CDN Coordinator’s Report from 2013 CDN Conference
Breanna Ellis, CDN Coordinator
Chronic Conditions Strategy Unit
NT Department of Health

The 17th Annual Northern Territory (NT) Chronic Diseases Network (CDN) Conference, themed Self-Management: A Partnership Approach brought together experts from around Australia to the Darwin Convention Centre on September 9 and 10, 2013. The Conference was opened by The Hon Robyn Lambley MLA and included an opening address by Dr Christine Connors, Acting Director, Health Development, NT Department of Health (DoH).

Other keynote speakers included:
Professor Malcolm Battersby, Director of Flinders Human Behaviour and Health Research Unit, Flinders University
Kate Warren, Research Associate, University of South Australia
Carolynanha Boyede, Quitline Counsellor, Cancer Council SA
Roy Batterham, Senior Research Fellow, Deakin University

The Conference was open to everyone working in areas of chronic conditions, education and health promotion, as well as consumers. Two hundred and forty seven delegates from all over Australia attended the Conference. Whilst the majority of delegates were from the NT, the conference had good representation from interstate and a third of delegates identified as being of Aboriginal and/or Torres Strait Islander descent, with many traveling from remote communities to attend the event.

The program had a strong focus on NT based and Aboriginal initiatives. Of the thirty two programmed concurrent sessions, seven featured NT projects. Two keynotes, six concurrent sessions and workshops were presented by Aboriginal and/or Torres Strait Islander presenters. A number of presentations were co-presented collaboratively between community members, community based workers and health professionals.

The conference also featured the CDN Recognition Awards. These awards recognise and celebrate innovation, leadership and achievements made by those working in the field of chronic diseases across the NT.
Winners were announced by Jeffrey Moffet, Chief Executive of DoH, with The Hon Robyn Lambley presenting the awards. The award categories included:

Program Delivery, Aboriginal and Torres Strait Islander Health and Leadership, Outstanding Contribution in the field of Chronic Diseases (urban and remote) as well as the Conference Theme Award for significant innovation or contribution in the area of this year’s conference theme Self-Management: A Partnership Approach.

The 2013 CDN Recognition Award winners were:

Program Delivery Award: *Milikapiti Health Centre Team (DoH)*

Aboriginal and Torres Strait Islander Health & Leadership Award: *Marlene Liddle, Strong Woman Program Coordinator for East Arnhem (DoH)*

Urban Outstanding Contribution Award: *Tess Ivanhoe, Nurse Practitioner-Remote with Centre for Remote Health & Nganampa Health*

Remote Outstanding Contribution: *Heather Andrews, Preventable Chronic Conditions Coordinator Tiwi Islands (DoH)*

By the end of the Conference it was anticipated participants would be able to:

- understand the principles of self-management and the importance of a partnership approach to facilitate a client’s capacity to self-manage their chronic conditions.
- understand the roles and responsibilities of the health practitioner to work with the client to identify their personal goals.
- identify strategies and resources that assist health professionals to provide evidence-based self-management approaches.
- identify various self-management models, including those that can be applied to specific population groups such as Aboriginal and/or Torres Strait Islander people.
The 17th Annual CDN Conference

Keynote Speaker - Professor Malcolm Battersby

Keynote Speaker - Dr Christine Connors

Keynote Speaker - Professor Roy Batterham

Keynote Speaker - Carolynnaha Johnson

Keynote Speaker - Kate Warren

Welcome to Country - Robert Mills

Stretching Break - Groovy Grans

Stretching Break - Pilates

Opening Speech - The Hon Robyn Lambley

Conference Sessions
Networking at the Conference

Poster Display

The Awards Entertainment

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Improving outcomes for growth faltering and anaemia in Early Childhood in the NT
Heather Ferguson, Child Health Nutritionist
Nutrition and Physical Activity Strategy Unit, NT Department of Health

Anaemia and growth faltering remain persistent and significant health issues for children under 5 years of age in remote Northern Territory (NT). The consequences of anaemia and growth faltering are both serious and largely irreversible after 2 years of age, leading to impaired cognitive development and learning ability and poorer adult health outcomes.¹

Recently published reports²,³ and analysis of Department of Health (DoH) records of a sample of children by the Child & Youth Health Strategy Unit (CYHSU), reveal:

- high rates of anaemia (up to 56%) in infants at 6 ≤ 9 months of age
- 30% of children recognised as anaemic receiving complete treatment
- high rates of stunting (19%) in children aged 6 - 24 months of age
- lack of recognition of growth faltering by clinical staff
- limited food variety and low intake of iron-rich foods eaten by infants and young children
- poor compliance with treatment guidelines provided in Central Australian Rural Practitioners Association Standard Treatment Manual (5th edition) (CARPA)

DoH is working on a specific project to reduce the high prevalence of growth faltering and anaemia in young children firstly by developing a more systematic approach to detection and management of these problems.

Currently, every child in remote NT communities should ideally be enrolled in the Healthy Under 5 Kids Program. This program provides a consistent and comprehensive approach to monitoring child health, helping health services to deliver the optimal health and developmental outcomes for children. This systematic approach can also assist staff to identify health problems early, such as anaemia and growth faltering.

Specific attention to surveillance and treatment of anaemia and growth faltering in the most vulnerable children aged 6-24 months is needed, in order to help remote staff identify these issues early. Specialist child health trained staff will assist with surveillance and help ensure appropriate treatment is provided according to existing treatment protocols found in CARPA.

An integral component of the project is to assess effectiveness, and a series of reports are being developed to achieve this. At an individual clinic level, reports will enable clinicians to monitor management of individual children including tracking adherence to treatment protocols. Progress across the NT will be monitored monthly by reports including the proportion of children with anaemia and growth faltering identified and treated according to CARPA.

In parallel with these initial activities, work will also continue to gain a more specific understanding of the factors that contribute to these high levels of anaemia and growth faltering. This is important to help guide development of the most effective approaches to prevent them happening in the first place.

References:

LOOKING BACK: Simplifying lifestyle to prevent chronic diseases
Breanna Ellis, CDN Coordinator
Chronic Conditions Strategy Unit, NT Department of Health

Over the last three to four decades Australia and the world have witnessed a significant increase in the prevalence of chronic diseases such as cardiovascular disease, chronic airways disease, type 2 diabetes and many cancers. The burden of cost associated with treating these chronic conditions is a concern for all governments around the world. The rapid rise of chronic conditions is impacting on health and social systems nationally and internationally and is expected to increase over the coming decades [1].

Many of these chronic conditions can be prevented or minimised through simple “lifestyle” changes. But this means different things for different people and the messages regarding lifestyle changes can be confusing at times. What is interesting to note is the focus in recent media around many of the lifestyle changes that have occurred since the 1970’s when there was an ideological change in what was considered “healthy eating” including low fat and nutrient based branding [3]. Unfortunately this shift also coincided with the rise of obesity and many chronic conditions in the developed world. The aim of this article is not to make recommendations but purely to review some of the views currently being presented in mainstream media around lifestyle change and preventing chronic disease.

