The Chronic Diseases Network

The Chronic Diseases Network was set up in 1997 in response to the rising impact of chronic diseases in the NT. The network is made up of organisations and individuals who have an interest in chronic disease, with Steering Committee membership from:

- Aboriginal Medical Services of the NT
- Arthritis & Osteoporosis Foundation of the NT
- Asthma Foundation of the NT
- Cancer Council of the NT
- Healthy Living NT
- Heart Foundation - NT Division
- Menzies School of Health Research
- NT DHF Allied Health/Environmental Health
- NT DHF Community Health
- NT DHF Health Promotion
- NT DHF Nutrition and Physical Activity
- NT DHF Preventable Chronic Disease Program

In Australia, about 50% of Indigenous people smoke. Smoking is making Indigenous people sick and causes 20% of Indigenous deaths. But we still do not know a lot about why Indigenous people start to smoke, continue to smoke or why they quit.

We collected smoking stories from 25 Aboriginal community members and from 13 health staff. Our research found that the family is very important in understanding Aboriginal smoking.

Starting smoking...

Family are strong role models for their children. Most people started smoking by copying their parents and family members who were smokers. In some families, even very young children can copy lighting a cigarette or picking up butts.

I had seen a lot of people smoking; well I copy from my mother and my grandmother.

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Aboriginal stories about SMOKING

Vanessa Johnston, David Thomas, Joseph Fitz
Menzies School of Health Research, Darwin

In Australia, about 50% of Indigenous people smoke. Smoking is making Indigenous people sick and causes 20% of Indigenous deaths. But we still do not know a lot about why Indigenous people start to smoke, continue to smoke or why they quit.

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The CHRONICLE

EDITORIAL COMMITTEE - CDN

CHRONIC DISEASES NETWORK

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Contributions appearing in The Chronicle do not necessarily reflect the views of the editor or DHF. Contributions are consistent with the aims of the Chronic Disease Network and are intended to:

- inform and stimulate thought and action
- encourage discussion and comment
- promote communication, collaboration and collective memory.
Continuing to smoke...

It was very hard for people to quit once they had started smoking. One of the main reasons for this is because so many family and friends are smoking around them. It is difficult for people to remove themselves from other smokers. Also smoking in these communities is a shared activity. People who smoke together feel like they have a bond between them and refusing to give or buy cigarettes for family may be seen as insulting. Being a non-smoker can make people feel like they are outside of the group. Sharing cigarettes was also described as a time for yarning and sharing feelings. Non-smokers can miss out on this. Other things that made it hard for people to quit were their addiction to nicotine, stress, boredom and having other difficult things going on in their lives (e.g. family problems).

My wife was a great smoker and we loved smoking together...sharing stories and good company and I loved my wife like that.

Quitting smoking...

Some people we spoke to have quit and many others wanted to try, even though it is hard to quit. The main reason people want to quit is for the sake of family. Smokers wanted to protect the health of their young children from second hand smoke. They also wanted to be positive role models for their children, and were tired of the problems smoking was causing for the family (e.g. cost, humbug and fighting over tobacco). The other main reason people wanted to quit was for their health.

My second eldest he don’t smoke now. He got two little beautiful boys. And I said “you better keep off the smokes, cause you got responsibility now. Think about them two, not just yourself you know.” The children come first, you know.

What does it mean...

This research tells us that the family is important in starting to smoke and continuing to smoke. At the same time, the health and well being of the family is the most important motivator for Aboriginal people in our study to quit. This means that programs to prevent smoking in young people and help smokers to quit need to include whole families, rather than just focusing on individual people. Such programs would be best delivered by trained Aboriginal tobacco workers, who have a relationship with their community. They could educate parents and other adult family members about how to support their children to not smoke, help them with making smoke free areas in the home and cars, and if they felt ready, support them in making a quit attempt.

A more detailed description of this research is available as: Johnston V, Thomas DP. Smoking behaviours in a remote Australian Indigenous community: the influence of family and other factors. Soc Sci Med 2008;67(11):1708-16

This research was funded by the Cooperative Research Centre for Aboriginal Health. We would like to gratefully acknowledge the assistance of Sandy Djabibba, Laurie Magaldagi, Jill McDonald, Paul Burgess, Pamela Hepburn, and other health staff for their assistance in the fieldwork for this study. All illustrations by Joseph Fitz.
Joy Pascall  
Preventable Chronic Disease Program - DHF, Nhulunbuy

The Yirrkala Laynhapuy Homelands Tobacco project aims to provide and support an integrated tobacco cessation/ intervention program. It involved a multi-disciplinary service approach drawn from a number of health disciplines from within the department of health and families and non-government agencies. The project was undertaken in partnership with Yirrkala/Laynhapuy homeland communities.

The tobacco project working party was initiated due to the impact that smoking has on chronic disease, and that East Arnhem has the highest incidence of lung cancer in the NT. Tobacco use is also responsible for the greatest burden of disease and injury in Australia (Begg et al. 2007).

After consultation with key stakeholders and the local people of Yirrkala/Laynhapuy communities, the two communities worked together to implement an anti smoking project. The tobacco project is called “Walala Baynuhna Bulu Narrali” (roughly translated to “All you – no more smoking”).

Specific issues addressed were:
- smoking in the general population
- smoking in pregnant women
- passive smoking
- youth/child health issues
- tobacco legislation by community retailers

Actions of the working party so far have involved:
- smoking flip chart
- mending school of health research – monitoring the sale of tobacco
- DVD of role models within communities telling their non-smoking stories
- movie nights with smoking adverts shown on homelands legislation enforced by AOD
- girls camps with smoking in pregnancy stories
- official opening of non-smoking clinics
- BI and NRT training for health staff
Ric Browne, Coordinator, Tobacco Control Program
Miwatj Health Aboriginal Corporation, Nhulunbuy NT

‘Starving for ngarali’ is a cry from Aboriginal people long heard in the settlements of East Arnhem Land - from the early missionary days when workers were paid in tobacco, or ngarali. Any observer of community life in this part of Australia today would have to conclude that almost everybody smokes. In this situation there can be little wonder about the cause of high death and illness rates.

A new tobacco control program, run by the local Aboriginal health service, aims to challenge that. But as the tobacco workers go about their job, they are realizing how deeply entrenched attitudes are. ‘Ngarali is culture’, they are told by the locals. And in some ways they are right - for tobacco did not arrive here with European settlers - it came much earlier than that. Parliamentary papers show that between 1894 and 1903 tobacco imports to the Northern Territory from Macassar were substantial, averaging many hundreds of pounds (weight) every year. It was Macassans who taught Aboriginal people from Arnhem Land to smoke - the people used hollowed claws of a mud crab as pipes. Just as Yolngu incorporated other aspects of Macassan culture into their own, so they incorporated ngarali.

So when the missionaries started paying workers with sticks of tobacco, they found many ready takers. But even then consumption was within limits. Old Aboriginal people from the region today say the time when they started smoking ‘seriously’ was when a supermarket arrived in the region for the first time in the 1970s. All verbal accounts say that when tailor-mades appeared on Woolies’ shelves, consumption levels soared: it is a lot easier to smoke a tailor-made than to deal with a tobacco stick.

And until very recently, there has been no opposition to this. Health services – both government and community-controlled – have been too busy with acute care to worry about long-term education. The Northern Territory regularly receives the ‘Dirty Ashtray’ award for its weak tobacco legislation. The one occasion on which there was serious opposition to official endorsement of tobacco was in the missionary days. In a fascinating series of incidents a world away from where Doll was conducting his famous research,

In 1950 the controversial ‘tobacco question’ strained relationships between the Church Missionary Society (CMS) and the Government, and brought divisions among the missionaries themselves. In December the Government ordered the missions to issue tobacco to the Aborigines under their care, as part of their rations. When the missionaries on the three CMS stations refused on the grounds that Aborigines were becoming addicted to tobacco and using endowment and other monies to buy it, the Administrator of the Territory threatened to withdraw CMS licenses to work in the (Arnhem Land) Reserve. A compromise solution was adopted whereby it was agreed that tobacco would not be made available to children, and that parents could not use endowment monies for its purchase. Some of the CMS missionaries resigned because of the controversy.

So, it is easy to see why tobacco is associated with culture for many Aboriginal people: it has been a central part of Yolngu life for hundreds of years, with its role reinforced even in recent times by governments and missions.

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This year the Commonwealth Department of Health and Ageing has funded a new tobacco control program in the region for 3 years. Managed by Miwatj Health, its starting point is awareness of the health dangers of tobacco. Operating with local Aboriginal staff and non-Aboriginal professionals, its initial goal is to promote the message that smoking kills – not just adults but also unborn children. They operate an outreach service which takes videos and simulation models out to communities and into people's houses at Nhulunbuy, Yirrkala, Gunyangara, Galupa, Gapuwiyak, Birriritjmi (Wallaby Beach) and the larger island community of Galiwin’ku. The team has taken mainstream videos and dubbed them in Yolngu language, seeking to use those which really confront people.

The Tobacco Control team also supports the clinical staff of Miwatj Health – particularly the Child and Maternal Health Team and the Chronic Disease Team – in providing information and education sessions regarding cessation strategies to clients who are referred to them as part of normal clinical operations.

A second focus of the project is to target current non-smokers, specifically children, to discourage smoking uptake. It has been enthusiastically supported by Aboriginal schools in the Miwatj region, with Yirrkala School devoting a block of 2 weeks in its secondary program to informing students of the health dangers. The school has produced media material such as an anti-smoking RAP song and anti-smoking posters, recording it as part of their media studies course and making it available for the outreach ‘road show’. Gapuwiyak School and Shepherdson Collage at Galiwin’ku have agreed to include similar curriculum in their programs during the second half of 2009.

