounded by the Achilles tendon posteriorly, the flexor hallucis longus muscle anteriorly and the calcaneus inferiorly. Normally, the angle where the Achilles meets the calcaneus is a sharp, acute, well defined angle. This angle becomes indistinct and blurred with RB due to scarring, swelling, and debris in the bursa.

An x-ray of SB is generally normal. Although NIT will display no distinct findings itself, an x-ray may display co-existing pathology.

Seventy percent of patients will respond to non-operative treatment. IAT and NIT are not inflammatory processes histologically so NSAIDS provide an analgesic role only. Any form of injection should be avoided, particularly steroids due the risk of rupture. I find simple heel lifts from the chemist can be helpful and are a cheap alternative to orthotics. The only two forms of non-operative treatment

continued on P24

Is the largest tendon in the body your Achilles Heel?

continued from P23

with strong evidence to support their use are eccentric strengthening exercises and shock wave therapy (similar to that used to treat kidney stones). A physiotherapist or an appropriate podiatrist is a good place to start.

Failing a minimum of three months non-operative treatment, surgery can be considered. The procedure depends on the condition but with better understanding of each and improved techniques the outcomes are very encouraging.

IAT still requires an open operation but with advances in suture anchor technology it is now quite safe to detach the entire Achilles tendon from the bone enabling complete debridement of diseased soft tissue and bone. The tendon is then reattached and mobilisation is commenced

at two weeks.

RB can be treated endoscopically as day surgery and the patient starts walking again in two weeks.

There is growing evidence that the pain of NIT comes not from the tendon itself (only 65% of symptomatic tendons are abnormal on ultrasound and cadaver studies) but from the peritendineum which in chronic cases displays neurovascular proliferation and myofibroblast induced scarring. With this knowledge, surgical treatment in the majority of NIT cases can be confined to keyhole “tendoscopic” stripping of the deep fascia and paratenon from the tendon, denervating the Achilles, freeing it from adhesions and releasing plantaris.

So yes, the largest tendon in the body is vulnerable, but it need not be your Achilles heel.



Fig 2. Kager's fat pad sign. Upper diagram and x-ray : normal.

Lower diagram and x-ray: retrocalcaneal bursitis with loss of definition of the soft tissue angle and a prominent posteriosuperior process.

Dogs as doctors (well, almost)

by Mike Fitzgerald, Veterinarian, Alstonville

As someone who works all day with animals, as a Veterinarian, I am often reminded of W.C.Fields' famous quote: “never work with children or animals”. It helps to trot this one out when my furry patient is not sticking to the script or has an entirely different agenda.

Last week I was reminded of the enormous value of animals, in particular the canine species, working with us humans, when I met Bruce the labradoodle who had been trained to work as an Assistance dog for a client who suffered from PTSD/Anxiety.

Bruce seemed like your normal happy, tail-wagging young dog during his checkup and immunisation. The only clue that he was different was the red harness his owner held, emblazoned with the words ASSISTANCE DOG.

Bruce's owner explained that it is only when this harness goes on that, like flipping a switch, Bruce “knows he's working”, and his demeanour and behaviour change. Bruce will constantly monitor his owner's body language, attitude, facial expressions and voice characteristics, probably detecting changes using his hyperacute sense of smell, and responding by staying very close, nudging gently or even placing his paw gently on his owner.

We all know how Labrador Guide dogs work wonderfully with the vision impaired,

with their leather harness that works the same way: “harness on”- I'm working, “harness-off” my downtime.) More recently, dogs have been trained to assist us in many more ways. For instance, detector dogs are trained to work in conservation projects to detect a particular plant or animal species. Imagine trying to find a single Quoll scat in a couple of hectares of thick bush - yet a dog can smell it from 100 metres away and take you straight to it!

There are Medical Alert dogs for Type 1 diabetes who can detect by smell and alert in both hyper and hypo glycemic states, Seizure alert and response dogs, assistance dogs for those with autism and also assistance dogs for persons with mobility impairment including cerebral palsy, para- and quadriplegia.