‘WHOLE FOODS Vs. PROCESSED FOODS’

Over the last 30-40 years there has been a plethora of processed foods that have taken pride of place on supermarket shelves. Author and food philosopher Michael Pollan refers to these as “food products rather than food” and are now forming a staple part of our diet. Most of these foods are highly processed, usually with high levels of fat, sugar, and branded nutrients such as “added fibre” designed to make the consumer believe they are making a healthier choice.

In a recent article “What we can learn for what our grandparents’ diet” it was highlighted that up until the second half of the 20th century food was rarely consumed in a packaged or processed form. Our forefathers ate most foods in their simplest form [2].

Processed food forms the end product of massive multinational industry of research and development, global buying of resources and massive income generation, so it is in the food industries’ interest for the public to continue to buy the 17000 or so products that hit the shelves every year [4]. This may not be in our best interests though, so when buying, look at how much processing and packaging has gone into the food and consider if you can purchase it in a simpler form. A varied diet of whole foods, vegetables, cereals, meats and diary could potentially reduce the risks associated with developing a chronic disease.

‘FAT Vs. SUGAR’

The BBC series “The men who made us fat” examines another interesting development of the last half of the 20th century with the move towards the notion that all fats and oils were bad. The food industry, in response to this, proceeded to produce low fat/no fat food products and animal fat substitutes (i.e. margarine). The problem with removing fat is that you remove flavour, so to compensate for this food manufacturers substituted sugar and salt to improve the flavour of low fat products [3]. So while consumers assumed that the low fat products were a healthier choice the caloric implications of increased sugar in them were not considered.

The question that many are asking is, ‘are these low fat options inadvertently killing us with the hidden sugars?’ The message: read food labels and be aware of sugar content in products and moderate (but not eradicate) your fat intake.

‘WALKING Vs. SITTING’

What a change a couple of decades make. Physical inactivity is a major cause for concern and something as simple as walking to school seems to be a thing of the past. Children are now regularly driven to school but it is this type of incidental exercise can assist with the decreased likelihood of developing chronic diseases later in life [5]. The same can be said for adults who now spend increasing amounts of time in sedentary type work. Some simple changes such as parking the car a couple of blocks away from work, walking to school with the children or walking in your lunch break can all contribute to maintaining a healthy weight and lifestyle.

‘CUT THE CALORIES’

It’s simple science really if input exceeds output that extra energy goes somewhere and that is...
usually thighs and stomachs! There are now more people in the world that are obese than undernourished which is a sobering thought. Pollan proposes the Okirawans practised principle called “Hara Hachi Bi” or eat until you are 80% full. While Pollan does not advocate fastidious calorie counting he does argue that the access to high caloric food is making our waist lines grow.\[4\] Once again our grandparents often had to work hard for their food and definitely didn’t have as easy access to food the way that we do now. It is important to be conscious of what we put in our mouth and to make sure they are quality calories not empty or unhealthy calories.

So the message is quite clear, if we think more about what we eat, how much we are eating and what we do during the day we may minimise our risk of developing chronic conditions later in life. If we adapt some of the practices of our society prior to the second half of the 20\textsuperscript{th} century, we may be able to turn around some of the risk factors that can lead to the development of chronic disease and subsequently make for a healthier society and environment.

References:

1 Northern Territory Chronic Condition Prevention Management Strategy 2010-2020
2 ‘What we can learn from our grandparents’ diet. Kristen Shorten, news.com.au October 24, 2013
3 ‘The men who made us fat’ BBC Television, July 2012
5 Walk to School Website, http://www.walk.com.au

The Healthy Living Network: improving access to health promoting programs
Emma O’Neill, Project Officer
Healthy Living Network

With the burden of chronic disease being felt heavily by our health system, there is not only an increasing emphasis on prevention but also a focus on the principles of self-management in order to empower the individual.\[1\]

The Medical Journal of Australia states that self-management education programs ‘aim to empower patients through providing information and teaching skills and techniques to improve self-care and doctor-patient interaction, with the ultimate goal of improving quality of life’.\[2\]

The Healthy Living Network (HLNT) is an online registration portal that is available for healthy lifestyle programs such as self-management education programs and the organisations that deliver them in community settings. All programs that are listed and searchable on the portal are required to meet the Healthy Communities Quality Framework standards and criteria. The Quality Framework requires the program to demonstrate that it is consistent with national guidelines, has sound evidence underpinning the program, is outcomes focused and has effective risk management processes, amongst other features. These considerations ensure that the program is of a high standard and that the participants reap the maximum benefit from attending and achieving their goals in a safe and supportive environment. Coming soon to the portal is Healthy Workers Quality Framework Registration, applicable to healthy lifestyle programs and providers that deliver to employees and workplaces.

“The vast majority of people with chronic conditions manage their conditions with only infrequent visits to health professionals. It is estimated that a large proportion of these people, if provided with appropriate support, can benefit from learning effective self-management skills”.\[3\] HLNT enables allied health professionals to advise and assist patients with chronic disease to search for suitable activities in their local area, facilitating access to appropriate support as discussed above and placing the emphasis on choice and responsibility.
The programs available on HLNT have a strong component of individual goal-setting. Participants are encouraged to have active engagement and responsibility for their own health status, an important feature of self-management. In addition, the programs have demonstrated a commitment to continuous quality improvement with mechanisms in place for ongoing improvement that consequently result in ongoing benefits for participants. For example, this may consist of regular evaluations including participant feedback, feeding into program review and redesign.

Registered programs range from physical activity and nutrition educational programs such as:

- HEAL (Healthy Eating Activity & Lifestyle), developed by Sydney South West GP Link
- Heart Foundation Walking, developed by the National Heart Foundation

There are also a range of programs for more specific target groups such as:

- BEAT IT (lifestyle management to assist those with or at risk of diabetes, from the Australian Diabetes Council)
- Healthy Living on a Plate (nutritional education for CALD communities, from Flinders University Nutrition & Dietetics department)

A full list of the registered programs and their details can be found via the HLNT online directory. One of the many benefits of registration against the Quality Framework is the ability for program models to be shared and adopted and to assist with this, applicants provide information such as regarding the flexibility of the program (for different target groups and environments etc.).

The HLNT is a component of the Healthy Communities and Healthy Workers Initiatives under the National Partnership Agreement on Preventive Health (NPAPPH) funded by the Australian Government.

References:

Self Management through Cancer Support Groups
Chelsey Dunne, Cancer Support Nurse
Cancer Council Northern Territory

Cancer Council Northern Territory’s (CCNT) mode of delivering support is congruent with the self management model. CCNT recognizes that cancer clients live with cancer and hence are the experts in the management of their health, in collaboration with health professionals. Through the use of self management framework, CCNT acknowledges the cancer client holistically, including the physical, psychosocial, emotional and spiritual aspects of the person. People with cancer are increasingly expected and given the opportunity to take some accountability and responsibility in managing their own care.

Cancer Support Groups (CSGs) play a role in assisting clients self manage their psychosocial and emotional needs whilst living their cancer journey. They are a form of self management in that the client chooses to participate in them as they are not prescribed by medical staff. A Support Group is a group of people who meet on a regular basis, either in person, over the phone or online, to discuss shared experiences. CSGs offer a safe place for people affected by a cancer diagnosis and can assist people to feel heard and understood by others who are empathetic to their situation. A CSG can provide an environment where members can give and receive support, develop friendships and share thoughts and ideas in a non-judgmental and caring way.