But it is a struggle. Tobacco Control Project Coordinator, Ric Browne, put the case that "we are just making up for the many decades when governments and missionaries actually encouraged Aboriginal people to smoke. We are dealing with an addiction that is grounded in every aspect of people's lives – from when they wake up to when they go to bed, smoking is seen as normal, as part of culture."

And culture sometimes impacts on the program in other – less obvious – ways. "Canberra bureaucrats often think the best people to provide education about awareness of the health dangers of tobacco are local Aboriginal staff. But it is not that simple", Ric explained.

Our project is showing we have to be careful about getting the right balance between Aboriginal and western knowledges, and between Aboriginal and western professionals. Local Aboriginal staff sometimes feel that cultural reasons prevent them from telling other Aboriginal people what they should and should not do – it is often not appropriate for one Aboriginal person to tell another what to do - including telling them not to smoke.

One early lesson from this project is that non-Aboriginal professional people can play an important role because their authority is seen as coming from western science. Yolngu expect non-Aboriginal people to 'lecture' them - they are used to that! But they do not expect their fellow Yolngu, whether health workers or not, to do so. Strong advice from an expert outsider, on the other hand - such as a highly-trained western doctor - is often taken seriously.

Smoking rates among non-Indigenous people only really fell when smoking began to be seen by society as not 'normal' – when it became difficult to smoke in offices, in hotels and with children around. There is a very long road to walk before this can happen in Arnhem Land. In East Arnhem Land, most Aboriginal people do not spend time in offices or hotels. In East Arnhem Land, until recent years tobacco use was encouraged by the authorities. In East Arnhem Land non-western world views about the causes of illness often prevail. In East Arnhem Land, smoke has an important ceremonial meaning. And in East Arnhem Land 'culture' can impact on a health program in unexpected ways.

For all these reasons, in this region there is no doubt it will take decades to achieve real results in terms of a reduction in mortality and morbidity rates. But at least now we've started.
Clients were provided with the resources, opportunities, knowledge and skills to cease smoking e.g. identify their triggers for smoking, and implement strategies tailored to their needs. The program highlighted the importance of considering the complex interaction between smoking, symptoms of mental health conditions, and some medications used to treat these conditions.

Given that a large proportion of those with a mental illness are also smokers, and burdened by chronic disease, such as respiratory and heart conditions, the program offers many benefits. Those clients with mental health conditions who did attend our courses reported that they benefited from the program – be it to cut back or cease smoking.

Having access to educational resources from QUIT SA, Alcohol and Other Drugs, and the respiratory nurse e.g. a model of damaged lungs as a result of smoking, smoke-alyzer (for measuring CO2 levels pre and post smoking), pamphlets for healthier lifestyle choices, and NRT options, was invaluable. In addition, the self reflection exercises after delivering the course e.g. what I felt went well, what could be improved etc was also beneficial.

Recently, Quit Victoria ran further Quit Educator training in Darwin. A handful of nurses from both Community Care Centres in Darwin completed the training - subsequently the pool of trained Quit educators has grown, with sessions being planned in both Centres (Palmerston and Casuarina).

For further details on the smoking cessation courses, please contact Palmerston Health Clinic 08 8999 3344.

**Currently** there is a plethora of local and national initiatives to improve the health of all Territorians e.g. Closing the Gap of Indigenous Disadvantage; the review of the NT Preventable Chronic Disease Strategy; the Department of Health and Families Smoke Free Policy; and the Preventable Health Taskforce.

Given the rapid rise in chronic disease locally, nationally, and internationally; and the resultant demands placed on all health systems, it is timely to focus on a collaborative, multi-disciplinary approach to addressing this current crisis.

Whilst it is acknowledged that chronic diseases are affected by an array of underlying social determinants of health e.g. income, employment, stress, and education; much can also be done to reduce the burden of disease by addressing the modifiable behavioural risk factors, such as tobacco smoking, obesity, and excess alcohol consumption.

The Community Health Branch has for some time been involved in delivering smoking cessation programs both within the Branch and to the wider community. However, this gathered momentum this year at Palmerston Community Care Centre, where staff that had been trained as Quit Educators (including a social worker and nurses) were able to utilise their skills e.g. running Quit courses, an information night for Activate NT, and a combined stall with Alcohol and other Drugs at Youth Week (hosted by Palmerston Town Council).

This has been an excellent opportunity to work collaboratively using evidence based, best practice, accredited training, to enhance each others efforts to address critical health issues. By working interdisciplinarily it enabled us to actively work together on the same project towards achieving a common goal; as opposed to working independently or parallel to each other, which had often been the case in the past.
The single biggest intervention we can make in Aboriginal health relates to smoking. Aboriginal people smoke three times the amount as non-Aboriginal people and our research tells us that this counts for 70 percent of avoidable mortality… From a health perspective, when it comes to chronic diseases, tobacco is the killer.

(The Weekend Australian, July 11-12 2009, Mick Gooda, Chief Executive of the Co-operative Research Centre for Aboriginal Health)

The Department of Health and Families Alcohol and Other Drugs Services Central Australia (ADSCA) has been working with the Santa Teresa community as part of the Feel Good Program 2008 – 2009. Other organisations forming the multidisciplinary team include the Heart Foundation NT, Preventative Chronic Diseases, Department of Education and Training, Maternal Child and Youth Health, Centacare NT, Territory Health Services Nutrition, Alice Springs Hospital and Menzies School of Health Research.

The aim of this project is to improve the health of community members by reducing the harm caused by chewing and smoking tobacco. The Feel Good Program's key focus areas are to:

- raise the awareness of the health effects of smoking and second hand environmental smoke
- help people to QUIT
- dedicate Smoke Free places within the community

Coinciding with National Youth Tobacco Free Day in March 2009, an educational Fun Day was held at the Community Education Centre (CEC). Activities included a skipping workshop, story telling sessions, Drug Education, Nutrition Workshops, Healthy Lungs Workshops and an entertaining performance by Veggie Man. All the staff and students enjoyed the presentations throughout the day.

Lyentye Apurte CEC Principal, Mr Greg Crowe is highly committed to providing healthy lifestyle choices to his pupils. Also this will provide the opportunity for local QUIT educators to deliver QUIT workplace seminars to his teaching staff.

Nina Nichols from the Heart Foundation NT is currently working with community members to establish a “Local Champions” support group. The Local Champions project will help bring people’s experiences and stories together.

Community Council residents have taken the initiative and introduced Smoke Free areas around the community at the Recreation Hall and Health Clinic.

Members of the Santa Teresa community have taken up the opportunity and received smoking cessation counselling and nicotine replacement therapy to help them quit smoking.

In the coming month ADSCA are looking forward to working with the local women at the Santa Teresa Spirituality Centre in order to deliver smoking and pregnancy information sessions.
The incidence of smoking rates and ill health go hand in hand. We are becoming increasingly aware of the growing body of evidence for smoking and poor health outcomes. In East Arnhem Region (EAR) we too are very concerned about smoking prevalence and its specific impact on lung disease. Let’s recap a few of the statistics to reflect why:

- Tobacco is the single most preventable cause of ill health and death and is a major risk factor for cardiovascular mortality and morbidity, cancer and a variety of other diseases and conditions [1].

We also know in Indigenous populations that:

- In 2004-05, the total national smoking average was 23% [3], for Indigenous populations it was twice this rate at approximately 50% [4]. The incidence is said to be much higher in remote Indigenous communities at almost 70% in 2006 [3]. Anecdotally some health professionals say it may be even higher.

- Tobacco smoking is said to cause an estimated 20% of all Indigenous deaths nationally in 2003 [2].

- Specifically for communities in remote EAR the incidence and mortality dramatically exceeded all other NT regions. EAR has more than twice the mortality from lung cancer compared to the Katherine region and more than seven times the Alice Springs rural region [6].

- Lung cancer is primarily a preventable disease with cigarette smoking by far the main cause. It is estimated that 75-88% of lung cancer cases are caused by smoking [5].

The path to reduce smoking and its impact started well before now but the momentum has slowed. It’s time for a renewed effort to reduce the extremely high mortality and morbidity rates from smoking in EAR. The message is there every time you drive past Gove District Hospital (GDH), with four of its five large banners promoting that the GDH as having smoke free grounds from the 1 July 2009. These are easily visible from the street. Another large banner has been erected at the local pool.

This gives maximum exposure to the campaign for smoke free grounds. All of the NT Department of Health and Families (DHF) EAR clinics and government buildings are now smoke free, with some of the non-government clinics following suit. Let us not forget that Groote Eylandt led this initiative way back in March 2007.

There are various signs used to get this message across, from the large GDH banners, to local imagery from Anindilyakwa Land Council on Groote Eylandt. Many remote clinics have yet to receive the new DHF signs which include the international smoke free logo. Not to be left out, some clinics have improvised and made their own. Some have local non smokers on posters; some have printed the international symbols which are stuck to the clinic walls with sticky tape. Typically, remote clinics have improvised with flair and individuality, but the message is being promoted.

Both government and non-government staff in the region are working together to produce local resources to increase awareness of the negative impact of smoking. There are DVDs and posters produced at Yirrkala CEC with Miwatj. The Yirrkala DVD, Tobacco Sickness was inspired by the Yirrkala Laynapuy Homelands Tobacco Project and the Anindilyakwa Land Council. Also developed collaboratively is the Smoking Story flip chart in both Yolngu Matha and English, and as a pictorial.

