Incontinence
a problem in anyone’s language

The pelvic floor and sexual function

Beth Wilson shares her story

Ask the expert
Editor’s Note

Habits start early, which is why school children have been the focus of the Continence Foundation’s most recent national project, Healthy Bladder and Bowel Habits in Schools, launched during World Continence Week last year. In this issue we talk to Elyce Blake (p.3), a teacher at Templestowe Valley Primary School – a participating school in the pilot study – who describes the project’s many benefits to date. By equipping children with knowledge in age-appropriate language and making it a fun and interactive part of their schooling, the project aims for all children to adopt healthy bladder and bowel habits for life.

This year’s national project to be launched during World Continence Week, June 24–30, focuses on Australians from non-English speaking backgrounds. Under the slogan, Talk about incontinence: A problem in anyone’s language, the Foundation tackles the stigma and personal embarrassment that many people of any cultural background experience when dealing with incontinence. Our national programs and partnerships coordinator Nives Zerafa gives an overview of the project (p.8–9), and continence nurse Lisa Wragg tells the story of how a Chinese woman’s minor ailment became wrongly diagnosed as a result of poor communication with her health providers (p.9).

Incontinence doesn’t discriminate, and former Victorian Health Services Commissioner and patron of the Continence Foundation Beth Wilson AM gives an insightful and humorous account of her experiences with continence issues (p.10).

We know that incontinence can impact on all aspects of life, and in this issue we take a look at issues some couples face around another topic not readily discussed – sexual function (p.4–5).

We also take a close look at the important work of urologist Karen McKertich (p.6), and Stephen Marburg, our National Continence Helpline coordinator, answers your questions (p.11). We always enjoy your feedback, so if you would like us to feature your story or a topic of interest, please email info@continence.org.au

Happy reading.

Maria Whitmore
Editor

Contents

3 5 minutes with...
4 Sexual intimacy and the pelvic floor
6 Bladders, bedwetting and Botox
8 Incontinence – a problem in anyone’s language
10 Laughter is the best medicine
11 Q&A with Stephen Marburg

NATIONAL CONTINUENCE HELPLINE
1800 33 00 66

Who is the Continence Foundation of Australia?

The Continence Foundation of Australia is the peak national body representing the interests of nearly one in four Australians affected by incontinence, their carers, families and clinicians. The Foundation, established in 1989, is a not-for-profit organisation dedicated to improving the quality of life of all Australians affected by incontinence. The Foundation manages the National Continence Helpline (1800 33 00 66) on behalf of the Australian Government, a free service staffed by continence nurse advisors who can provide information, referrals and resources. The Helpline is staffed 8am–8pm AEST Monday to Friday.

Bridge welcomes contributions from you, our readers. Please email your submission to bridge@continence.org.au

© Continence Foundation of Australia

Bridge is published quarterly by the Continence Foundation of Australia. It is supported by the Australian Government Department of Health and Ageing under the National Continence Program. The information in Bridge is for general guidance only and does not replace the expert and individual advice of a doctor, continence nurse or continence physiotherapist. Bridge cannot be reprinted, copied or distributed unless permission is obtained from the Continence Foundation of Australia. No information taken from Bridge can be placed on any website without prior permission from the Continence Foundation of Australia.
ESPRESSO RUN

A study last year at the University of Alabama revealed that men who drink about two cups of coffee a day, or the equivalent in caffeine, are more likely to suffer from urinary incontinence than men who drink less.

The research, published in January in The Journal of Urology, surveyed more than 5,000 American men aged 20 and older in its studies. However, a more recent study of 725 Japanese men found no evidence of an association between urinary incontinence and habitual coffee consumption. While links between caffeine intake and incontinence in women is established, the study, published in the winter edition of the Australian and New Zealand Continence Journal, found the link in men was not as clear.

5 MINUTES WITH ELYCE BLAKE

Elyce Blake is a teacher at Templestowe Valley Primary School, which took part in the Continence Foundation’s national Toilet Tactics pilot study.