Participants may learn about many cancer-related topics which in turn can support them to make informed decisions about their health and
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wellbeing and management of care.

According to research, the top five reasons that people join CSGs are as follows:

1. to feel that they are not alone
2. to hear about current medical research from health professionals
3. to learn how to become more informed about cancer treatments and side effects
4. to hear how other people deal with cancer
5. to relax with others who understand what they’re going through

Studies have shown that CSGs are a powerful way to improve wellbeing by reassuring people that their reactions are normal and increasing a person’s sense of control. It is the sense of belonging, reduction of isolation, feelings of being safe and understood that contribute to long term membership of a CSG.

In 2012, CCNT conducted a survey which was aimed at collecting results to address the CSG program. 52 CCNT clients participated and 72.9% had attended a CCNT CSG meeting. The survey demonstrated that 83.3% of attendees felt that the CSG met their needs and 81.8% would like a CSG to provide a mixture of both social interactions and informative sessions. The survey gave participants the opportunity to advise CCNT of the topics they would like addressed at future CSG meetings. CCNT used the results of the survey to strengthen the usefulness of the support groups for the participants. A CSG program that is consumer-driven is much more likely to have positive outcomes for attendees.

A range of face to face groups are conducted throughout the Northern Territory (NT) to provide people affected by cancer with an opportunity to interact with peers who may be on a similar journey. Telephone and Internet CSGs are professionally facilitated on a national level and are moderated, peer support groups designed for more remote people, people affected by rare cancers or those who are unable to attend the face to face sessions due to personal circumstances. CCNT offers a number of different CSGs to cater for many different cancer clients in the NT. Support services staff are able to work with organisations and community members in the NT to support the implementation, facilitation and development of CSGs if a need is determined and warranted.

Self management encourages people to take the central role in managing their health care by empowering them to make informed decisions regarding cancer treatment and management. Incorporating self management into the health care model is increasingly used and widely supported by health professionals. CCNT will continue to use this approach to ensure the CSG program offered through support services is current and effective in assisting cancer clients self manage the psychosocial impact of cancer. Through the provision of information and support, CSGs can develop an individual’s motivation, knowledge and self-efficacy to self manage certain aspects of their lives.

Reference:

1. Cancer Council Australia, June 2013, ‘Cancer Support Groups – A guide to setting up and maintaining a group’

Health Professional’s role in Self Management

Jeanette Smith, Education Consultant
Chronic Conditions Strategy Unit,
NT Department of Health

Engaging clients in their care is not just a nice thing to do; it is essential to improving health care outcomes. The health professionals role in promoting client self management is pivotal in turning around the current chronic conditions epidemic in Indigenous communities. Some of the ways we can actively promote self management include:

• providing the knowledge and communicating this effectively to engage clients in their self care
  • helping clients assume responsibility for implementing and actively monitoring
therapy by examining our work practices. E.g. do the diabetic clients have glucometers at home? Is it better to provide an area where diabetic clients can self monitor on a daily basis within the health centre?

- encouraging clients to make changes by undertaking Brief Interventions in the workplace
- assisting clients to set goals for change by actively undertaking motivational care planning with clients in the clinical setting
- providing ongoing support by case management and care coordination of clients with complex chronic conditions

Taking the time to examine the health service and engaging clients actively in their own care has proven to decrease acute exacerbations of their conditions.

Many health professionals are reluctant to explore the emotional issues of the illness for the person. Health professionals need to create an environment where emotion can be freely expressed, take the time to talk, support and engage with clients. Effective, experienced primary health care workers can even do this in a busy work environment. Instead of solving problems for a client we need to reinforce a joint approach and the clients responsibility and ability to self manage.

The Chronic Conditions Strategy Unit has been actively engaged in multiple activities to explore and promote improved self management; for example using a coordinated approach to diabetic foot care. The current statistics relating to diabetic foot complications are shocking and include:

- The rates of diabetic foot amputations in Australia have increased 30% in the last 10 years
- The five year mortality rate for people with diabetes amputations are 50% higher than many cancers
- Indigenous Australians are 38 times more likely to need a lower limb amputation for survival
- Diabetic foot complications are a major cause of death related to diabetes (Australasian Podiatry Council 2013)

Promoting self-management in newly settled Refugee background communities in the Northern Territory

Dr Liam Johnson, Lecturer
Exercise & Sports Science
Charles Darwin University

Jerrad Borodzicz, HEAL™ Program National Coordinator
South Western Sydney Medicare Local

Dr Sharon Hetherington, HEAL™ Project Officer
Exercise & Sports Science Australia

Groups of newly settled Refugee background communities, including predominantly Swahili speaking women have been learning about the benefits of healthy eating and regular physical activity in classes of the Healthy Eating Activity & Lifestyle (HEAL™) program run by Charles Darwin University (CDU). The program, supported via partnerships developed between City of Darwin, CDU, NT Refugee Health Service, Melaleuca Refugee Centre and HEAL™, runs from the Casuarina campus of the University.
Susan Clunies-Ross, a registered nurse working with the NT Refugee Health Service, commented that many new migrants tend to gain weight within 6-months of arrival to Australia as well as develop multiple risk factors for chronic disease due to changes in their living environment and adopting a more Western diet. Further recent evidence has highlighted emerging health problems for newly settled Refugee background groups, including:

- Culturally and linguistically diverse (CALD) migrant groups are at a higher risk of developing hypertension, diabetes mellitus, obesity and cardiovascular disease
- People from CALD groups are less likely to avail themselves of health care services or engage in preventative health initiatives including physical activity programs

Recent research also suggests that there is a distinct shortage of physical activity programs aimed at promoting preventative health for CALD groups.

The Darwin Refugee HEAL™ programs aim to assist new migrants to make a healthier transition to their new country of residence, by improving health literacy, promoting healthy lifestyle behaviours, reducing the risk of developing lifestyle-associated chronic disease and by tailoring a lifestyle modification program, including physical activity classes to meet the unique needs of the group.

City of Darwin, in partnership with the NT Refugee Health Service and CDU, implemented an identification and referral pathway for new migrants in high need of receiving nutrition and physical activity education to attend HEAL™. Nursing staff and GPs at the Melaleuca Refugee Centre identified potential participants from Refugee background community groups and referred suitable participants to the culturally specific classes held at CDU, where small groups with persons from the same Refugee background were held. Over 18 people attending the health service have subsequently been referred. The classes were enthusiastically received with increases in awareness, knowledge and skills around healthy lifestyle choices being adopted by participants and their families. Participants have seen positive improvements to their blood pressure, walking and functional capacity after completing the program.

Tier 1 HEAL™ facilitator Liam Johnson, who is working closely with a translator to deliver the program, says that the groups have been making considerable progress in their understanding of healthy eating choices and the benefits of being physically active. Susan and Liam both commented that many of the women in particular are really enjoying the classes.