A collaborative approach is building in the communities as we discuss the smoking policy with DHF, local and community shires, ALPA stores, strong community groups, and other non-government organisations. Local community knowledge will continue to build around smoking as local research through the Menzies Tobacco Project now in four EAR DHF communities (including Groote) and James Cook University Project which is in one EAR community. Alcohol and Other Drugs (AOD) and Health Development teams have been supportive in these discussions.

In EAR we have been fortunate to have with us visitors from near and far to impart knowledge. The Centre of Excellence in Indigenous Tobacco Control (CEITC), QUIT Victoria, Smoke Check QLD, NT AOD Tobacco enforcement officer Warwick Kneebone and Roz Treslove project officer for smoking in...
pregnancy have inspired us recently. At these sessions it has been excellent to see a broad spectrum of participants from EAR interested in changing the way we approach smoking as a health issue.

As participants of the EAR, AOD and Health Development and Oral Health team, we are equipped with a barrage of tools and health promotion equipment to increase awareness of the negative impact of smoking. We have a range of tools including flip charts, The Smoking in Pregnancy Story Board, health promotion boards, “Shortness of breath cigarette, Smoking Suzies, Deadly Dan the smoke free man and QUIT stress balls. The Fagerstrom tool and Nicotine Replacement Therapy has become our friend and ally as we fight against the smoke haze of denial.

Major smoking issues addressed are:

- smoking in pregnancy
- reduction of Environmental Tobacco
- tobacco legislation and the implementation of policy
- improving local information for communities.

As AOD and Health Development in EAR, the message is going out through the spectrum of levels individual to policy. Nationally accredited Brief Intervention courses have been conducted with a wide variety of participants and organisations attending and are still on offer to GDH and the communities. Four QUIT courses have been offered to hospital staff and further courses will be available to GDH staff, community clinics and other community non-government organisations in the future. Health promotional activities have occurred at the Nhulunbuy High school and CBD, Ramingining Community, GDH, Nhulunbuy community as part of Drug Action week, Gapuwiyak opening of the Football and Arts Centre, and the Indigenous Women’s Look Good — Feel Good expo aimed at 17–35 year old women. The effects of smoking in pregnancy are demonstrated in the communities with Smoking Suzie, posters and flip charts by our visiting outreach midwife. There are also plans to develop “smoke free” t-shirts for newborns at GDH. SIDS education is happening as a project in GDH and in the communities. The Core of Life (a teenage program on positive parenting including smoke free messages) has been delivered in five schools, one women’s centre, and to well over two hundred participants. Future health promotion activities are planned for the GARMA Youth Forum and Gove Community “Festival by the Sea” in August.

Together as front line members of the EAR team promoting health and well being, we are working to improve local knowledge at an individual and community level. We will work together to support local decision making and policy change. We understand that a collaborated and consistent approach is essential to reduce environmental tobacco harm and reduce the prevalence of smoking.

It won’t happen overnight but positive change for all EAR people, families and communities is within reach.

Reference

The National Public Health Institute in Oulu, Finland has published the results of a nested case control-study within Nordic biobanks by Kapeu AS et al, which evaluates the independent role of smoking in Cervical Cancer.

**Their conclusion:**

This study confirms that smoking is an independent risk factor for cervical cancer/SCC (Squamous Cell Carcinoma) in women infected with oncogenic HPVs (Human Papilloma Viruses). These findings emphasize the importance of cancer prevention among women exposed to tobacco smoke.¹

From a health promotion perspective, the cessation of tobacco smoking is an important tool in lowering the rate of cervical cancer, as well as many other cancers and preventable chronic diseases. Of course the best tool for preventing up to 90% of cervical cancer is regular Pap smears. An article about the study can be found at: aje.oxfordjournals.org/cgi/content/abstract/169/4/480


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Most carers and parents are aware of harmful ‘second hand’ smoke.
Don’t forget ‘hidden’ smoking hazards, such as cigarette butts, lighters and fire.
Having lit cigarettes, ashtrays, lighters and other smoking related paraphernalia in the child’s vicinity increases the risk of fires starting accidentally.
Commonly, these items are unattended within curious children’s reach.
Remember it only takes one slightly ‘live’ ember to burn down a house!

Little children have eaten cigarette butts, causing poisoning.
Cigarette butts are very toxic, even if regurgitated.
The child should be taken to emergency care ASAP if a cigarette butt has been consumed.
With all the health risks for children such as asthma linked to passive smoking - Kidsafe NT asks all Territory parents and carers to set a great, safe health example for our children and throw away the smokes!

For more information on child safety, contact:
Kidsafe NT  T: 08 8985 1085  E: nt@kidsafe.com.au
Tobacco smoking is the largest preventable cause of cancer, responsible for more cancer deaths in Australia than any other single factor. It is also directly responsible for many heart and lung diseases. Smoking not only affects the smoker, but those that are around them 1.

While Australia should be acknowledged as a world leader in tobacco control policy, more than 17% of Australians smoke every day (almost one in five people) half of whom will die as a result of smoking. Despite substantial reductions in smoking rates over the past 30 years, tobacco use continues to generate a significantly higher disease burden than any other preventable cause. Around 19,000 Australians die from diseases caused by smoking each year and lung cancer rates in women continue to rise 2.

In 2001, there were 10,592 new cases of cancer reported that were all attributed to smoking that is 12% 3.

The need for tobacco control in the Northern Territory

Evidence shows that a comprehensive policy commitment and sustained campaign funding can reduce smoking rates in Australia to less than 5%. None of the required measures would involve banning tobacco products.

Lung cancer is largely preventable given effective tobacco control and smoking prevention and cessation strategies 4 and is increasing at an alarming rate in the Northern Territory.

The Northern Territory usually claims the humiliating Dirty Ashtray Award by the AMA for making the least progress in combating smoking. However in 2008, although again ranked lowest, the AMA decided the NT's record is so bad it cannot be judged by the same standard as other states and territories. This is an area that all Territorians need to be addressing and working towards improved tobacco control. With the support of the NT Government, the Cancer Council Northern Territory is proud to be hosting the Oceania Tobacco Control conference in October 2009.

Oceania Tobacco Control 2009 – reducing inequality through tobacco control is shaping up as one of our best ever tobacco control conferences featuring innovative speakers and in-depth discussion of key issues across the region.

A major focus of this year’s conference is on tobacco and equality, looking at the challenges of reducing smoking in Indigenous communities, inequality in mental health, exciting innovations in national policy and how tobacco takes a suck on new media to drive youth recruitment.

To find out more information on the conference and to register, please go to www.oceaniatc2009.org

The Nigel Gray Award for Achievement in Tobacco Control

The Nigel Gray Award will be presented at the Conference and recognises an individual's contributions in tobacco control, with a bias towards recognition of relatively 'unsung heroes.' People working in tobacco control in Australia, New Zealand, the South Pacific Islands region and PNG are eligible for nomination.

Previous Recipients:
2005, Inaugural award presented to Michelle Scollo
2007, Melanie Wakefield & Caleb Otto

Criteria for selection:
The award is for contributions to the field of tobacco control by any individual. It is hoped that nominations will be received for those whose work is behind the scenes as well as in the front line. Depth of achievement at a local or regional level will be valued, as well as achievements at national and international levels. Criteria include:

- creativity;
- persistence;
- effectiveness;
- contributions to change; and
- skill in application or generation of evidence and argument for tobacco control.

Please email your nomination for The Nigel Gray Award for Achievement in Tobacco Control addressing all selection criteria to kathleen.quartermaine@cancer.org.au by the 7th August 2009.

References:
1 Smoking and Tobacco, Cancer Council Australia Website, 2009
2 Myths and misconceptions about tobacco control, Cancer Council Australia website, 2009
4 Case Statement Lung Cancer Update for 2006, the Australian Lung Cancer Foundation.
Tobacco smoke irritates the airways in the lungs, causing the cells to produce lots of mucus. It also damages the tiny hairs in the lungs, called cilia that move in a wave-like motion to sweep dust, pollens and other irritants out of the lungs when you cough. This makes smokers and those exposed to cigarette smoke more prone to chest and throat infections and may also damage their airways permanently.

Smokers with asthma have:
- more asthma symptoms
- less control of their asthma
- a more rapid decline in lung function
- more airway inflammation and
- less response to preventer medication

Despite the known additional health risks, just as many people with asthma smoke as people without asthma. Young people with asthma do smoke more commonly than older people with asthma for example in the 18-24 year old age group 40% of males with asthma and 31% of females with asthma are smokers.

Passive smoking can be just as harmful to a person with asthma, especially children.

Passive smoking describes the involuntary inhalation of other peoples’ tobacco smoke. It may take the form of either “mainstream smoke” that is inhaled and exhaled by the smoker or “sidestream smoke” emitted directly from burning tobacco. The term “environmental tobacco smoke” refers to the combination of sidestream and exhaled mainstream smoke in the atmosphere.

Young children have smaller more delicate lungs than adults and therefore are more affected by tobacco smoke and the chemicals it contains. A developing lung is very sensitive and early damage is often permanent.

Research has shown children exposed to cigarette smoke after birth are more likely to develop respiratory problems such as asthma in childhood. Children already diagnosed with asthma whose parents smoke are more likely to have more severe asthma symptoms compared to children with asthma whose parents do not smoke.