Why did your school agree to take part in the Toilet Tactics pilot?

Our school decided to take part in the pilot program because it promotes healthy bladder and bowel habits in a fun and educational way and supported our students in being aware and talking openly about toileting. We believed that there was a need in our school for further education in this area because it is a common issue among children, which can affect their learning. We wanted to make our students aware of the signs of incontinence so that they could recognise the symptoms and talk to an adult if problems persisted.

Toilet Tactics provided our school with a kit that was easy to follow and enabled us to carry out the program effectively. Parents, students and teachers got to work together to assess, report and make changes for our school.

What was the students’ reaction to the project?

At the beginning of the program there were the initial giggles and embarrassed red faces but once they realised that it was an issue they could all relate to they began to open up and share their experiences and learn about healthy toilet habits.

As part of the program, the students got to have their say about the school’s toilet facilities. Students were surveyed and the data was collected and graphed accordingly. As a result, the school was able to make some changes to ensure students felt comfortable to use the school facilities.

Since its completion, has the school or students continued with aspects of the program?

Toilet Tactics is a focus for the health and wellbeing of our students and it’s something that comes up in discussions in the classroom. As teachers, we talk about healthy habits in general and this is one aspect that does occasionally arise. Some students complain of a sore stomach, feeling uncomfortable or a lack of concentration and we can help the students identify when they need to go to the toilet and the importance of going to the toilet properly.

Would you recommend other schools incorporate the Toilet Tactics Kit into their curriculum?

I would recommend schools have a go at the Toilet Tactics program as it was an insightful learning process for the students and the teachers. Incontinence is an issue for a lot of young children and can affect their health later in life. The health and wellbeing of our students is a priority and to be able to inform them of the right ways of toileting and recognising the symptoms can go a long way, and hopefully make a difference in someone’s life later on.

The Toilet Tactics Kit is a health program developed by the Continence Foundation of Australia for teachers to use to engage the whole school community in promoting good bladder and bowel habits and maintaining toilet standards. The program can be integrated into classroom activities. For more details go to www.continence.org.au or phone the National Continence Helpline on 1800 33 00 66.
The pelvic floor muscle in men and women controls the bladder and bowel, supports the pelvic organs, and plays a role in sexual function. Pelvic floor disorders affect sexual function in both physical and psychological ways. In my practice, we see men and women with pelvic floor dysfunction who are experiencing pelvic and sexual pain, erectile dysfunction, bladder and bowel problems and pelvic organ prolapse. Not only do all of these conditions have a negative impact on quality of life, they can also have a profound impact on sexuality and sexual activity.

Pelvic pain
Persistent pelvic pain is a common and debilitating condition experienced by at least 20 per cent of women and 15 per cent of men. One of the most misdiagnosed and mistreated of all areas of medicine, most of these sufferers have pain with sexual activity. There is a range of possible underlying causes, one of which is pelvic floor dysfunction. The pelvic floor muscles can contribute to pelvic pain, most commonly because they are not relaxing effectively or because they have become painful to touch.

Most of the women we see are experiencing vulval and vaginal pain, which can have a negative impact on every aspect of their lives. They are unable to enjoy a satisfying sex life and usually avoid all sexual activity because it hurts too much. Their concerns include the impact on their partner or future relationships, their ability to fall pregnant and whether or not they will ever feel “normal” again.

Even more hidden is persistent pelvic pain experienced by men. They experience pain in the penile, rectal, perineal or pelvic area, sometimes described as a “headache in the pelvis”. I have seen many men with this condition, and one of them has even written a book about his experiences. Core Matters describes his journey, from enduring years of pain that compromised his sexual activity, sleep, relaxation, urination and defecation, to discovering help and regaining hope.

Pelvic floor disorders affect sexual function directly and indirectly, in both physical and psychological ways.

Physiotherapy management of pelvic and sexual pain involves many facets of pelvic floor rehabilitation, including focusing on improving the ability of the muscle to relax, manual therapy, pain education and positive lifestyle changes.