HEAL™ is an evidence-based, 8-week lifestyle modification program that supports participants at risk of developing chronic disease to develop lifelong healthy eating and physical activity behaviours using a self-management approach. Participants attend pre and post program individual health consultations and each week then undertake 1-hour of supervised group-based physical activity and a 1-hour healthy lifestyle education class. The program is a developed ‘off-the-shelf’ program now available to health service providers Australia-wide.

For further information about HEAL™ including facilitator training, visit the National HEAL™ program page on the SWSML and ESSA websites: www.swsml.com.au/site/heal-program---national and www.essa.org.au/for-gps/heal-program/

Please direct enquiries to HEAL™ National Coordinator, Jerrad Borodzicz, by email jborodzicz@swsml.com.au or phone 1300 179 765, or to HEAL™ Project Officer, Dr Sharon Hetherington by email Sharon.Hetherington@essa.org.au or phone (07) 3149 3340.

References:

3. Henderson S, Kendall E, See L. (2011). The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistically
Self managing health care requires collaboration between service providers, patients, families and other involved parties. Collaboration implies a shared communication and understanding. Lowell et al’s work identified communication related to chronic disease as ineffective and restricting patient’s ability to make informed decisions in managing their health. Mental health service providers, patients and families similarly face a constant challenge in reaching an on-going understanding about self managing health needs. Andary et al and Morice discuss the difficulties in understanding expression of emotions across cultures. This challenge was also recognised by the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council (NPYWC) and Mark Sheldon Remote Mental Health Team (MSRMHT) in Central Australia and its impact on self management of health care needs. To address this challenge NPYWCand the MSRMHT have been working together on a language project: “Utira Kulintjaku” which literally means making listening and thinking clear or easily seen, that is, enabling mutual understanding.

The Utira Kulintjaku NPYWC project commenced as a series of workshops held over twelve months, with Ngangkari (traditional healers), other senior Anangu people, interpreters and mental health clinicians. The project recognises that there are multiple knowledge systems about mental health in the Central Australian region, as well as many languages. The aim was to create a shared understanding of commonly used mental health terms, words and concepts, as well as a compendium of words and phrases Anangu use to describe feelings and emotions. The workshops aimed to create a consensus about how we talk about common mental health disorders and problems. An increase in mental health literacy facilitates increased help seeking behaviour, better communication between Anangu and mental health clinicians and overall better health outcomes. Another aim of the workshops was to develop a group of local experts with a shared understanding of mental health.

To date three workshops have been held, facilitated by NPYWC. The MSRMHT has been invited to participate and contribute the medical, psychological and nursing perspective of mental health for translation into different languages. The MSRMHT provided education in regards to the neurobiology of brain structure and function, and the assessment, diagnosis, evaluation processes used by mental health clinicians. These concepts were translated into different languages and a story developed using local metaphors to explain the way Western clinicians seek out the information they need to suggest options for care. Following the second workshop a group of
Anangu returned to their home community and translated the story to a painting, illustrating the journey a person, their family and the community takes from ill health to wellness. On returning for the next workshop, with the painting, the Anangu described how the painting had attracted much attention, even during a sorry camp, as others came to contribute and talk about the issues it raised.

Other resources are developing out of the workshops for both Anangu and service providers. The workshops are also creating a team of local “experts” with a shared understanding of mental health. These people present their work to local communities and are available to educate service providers using the resources developed.

The project is an innovative response to cultural and language differences and the obstacles these can create between mental health services and those who need help. It brings together the considerable skills and knowledge of Ngangkari, the MSRMHT, NPYWC and senior Anangu, with specific language and literacy skills from local Central Australian communities to work together with a shared objective of improved health through informed self-management.

References:


Better living with your lung disease: self-management education for patients
Melissa Ram, Project Manager
Self-Management
Lung Foundation Australia

Lung Foundation Australia is a not-for-profit organisation founded in 1990. We are a national organisation with our head office in Brisbane. We have a strong focus on providing support to patients and carers who are affected by lung disease, and to ensure lung health is a priority to all in Australia. Lung disease is a significant and growing health burden in Australian. According to the 2007/08 National Health Survey, about six million Australians suffer from a chronic respiratory disease. Lung cancer is the biggest cancer killer with the incidence estimated to increase by 40% by 2020. In addition Chronic Obstructive Pulmonary Disease (COPD) is the second leading cause of avoidable hospitalisations in Australia.

Lung Foundation Australia is striving to reduce these statistics by increasing awareness and advocating lung health messages to the community, by developing training and education for health professionals, supporting research and clinical trials and providing education and support to all those affected by lung disease.

It’s evident that self-management reduces both short term and long term hospitalisation in people living with Chronic Obstructive Pulmonary Disease (COPD). It is a firm belief of the Lung Foundation that by educating and promoting self-management among lung disease patients, the burden of disease can be significantly reduced. This can be indicated by reduced hospital admissions, reduced exacerbations, improved quality of life, slowed disease progression, increased physical function and ability to carry out daily activities.

In 2011, Lung Foundation Australia received funding from the Australian Government under
The Chroni

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the Chronic Disease Prevention and Service Improvement Fund to develop and deliver a self-management project – Better Living with Your Lung Disease. This incorporates the development of ten evidence-based; self-management focused patient educational DVDs and a series of national regional patient education seminars.

Better Living with Your Chronic Lung Disease explores common topics among those living with a chronic lung disease. These include but are not limited to managing your breathlessness, managing your fatigue and energy conservation, tips for looking after yourself and your disease, and benefits of exercise programs and ongoing support. The data was collected for the topics throughout 2011 from Lung Foundation’s Information and Support Centre. The most frequently asked questions, were identified and integrated into the Better Living with Your Lung Disease DVD series. The main purpose of the series is to increase a patient’s self-efficacy and management of their lung disease, and to participate in a collaborative approach with their health professionals, whilst increasing their health literacy and understanding of their disease and its symptoms.

The DVDs are available to view on Lung Foundation’s website or to purchase through the online shop. The 2013 round of regional seminars is drawing to a close with only two left to run in Bendigo, VIC and Port Macquarie, NSW. The feedback from patients has been overwhelmingly positive, many very appreciative that we have been able to come to their ‘regional’ areas to help educate them about their disease. We look forward to an exciting year in 2014 visiting the same areas to deliver the regional seminars, which we predict will be even more successful.

Lung Foundation Australia has a number of projects which incorporate self-management and patient-centred care. These include maintaining a national list of pulmonary rehabilitation programs (350 classes), a Lung Foundation developed maintenance exercise program for those who have recently completed pulmonary rehabilitation called Lungs in Action (60 classes), Patient Support Groups (100) and fortnightly Lung Cancer Telephone Support Groups. For more information on Better Living with Your Lung Disease or any other Lung Foundation initiatives please visit our website www.lungfoundation.com.au or call our Information Support Centre on 1800 654 301.