The Medical Alert dogs are multi-skilled. Not only can they detect, say, an imminent seizure episode in a child up to 20 minutes beforehand and alert an adult guardian, they can also be trained to retrieve medication, roll a person into the recovery position, move furniture or objects out of the way, rouse an unconscious person, retrieve a phone and use a medical alert device to summon help.

Mobility assistance dogs are trained to open and close doors, drawers and fridges, act as a brace to assist in balance and maneuvering, turn lights on and off, press the button at the traffic lights, carry stuff, and alert someone if they detect a child in



Veterinary surgeon Mike Fitzgerald with an animal not recommended for providing assistance to humans in need.

danger.

One might suggest that that little red harness is less of a work uniform and more of a super-hero suit. Much of what these dogs do relies on sensory abilities outside the range of human visual, auditory and certainly olfactory capacity, so I think it's fair to say they have “Super-powers”.

And of course there is the 24/7 loyal and unconditional companionship and friendship.

Have you heard of the TT Cat? It's a new breed that can detect and calm a toddler having a tantrum... just kidding. Cats, much like toddlers, are untrainable. W.C Fields was partly right!

ACON wants to help GPs with sexual and gender health

Not many years ago a diagnosis of HIV-AIDS was generally regarded as a death sentence, and many gay men, or men who had occasional sex with men, began planning for the end of their days. Hoping to make the most of the time left, a good number sold up down south and moved to the NSW Northern Rivers, a place of tolerance, cultural and climatic appeal, and decent health services.

Most expected to die, but one of those rare medical ‘miracles’ occurred, slowly at first, as is the way with research, and then picked up pace: treatments for the HIV virus, and more recently, preventative medications, were developed, found successful, and became widely available. Today, the anti-viral prophylactic PREP and the ‘morning after’ pill PEP, both prescribed by GPs, are the new normal.

The downside is that while many in the early generation of sufferers have enjoyed a clinical reprieve they face financial hardship as they move into later life. Fortunately, the local community remains as supportive as ever, epitomised by the Lismore-based regional team at ACON Health, a not-for-profit dedicated to promoting the lifelong health of sexuality and gender diverse people, and people with HIV.

This distinct cohort is just one of the communities being helped by the NSW Health-backed organisation led by Michael Tizard, a social work graduate who came to the role after five years as CEO of Queensland’s Creche and Kindergarten Association, known as C & K.

For more than a year prior to his move south in January, accompanied by two teenaged twin sons, Michael had another group of charges to look out for. In 2017 he bought 200 acres at Fairy Hill, west of Casino, and set up a beef cattle breeding operation that now carries 88 Angus cows and one obviously hard-working bull (he aims to buy another soon).

No stranger to the land, he had run cattle and horses on a property in Victoria – where he volunteered with the AIDS Council – before moving to Brisbane to run



Michael Tizard, ACON Health

an organisation overseeing 350 childcare centres. He now commutes daily between the farm and ACON’s office in Uralba Street, in Lismore’s well-established health hub.

Headquartered in Sydney and with Northern Rivers and Hunter offices, ACON (founded as the AIDS Council of NSW), is committed to improving the physical and psychological wellbeing of a client base it refers to as “people who are sexuality and gender diverse”, a catch-all term that avoids the alphabetical complexity of terms such as LGBTIQ.

Noting that it will continue to use such terms as “lesbian gay bisexual and transgender... in programs and services where relevant”, ACON Health’s new strategic plan stresses the “importance of self-determined identities to those who have fought for and earned them.”

Key to ACON’s plan, and at the heart of the Lismore team’s mission, is to focus on the “Issues that arise from experiences of marginalisation, limited access to sensitive and appropriate health services for sexuality and gender diverse people, and fear of, or experiences of, stigma and discrimination.”

The local team includes three counsellors to assist clients with mental health issues arising from past trauma or substance misuse issues, stigmatising, and a gamut of complex issues – including the one that began this story – that can affect people whose sexualities or sexual practices are outside the mainstream.

Michael estimates that each counsellor has a case load of 8-12 clients, each with specific needs. Twelve free counselling sessions are offered, with referrals to specialised practitioners/services when required.