Male pelvic floor dysfunction
The pelvic floor muscles play a role in gaining and maintaining an erection. While there are many causes of erectile dysfunction, strengthening the pelvic floor muscles has been shown in some men to improve erectile function. Bladder symptoms in men have also been associated with sexual dysfunction.

At my practice, we see men before and after prostate cancer surgery, to reduce the severity and impact of post prostatectomy urinary incontinence. The surgery also causes erectile dysfunction; both have an impact on sexuality and sexual functioning.

Incontinence and erectile dysfunction have a negative effect on self-esteem, confidence and masculinity. It is important to seek help for incontinence and speak with a doctor about treatment options available for erectile problems. Couples should maintain intimacy and broaden thoughts about what sex involves, focusing on enjoyment and other ways of achieving pleasure.

Most of us take our pelvic floor for granted, until it stops working. Here, continence and women’s health physiotherapist Shan Morrison explains the wide-ranging impact pelvic floor dysfunction can have on our physical and emotional wellbeing.
Female pelvic floor dysfunction

Urinary incontinence (UI) can affect a woman’s physical and psychological wellbeing in many ways, including sexual function. Urine loss can occur during sexual intimacy, either with penetration or orgasm. Women with UI have decreased libido, more vaginal dryness and pain during intercourse compared with women without UI.

In a recent study of 200 women with UI and urinary urgency, 43 per cent of women and 22 per cent of their partners reported that bladder problems impaired their sex life. Women commonly report to me that they find it hard to relax, are anxious about the smell of urine and don’t feel clean or attractive. Interestingly, research shows that men are less bothered by the actual urine leakage. Bowel incontinence similarly impacts self-esteem, which negatively affects libido and sexual function. Pelvic organ prolapse impacts sexual function, with women worried that sex will be painful and may feel different for their partner. It also has a psychological impact on their sexual body image and perceived attractiveness. Numerous studies have shown that successful treatment of pelvic floor disorders improves female sexual function.

What can be done?

There is a strong link between sexual function and pelvic floor disorders. The first important message is to seek help from a physiotherapist who specialises in pelvic floor rehabilitation. It is also important to openly communicate with your partner; support and maintaining a sense of closeness and intimacy fosters self-esteem and confidence.

Some practical strategies that might help include emptying your bladder, using mattress protection and big fluffy towels. Explore new bathroom possibilities; have a shower together using erotic bathroom products, and remove any concern about odours.

There are health professionals trained in sexual counselling who can help with sexual difficulties, including sex therapists, psychologists and psychotherapists. Your GP or physiotherapist will be able to refer you to an appropriate professional. Above all, remember you are not being “marked” on your sexual performance; get creative, communicate, try new things and seek help.

Shan Morrison is the director of Women’s and Men’s Health Physiotherapy, a private practice specialising exclusively in managing pelvic floor dysfunction.
From treating kidney stones to prostate cancer, bedwetting to incontinence, it’s all in a day’s work for urologist Karen McKertich. Here, Dr McKertich answers some common questions about her work and incontinence treatments.

Urologists are specialist surgeons who treat problems of the urinary tract in women, men and children. Our specialty looks after diseases and conditions affecting the bladder, kidneys, ureters (tubes draining urine from the kidney to bladder) and the reproductive organs of both men and women. Problems with urinary control and bladder disease are central to a urologist’s expertise and training.

An average day for a urologist could see us treating a woman with incontinence, a child or adult with bedwetting, a man waking too many times to urinate at night, as well as other diseases such as kidney stones, urinary tract infections and cancers such as prostate cancer.

All urologists are fully trained surgeons. Urological surgical training involves a minimum of six years of dedicated study and work after medical internship.

While all urologists are trained to treat bladder and continence problems, further sub-specialisation is often undertaken in specific areas, including female urology, pelvic organ prolapse surgery, neurological problems with the bladder, and paediatric urology.

What sort of bladder problems do urologists treat?