References:

1. Australian Institute of Health and Welfare, Asthma, chronic obstructive pulmonary disease and other respiratory diseases in Australia, 2010
3. Australian Bureau of Statistics, Underlying causes of deaths in Australia, 2009
For those with end-stage kidney disease (ESKD) the treatment options are transplant, dialysis or supportive care (non-dialysis). Research finds that patients would rather have treatment at home.1 In 2011, in the NT, 6% of ESKD on dialysis used peritoneal dialysis (PD) and 6% used home haemodialysis (HHD).2 For the NT home dialysis certainly offers the best opportunity to return to community, with a bonus of better health outcomes and being cost effective for the health system. Of note it is estimated that 50% of those with ESKD never start treatment and approximately 20% of those who do withdraw later voluntarily.

There is a wide variance in utilization of treatment options throughout Australia that is not attributable to demographics alone. Educational research has determined ESKD patients who enter a comprehensive education programme in a timely manner are more likely to choose a home modality.3 In an Australian survey of education practices, HHD was more likely to be chosen when longer and more in depth education was offered.4

Traditionally ESKD education about treatment options has had a strong focus on how the different treatments work. However more recently, it has been recognised that the person with ESKD is most worried about their daily lifestyle and priorities. In a world that is encouraging empowerment and self-management for any disease process, it is appropriate that people are allowed and encouraged to choose appropriate treatments with multidisciplinary team support.

The ‘My Kidneys, My Choice’ decision aid (DA) was designed to empower patient decision making by supporting comprehensive treatment option education with a structured decision making process. Shared decision making is defined as the health professional guiding the person and their significant others through the process of decision making.5 It removes the temptation for health professionals to make the decision when they are not an expert about the patients’ life.

The DA follows structured decision making:

- Deliberation Become aware of the need to make a decision
- Choice Talk Acknowledge the fact there are choices
- Option Talk Gather all the facts and be comprehensively educated
- Decision Talk Seek opinions and consider the influence of the decision on your own life and those around you. Make the preferred decision

The DA was designed to be used at more than one visit and be taken home. It has not been designed to replace education but rather to guide the process and make sure all steps are followed. It deliberately exposes the patient to every option, but with educator guidance offers opportunities to validate the relevance of each option to that particular person. The five sections are:

**My Kidneys (deliberation):** An introduction that incorporates adult learning principles by ensuring the person knows why they need education. It allows an opportunity to explore for denial and any cultural concerns that may affect shared decision making.

**My Lifestyle:** The health professional learns about the individual, their current life priorities, their feelings about themselves and how they view their future with kidney disease. It can be filled out by the person or used as a discussion tool.

**My Options (choice and option talk):** The first part provides a comparison between transplant, dialysis and supportive care. The comparison tables are split into lifestyle areas such as my diet, my travel and my body. The second part is a comparison of automated PD, continuous ambulatory PD, HHD and centre based HD. The summaries are designed to start or end educational processes and to be shared with families.
My Choice (decision talk): This section is a check to make sure that it is the right time to make a choice and document and support that process. There is also a My Questions section, to allow the recording of any questions.

Official research about consumer and health professionals' opinions is now occurring. In the NT the staff of Danila Dilba are early adopters of the DA. To date it has been used with eight people as an adjunct to the existing NT resources. As it follows the same strengths/weaknesses approach it functions well as a discussion guide and document for recording client's responses.

The DA is available as a downloadable PDF from the Kidney Health Australia home dialysis website and is accompanied by the health professional user guide at [www.homedialysis.org.au](http://www.homedialysis.org.au)/health-professionals/publications

For more information email Debbie at: homediaIysis@kidney.org.au

Acknowledgments to the dedicated multidisciplinary group who developed the DA.

References:


Mary’s story as related by Mary

Mary Amagula has been managing her own dialysis for three and a half years; both in a remote community and in the drop in centre at Nightcliff Renal Unit. She has kindly agreed to share her story. The following is a transcript of what she told me:

“When I was in the main building (Nightcliff Renal Unit) I used to watch the nurses - how they put the numbers in the machine and I kept it in my head. I wanted to go home so I started training in the “Donga” (home haemodialysis training demountable). The first needle I put in was very frightening. I was very nervous. The nurse helped me but I picked it up after a few days. I went home and I was confident.

I prefer to do my own dialysis. My life is easier because I know how to (do dialysis). When people come in to talk to me they think that it is not my blood but I understand that it’s my blood and this (points to dialysis machine) is like a washing machine to get rid of the dirty blood. I explain to people and educate them about how it all works and people start realising that it is my blood. I feel like I need to explain and help people to let them know that they need to look after their body and what is going to happen to them and how it all works so they don’t get frightened of dialysis. I need to support them because I know what it is like. If you miss your day (for dialysis), you feel the difference. I pass on the information - I explain that dialysis is your second chance.

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When I go to the Community for funerals and if I miss my grand kids, I look after myself. I let the nurses know first, then I can go to meetings and catch up with family and when there is a funeral I can do my dialysis the next day. I have more freedom. I can

Continued on Page 19
do dialysis on one day then I can go to the beach, go fishing, cook damper with my family, stingray, turtle,... Once you are at home you can go camping and do your dialysis around it so you don't have to miss out.

The dialysis is not a struggle any more. I feel settled inside now.”

Renal patients who have trained in self-care, manage their own peritoneal dialysis and haemodialysis either at home or in one of the 18 purpose built multi user haemodialysis facilities scattered over the Northern Territory (NT). Currently 22% of dialysis patients in the Top End of the NT and 7% in Central Australia perform self-care dialysis.

As Mary’s story testifies, the advantages of self-management for renal care are that it maximises the wellbeing of those living with renal failure, gives greater flexibility for treatment times with better outcomes, enables access to treatment closer to home, increases the client’s knowledge of dialysis treatment and symptom management empowering them to participate in decision making about their care. Mary’s story also emphasizes the very valuable role that patients who self manage their care often have in the community i.e. to support, educate and mentor others with the same condition.

The Kidney Health Australia (KHA) website contains a wealth of information to help in the management of Kidney Disease however, recently a new self-management tool “My kidneys - My Choice decision aid” has been made available to help those with Chronic Kidney Disease (CKD) to make informed choices about their treatment. It guides the client through a self-assessment form which those who do not have good English literacy skills, may require assistance from a family member or a health professional to complete. It looks at the topics of “My kidney, My lifestyle, My options, My choice and My questions”. The identification by the client of what they value will influence and facilitate their choice of treatment and enable them to participate in planning for a smoother transition to dialysis.

Ideally the empowerment of CKD clients will prepare them to seek self care dialysis (either peritoneal dialysis or home haemodialysis) as a primary option of dialysis treatment avoiding the need to permanently relocate to major centres to receive treatment and to increase both the quantity and quality of their life.

The MOST Frequently Asked Question
Jill McGee, Education Manager
Asthma Foundation NT

1. Where can we attend the Nationally Accredited Asthma and Anaphylaxis Courses regulated for Centre-based services which include long day care, outside school hours care and preschools?

Since the introduction of Nationally Regulated training by January 1st 2013 Asthma Foundation NT has been inundated with requests to provide Asthma and Anaphylaxis training across the territory. One in ten people are affected by asthma and the incidence of anaphylaxis is of increasing concern. Competency based training is providing skills to assist in the management of asthma and anaphylaxis.

The Asthma Foundation NT provides two nationally accredited courses to assist people to fulfil their obligations in children’s services.