Surprisingly around 40% of Australian children with asthma are exposed to passive smoke in the home. These children are also more likely to attend emergency departments with asthma.

The unborn child is passive smoking when the mother is a smoker or is exposed to smoke. This is because the baby receives tobacco by-products through the mother’s bloodstream. These by-products include nicotine and carbon monoxide. Nicotine increases the baby’s heart rate and the carbon monoxide takes the place of the oxygen in the blood, leaving less oxygen for the baby.

Maternal smoking is associated with increased risk of abortion, low birth weight of the infant and increased risk of asthma and respiratory diseases in childhood.

In the NT between 2000 and 2004 nearly one in three Indigenous mothers and one in five non-Indigenous mothers reported smoking during early pregnancy.

The most recent NT smoking prevalence data is available by a combination of two national surveys.

The 2004 national Drug Strategy Household Survey for the NT non-Indigenous population aged 18 years and over reported that:
- One in three (31.3%) of non-Indigenous NT adults smoked tobacco daily, weekly or occasionally. Of these nearly 87% smoked on a daily basis.

In 2004-05 the National Aboriginal and Torres Strait Islander Health Survey for the NT Indigenous population aged 18 years and over reported that:
- More than half (55.9%) were current smokers. This is a prevalence of 1.8 times the NT non-Indigenous prevalence and 2.6 times the national prevalence.

In the NT, nearly 20% of adult (15 years and over) deaths have been directly attributed to smoking.

Smoking has been banned in enclosed public places in all States and Territories across Australia with the exception of the Northern Territory. It is time for a comprehensive review and strengthening of the NT Tobacco Control Act.

For further information on asthma and smoking contact Asthma Foundation NT on 1800 645 130.
“CHOP-CHOP” TOBACCO SMOKING

Jan Saunders
Asthma Foundation NT

‘Chop-Chop’ is an Australian term for illicit tobacco that has been grown and clandestinely distributed by farmers and wholesalers and sold on without government intervention or taxation.

There is no quality control over this illicit substance, which may be adulterated or ‘bulk ed up’. It is sold illegally ‘under the counter’ by weight for self-rolled cigarettes by unscrupulous tobacconists, grocers, news agencies, farmers, petrol stations and pubs. This type of tobacco, which has been roughly chopped up (hence the term ‘chop-chop’) is very cheap compared with legally produced manufactured cigarettes.

The prevalence of the use of ‘chop-chop’ in the smoking community is unknown. However the Australian Taxation Office (ATO) has a keen interest in the distribution of this substance and estimates that many millions of dollars are lost in revenue from the illegal sale of ‘chop-chop’. Arrests and fines initiated by the ATO have so far occurred primarily in Queensland and Victoria.

Analysis results for ‘chop-chop’ vary from batch to batch but samples have been shown to include nicotine. It may also be fumigated with bleach and may be bulked up to add weight. Research has shown that chop-chop can also contain contaminants such as twigs and pulp from raw cotton, hay, cabbage leaves, grass clippings, chloride products, pesticides, mould and fungi.

Although most people smoke it because it is cheap, many have the misguided belief, for which there is no evidence, that it is ‘better’ than other forms of tobacco.

Smoking ‘chop-chop’ has the potential to cause greater illness than branded tobacco and can be fatal for those who use it. This is due largely to the dense volume of fungal contamination that is usually found in samples. These fungi can cause toxic responses in the lungs, liver, kidneys and skin. The illnesses range from allergic reactions, chronic bronchitis and asthma, to lung cancer and legionnaire’s disease.

Although smokers are loathe to volunteer their use of this illegal tobacco, smokers and clinicians should be warned that smoking ‘chop-chop’ is not less harmful than legal tobacco products and may be quite dangerous. Quitting smoking altogether is the best health move.

Reference:

Bittoun, Renee. Letter to the Editor – “Chop-chop” tobacco smoking. Medical Journal of Australia, 2002 177 (11/12); 686-687
Smoking tobacco is a leading cause of burden of disease in Australia (Begg et al, 2007). It is a risk factor for many serious illnesses, including heart attack, stroke, lung and other cancers, and chronic respiratory disease. In order of importance, the most common causes of death attributable to smoking in the Northern Territory (NT) between 1986 and 1995 were (Measey et al, 1998):

- chronic obstructive pulmonary disease (eg emphysema)
- heart attack and related disease (eg ischaemic heart disease)
- lung cancer
- stroke
- pneumonia
- throat cancer (oropharyngeal cancer).

Among NT Aboriginal people, the two leading causes of death and disability are heart disease and respiratory disease. Smoking is recognised worldwide as a significant risk factor for these diseases.

Who smokes?

Young people

Research indicates that the earlier people start to smoke, the longer and more heavily they are likely to smoke. Eighty percent of all smokers become addicted to nicotine as teenagers (US Department of Health and Human Services, 1994).

A 2005 survey of middle and high school students found that prevalence of smoking among children increased with age. Smoking was very much a minority behaviour among 12-year-olds, but by the age of 17, 19% of males and 17% of females had smoked in the previous week. Smoking among secondary students declined during the 1980s but stalled during the first half of the 1990s. Between 1996 and 2005 a significant fall in smoking prevalence was seen in all age groups and the prevalence rates recorded for 2005 are the lowest since the survey series began in 1984. (White & Hayman, 2006).

Adults

Despite a decline between 1977 and 2001, NT smoking rates continue to be higher than national rates. In 2007 prevalence of daily smoking in the NT among people aged 14 and over was 25%, while nationally the proportion was 17% (AIHW, 2008). This figure is an underestimate of the true prevalence because of the under-representation of Aboriginal people in the survey. The actual smoking prevalence has been estimated to be 35% (Chondur and Guthridge, 2006). Females were less likely to have smoked. By a slender margin, smoking rates were highest between ages 20 and 29 years, and declined with increasing age after age 30 years.

Aboriginal people

Tobacco use is widespread among Aboriginal populations. Approximately half of the adult Aboriginal population are daily smokers, which is more than double the prevalence among the Australian population as a whole. The Australian Bureau of Statistics reported that Aboriginal men smoke at a higher rate in the NT (64%) than Australia-wide (51%), but Aboriginal women smoke at a slightly lower rate in the NT (48%) than Australia-wide (49%) (Trewin, 2006). Patterns of smoking vary within the NT, with higher rates in the Top End than in the Centre.

Chewing tobacco is practised by Aboriginal women and some older Aboriginal men in Central Australia.

continued next page >>
The Chronic Diseases Network

Publication of

Attitudes to smoking

Although the formal research about Aboriginal people and their use of tobacco is minimal, a review of the available literature reports the following findings (Ivers et al, 2001).

Social and cultural factors for tobacco use

There are a number of similarities between Aboriginal people’s and other Australian’s reasons for using tobacco. However, there are some important differences which can be explained by historical, social, cultural and economic factors which have resulted in different Aboriginal lifestyles, needs, vulnerabilities and priorities.

These factors include:

- Socioeconomic inequity. Low rates of education, high rates of unemployment and poor housing are linked with higher rates of tobacco use.
- Lack of knowledge about harmful effects. Some (but not all) Aboriginal people know less about the harmful effects of tobacco. Some studies of Aboriginal people have shown very low levels of awareness of the medical problems caused by smoking.
- Cultural beliefs. Among some Aboriginal people, tobacco continues to be linked with traditional cultural practices and beliefs.
- Social contexts and pressures. Sharing tobacco plays a large part in the social life of many Aboriginal people, and using tobacco reinforces family relationships and friendships. People who do not use tobacco may end up feeling isolated from the community.
- Early uptake of smoking. Aboriginal children and adolescents take up smoking earlier than non-Aboriginal young people.
- Health priorities. Aboriginal people have often prioritised other health related issues above tobacco use – for example, alcohol use (as it has acute disruptive effects), housing and infrastructure improvements, and nutrition.
- Less access to medical services and resources. Aboriginal people may have poorer access to health services compared to other Australians. Even where health services are available, there may be barriers to access including language barriers.

Attitudes to quitting

- Most ex-smokers have quit by themselves, without help, for health reasons.
- Most smokers believe that they would quit if there was external support, such as the provision of nicotine replacement therapy, or legislative or other restrictions on tobacco use.
- A smaller proportion of Aboriginal smokers are ready to quit than smokers in the general population.
- There are indications that many Aboriginal people make a number of unsuccessful quit attempts and that, like other smokers, they face problems with addiction and social contexts conducive to smoking.

Costs of smoking

The costs of tobacco smoking ($31 billion in 2004/05 in Australia) far outweigh the revenues which the governments collected from tobacco taxation (around $7 billion). Of the total, 38% were tangible costs (including health care, reduced workforce, sick leave, accidents and crime attributable to tobacco) and 62% were intangible (loss of life, pain and suffering caused by tobacco consumption) (Cancer Council Victoria, 2009).

References

Smoking is the single greatest risk factor for health and is estimated to cause 10% of the total Australian burden of disease. In the Northern Territory (NT) between 1986 and 1995, nearly 20% of adult deaths (15 years and over) and 3% per cent of hospital admissions for people aged 15 years and over have been directly attributed to smoking.\(^1\)

In 2004, one in three (31.3%) non-Indigenous NT adults aged 18 years and over smoked tobacco daily, weekly or occasionally. Of these nearly 87% smoked on a daily basis. In the NT Indigenous population aged 18 years and over, more than half (55.9%) were current smokers in 2004/05. This is a prevalence of 1.8 times the NT non-Indigenous prevalence and 2.6 times the national prevalence.\(^2\)

In the NT, tobacco related disease accounts for one-sixth of the life expectancy gap between Indigenous and non-Indigenous Australians. Heart attack, stroke and cancers associated with smoking are the leading causes of death and admissions to NT hospitals.