One innovative and important project is known as ‘Silver Rainbow’, addressing the need to foster acceptance of older people of various sexualities in residential aged and other care facilities.

As one resource for aged care workers notes, “The onus should be on... policy-makers and service providers to proactively make changes.”

Michael is pleased that GPs are increasingly interested in developing skills in gender pathways, stressing that ACON is keen to work with practices to further expand the support currently offered to patients, and is equipped, “and happy”, to run training sessions that qualify as professional development.

“At present, there are not enough local GPs who are trained and feel sufficiently confident enough to advise on, for example, hormone treatment, or upper and lower gender re-alignment surgery. ACON has extensive experience in these fields and a wide range of top-level clinical expertise to draw on.

“Anyone reading the news would know what an expanding and important field of medicine this is, and we are ready to help wherever we can, for the benefit of medical professionals and their patients.”

• ACON Health can be contacted on (02) 6622 1555

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Book Reviews by Robin Osborne

Never Enough

Judith Grisel

Scribe 241pp

The Recovering

Leslie Jamison

Granta 534pp



The female authors of these extraordinary books, now highly regarded academics, had long personal histories of drug and alcohol misuse, as each makes clear before taking us on their harrowing but ultimately liberating journeys.

“The first time I ever drank in secret, I was sixteen,” recalls US-based Jamison whose memoir of getting straight combines an increasing awareness of her own problems with reflections on such talented but afflicted creatives as John Cheever, Jean Rhys, John Berryman, Billie Holiday and Amy Winehouse.

Like her at the time, they led “intoxicated lives”. Unlike her, they succumbed to untimely deaths.

“The first time I ever got high,” she continues, “I was smoking pot on a stranger’s couch, my fingers dropping pool water as I dampened the joint with my grip... I thought: What is this” And how can I keep being this? With a good feeling, it was always: More. Again. Forever.”

Dr Grisel, a behavioural neuroscientist,

reflects this in her title, writing that addiction is “epidemic and catastrophic”, with consequences that are “almost too large to grasp.”

Jamison notes that, “Scientists describe addiction as a dysregulation of the neurotransmitter functions of the mesolimbic dopamine system,” adding, “Which basically means your reward pathways get fucked up. It’s a ‘pathological usurpation’ of survival impulses. The compulsion to use overrides normal survival behaviour like seeking food, shelter, and mating.”

The statistics are indeed alarming: “In the United States, about 16 percent of the population twelve and older meet criteria for a substance use disorder, and about a quarter of all deaths are attributed to excessive drug use... Along this path to the grave is a breathtaking series of losses: of hope, dignity, relationships, money, generativity, family and societal structure, and community resources.”

Yet as both know from experience, there is another side to the drug story: not everyone who takes drugs (or drinks) becomes addicted, and most continue with their controlled usage because mood enhancing substances can be fun.

Jamison, also an impeccable researcher, picks up on what she terms the “drug-scare narrative”, noting that addiction can be “a contagious epidemic, a wilful abnegation of civic duty, a valiant rebellion against the social order, or the noble outcry of a tortured soul [e.g. Winehouse]”.

“It depends on who is doing the telling, and the using... Addiction has been presented as both inevitable and unilaterally devastating in order to serve various social agendas – most notably, the War on Drugs.”

In Dr Grisel’s agrees: “The ‘war on drugs’ has been a recurrent and dismal failure... finger-pointing and violence do nothing to subdue the drive to escape the pain of our existence.”

Along with her personal narrative she dedicates chapters to the main substances of abuse, THC, opiates, alcohol (“low potency in the brain thus belies its disproportionate



Judith Grisel

influence on human suffering”), stimulants, psychedelics and other drugs.

As we share their journeys we see how both authors transcended addiction to develop successful careers and lead happy lives. Of course, they are among the lucky ones.

As Grisel says, “I’d finally reached the dead end where I felt I was incapable of living either with or without

mind-altering substances. This bleak situation describes the condition of many if not all, addicts and illustrates why relatively few recover. Despite being depleted, they think the cost of abstinence seems much too high: Without drugs, what is there to live for anyway?”

She adds, “The understanding I’ve gained has helped me stay clean by informing better choices. My hope is that by illuminating the seeming insanity of colluding in habits that are not only joyless but lethal, this book will contribute to a path of freedom for others.”

The efforts of Alcoholics Anonymous are lauded, and mention made of one member who promoted LSD to combat alcoholism – despite some success, AA did not approve, although interest is again being shown in this approach.

However, both authors agree that abstinence is not the only possible path to what might be termed salvation.

“The opposite of addiction,” Grisel writes, “is not sobriety but choice. For many like me, drugs act as potent tools that obscure freedom. But there are countless ways any of us might jump the rail, unwrapping familiar cloaks of vocation, family, or other disguise... just pray that habits, bank accounts, or other props remain securely in place.”

Jamison observes that, “Supporting harm reduction involves acknowledging that sobriety might not come immediately, or even eventually, for everyone – that it might not be the triumphant concluding chapter at the end of every addiction story.”

A sobering thought indeed.

University of Wollongong Rural Taster Experience

Six-months into their degree, University of Wollongong (UOW) medical students never anticipated that on a rural clinical placement they would be removing sutures, shadowing ward rounds, and detecting heart murmurs. However, on their recent 'Rural Taster' experience these are some of the opportunities that students had access to, plus so much more.

In June 2019, six UOW medical students made the trip to the NSW North Coast, four to Lismore- Ballina region and two to Grafton, so they might gain an understanding early on in their studies of medical and health services in regional and rural areas.

With the support and coordination of the North Coast University Centre for Rural Health and the Northern NSW Local Health District, the students had opportunities to go on home visits with community nurses, attend outpatient podiatry clinics, shadow the paediatric team on ward rounds and experience what it means to provide essential healthcare services in rural communities. This ranged from wound dressings and general health education to observing palliative care teams working in the community.

The two weeks spent on the North Coast gave students a deeper insight and understanding of rural health and medicine. This experience has also allowed for a greater appreciation of allied health, in particular, the range of allied and community services working with a doctor to support patient health in the community. Students observed teamwork and the relationships developed between the hospital staff and their patients as well as the wider health community. The Rural Taster was a great introduction and exposure to what the future will hold for these students as healthcare professionals.

All the students were very fortunate to be welcomed into the Indigenous Aboriginal cultures of the Grafton, Ballina and Lismore regions. The staff and communities were incredibly warm and welcoming and shared their successes and challenges of providing quality health care to Aboriginal people in the region.

On this whirlwind two-week experience, students also managed to visit the local sights and experience life in the beautiful northern NSW region. It's not often you can spend a weekend in Byron Bay spotting whales and watching dolphins catch the waves, cruise the Bangalow markets, attend local trivia nights and the Lismore Lantern Festival... students definitely felt part of the unique community spirit. We hope to see these students back on the North Coast for extended clinical training in Phase 3 of their medical program.

- by Joanne Chad and Rebekah Hermann UOW



UOW First Year medical students in Lismore Kieren, Maili, Thimithi and Tamara



UOW First Year medical students Dylan and Channel at Grafton Base Hospital

We are so thankful to the wonderful Lismore and Ballina health professionals who took time to teach us during this placement. UOW First Year students Lismore Kieren , Maili, Thimithi and Tamara

The Grafton team have gone above and beyond to make us feel welcome and have given us the best possible experience. The last fortnight has reinforced our desire to work in a rural area. UOW First Year students Grafton Dylan and Channel.

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Tomorrow's doctors are loving the North Coast

It has been an exciting time, with new senior medical students commencing their year-long placement in various locations across the North Coast. The University of Wollongong (UOW), in collaboration with the University Centre for Rural Health North Coast (UCRH), has three training hubs across the North Coast, including Murwillumbah, Lismore and Grafton. Each year, these hubs offer 20 extended clinical training opportunities that are highly contended amongst the University's medical students.