The Australian Children’s Education Quality Authority approved courses are:

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<th>COURSE</th>
<th>TIME</th>
<th>COST</th>
<th>ASSESSMENT</th>
<th>Outcomes</th>
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<td>$60 per participant</td>
<td>3 ASSESSMENTS</td>
<td>Nationally Accredited Course</td>
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<td>Valid for 3 years</td>
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Continued from Page 18

Continued on Page 20
2. Why do I have to take my preventer medication every day even when I am not experiencing asthma symptoms?

There is also a common misconception that preventative medication is taken until the symptoms of asthma improve and then can be discontinued.

The Asthma Foundation provides free one on one asthma education for approximately 35+ people each month. Much of our discussion is on the benefits of taking daily prevention medication and understanding how asthma medication can be most effective.

An individual’s inhalation technique is observed and assistance provided. There are many studies outlining the importance of correct inhalation technique as being of utmost importance.

Following diagnosis of asthma by your GP or Respiratory specialist daily preventative medication will be prescribed for a period of time. This may range from approximately six weeks to a much longer period of time depending on the severity of your asthma. In many cases the medication will be an inhaled corticosteroid.

According to Asthma in Australia 2011 Australian Institute of Health and Welfare: Inhaled Corticosteroids are used to reduce airway inflammation, a key feature of asthma. For people with asthma this results in better control of symptoms and disease exacerbations. Inhaled corticosteroids are most effective when used on a regular basis, either daily or twice daily.

Short acting bronchodilators are used for the relief of asthma symptoms. Symptoms can include coughing, wheezing, shortness of breath and a feeling tightness in the chest. Symptoms can progress with severity over time or very quickly and should not be considered “normal for asthma”.

According to Global Initiative for Asthma (GINA) Good Asthma Control is represented as:

− able to exercise normally
− no sleep disturbance due to asthma symptoms
− free of symptoms on waking
− no symptoms during the day
− minimal or no adverse effects from medication
− using reliever puffer less than 3 times per week (except for exercise)

If you require assistance to manage your asthma with confidence, call the Asthma Foundation NT – 1800 ASTHMA.

For more information please contact: Jill McGee / Education Manager / Asthma Foundation NT / schools@asthmant.org.au
Frequently Asked Questions
Liz Kasteel, Senior Policy and Program Manager
Chronic Conditions Strategy Unit
NT Department of Health

1. What is self-management?

Self-management is what the person with a chronic disease does to manage their own illness; it includes engaging in healthy lifestyle choices, working with health professionals in making decisions regarding ongoing treatment options that fit within the person’s broader social context, actively monitoring and managing symptoms and impacts of chronic health conditions.

2. What is self-management support?

Self-management support is what health care practitioners provide to assist a person with their self-management practices, and to support the person’s self-efficacy and ability to effectively self-manage.

3. Can self-management support be delivered in a group setting?

Yes. Self-management support can be provided through a range of strategies and approaches: individual and group based, face-to-face or by phone, as part of clinical intervention and/or as a separate interaction with the person with a chronic disease.

Self-management support can also be provided to a group of clients with one or more chronic conditions (not necessarily with the same chronic conditions). The important things to remember are to include the essential criteria (refer to Q.6) and to set the group’s rules in particular in relation to confidentiality of information.

4. Is self-management the same as patient/client health education?

No. Self-management incorporates patient/client health education; however, it does not stop at only improving patient/client knowledge about their health: it goes further to empower the patient/client to have problem solve skills and ability to set personal goals.

5. Why provide self-management support?

There is a strong evidence base around self-management as a core component of integrated chronic disease management. Cochrane reviews on self-management strategies for COPD, diabetes and arthritis have demonstrated evidence of:

- decreased presentations to hospital
- improved clinical indicators (such as HBA1C)
- increased self-efficacy and wellbeing

6. What are the essential characteristics of self-management support?

Self-management support should:

- be delivered by a person who is skilled and trained in self-management
- respects choices and individual circumstances of the person with a chronic condition; and assists that person to address barriers to self-management
- involves goal setting and problem solving as key components
- is an ongoing collaborative process between the health care practitioner and person with a chronic condition; not something that is completed in a time-limited intervention

CHANGE DAY

The Pledge Counter has started turning and the countdown has begun to Change Day. We are aiming for 50,000 pledges by 6th March 2014.

“I’m pledging to improve the early recognition and detection of deteriorating patients, resulting in the reduction of cardiac arrests and hospital mortality in NSW hospitals.”

The genesis of this idea came from NHS Change Day 2013 held in the UK. The NHS event started with a single tweet shared between a group of young improvement leaders in the summer of 2012. They began talking about how they could improve their health service and make patient care even better.
Before long this developed into a shared vision about bringing together staff across the NHS and its supporters to produce positive change and improvement.

This led to the very first NHS Change Day held on 13th March 2013. Its shared purpose was to organise a grassroots movement of people to take a specific action to improve the outcomes and experience of care for patients on a sustainable basis. The initial goal was to mobilise 65,000 people – 1,000 for each year since the NHS was established.

In fact, it generated 189,000 online pledges of action and subsequent actions for change. Put simply: it was a phenomenal success. NHS Change Day will be held in March 2014 to coincide with the Australian event. You can find out more about NHS Change Day at www.changeday.nhs.uk

Australia, along with a number of other countries, were invited by the NHS to become involved in 2014 and a small group of health workers and improvement leaders answered the call with a resounding YES!

“I pledge to ask my colleagues ‘are you ok?’ and take time to listen to the answer.”

Our goal in Australia in 2014 is to mobilise 50,000 people to participate in Change Day by making online pledges of action (agreeing to do one thing differently to improve the health and wellbeing of others) and committing to make a positive difference.

On 6th March 2014 Australia will join with the UK and create a global link for change. We are aiming for 50,000 pledges by 6 March 2014 from people who work to improve health outcomes. You might be an administrator, a researcher, a dentist, a physiotherapist, a leader, a patient or resident in an aged care facility, or a hospital cleaner – whoever you are if you care about better patient and client outcomes and you want to see quality improvement across our health care system – Change Day is for you and your team.

“*I pledge to immerse myself in the evidence relating to user-centric policymaking to ensure my work as a policymaker is closely connected with the interests of patients and carers.*”

Change Day is a social movement not a big business. It runs on energy and creativity. We are just like you – we want to be the change!

Making a pledge is your way of letting everyone know about the action you will take to contribute to this social movement. Being the very best version of yourself and creating great outcomes is free – simply visit www.changeday.com.au and make your pledge then tell others about it and encourage them to do the same. Follow us on Twitter @ChangeDayAus

“I pledge to walk along side my clients from the waiting room, rather than ahead of them.”

Here’s what we are asking you to do. 4 easy steps to be the change you want to see in the world.

2. Let your colleagues and friends know about your pledge by sending them a link to the website and encouraging them to join in.
3. Visit our facebook page and share it with others www.facebook.com/changedayaus and follow us on Twitter @Changedayaus
4. Go on our mailing list so we can keep in touch and let you know how Change Day is growing, then you can send our emails onto others.