Cigarette smoking has now been banned in all enclosed public places in all States and Territories except for the NT.

Although the NT introduced the NT Tobacco Control Act in 2003, the extent of the ban on smoking in public areas is limited. Smoking is not outlawed in all indoor licensed areas, with areas of equal standards only being designated as non-smoking. This means that employees and non-smoking patrons at entertainment and public venues still suffer from second-hand cigarette smoke. Although the NT Act appears to restrict second-hand smoke in enclosed areas, the regulations under the Act still allow licensed premises to declare significant public areas where smoking is still allowed. This has been in place since 2003, and as a result both hospitality workers and patrons continue to be exposed to the dangers of second-hand smoke.

The Good Health Alliance NT, comprising Asthma Foundation NT, Cancer Council NT, Healthy Living NT, Heart Foundation NT, Arthritis and Osteoporosis NT, Kidney Health Australia and the National Stroke Foundation, continues to urge the NT Government to speed up a review and change the Tobacco Control Act.

The Good Health Alliance NT recommends the following:

- **Expand smoke-free public places legislation to include:**
  - pubs, clubs, casinos (all serviced areas)
  - all outdoor hospitality areas
  - health service settings (all)
  - sporting facilities
  - outdoor entertainment venues

- **Remove all ‘Point of Sale’ displays and marketing.** Tobacco products should be out of sight and under the counter (an important policy for de-normalising tobacco use among youth)

- **Prevent sales from external areas of premises.** Sale of tobacco products must be made from within the retail premises to prevent preferential sales to customers not entering the store, and to customers not purchasing food e.g. Supermarket

- **All school environs to be smoke free.** Prohibit designated smoking areas within school grounds to assist with de-normalising smoking.

- **Review the licensing of tobacco retailers and establish licence fees.** Fees to be channelled into health promotion.

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The Good Health Alliance of the Northern Territory
In the NT, tobacco related disease accounts for one-sixth of the life expectancy gap between Indigenous and non-Indigenous Australians. Heart attack, stroke and cancers associated with smoking are the leading causes of death and admissions to NT hospitals.

Other measures needed:

- **Improve coordination across Government**
  A coordination mechanism is required to bring together knowledge and expertise from all areas of Government involved with tobacco regulation. This includes NT WorkSafe, the Licensing Commission, and the Department of Education and Training for its role in improving health literacy among young Territorians.

- **Progress smoke-free workplaces across Government**
  GHANT applauds the initiative of the Department of Health and Families in launching its smoke-free policy applicable from 1 July 2009. If nominated as the lead agency, Health could share its detailed analysis and workflow in order to replicate its smoke-free policy across the entire Territory public sector, including Parliament House.

- **Commission an analysis of the full cost of tobacco harm to the NT**
  Provide a commissioned detailed report by a Health Economist on the cost to the Territory of tobacco use, including costs of primary care, hospitalisation and smoke related illness. This would provide clear and irrefutable data on the burden of tobacco use on the NT Budget, and provide evidence to support an argument for more effective preventative measures.

- **Establish a systematic approach to tobacco control**
  Establish an administrative unit dedicated to management of tobacco control that can assist in the development of an achievable plan and targets, to monitor, coordinate and progress work done by the Department and by external groups such as GPs, professional bodies and unions. This administrative unit could also source data on tobacco usage that will enable establishment of a baseline from which to measure progress.

- **Focus on Aboriginal tobacco control**
  The administrative unit managing tobacco control should give priority to implementing and coordinating evidence-based tobacco control initiatives for, and with, Aboriginal Territorians.

- **Report annually on progress**
  Report annually both to Parliament and Territorians on progress in reducing smoking related death and illness in the NT.

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The Chronicle

POSITION STATEMENT

Health risks of passive smoking

Even small amounts of exposure to tobacco smoke can be harmful to people’s health. A smoke-free environment is the only way to fully protect non-smokers from the dangers of second-hand smoke.

Key messages

Passive smoking is a cause of premature death and disease in children and in adults who do not smoke. Even small amounts of exposure to tobacco smoke can be harmful to people’s health.1

A smoke-free environment is the only way to fully protect non-smokers from the dangers of second-hand smoke. Separating smokers from non-smokers, cleaning the air, and ventilating buildings cannot eliminate exposure of non-smokers to second-hand smoke.1

Cancer Council Australia recommends:

- People avoid tobacco smoke, to eliminate the risk of health problems caused by passive smoking;
- Children are protected from second-hand smoke, including in the home and car. The hazard in the home and car requires greater public education so that everyone recognises the risk to which their families and others are exposed;
- All indoor workplaces, public places and popular outdoor venues such as al fresco dining areas, leisure and cultural settings be completely smoke-free.

What is passive smoking?

Passive smoking describes the inhalation of other people’s tobacco smoke or “second-hand smoke”.

Second-hand smoke comprises side-stream smoke (the smoke released from the burning end of a cigarette) and exhaled mainstream smoke (the smoke exhaled by the smoker).1

While second-hand smoke has been referred to as environmental tobacco smoke (ETS) in the past, the term second-hand smoke better captures the involuntary nature of the exposure: most non-smokers do not want to breathe tobacco smoke.1

Tobacco smoke contains more than 4,000 chemical compounds. Second-hand smoke contains many of the same chemicals that are present in the smoke inhaled by smokers. Side-stream smoke contains higher concentrations of many of the toxins found in cigarette smoke, because it is generated at lower temperatures and under different conditions than mainstream smoke.1

The US National Toxicology Program estimates that at least 250 chemicals in second-hand smoke are known to be toxic or carcinogenic.1

Health effects of passive smoking

Major reviews of the evidence on health effects of exposure to second-hand smoke by a number of eminent and authoritative scientific bodies conclude that passive smoking causes the following diseases and conditions.1,2,3

In adults:

- heart disease
- lung cancer
- irritation of the eyes and nose.

In children:

- Sudden Infant Death Syndrome (SIDS or cot death)
- lower birth-weight babies (where the mother was exposed to second-hand smoke)
- bronchitis, pneumonia and other lung/airways infections
- asthma exacerbation
- middle ear disease (otitis media or ‘glue ear’)
- respiratory symptoms (e.g. coughing, wheezing).

There is evidence that is suggestive, but not sufficient to infer a causal relationship between, exposure to second-hand smoke and the following adverse health effects.1

In adults:

- breast cancer
- nasal sinus cancer
- stroke
- acute and chronic respiratory symptoms
- adult onset of asthma
- worsening of asthma control

continued next page >>>

The Chronicle August 2009
Health effects on the unborn child, infants and children

Children who are exposed to second-hand smoke are inhaling many of the same cancer-causing substances and poisons as smokers. Because their bodies are developing, infants and young children are especially vulnerable to the poisons in second-hand smoke.¹

Both babies whose mothers smoke while pregnant and babies who are exposed to second-hand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke.¹

Babies whose mothers smoke while pregnant or who are exposed to second-hand smoke after birth have weaker lungs than unexposed babies, which increases the risk for many health problems.¹

Among infants and children, second-hand smoke causes bronchitis and pneumonia, and increases the risk of ear infections.¹

Second-hand smoke exposure can cause children who already have asthma to experience more frequent and severe attacks.¹

The human and health care costs of passive smoking

The human and health care costs caused by exposure to second-hand smoke are staggering.⁴ In 1998-99, passive smoking in the home caused 224 deaths, more than 77,000 hospital bed-days and over $47 million in hospital costs. Children under the age of 15 years accounted for a large proportion of hospitalisations and hospital costs.⁴

Table 1: Human and hospital costs of passive smoking in Australia, 1998-99⁴

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Passive smoking and hospitality venues

Hospitality venues where smoking is still permitted tend to have higher levels of tobacco smoke than other workplaces. As a result, hospitality workers are more likely to suffer from health problems such as wheezing, shortness of breath, coughing, sore eyes and sore throats.⁵

Bar workers are typically exposed to concentrations of second-hand smoke up to 4 to 6 times higher than in other workplaces.⁶ Both bar and restaurant workers have a higher risk of lung cancer compared to the general population, partly due to exposure to second-hand smoke in their workplace.⁶ Importantly, research also shows that when smoking is banned in indoor venues, the health of bar staff improves, even if they are smokers.⁷ The health of casino workers and patrons has also been shown to be affected by exposure to second-hand smoke.⁸

continued next page...
Studies in both workplace and hospitality settings confirm that only those policies that require establishments to be totally smoke-free adequately protect non-smokers from exposure to second-hand smoke.9

Public support for smoke-free spaces
Public support and demand for smoke-free work places and public spaces has continued to grow over the past 20 years: over this same period there have been significant falls in the prevalence of smoking as people have become more aware of the effects of smoking on their own health and others.

Today, most Australians support smoke-free dining (89%), workplaces (87%), pubs and clubs (73%) and shopping centres (72%). Indeed more and more Australians are choosing to avoid places where they might be exposed to second-hand smoke. A 2004 survey found that two in five (39.2%) non-smokers always avoided places where they might be exposed to other people’s tobacco smoke; one in 25 (3.8%) smokers did so. What is more, the same survey found that 20% of smokers who said they had changed their smoking behaviour over the past 12 months did so because they were worried their smoking was affecting the health of those around them.10

Cancer Council recommendations
Cancer Council Australia recommends:

- People avoid tobacco smoke, to eliminate the risk of health problems caused by passive smoking
- Children are protected from second-hand smoke, including in the home and car. The hazard in the home and car requires greater public education so that everyone recognises the risk to which their families and others are exposed
- All indoor workplaces, public places and popular outdoor venues such as al fresco dining areas, leisure and cultural settings be completely smoke-free.