"The word amongst my peers and classmates that have completed placement on the North Coast, is that the educational opportunities are excellent. Staff are welcoming and so willing to teach, the clinical experiences so diverse" says current UOW medical student Alexander Mills.

The University of Wollongong is committed to training doctors with the capacity and desire to work in regional, rural and remote communities and is the only medical program whose admission process specifically targets talented students from a rural/regional background. Part of their program involves a year long clinical placement where students spend time learning in general practice, community and hospital settings. This unique type of placement offers students an insight to what living and working as doctors in regional and rural areas might look like. "They get to know the community and are able to add value as a team member within the medial workforce", Regional Academic Leader for the University of Wollongong and senior medical officer in Grafton ED, Dr Alastair McInnes, says.

The beautiful location also helps. Medical student Harriet Raleigh says, "One thing that attracted me to complete my placement on the North Coast is the great work and lifestyle opportunities that the Clarence Valley offers".

So if you happen to come across these medical students in general practice or the hospital, please make them feel welcome. We thank you for your supporting them as they train to become future rural doctors who will hopefully one day return to our community!

- by Greta Enns UOW



Students from all three hubs, enjoy an immersive day, discovering the culture, community and country.

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'Break it down' Aboriginal youth program funded

North Coast Primary Health Network is partnering with local organisation Desert Pea Media (DPM) to produce a social and emotional wellbeing program worth \$800,000 to support local Aboriginal communities.

Young Aboriginal people on the North Coast experience disproportionate levels of mental health issues, including self-harm and suicide while cultural continuity and self-determination are protective factors for Aboriginal and Torres Strait Islander peoples' social and emotional wellbeing.

Since 2002, DPM has worked with Indigenous young people across Australia using contemporary storytelling techniques and audio-visual media to facilitate important social and cultural conversations. Working collaboratively with Elders, young people, community leaders and local service providers, DPM's Break It Down is an Aboriginal youth mental health literacy program. The program is relevant and

appropriate to the needs of individuals and communities.

Break it Down provides a safe space for young people to express themselves about difficult topics like mental health, and the use of alcohol and other drugs.

Break it Down North Coast will seek to improve young Aboriginal people's social and emotional wellbeing through a community development and engagement approach in eight communities across the region, chosen on high levels of need.

Throughout the work, the DPM team will work closely with mental and allied health professionals to produce media content that articulates an innovative conversation around mental health, and helps young people to 'break down' stigmas associated with these topics. Community roadshows and a region-wide evaluation will also be delivered as part of the project.

NCPHN's Chief Executive, Julie

Sturgess, said the funding is designed to build resilience and pride among young Aboriginal people.

"Break It Down will engage young people in a language that they are already fluent and engaged in. It's an exciting opportunity we are pleased to support in eight North Coast communities," she said.

Previous DPM programs have produced songs playlisted on Triple J, with past community music videos winning Community Music Clip of the Year at the National Indigenous Music Awards.

Toby Finlayson, DPM's CEO, said, "We are really excited to be bringing the Break It Down program to North Coast communities. The work that is created in these projects becomes a long-term tool for communities and service providers, as a social wellbeing, cultural and educational resource."

Farewell to Hastings Macleay General Practice Network

At the Annual General Meeting of the Hastings Macleay General Practice Network (HMGNP) on 19 March 2019 it was announced that the organisation would be wound up.

HMGNP started in 1994 as part of the Labor government's initiative to build a framework for supporting general practice at the local level. It was one of four Divisions of General Practice, as they were then known, covering the North Coast footprint from Tweed Heads to Port Macquarie.

The Divisions and later Networks ceased further direct Federal government funding after the establishment of Medicare Locals in 2013, putting great financial pressure on these organisations and causing many of them to cease operation.

With the demise of the Tweed Heads GPN several years ago and now the HMGNP the number of GP Network members of the North Coast PHN is reduced from four to two.

The NCPHN Board has paid tribute to the HMGNP and "acknowledged the work done by the Hastings Macleay GPN, and their commitment to the community".

The last Chairman of the HMGNP, Dr John Vaughan, pays tribute to those that have led and worked with the organisation over the last 25 years.