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Tackling smoking and alcohol in Tennant Creek with Shellie Morris
Clare Anderson, Regional Co-ordinator
Barkly Region
Kalpa Purru Wirranjarlki (Public Health Unit), Anyinginyi Health Aboriginal Corporation
Joanna Schwarzman, Indigenous Health Project Officer
AMSANT, Central Australia

The Barkly Regional Tobacco Team in Tennant Creek have been doing great things making music and videos to get their health promotion messages across.

Anyinginyi Aboriginal Health Corporation Public Health Unit released a music and information video, titled ‘Respect Yourself’ on YouTube and the Anyinginyi website. The video was launched in Tennant Creek on 6 July at the 10th Anniversary of Nyinkka Nyunyu Aboriginal Art and Culture Centre, and was shown at various functions in Tennant Creek during the NAIDOC week celebrations. The six minute video was developed during a four day workshop with NT singer Shellie Morris and local Tennant Creek women.

The Regional Tobacco Coordinator at Anyinginyi, Clare Anderson initiated the workshop as a social marketing initiative with funding received under Closing the Gap - Tackling Indigenous Smoking Program.

Smoking and drinking during pregnancy are recognised as important issues. The ideas for the music workshop and video came about in November/December 2012, focusing on empowerment and preventative health through music and song. Fortunately, Shellie Morris was passing through Tennant Creek and initial talks for the proposed music workshop were held. Six months later, in early June, a workshop was held with the Stronger Sisters from Tennant Creek High School and women from the Anyinginyi Stronger Families Unit.

Over the four day workshop, from 3rd to 6th of June the participants wrote, performed and recorded the song ‘Respect Yourself’. The key messages were about being strong in self and culture, enabling women to make positive choices, especially during pregnancy.

In addition to getting the message out there, Clare says that the process of making the video has strengthened partnerships between the Stronger Sisters group at Tennant Creek High School and Anyinginyi Health.

To watch the video go to http://www.youtube.com/watch?v=oftkpVnF6rU or search for Respect Yourself Anyinginyi in YouTube, or the Anyinginyi website http://anyinginyi.org.au/news-media-publications/publications

To find out more about the making of the video contact Clare Anderson, Regional Tobacco Coordinator, Anyinginyi Aboriginal Health Corporation, Public Health Unit on 8962 2615 / clare.anderson@anyinginyi.com.au


To find a Regional Tobacco Coordinator and team in your area contact the Indigenous Health Project Officers at AMSANT, Sharon (sharon.wallace@amsant.org.au (Top End)) or Jo on 8959 4611 / (joanna.schwarzman@amsant.org.au (Central Australia))

Be Strong TV series: tackling smoking and encouraging healthy lifestyles
Clair Stock, Communications Manager
Rural Health Education Foundation

Members of the Rural Health Education Foundation have been filming this last year to showcase what Aboriginal and Torres Strait Islander communities have been doing to tackle smoking and encourage healthy lifestyles amongst their people. The programs developed from the filming make up the Be Strong TV series which has been broadcast on the Rural Health Channel and is available to view online.
The emphasis of this series is to showcase initiatives and programs from around Australia to inspire and share innovative ideas in tackling these lifestyle issues. The programs feature interviews with Tobacco Action Workers, individuals who have faced the quit smoking challenge and community members at local events.

Through this series we hope to encourage partnerships and collaboration within the Aboriginal and Torres Strait community. Sharing existing initiatives and triggering conversations is a key element of this Be Strong series.

“It is not our goal to show programs that work and therefore should be copied, rather to showcase programs and encourage communities to see what could be adapted or modified to work best for them”, says Helen Craig, CEO of the Foundation, “the wealth of opportunities is undeniable”.

There are currently 11 programs available in this series. Visit the Be Strong series webpage http://www.rhef.com.au/be-strong/ to view them online or to see what’s coming up. Three recent programs are outlined here:

**Exercise to Be Strong** (first broadcast 6 September)
You can exercise in many ways. The impact of exercise on your health and wellbeing is well documented. Understanding how this works, why it is important and the ways in which exercise can be factored into your daily routine are elements of this ‘Be Strong’ series program. Join community members and health professionals as the ‘exercise’ story unfolds. See how simple it can be to ‘Exercise to Be Strong’, stop smoking and combat the health risks of chronic disease.

**Eat Well to Be Strong** (20 September)
Eating well is often quite challenging. Having access to fresh food at a reasonable price and having the time to plan menus and prepare meals are integral to the process of eating well. In this program we will look at fresh food access, the ways to make meals nutritious and well balanced and review the impact of healthy eating on health and chronic disease management.

**It’s Deadly to Be Strong** (4 October)
See how the variety of Deadly Choices programs can be adapted to suit local community needs, while still operating within the original format.

From Brisbane to Bundaberg and beyond, the program works well. The Deadly Choices Program is adaptable, relevant and built around clear health, educational and community needs.

The Department of Health and Ageing, Indigenous Chronic Disease Prevention Section has funded this series for the Foundation.

Programs will continue to be broadcast on the 1st and 3rd Friday of each month at 12.30pm NT time. (Available nationally – see the www.rhef.com.au/rhc for times in other states.)

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**Staying quit beyond release: A continuum of support for inmates and their families in community**

Katharina Kariippanon, Regional Tobacco Coordinator
Miwatj Health Aboriginal Corporation

On July 1st 2013 the Northern Territory (NT) was the first jurisdiction in Australia to enforce a total smoke free environment in all correctional facilities. The Miwatj Health Aboriginal Corporation Tobacco Program team in East Arnhem Land applauded this significant step forward; however it immediately raised for us the question about what happens beyond release.

Forced tobacco abstinence alone during incarceration has little impact on post-release smoking status and does not result in long term cessation, with the majority of prisoners returning to smoking upon release1. Given the high rate of smoking in community and the fact that upon release, prisoners typically return home to the same environment that they left behind, often facing great socio-economic challenges, relapse is highly likely. Further, Indigenous prisoners typically serve relatively short sentences, so the time they ‘are quit’ in prison is often not long enough in duration to sustain long term change.

For us working at the community level, it became apparent that this was a great opportunity to build on the successful period of cessation achieved in prison, by providing ongoing quit support services to released detainees.

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In May 2013 Miwatj Health hosted a three day Tobacco Forum where a range of guest speakers presented on current topics in tobacco control. The NT Department of Correctional Services shared with us their program underway in the prisons and the team brainstormed ways in which to provide ongoing support to the prisoners. The Tobacco Action Workers painted a banner with encouraging messages, advising Yolngu in prisons that there is a service to support them when they return home. The banner was received with much enthusiasm and now hangs in the Darwin correctional centre, which houses the majority of Yolngu inmates. With this a process was initiated in which inmates became aware that quitting is not something that needs be restricted to their prison experience, but that support is available to them to ‘remain quit’ back home. Letting them know that there are people out there that care about their smoking behaviour, was greatly appreciated.

In an attempt to be able to follow up with as many prisoners as possible, we wanted to alert them to the support available in the community, prior to their release from prison. An information poster was developed and hung up around the prison. It features the names of our tobacco workforce in four communities around the region, and encourages inmates to seek them out when they get back home. We also laminated small information cards to be given to prisoners as part of the pre-release program. Miwatj further thought it would be beneficial to provide an incentive, so the workers designed a logo and slogan for a T-shirt to be given to prisoners when they make contact with a Tobacco Action Worker, and are willing to receive their support to stay quit.