Further information
Health effects of passive smoking
The Health Consequences of Involuntary Exposure to Tobacco Smoke (USSG, 2006)
www.surgeongeneral.gov/library/secondhandsmoke/report/
Environmental Tobacco Smoke: Toxic Air Contaminant Report (CalEPA, 2005)
www.arb.ca.gov/toxics/ets/ets.htm
Tobacco Smoke and Involuntary Smoking (IARC, 2004)
http://monographs.iarc.fr/ENG/Monographs/vol83/volume83.pdf
Tips on how to minimise exposure to second-hand smoke
Car and Home – Smoke-free Zone
www.smokefreezone.org
Smoke Free Australia – Workplaces
www.ashaust.org.au/SF'03/index.htm
Quit Victoria
www.quit.org.au

Smokefree Victoria
www.smokefree.org.au

For help to quit smoking
- Call the Quitline on 137 848 (available 24 hours a day, 7 days a week)
- Or contact your State Quit Campaign or Cancer Council

This statement draws heavily on the US Surgeon General’s 2006 report, The Health Consequences of Involuntary Exposure to Tobacco Smoke.

Cancer Council Australia, GPO Box 4708, Sydney NSW 2001
T: 02 8036 4100 F: 02 8036 4101 W: www.cancer.org.au

References
Every year on World No Tobacco day (31 May) the Australian Medical Association (AMA) and the Australian Council on Smoking and Health (ACOSH) presents the dirty ashtray award to the state or territory that made the “least progress” on combating smoking. From 1999 – 2002 and for the past three years 2005 – 2008 the Northern Territory has won the award but this year because the level of action had been so poor over several years that it was not appropriate to judge the NT by the same standards of other states and territories.

Below is the national tobacco scoreboard by which the award of dubious honour is calculated. This year the award went to South Australia for having the least activity or progress in tobacco control over the past year (following the exclusion of the NT).

Many of us in the NT health workforce including non government agencies and particularly members of the Good Health Alliance find it frustrating and embarrassing that there is not better support in Legislation to enable change in behaviour to stop people from taking up smoking and to help people wanting to give up tobacco use. However, a positive example that change may be occurring is the introduction of the NT Department of Health and Families “Smoke Free Policy” on the 1st July this year.

As part of the announcement of the “award”, the AMA, along with Cancer Councils around Australia has called on the Commonwealth Government to significantly increase tobacco taxes and ensure funds go back into health programs. They have also said that there is an urgent need for the NT Government to protect the health of its community, which should include a special focus on Indigenous smoking.


NT NOT WORTHY OF THE “DIRTY ASHTRAY” AWARD?

Jane Boughen
Diabetes Educator, Health Living NT, Alice Springs

AMA/ACOSH National Tobacco Scoreboard Results 2009

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The Chronicle August 2009
The Northern Territory Tobacco Action Plan 2009-2012 has been developed to address the burden of ill health in the community and the need for hospitalisation as a result of tobacco use.

**Overview of the Tobacco Action Plan**

The Northern Territory Tobacco Action Plan 2009-2012 (Action Plan) provides strategic direction for the development and implementation of priority tobacco control activities across the NT. The Action Plan is a comprehensive approach to reducing tobacco-related harm, and includes a range of priority activities that address three key areas for action: health care interventions; community interventions; and policy and legislation interventions.

**Goal**

To improve the health of all Territorians, with an emphasis on Aboriginal and Torres Strait Islander people, by reducing the harm caused by tobacco consumption and exposure to tobacco smoke.

**Objectives**

- reduce the uptake of tobacco use
- reduce consumption of tobacco
- increase protection from exposure to second-hand smoke

**Who is it for?**

The Action Plan is designed to guide the efforts of anyone working in tobacco control in the Northern Territory.

It is intended that this document will be used by health care providers, community groups, Aboriginal Community Controlled organisations, research institutes, government departments, non-government organisations, and the private sector.

To achieve successful outcomes, it is conceived that the Action Plan will coordinate efforts across these sectors.

**Priority Activities**

The activities set out in the Action Plan provide a guide for developing, implementing and reporting on tobacco control initiatives. Stakeholders will have an opportunity to report annually on tobacco control activities against performance indicators. This information will be collated by a lead agency (Department of Health and Families) and provided to a Tobacco Control Advisory Committee for analysis and dissemination.

**Background**

The development of the Tobacco Action Plan was funded by the Northern Territory Department of Health and Families and coordinated by the Heart Foundation Northern Territory. The process to develop the Action Plan involved a number of steps, including: a forum with key agencies and individuals to develop a framework for tobacco control, held in 2002; a Northern Territory Tobacco Summit, held in March 2009; and the establishment of a NT Tobacco Summit Steering Committee to oversee the tobacco summit and assist with the preparation of the Action Plan.

Steering Committee members are Dorothy Morrison (Heart Foundation Northern Territory); Helen Smith (Cancer Council Northern Territory); Dr David Thomas (Menzies School of Health Research); Dr Liz Moore (Aboriginal Medical Services Alliance Northern Territory); Dr Christine Connors (NT Department of Health and Families); James Smith (NT Department of Health and Families); Warwick Kneebone (NT Department of Health and Families); and Nina Nichols (Heart Foundation Northern Territory).

For further information on the NT Tobacco Action Plan contact Nina Nichols at: nina.nichols@heartfoundation.org.au
What is the DHF Smoke Free Policy?
On Wednesday, 1 July 2009, all Department of Health and Families premises became smoke free, including all indoor and outdoor areas on hospital campuses, remote clinics, community health centres and administration premises. This policy applies to all staff, patients, clients and visitors.

Why go smoke free?
Smoking is still a major cause of ill health in the Northern Territory. Between 1989 and 1995, nearly 20% of adult deaths (15 years and over) and 3% of hospital admissions for people aged 15 years and older were directly attributed to smoking in the Northern Territory.

Hospitals are a key site in which to identify and provide cessation support to people who smoke tobacco. Supports include brief interventions, assessment, cessation programs and referral to cessation agencies. Going smoke-free also helps to demonstrate to patients the serious impact smoking has on their health.

Because smoking also puts a person at much higher than normal risk of serious complications during and after surgery, and can prolong the healing process, it is timely to promote smoking cessation to people who are to undergo surgery. Stopping smoking in the workplace has also been found to be effective in protecting workers from exposure to second hand tobacco smoke, of which there is no safe level of exposure. It also reduces the amount people smoke each day and increases the chance that smokers will quit successfully.

Are there any exemptions to the Smoke Free Policy?
Yes. All NT hospital sites can develop up to two designated outdoor smoking areas for patients only.

What does this mean for patients?
All DHF patients can expect a smoke-free environment when accessing services from DHF staff. This includes arrival and exit areas at the service. Patients who still smoke can access designated outdoor smoking areas in hospitals where available. Inpatients who are smokers will be offered medications to assist them to abstain from smoking during their stay in hospital.

What does this mean for staff?
All DHF staff members have the right to work in a smoke-free environment, whether on DHF premises or in the community setting.

Staff who are on official duty and are exposed to another person’s tobacco smoke can ask the person to extinguish their cigarette (cigar or pipe) or ask them to move away. If a client or patient refuses to comply with the smoke-free policy the staff member can cease service and return at the next practical time.

Staff members who smoke can do so only in official breaks. The staff member must leave the worksite to smoke. This applies to staff members who work in a community setting.

Staff who smoke will be able to access a range of supports provided by DHF.

What if a visitor does not comply with the Smoke Free Policy?
Compliance guidelines to the policy have been developed. The DHF encourages an educative compliance regime.
What resources have been developed to assist the Policy implementation?

Resources have been developed to assist staff, managers, patients and clients to implement the Smoke-Free Policy. Resources include:

- DHF Tobacco Smoking Cessation Support Framework
- DHF Tobacco Smoking Cessation Support Framework Guidelines
- Guidelines for Staff and Managers on Supporting Staff to Quit Smoking
- Clinical Guidelines for the Management of Nicotine Dependent Inpatients
- Fact-sheets for staff, managers and patients
- Signs and posters to promote the smoke-free DHF
- Guidelines for Managers and Staff on Employee Compliance

This Policy is a major milestone for health care and family services in the Northern Territory.

Further detailed information about the Policy and relevant questions and answers can be viewed at the following internet page.

The revision process has attracted the attention of many people throughout the NT including non Government organisations, AMSANT members and Department of Health and Families staff. The Steering Committee is providing direction and support and ensuring the interests of all parties are considered.

Progress to date:

- Circulated and available on PCD website:
  - Background paper: "A comparison of frameworks and models of care".
  - Background paper: "Chronic disease in Aboriginal populations".

Feedback on background papers has been received from broad range of people.

- Circulated and available on PCD website:
  - Draft Chronic Disease Strategy

Consultations are being undertaken throughout NT during June. Dates of the consultations are available on PCD website. Comments can be made via email to Project Officer and are welcome until end of June.