Some of the bladder problems treated by urologists include:
- All types of urinary incontinence in women, men and children
- Female incontinence occurring after childbirth
- Male incontinence related to prostate disease or its treatment (e.g. incontinence after surgery for prostate cancer)
- Neurological problems with the bladder resulting from spinal cord injury, multiple sclerosis, Parkinson’s disease, strokes as well as congenital problems such as spina bifida
- Recurrent urinary tract infections, especially in women
- Pelvic organ prolapse in women
- Painful bladder problems such as interstitial cystitis
- Complications after previous incontinence surgery or pelvic surgery
- Bladder cancers and stones

Does management of incontinence always involve surgery?

No. In fact, one of the two main types of urinary incontinence, called “urge incontinence” (where a sudden severe desire to urinate is associated with loss of urine on the way to the toilet), is usually managed by non-surgical measures including:
- Bladder retraining techniques
- Pelvic floor physiotherapy
- Changes in fluid intake
- A group of medications called anticholinergics, which help reduce excessive bladder contractions

Surgery is not commonly required to treat this problem, but when needed is usually minimally invasive, with treatments such as Botox injections into the bladder or neuromodulation (modification of messages sent in the nerves controlling the bladder).

How is Botox used to treat bladder problems?

Botox is a protein derived from the bacteria that cause botulism and can be injected in small doses into a muscle to cause partial muscle paralysis. Botox is one option used to treat urge urinary incontinence in patients who do not respond to conservative measures and anticholinergic medications. Botox is injected into the wall of the bladder using a cystoscope (telescope), aiming to cause partial paralysis of the bladder muscle and stop problems with urgency and urge incontinence. The effects are temporary and last between six to 12 months.

The main potential risk of Botox is that it can worsen bladder emptying. The risk of urinary retention (not being able to empty the bladder) is dependent on the dosage of Botox and the underlying bladder problem. Due to the risk of urinary retention, only patients who are able and willing to potentially use catheterisation (bladder drainage using a fine tube) after treatment should consider this treatment.

Botox has been approved for use by the Therapeutic Goods Administration for patients with urinary incontinence associated with urge incontinence due to a spinal injury or neurological illness.

What is neuromodulation for urge urinary incontinence?

Neuromodulation uses mild electrical impulses to alter abnormal messages and communication in the sacral nerves (located near the tailbone) that are one of the control centres for urination.

InterStim neuromodulation therapy uses a permanent implantable device that works like a pacemaker for the bladder to control abnormal messages in the sacral nerves. It is a minimally invasive surgical treatment option in patients with an overactive bladder who have not responded to conservative measures and anticholinergic medications. The procedure involves two stages, with an initial trial period to see if the treatment has the desired effect in improving bladder symptoms prior to consideration of permanent device implantation.

Do urologists treat women with stress incontinence?

Yes. Urologists commonly perform surgery to treat stress incontinence in women, which is the loss of urine associated with coughing, sneezing or exercise. Surgery is usually reserved for those women who have not responded to conservative measures such as weight loss and pelvic floor exercises.

Many minimally invasive surgical options such as sling surgery are available for women with stress urinary incontinence and these can dramatically improve quality of life for incontinent women.
What can I do to help reduce problems with incontinence?

- Most importantly – ask for help. The field of incontinence treatment is constantly evolving and much can be done to cure or significantly improve incontinence issues in most patients.
- See your GP and discuss your problems. Most patients don’t require specialist referral and can respond dramatically to treatments prescribed by your GP and measures such as pelvic floor physiotherapy.
- Stop smoking. Smoking is the main cause of bladder cancer.
- Maintain a healthy weight. Obesity can worsen problems with incontinence.
- Perform pelvic floor physiotherapy. A session with a dedicated continence physiotherapist can provide excellent training in correct pelvic floor physiotherapy techniques, an individualised program of exercise and education about good bladder habits.
- Exercise regularly to maintain your general health and levels of fitness.
- Eat a healthy diet.
- Avoid constipation as it can worsen problems with bladder function.
- Avoid straining when emptying your bladder and bowels.
- Avoid excessive intake of bladder irritants such as caffeine (e.g. coffee, tea, cola) and alcohol.