A key element of the support that can be given is regular encouragement and talking through the options, delivered through home visits, essentially a case management approach. Further we are keen to engage the prisoners in our broader program, as role models who have successfully quit, instilling in them a sense of pride and achievement and capitalising on that positive sentiment. Facilitating access to NRT in cases where relapse is becoming a concern is also something our team assists with. We are assuming that because the detainees have had an experience with NRT in prison, they are hopefully more open to trying it again. NRT is generally underutilised in our communities.

Given the extremely high rates of smoking in the environment to which detainees return, we also place importance on connecting with the households where they normally reside and their immediate family members. This involves working closely with these families, initially assessing their openness to discussing their own smoking in light of their family member having quit in prison.

Our approach is one of support, applying motivational interviewing techniques to engage individuals in the household. We take emphasis away from the individual themselves, making the discussion not so much about their own smoking but rather about protecting others from the second hand smoke they generate, and supporting those who have or are trying to quit. A further emphasis is placed on encouraging a smoke free home and facilitating this by equipping the household with knowledge about why this is important, as well as providing “smoke free home” signs.

Only a handful of prisoners have been released back to our communities since the initiative started and we are finding that they are definitely willing to engage in discussion with our Tobacco Action Workers. Those we have spoken to have certainly expressed that they are feeling challenged by being surrounded by so many smokers again. This reaffirms for us the validity of our initiative and the role we have to play in supporting released prisoners and their families on their quit journey.

This initiative was presented at the Oceania Tobacco Conference in NZ in October 2013.

Reference:

NT Chronic Condition Prevention and Management Strategy 2010-2020 (CCPMS) – an update
Liz Kasteel, Senior Policy and Program Manager
Chronic Conditions Strategy Unit
NT Department of Health

Self-management and the NT CCPMS

Under Key Action Area-4 of the NT CCPMS, the Northern Territory (NT) committed to develop a self-management framework; this framework provides guidance for self-management practitioners, managers and policy makers about best practice self-management approaches.

Self-management was identified as the theme for the 17th Chronic Diseases Network Annual Conference. This was in response to meeting one of the implementation priorities set out in the NT Chronic Conditions Self-Management Framework 2012-2020, to provide the NT health professionals with an opportunity to improve their knowledge in self-management, to share experience and learn from each other about a range of self-management approaches, models and programs that can be applied to support clients to self-manage their chronic conditions.

During March to July 2013, the Department of Health, Menzies School of Health Research and the Flinders University of South Australia undertook a small pilot project to test a new self-management assessment tool across eight NT sites, five of which were in remote sites of the Top End/Central Australia. 22 health professionals participated in this trial. The project evaluation was on the effectiveness and appropriateness of the tool. The evaluation report has recently been finalised and will be circulated to key stakeholders. There are useful key learnings from this pilot project for the NT to progress the implementation of self-management approach for clients with chronic conditions.

On-line self-management training has been made available to selected health professionals (ie those who are delivering self-management support and are working in the priority work units as identified in the Chronic Conditions Self-Management Framework). To date, of the 250 licences offered, only 53 licences were used (53 health professionals registered) with various degrees of assessment results. This training is available until December 2014. Health professionals are encouraged to undertake self-management training, which provides evidence based strategies on how to work with and support clients to enhance their ability to self-manage their chronic conditions. This is a five-hour five module on-line training based on motivational interviewing and cognitive behavioural therapy with strategies that can be applied for groups or individuals.

The 2nd triennium CCPMS Implementation Plan 2014-2016 will be released early 2014. A range of activities have been identified for the NT to continue the implementation of the NT self-management framework.

Reference:

Health Promotion Subject Guide

The Health Promotion Strategy Unit (HPSU) is pleased that the Health Promotion Subject Guide available at http://www.elibrarygroups.health.nt.gov.au/healthpromotion is now live for people to access. This Guide has been developed to support Department of Health (DoH) and others working in the area of Health Promotion.
The guide links you to quality print and online resources available through the DoH Library.

Find useful databases, journals, books and other resources by clicking on the tabs.

Key topics include: Health Literacy, Partnership/Intersectoral collaboration and Social Determinants of Health.

It also provides links to key Frameworks/Documents for the NT including the Health Promotion Framework and the NT Chronic Conditions Prevention and Management Strategy.

If you know of a good health promotion resource that isn’t listed as part of this Guide, please submit the link via the ‘suggest a resource’ function within this Guide.

**QIPPS Version 4 – NEW**

The Quality Improvement Program Planning System (QIPPS) is a unique and innovative all-in-one health promotion planning and evaluation project system.

QIPPS facilitates a consistent and structured approach to project design and management. QIPPS is utilized in organisations across Australia and New Zealand, including those within the NT. QIPPS version 4 was launched in September, with added functionality and a streamlined planning and evaluation template, making it much easier to integrate the tool into day-to-day program planning.

Some features of the new version include Project Management functionality such as Task Management, Key Stakeholder Management and a Risk Register compliant with Australian/New Zealand International Standardisation Organisation standards. If your organisation is not a user of QIPPS yet and would like to know more about this Australian wide health promotion planning and evaluation tool please visit [http://www.qipps.infoexchange.net.au](http://www.qipps.infoexchange.net.au)

**Northern Territory Only**

Over the next few months the HPSU will be managing the migration of projects and users from version 3 to the new version, with an aim to have all DoH QIPPS users migrated by the end of November 2013.

As part of the migration process HPSU will develop comprehensive training packages to update all users on the new layout and functionality of version 4. In the meantime it is advised that users continue to use the ‘old’ QIPPS, which will continue to be available at: [http://old.qipps.com](http://old.qipps.com)/Regular email communication will be disseminated over the coming months to keep QIPPS users informed at certain milestones. For further information please contact the HPSU on (08) 8985 8019 or email morgan.aldridge@nt.gov.au

**Health Promotion – Strong Woman Strong Babies Strong Culture (SWSBSC) Program**

A series of five SWSBSC Professional Development Workshops were facilitated by HPSU and funded under the National Partnership Agreement Indigenous Early Childhood Development. The theme for Workshop Four was Health Promotion and all community based Strong Woman Workers were required to plan, implement and review a
Health Promotion Project. A part of this project was that they present their work at the Fifth and final Workshop held in August 2013.

Pictured below is the presentation by community based Strong Woman Workers Violet Nelson and Rachel Corby from Papunya and their Strong Woman Coordinator Lynette Windsor (lynette.windsor@nt.gov.au); the contact for information on the Papunya Health Promotion Project.

The Project was promoting:

- mothers taking children for child health checks
- supporting young mothers and their babies
- going hunting for bush tucker with grandmothers and Strong Women Workers
- grandmothers taking children out on country
- health Education in a supportive environment

For more information about the SWSBSC Workshop Program, please contact HPSU staff, Lisa Fereday (lisa.fereday@nt.gov.au) or Jeanne Lorraine (jeanne.lorraine@nt.gov.au)