- Expert Advisory Groups have been established to address:
  - Workforce planning and development
  - Health promotion and prevention
  - Monitoring and evaluation

Next steps

- Publish the PCD Strategy document
- Develop the implementation plan

For more information contact:
Tel: 08 89 858071  Email: cynthia.croft@nt.gov.au

Come to the Chronic Disease Network Conference 10th & 11th September 2009 to hear more about the Strategy.
NHMRC Project Grant 436012 (2007 – 2011)

Aim
To reduce tobacco smoking in three remote Aboriginal communities in the Top End of the Northern Territory over a five year period (2007 - 2011).

Strategies
- baseline and follow-up surveys of tobacco use in each community;
- ongoing measurement of tobacco sales;
- support for community-developed activities to reduce tobacco use;
- improved access to Nicotine Replacement Therapy;
- employment of local research workers; and
- provision of regular feedback to each community and key stakeholders.

Project Progress

Top End Tobacco Project 2008 Baseline Survey
400 Survey Participants

Base line survey complete: while the prevalence rate has changed little in this region over the last 20 years it is encouraging that so many are thinking of making changes to their smoking. This is an indication that efforts to inform remote populations of the effects of tobacco consumption are having some impact. Dependency was common with 55% of smokers reporting they smoked first thing in the morning or through the night. With many dependent smokers, high rates of smoking and widespread cue exposure, there is a high need for intensive quit support.

Feedback of survey results: has been completed in two communities. Preliminary data has been shared with key stakeholders in NT Department of Health and Families and Heart Foundation Northern Territory.

Implementation of locally-developed and driven strategies:
These strategies have been formed through feedback of the survey results to community members and service providers. They include:
- Training of local Health and Community Workers by project staff in brief interventions in tobacco;
- Provision of quit support and use of health promotion tools including an expired breath carbon monoxide monitor;
- Quit competitions between local sporting teams using an expired breath carbon monoxide monitor to confirm abstinence;
- Development of tobacco resources in local languages. Where appropriate these will be made available to NT Health and NGOs; and
- Some communities have developed an interest in strengthening workplace smoking policies.

Collaboration with community groups, service providers and local co-workers has continued.

References:
Robertson JA, MacLaren DJ, Clough AR. Should the Pharmaceutical Benefits Advisory Committee extend the range of free nicotine replacement therapy for Aboriginal and Torres Strait Islander people? Medical Journal of Australia [in press]

Clough AR, Robertson JA, MacLaren DJ. The gap in tobacco use between remote Indigenous Australian communities and the Australian population can be closed. Tobacco Control [in press]

For further information contact: Jan Robertson, jan.robertson@jcu.edu.au  Ph 07 4042 1635
Smoking is now recognised as the number one risk factor that contributes to Aboriginal and Torres Strait Islander poor health. With smoking rates at more than double those for non-Indigenous Australians it is essential that tobacco control becomes a primary focus for all health professionals, policy makers, community leaders and community members.

The Centre for Excellence in Indigenous Tobacco Control (CEITC), which is funded by the Australian Government’s Department of Health and Ageing, focuses on advocacy, research, capacity building and knowledge exchange in the area of Indigenous tobacco control. CEITC’s small team of 2 full-time and 6 part-time staff works to raise awareness of tobacco control’s importance, and to encourage community ownership by supporting community-initiated and controlled action.

CEITC, established in 2004 and based at the University of Melbourne, has produced a number of publications including a comprehensive resource kit called Talkin’ Up Good Air. This kit aims to provide tools for Aboriginal Health Workers and other health professionals to run tailored tobacco control programs within their individual health setting, and has been distributed free of charge. In addition CEITC is currently delivering training based on the kit to selected sites across Australia.

CEITC has continued to build on its role as a national Indigenous tobacco control advocate by providing a Review of Evidence to the Department of Health and Ageing. We are confident that this review will inform the Government in deciding how best to address Indigenous peoples high smoking prevalence rates as part of the $1.6 billion Closing the Gap initiative. The review includes 10 key recommendations that focus on building community driven and controlled projects, which are well resourced, sustainable and evaluated so that best practice models can be evolved and implemented in urban, remote and rural settings. It will be published in September and available for download on our website.

So far CEITC has conducted two national Indigenous tobacco control roundtables and published a report, Indigenous Tobacco Control in Australia: Everybody’s Business, based on the outcomes of the roundtable. Held with the support of the Cooperative Research Centre for Aboriginal Health, the roundtables brought together researchers, government and non-government agencies and members of the Aboriginal health workforce to develop a research agenda. Roundtable participants were asked to nominate a research question to workshop further, and results of this are included in the report. As a follow-up to this, CEITC is establishing a Researchers Network to continue the momentum established at these meetings.

CEITC’s website at www.ceitc.org.au provides an important source of information and contacts for anyone with an interest in Indigenous tobacco control. Via this website people are able to download CEITC resources, share their experiences, and read about and contact other projects. The website also provides comprehensive information about tobacco use and its associated health risks. All CEITC publications are available for free download at www.ceitc.org.au/ceitc_publications or in hard copy by calling 03 8344 0870.
SMOKING CESSATION

Useful Resources & Websites

www.quit.org.au – Information and resources, Get help to quit
www.heartfoundation.org.au – Information, events, resources
www.outsmartcigarettes.com.au – Get help to quit
www.healthinsite.gov.au/topics/Quitting_Smoking – Information and resources
www.oxygen.org.au – Fun stuff, School Resources

- Clinical Guidelines for the Management of Nicotine Dependent Inpatients
- Smoking Assessment And Intervention Form
- Fagerstrom Test for Nicotine Dependence
- Prescribing Information for Nicotine Replacement Therapy
- Preparing your Patient for a Smoke Free Hospital
- Patient Smoking Waiver Form
- Enforcement Procedure for Dealing with the Public
- Guidelines for Managers and Staff on Employee Compliance
- Corrective Counselling Agreement template;
- Guidelines for Designated Outdoor Smoking Areas (DOSA’s)
- Guidelines for Smoking in DHF Accommodation for Staff
- Guidelines for Staff and Managers on Supporting Staff to Quit Smoking
- Tobacco Cessation Framework
- Tobacco Smoking Cessation Support Framework Guidelines

Tobacco Resources

www.ashaust.org.au - Action on Smoking & Health Australia
The focus of this update is to highlight the many exciting things that are happening at this year’s CDN conference.

**Registrations are still open, so don’t miss out!!**

Register on line at cdnconference2009.com or fill in the registration form enclosed and fax it to our conference organiser – Eventuate: Fax number: 08 8942 2699
Pre-Conference workshops - Wednesday 9th September
(see attached fl  iers for details)

1. Socio-demographic distributions of health-related
behaviours among Australian children
Presenter - Jim Dollman
Sponsored and bought to you by the Australian Health
Promotion Association
9.30 – 11.00am
Holiday Inn Esplanade

for health professionals”
Presenter – Patrick Harris
Sponsored and bought to you by the Health Promotion
Strategy Unit – Department of Health and Families
8.30am – 4.30pm
Holiday Inn Esplanade

Social Program
The social program has been designed to maximise
opportunities for delegates to meet, mix and enjoy!

Wednesday 9th September 2009

• Conference launch and welcome function
  Generously hosted by the NT Minister for Health and Families, the Hon Kon Vatskalis.
  All registered conference participants are invited to attend
  Costs are included in your conference registration fees
  Venue - Parliament House
  Time to be confirmed

• Dinner with the Keynotes
  This is a great opportunity to mingle with our keynote
  speakers and other delegates in an informal setting at the
  exciting new restaurant “VIBE” looking out over the Darwin’s
  waterfront.
  The dinner is not included in the conference registration and is an additional cost.
  To book contact Eventuate Ph: 08 8942 2644

Thursday 10th September 2009

• Official Conference dinner: Mindil Beach Sunset Markets
  Join your colleagues and gather in your own private area
  at Mindil Beach Sunset Markets. Relax, discuss the day’s
  proceedings, watch the sunset, and enjoy the atmosphere.
  Your ‘Mindil Money’ may be used at any stall in the market – food, beverage or anything that takes your fancy!
  Cost $40 per person - includes exclusive dining area with tables & chairs, sunset drink & nibbles, private performance and $10 Mindil Money. Eskies provided for BYO bottles.

CDN Recognition Awards
The NT CDN Recognition Awards provide an opportunity to
recognise and celebrate the achievements of individuals, teams
and organisations involved in a variety of activities including
service delivery, program development and implementation,
policy/legislation, research and advocacy, in the field of chronic
diseases across the NT.

Recipients of this year’s awards will be announce and presented
at the conference Welcome Reception – Parliament House

And just for something a little different…..
Join in on a range of health promotion activities that will be
happening in, around and during the conference – get some ideas to take back to your work place and have fun doing it …

• “Walkshops” The Heart Foundation will be hosting a series
  of “Walkshops” for you to enjoy, stretch your legs and soak in
  the fantastic sights of Darwin. Bring your walking shoes, hat
  and drink bottle ……

Walkshop times:
  • Thursday lunchtime
  • Thursday evening (walking to Conference Dinner @
    Mindil Markets from a designated meeting point - the
    dinner will be at the Market. People can then taxi, bus or
    walk back - their choice)
  • Friday morning
  • Friday lunchtime

• Yellow Brick Road  Your Conference satchel will contain
  an entry form for you to participate in an interactive trail
  that will take you on a journey among all the Conference
  exhibitions and posters.
  Collect information and answer all the questions!
  Put your entry into the box to be in the draw for a fabulous
  collection of Health Promotion resources and goodies.

• SunSmart  Lunch will be served outside on the “The Raft”
  – a lovely courtyard and deck area of the venue. NT Cancer
  Council will be there to provide you with your sunscreen
  protection.