Common myths ABOUT INCONTINENCE

MYTH: Incontinence is a natural part of ageing and can’t be treated.
FACT: While rates of incontinence increase with age, you don’t have to put up with what is a socially debilitating and often demoralising problem.

MYTH: Most incontinence requires treatment with surgery.
FACT: Not all incontinence requires surgery. Many types of incontinence can be treated with modification of fluid intake, physiotherapy and bladder training as well as medications. Although urologists are surgeons, we definitely do not treat all patients with surgery.

MYTH: Drinking large volumes of water is good for you.
FACT: Excessive fluid intake can worsen bladder symptoms. Urologists use a bladder diary to measure fluid intake and urine output to determine if your fluid intake is in the correct range.

MYTH: Urologists only treat men.
FACT: Urologists are experts in treating bladder problems that occur in both men and women. Many urologists now have a specialty interest in female urology and voiding problems.

MYTH: All urologists are men.
FACT: There are an increasing number of female urologists, many of whom have a special interest in female pelvic health.
Incontinence
– a problem in anyone’s language

Ethnic communities face challenges accessing continence care due to language barriers, poor health literacy and difficulties in accessing interpreting services. Tailored communication using select media platforms can help to overcome these barriers, explains Nives Zerafa.

Studies show that general health promotion campaigns do not successfully engage ethnically diverse communities, who prefer communication that is culturally appropriate and delivered in a familiar language. Providing audio and visual options such as videos and photos help address literacy challenges, particularly for communities who have oral rather than written language traditions, or those who have low education levels.

The increasing use of digital technology has led to an increasing reliance on the internet for health information, highlighting its importance in health promotion. Current research provides differing views on how ethnic communities in Australia engage online. Some evidence suggests there are significant barriers, such as literacy and familiarity with technology when accessing health information online. Other research, however, has found that ethnic communities such as the Vietnamese, Samoans and Sudanese, are regularly using the internet, irrespective of age, levels of education and exposure to English.

People born overseas are slightly more likely than those born in Australia to use the internet. Youth adapt very quickly to accessing online information and many adults learn these skills from younger members of their community. The low cost of the internet, compared with telephone or travelling to visit family members, is important to many young and newly-arrived refugees and migrants because the internet is often seen as their only link to their home country.

The Continence Foundation has used these findings to develop Incontinence Outreach in CALD Communities, a new initiative to be launched during World Continence Week (June 24–30). The Foundation’s website has been redeveloped to include language-specific web pages for non-English speaking communities and health professionals working with these communities.

The web pages will be available in 20 languages, including Cantonese, Mandarin, Vietnamese, Arabic, Greek and Italian, providing links to 17 new bilingual fact sheets on topics such as bedwetting, pregnancy, pelvic floor muscle, prostate and continence products. These web...
A TALE OF TWO COUNTRIES

As a former nurse manager at a busy continence service in Melbourne, Lisa Wragg is experienced in treating clients from ethnic backgrounds. Here, she recounts how a minor ailment in a non-English speaking patient resulted in a wrong diagnosis and inappropriate hospitalisation.

Every Wednesday my colleagues and I would triage the referrals to our Continence Service, based in the southern suburbs. According to their urgency, we would prioritise and delegate the initial assessment to the most appropriate clinician within our service, which enabled us to attend to the more urgent referrals so they would not be waiting the standard four to six weeks. The Continence Service receives approximately 80 to 90 referrals each month and is part of a large healthcare network in metropolitan Melbourne. It services a large culturally and linguistically diverse (CALD) community, and consequently could require interpreters for up to 15 languages in any given month. Unfortunately, people who are not proficient in English are not always able to readily access interpreter services, which can have adverse health outcomes for the patient.

One such case involved an 81-year-old Chinese woman who spoke Cantonese and lived at home independently with her son, a businessman who frequently travelled interstate and overseas. It was a particularly hot summer and this lady had collapsed while walking home from the local shops. She was taken by ambulance to a hospital’s accident and emergency department suffering dehydration, and within 24 hours had developed urinary retention and delirium. She was diagnosed with a urinary tract infection and was given intravenous fluids and antibiotics, and had a urinary catheter inserted. It was also noted that she had severe constipation (faecal impaction). However, this did not appear to be actively treated while she was an inpatient in the acute hospital.

Once the delirium subsided and her symptoms were stable she was transferred to a subacute ward with a label of dementia. She still had a catheter inserted and was still suffering with faecal impaction. She had no other next of kin and her son was away on a business trip, and due to the language barrier, he was not contacted.

We received this referral after she was transferred to the hostel attached to this health service because they needed information and education on how to care for the catheter. Prior to my consultation with this client, I organised for a Cantonese-speaking interpreter to be present. As part of this initial consultation, it became clear to the interpreter, and then to me, that this lady was not demented, but simply had not had access to an interpreter until now, and was extremely relieved to be able to speak with someone who could understand her. She became extremely emotional and wanted to know why she had been fitted with a catheter, and when she was going home. She also wanted to know where her son was and if anyone had contacted him. The hostel staff were made aware that this lady was lucid and could communicate with an interpreter.

At this point, I established that this client had had lifelong problems with constipation and that she had been eating and drinking very little because she felt full, and that the food was not consistent with her normal dietary intake.

Working with the hostel staff and my client, I established a bowel regime. It was explained to her through an interpreter that it was very important to establish regular bowel actions that could be easily passed before the catheter could be removed.

After six weeks of routine recording of her bowel actions, I organised an abdominal X-ray to establish the degree of constipation. It is important to ensure that the client is not constipated prior to the removal of the urethral catheter. The abdominal X-ray showed that she no longer had faecal impaction, and after discussion with the continence physician, the catheter was removed.

During this time, the lady started to gain weight and had found ways to communicate with staff. Once her son had returned from his business trip, she was mobile, lucid and able to make a conscious decision about where she would like to live. She acknowledged that she did require more assistance than her son could provide and moved to a more culturally appropriate hostel.

While this case is an extreme example of the potential problems associated with treating people who speak little English, it highlights the need for health practitioners to be sensitive to the needs of the CALD community, and to access interpreter services where necessary to ensure optimum health outcomes for patients.

Lisa Wragg is the executive officer of the Victorian Continence Resource Centre.

www.continence.org.au
I am extremely proud of becoming patron of the Continence Foundation of Australia for several reasons. The first is the “personal story” aspect, which is a common feature of many people who support particular causes, or pursue a specialist profession. So a psychiatrist, more often than not, will have had some personal experience of mental illness in their own family that sparks their interest and urges them to understand the condition better so they can assist other people.

For my family, urinary incontinence (most often stress incontinence), has been an annoying aspect of life for many years. It has mainly affected the women but some of our men are now experiencing prostate problems, with incontinence resulting from treatment. Incontinence, in common with mental illness, is a stigmatised condition. People are embarrassed by it; may have experienced teasing as a child or been the subject of poor taste humour. The best way to tackle stigma is to come out and talk about it.

Some 10 years ago, following temporarily successful surgical treatment for stress incontinence, I decided to “come out”. At that time I was Victoria’s Health Services Commissioner and when approached by the Continence Foundation, I considered going public. I decided to do so in a feature article for The Age that was supposed to be published during World Continence Week, and I waited for reactions from friends and colleagues.

During that awareness week, I waited nervously for the article to be published. It didn’t appear. I experienced a mixture of disappointment and relief. Some six months later, I was reading a feature article in The Age during the silly season, which had an accompanying photograph of someone who looked familiar. It certainly was because it was me! I suffered a pang of anguish when I saw my name and the word incontinence in the headlines, especially because it was no longer World Continence Week, and I waited for reactions from friends and colleagues.

Michel Gorton is a senior partner of law firm Russell Kennedy and was the president of my advisory council, the Health Services Review Council. He called to say that his wife, a GP, had read the article at the breakfast table with him looking on a little nervously. When she finished reading she banged her hand on the paper and declared, “This is great. This is going to help so many people”. I hope it did. I certainly had many people, mostly women, calling me to thank me for spurring them into action rather than remaining unhappy and passive about their condition.

I am really looking forward to working with the Continence Foundation as patron. The board members are certainly a fun group of people, with rich senses of humour. Good humour, storytelling, writing and speaking are the tools I’ll be using to continue with the stigma-reduction message.

I’m also having a lot of fun telling people I’m patron of the CFA. In Victoria, that is immediately misinterpreted as the Country Fire Authority and it’s fun to say, “No, I mean the Continence Foundation of Australia, which needs all the support it can get. Please excuse the pun!”
Q. My 70-year-old mum seems to have lots of bladder problems but she is too embarrassed to talk about it. English is not her first language, so she has difficulty explaining herself. The one time she spoke to a doctor she was told they couldn’t do anything without tests. She says she prefers to use cloth towels and “women’s napkins”. What can I do to help her?

A. Incontinence can be an embarrassing problem, but much can be done to help, even if you don’t speak English well. You mother can phone the National Continence Helpline 1800 33 00 66 and request an interpreter. She needs to tell us her name, phone number and language. We would then organise a female interpreter and call her back. All the nurses on the Helpline are skilled in three-way conversations with interpreters. Female callers can request a female nurse (and interpreter), and males can request a male nurse (and interpreter).

During the anonymous conversation we could discuss with your mum the different types of bladder problems, how they can be managed better, and if necessary, where to go to get further support. We also have brochures in 17 languages at present, discussing the basics of bladder and bowel control. Even if your mum still does not want to see someone, we could talk about more appropriate products for her problem and where they can be purchased. She would not be eligible for financial support until a doctor or specialist can make a diagnosis that meets the current criteria. We would also reassure your mum that most continence services have access to skilled interpreters, and she would benefit from seeing a service to help with her problem.

Q. I am caring for my mother who has incontinence. I have been told by a friend that I can get some money to help pay for the cost of her pads. Who will help me to get this funding?

A. There are various funding schemes available for continence products, funded by the Australian Government. These schemes have differing eligibility criteria and funding allocations, and it is important to note that you may be eligible to apply for government funding through several schemes. Australian Government funding schemes are open to all Australian citizens who meet the eligibility criteria, regardless of which state of Australia they live in.

The Continence Aids Payment Scheme (CAPS) is available to people aged five years and older, with permanent and severe incontinence due to:

• neurological conditions such as paraplegia, cerebral palsy, multiple sclerosis, spina bifida, dementia or permanent and severe intellectual impairment
• other causes such as certain cancers, prostate disease or prolapse, and they have a valid Centrelink Pensioner Concession Card (or if they are under 16 years of age, their parent/guardian holds a Pensioner Concession Card).

To apply on behalf of your mother, you will need to complete a CAPS application form, which includes a health report from your medical practitioner or continence nurse about her condition. To obtain a hard copy of the CAPS application form and guidelines, phone the National Continence Helpline on 1800 33 00 66. For an electronic copy you can email continence@health.gov.au

If your mother is an entitled veteran or war widow, she can access funding through the Commonwealth Department of Veterans’ Affairs (DVA). There are also a range of state/territory government funding schemes available. For more information please contact the National Continence Helpline on 1800 33 00 66.
Some of the benefits offered by Independence Australia are:

- Monthly specials across a range of continence, wound care and health care products
- Prompt delivery direct to the home with discreet packaging if required
- No minimum order required *
- Free delivery for all orders over $250

*Terms and Conditions Apply

Contact us today for more information or to place an order:
T 1300 788 855  www.independenceaustralia.com
F 1300 788 811  E customerservice@independenceaustralia.com