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It is with sadness that we announce the folding of the Hastings Macleay General Practice Network.

HMGNP started in the 1990s and owes its inception to the enthusiasm and energy of people like David Gregory and his initial Board who gave the organisation a wonderful lift off. The concept of a local organisation to represent local GPs was inspired. It allowed small disparate general practices to have a voice in the local health system and it raised the profile of GPs who are essential to delivering better care.

GP Networks provided the framework for us to interact with other parts of the health system in order to pursue our goal of improved patient care.

Unfortunately, no funding meant we could not continue and the decision was made to fold the organisation. With the advent of Primary Health Networks, representation for all primary care practitioners on the North Coast has



Dr John Vaughan receiving the Supervisor of the Year Award (North Coast) in 2017

passed, in the local case, to the NCPHN.

I would like to pay tribute to all those GPs who contributed to the HMGNP over the nearly two decades of its existence. There were many who were involved and gave of their time and energy. I would like to acknowledge two in particular - Sharon Sykes who was instrumental in organising the educational events for GPs for many years and has been a Board stalwart, and Libby Scalloway who has provided fantastic administration support for almost the whole existence of the organisation as well providing emotional support for the Board through some tough times.

We trust that GPs will continue to have a voice through the NCPHN.

Health from the Grass Roots

Aboriginal health priorities project Northern Rivers, NSW

Aboriginal staff at the University Centre for Rural Health (UCRH) in Lismore are leading the Health from the Grassroots Project aimed at giving voice to local mobs (from the Tweed to Clarence Valley) to talk about their priorities for community health and wellbeing and perspectives on what's working well and what needs improvement to support community health and happiness.

We aim to collate the many comments and feedback received into actions to inform service provision and research.

Our motivation is the persistent inequities in health outcomes between Indigenous and non-Indigenous communities. It's been said many times that solutions need to come from the ground-up, involving the communities, as they know what works and doesn't work. It will also require a focus beyond the health sector, given that a significant proportion of the health gap is attributable to social and cultural determinants of health.

Late last year we conducted a community survey (paper-based and online) to collate perspectives from Aboriginal and Torres Strait Islander people living on Bundjalung and Yaegl country. At the same time, yarning circles were held in various locations across the Northern Rivers to learn more about community experiences and ideas for service improvements. From this first round of consultations, a picture emerged as told by community, depicting a vision for a healthy future with priority areas that need to be addressed along the way.

Key to a healthy future is strengthening connection to culture and country, also



employment etc). The priority areas provide a roadmap for the development of system change actions. Crucial to this will be addressing institutional racism and improving cultural safety of services.

Over the next few months, we will be going back to community to check-in about what we've heard and to talk further about the priorities and relevant actions needed for a healthy future. We will advertise these consultations on [our website](#). If you'd like to talk to us or would like us to visit your organisation, please contact Frances Parker (frances.parker@sydney.edu.au; 0487 966 547) or Veronica Matthews (veronica.matthews@sydney.edu.au; 6620 7224). We aim to produce the community-led action plans by the end of the year.

This is the first step in a community-led journey about thinking and acting differently. The project centres local Aboriginal and Torres Strait Islander communities within a collaborative

process, leading systems change and devising strategies to improve health and wellbeing. It will generate new knowledge about how to facilitate community-led solutions utilising a whole-of-system approach. For without transformational change and Indigenous empowerment, current systems won't adequately address health inequities¹.



Grassroots team from UCRH (L-R): Aimmee Waddell, Faith Lewis, Susan Parker Pavlovic, Frances Belle Parker, Tracey Piccoli, Emma Walke, Veronica Matthews, Collin Anderson (Absent: Dave Edwards, Holly Jenkins, Tara Bayles).

associated with good nutrition, physical activity and social connections. Responsive and coordinated services are vital not only within health but across the whole system (family services, education, housing,

health of indigenous people: a call for the use of systems thinking to tackle health inequity. *Int J Equity Health*. 2017;16:22-30.

1. Hernández, A et al. Engaging with complexity to improve the

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