• Exercise & stretching sessions  This year’s program is
dynamic and physical - your Conference bag will contain
your very own piece of “Theraband” and throughout the
Conference, Kia Naylor from BodyFit NT, will be taking you
through a range of activities to keep you moving.

• Healthy food choices  Conference catering will be in line
  with healthy food choices

• Tai Chi for Health session  Enjoy a relaxing and
  stimulating start to your day. Join in a Tai Chi for Health
  session on Friday morning. Details to be announced.

LOOKING FORWARD TO SEEING YOU THERE
**WEDNESDAY 9TH SEPTEMBER 2009**

<table>
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<tr>
<th>Time</th>
<th>Event</th>
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| 9.30am - 11.00am | Pre-Conference Workshop  
Low SES and Health Behaviours  
Dr Jim Dollman  
Sponsored by the Australian Health Promotion Association |
| 8.30am - 4.30pm | Pre-Conference Workshop  
Conducting Health Impact Assessments: A practical guide for health professionals  
Patrick Harris  
Sponsored by the Health Promotion Strategy Unit  
Pre-Conference Workshop  
Hunting in the Mangroves |
| 5.30pm - 7.00pm | Conference Launch - Parliament House  
Hosted by the Minister for Health  
Incorporating the CDN and Heart Foundation Award Presentations |
| 7.00pm         | Dinner with the Keynotes - Vibe Hotel Darwin |

**THURSDAY 10TH SEPTEMBER 2009**

<table>
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<tr>
<th>Time</th>
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<tr>
<td>7.30am - 8.15am</td>
<td>Registration</td>
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| 8.15am - 10.30am | Session 1  
Welcome to Country and Opening Remarks  
Keynote Address - Professor Fran Baum  
"Taking Practical Action on the Social Determinants of Health - A Vision for 2030"  
Keynote Address - Dr Jim Dollman  
"Kids Eat Kids Play - an Opportunity to Plan Preventative Health Action for Future Generations"  
Keynote Address - Professor Helen Keleher  
"Turning the Key on Health Literacy to Achieve Better Health Outcomes" |
| 10.30am - 11.00am | Morning Tea Break |
| 11.00am - 12.30pm | Session 2 - Concurrent Sessions  
A tool for assessing and guiding improvements in health promotion: application in practice  
Lynette O’Donoghue, Bernadette Shields, Nikki Clelland  
Indigenous Carer Education Program  
Marie Stillwell, Carers NT  
Familiarity, Understanding, Competence - Evaluating Health Education  
Valmai McDonald, Belinda Inglis  
Improving the Management of Chronic Disease in the General Practice and Primary Health Care Setting Utilising the Collaborative Model (APCC – Australian Primary Care Collaborative)  
Marie Bottolfson  
Community Health Literacy: Effective Indigenous Health Promotion  
Dr Alyssa Vass, Alice Mitchell |
| 12.30pm - 1.30pm | Lunch Break |
| 1.30pm - 2.45pm | Session 3  
Keynote Address - Professor John McDonald & Jason Bonson  
"National Policy Agenda - The Men’s Health Example"  
Keynote Address - Dr David Thomas  
"Tobacco Control - The Single Biggest Preventative Health Strategy" |
PROGRAM SUBJECT TO CHANGE
Conducting Health Impact Assessments:  
A Practical Guide for Health Professionals  

A Chronic Disease Network, Pre-Conference Workshop -  
Sponsored by the Health Promotion Strategy Unit  

Facilitated by: Patrick Harris, Coordinator & Research Fellow on the New South Wales  
Health Impact Assessment project at the Centre for Health Equity Training, Research and Evaluation, UNSW  

Venue: Holiday Inn Esplanade  
Date: 9th September 2009  
Time: 8:30 am – 4:30 pm  
Cost: $50 per attendee  

Limit of 30 places.  

To Register:  
Please complete the following  

Name: ..................................................  
Organisation Details: ..................................................  
Phone: __________________________ Fax: __________________________  
Email: ..................................................  

Please return via fax to Eventuate - Conference, Event and Destination Management.  
Ph: (08) 8942 2644  
Fax: (08) 8942 2699  
Email: info@eventuate.com.au  
Web: www.eventuate.com.au
The Health Promotion Association (AHPA) NT Branch presents an interactive workshop on:
Sociodemographic distributions of health-related behaviours among Australian children

**Presenter:** Dr James Dollman, Nutritional Physiology Research Centre, Division of Health Sciences, University of South Australia.

**When:** 9 September 2009 9.30 -11.30

**Where:** Kakadu Room, Esplanade Holiday Inn, 116 The Esplanade, Darwin

**Cost:** No Charge

**To Register:** Email Schmitt@internode.on.net

**Workshop Outline:**
- Dr Jim Dollman will present evidence for the maldistribution of ‘health wealth’ among Australian children.
- In his discussion, Jim draws on data from recent national and state-based surveys; to highlight health gradients according to socio-economic status, cultural background and location of residence.
- Dr Dollman presents a unique approach to researching these phenomena by focusing on those with healthy lifestyles in ‘unhealthy’ environments.
- Workshop participants will be invited to share ideas and experiences that will help identify potential solutions to these major public health issues, at local and national levels.

**Background of the Presenter:**
Dr Dollman has researched extensively in the area of physical activity measurement, as well as the predictors and consequences of regular physical activity in young people.

Some of his more notable achievements include:
- Coordination of 4 South Australia-wide surveys of children’s physical activity and fitness.
- Academic advisor for the physical activity component of the Eat Well be Active community intervention, sponsored by the South Australian Department of Health.
- Co-chair of the Physical Activity Measurement Special Interest Group, within the Australasian Child Obesity Research Network (ACAORN).
AOD Training

DEPARTMENT OF HEALTH AND FAMILIES

ALCOHOL & OTHER DRUGS

HLTOP403B ‘Provide information on smoking and smoking cessation’
HLTOP404B ‘Provide interventions to clients who are nicotine dependent’

Target: This training applies to workers/volunteers in the health & community services sector who are required to attain knowledge and skills in providing information on smoking & smoking cessation, and providing interventions to clients who are nicotine dependant.

Purpose: This unit describes the competencies required to provide information on smoking & smoking cessation, and providing interventions to clients who are nicotine dependant.

Content:
- Day 1: Providing information on smoking cessation
- Day 2: Providing interventions to clients who are nicotine dependant, and Assessments

Accreditation requirements are:
- Attendance and participation in 2 full days of workshop.
- Assessment Tasks, including verbal Q&A and a simulated smoking cessation intervention, or a report on a smoking cessation project conducted in the community.

The workshop dates are

Date: 21-22nd Sept 2009
Time: Both 2 days will be 8.30am – 4.00pm.
Venue: NARU: 23 Ellengowan Dve, Brinkin
Information: For more information call Liza Shaw on 89228795
To Book: Telephone bookings can be made on 89228795, or via email: elizabethz.shaw@nt.gov.au
Lung Awareness Month is November and this year World COPD (Chronic Obstructive Pulmonary Disease) Day will be celebrated on Wednesday November 18. The Australian Lung Foundation will be promoting their signature event again this year with the Catch your breath…walk for COPD event. As in previous years, we are calling for all COPD Support Group members, Pulmonary Rehabilitation Centre staff and participants, Allied Health professionals and patients and their carers to get involved.

The goal is to have as many participants as possible raise awareness about COPD, its prevalence, symptoms and treatment. Whether it is an information stand at a shopping centre, pharmacy or library, a talk at a local social club, a BBQ or a walking event, all activities will be encouraged and supported by the Australian Lung Foundation. Some groups choose to offer FREE spirometry which is always popular with the general public. As in previous years, resources such as brochures, posters, balloons and t-shirts can be obtained from the Australian Lung Foundation to ensure the success of your event.

In 2009, we hope to have over 100 groups register to coordinate an event, with participants collectively achieving over 2000km in walking distance across the nation.

Should you wish to be involved and register an event, please contact Karen Wright at projects@lungfoundation.com.au or call 1800 654 301 to indicate your interest.

Visit our website www.lungnet.com.au
The theme for National Asthma Week is “Asthma- do you know what to do?”

The Asthma Foundation of the Northern Territory will be joining together with the Asthma Foundations of Australia and asking “Do you know what to do to manage asthma daily?” and “Do you know what to do in an asthma emergency?”

To help answer these questions in the affirmative a range of community information sessions will be held throughout the week of 1st-7th September. For more information, or to book in for Asthma Emergency First Aid training on Wednesday 2nd September at 10.30 T: 1800 645 130.
The Safe Places in Aboriginal Communities

As part of the Australian Government Family Support Package, the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), and the Northern Territory Department of Health and Families (DHF), have committed funding to June 2012 to support the establishment and opening of 20 Safe Places in 15 remote communities across the Northern Territory, and two urban houses.

Safe Places across the Northern Territory started to open in January 2009.

Safe Places aim to provide increased safety options in remote communities by providing safe houses for women and children, and cooling down places for men and youth. Safe Places are more than a crisis accommodation services, their primary function within the community is to serve as a hub for family violence education and intervention, as well as family and individual well being.

The Safe Places in remote communities employ local people and are a place of respite and support for adults and children escaping violence. The Safe Places will be available to the community 24/7 through the use of a full time and casual workforce.

The Safe Places will work closely with Police, night patrols and clinics, as well as provide regular activities and community education programs related to strengthening community safety and families.
The Chronic Diseases Network acknowledges the participation and support of the CDN Steering Committee members from the following organisations: