The Chronicle

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PUBLICATION OF THE CHRONIC DISEASES NETWORK

In this issue...

Mental Health Feature

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:

- Arthritis & Osteopororis Foundation of the NT
- Healthy Living NT
- National Heart Foundation - NT Division
- Cancer Council of the NT
- Asthma Foundation of the NT
- General Practice and Primary Health Care NT
- Top End Division of General Practice
- Central Australian Division of Primary Health Care
- Aboriginal Medical Services of the NT
- Office of Aboriginal and Torres Strait Islander Health
- NT DHCS Preventable Chronic Disease Program
- NT DHCS Nutrition and Physical Activity
- Menzies School of Health Research
- NTDHCS Community Health

Sharing info to improve Indigenous social and emotional wellbeing

Painting by Doris Gingingara of Maningrida: "Around the big yam are different types of bush tucker, or Munbanda. There is Walila, a yam; Warpiritja, a kind of bush onion; Nalpur , a plant that is used for colouring leaves for making baskets; and Pinyi-pinya, another type of yam"

Ineke Krom and Neil Thomson

Australian Indigenous HealthInfoNet

The need for information

The national Aboriginal and Torres Strait Islander social and emotional wellbeing framework recognised that Indigenous people experience higher rates of both social and emotional wellbeing problems and some mental disorders than other Australians (Social Health Reference Group, 2004).

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Based on information collected in the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (Australian Bureau of Statistics, 2006, Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008):

- the level of psychological distress experienced by Indigenous people is around twice that of non-Indigenous people; and
- the level of stressors – such as death of a family member or friend in the previous 12 months, or serious illness or disability – was also much higher for Indigenous people than for non-Indigenous people.

There are no population-wide indicators of the impact of the psychological distress and stressors experienced by Indigenous people, but they are reflected to some degree in admissions to hospital and deaths classified as 'mental and behavioural disorders' and in self-inflicted harm (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008).
For Indigenous people living in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory in 2005-06 (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008):

- mental and behavioural disorders were responsible for 7.5% of Indigenous hospital admissions (excluding those for care involving renal dialysis) at a rate 1.9 times that of non-Indigenous people;
- the most common diagnoses for hospitalisations for mental and behavioural disorders among Indigenous people were 'mental disorders due to psychoactive substance use' (at a rate 4.0 times that of non-Indigenous people) and 'schizophrenia, schizotypal and delusional disorders' (2.6 times); and
- hospitalisation rates for intentional self-harm were three times higher for Indigenous males and twice as high for Indigenous females than for their non-Indigenous counterparts.

For Indigenous people living in Queensland, Western Australia, South Australia and the Northern Territory in 2001-2005 (Australian Bureau of Statistics and Australian Institute of Health and Welfare, 2008):

- death rates for mental and behavioural disorders were 5.8 times higher for Indigenous males and 3.1 times higher for Indigenous females than for their non-Indigenous counterparts
- the suicide rate for Indigenous males was three times that of non-Indigenous males. The rate for Indigenous males aged 25-34 years was four times that of non-Indigenous males of that age group';
- the suicide rate for Indigenous females aged 0-24 years was five times that of non-Indigenous females of that age group. The rate ratio was also more than two for females aged 25-34 years.

Bearing in mind the high levels of psychological distress and stressors among Indigenous people, and their higher rates of hospitalisation and death for related conditions, better sharing of information was recognised in the national social and emotional wellbeing framework as important both in promoting the social and emotional wellbeing of Indigenous people and in addressing social and emotional wellbeing problems and mental disorders (Social Health Reference Group, 2004). This recognition prompted the Australian Government's Office to fund Aboriginal and Torres Strait Islander Health for the development of the Indigenous social and emotional wellbeing web resource and related yarning place (electronic network).

Australian Bureau of Statistics (2006) National Aboriginal and Torres Strait Islander Health Survey: Australia, 2004-05. (ABS Catalogue no. 4715.0) Canberra: Australian Bureau of Statistics

Australian Bureau of Statistics, Australian Institute of Health and Welfare (2008) The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples 2008. (ABS Catalogue no. 4704.0 and AIHW Catalogue no. IHW 21) Canberra: Australian Bureau of Statistics and Australian Institute of Health and Welfare

Social Health Reference Group (2004) Social and emotional well being framework: a national strategic framework for Aboriginal and Torres Strait Islander mental health and social and emotional well being 2004-2009. Canberra: Australian Government

The Indigenous social and emotional wellbeing web resource and yarning place

The web resource and associated yarning place have been designed to improve the sharing of information, knowledge and experiences about Indigenous social and emotional wellbeing. The web resource provides people working or studying in the area of Indigenous social and emotional wellbeing with the full range of information and resources, and the yarning place enables them to communicate with, learn from and support each other.

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The web resource contains:

- reviews and summaries;
- information about relevant policies and strategies;
- information about relevant programs and projects (including an up-to-date map of Bringing them Home and Link-Up services, and the regional SEWB centres across Australia);
- details of publications, key references and a downloadable bibliography;
- details of organisations of relevance to people working in the area; and
- details of resources, such as health promotion resources, grants available, and guidelines.

The ***yarning place*** provides members with electronic services to support their networking with people working or studying in the area of Indigenous social and emotional wellbeing.

The electronic networking services (e-yarning) provided include:

- e-yarning board - an electronic board for discussion and debate;
- e-message stick – a listserve (email distribution list) that allows a member to send a message to other members; and
- e-mob list – contact details of yarning place members (with their approval).

It is strongly recommended that first-time users of the web resource and yarning place – which are totally free – devote 5-6 minutes in working through the online guide that is accessible from the web resource's home page.

Development of the web resource and yarning place is being guided by a national reference group.

For further information about the Indigenous social and emotional wellbeing web resource and yarning place contact Ineke Krom, Senior Research Officer, Australian Indigenous HealthInfoNet, (08) 9370 6470; i.krom@ecu.edu.au or visit the web resource homepage on www.healthinfonet.ecu.edu.au/sewb

The Australian Indigenous HealthInfoNet would like to acknowledge the artist Doris Gingingara whose artwork was used in the design of the social and emotional wellbeing web resource. The artwork is provided by the Edith Cowan University Art Collection.

Tracey's story:

making the most of HeathInfoNet

In planning for a project in her community, an Indigenous mental health promotion officer (who we'll call Tracey) visited the HealthInfoNet's web resource (www.healthinfonet.ecu.edu.au/sewb). She initially focused on information about projects and programs similar to what she wanted to do in her community, learning from the issues they encountered. Under resources, Tracey then found out about health promotion resources she could use in her community, so she wouldn't have to 're-invent the wheel'. She also identified, under 'funding', financial opportunities to get her project started. Under 'organisations', Tracey obtained contact details for relevant government and non-government agencies. The details available under 'publications' (and through her search of the online bibliography) gave her the evidence necessary to convince the funding agency to support her project.

By joining the Indigenous social and emotional wellbeing yarning place (www.healthinfonet.ecu.edu.au/sewb_yarningplace), Tracey could access its e-mob list (a form of 'yellow pages') to identify people working across Australia in similar areas. This helped her to set up and evaluate her project. Tracey now also advises other people who want to do projects like hers, and assists in the development of resources requiring a 'grassroots' perspective.

The Chronicle

Chronic Obstructive Pulmonary Disease (COPD) and Depression

Jan Saunders
Asthma Foundation

Research indicates that there are strong links between depression and chronic physical illness. One example of a chronic physical illness is COPD, a debilitating and enduring health problem that can be managed, but not cured.

COPD demands continual psychological adjustment as the disease progresses. People with COPD must cope with shortness of breath, cough, sputum production, wheeze, pain, reduced exercise tolerance, changing body image, loss of independence, social stigma and uncertainty about the future.

Along with these respiratory associated stressors people with COPD must also deal with changing environments, family pressures and other critical events that occur at this time. They must be able to manage their chronic disease while still trying to maintain effective relationships with their spouse, friends, acquaintances and health care staff. However due to the disabling nature of the disease it can cause relationships to be strained and may result in many people being socially isolated and not seeking treatment.

The body reacts to stress through a variety of physiological responses which include:

- Increases in heart rate, blood pressure and blood flow
- Voluntary muscle tension
- Excess perspiration
- Frequent shallow breathing
- Nausea
- Diarrhoea
- Hot flushes and
- Cold chills

In some instances this automatic fight or flight response can be misinterpreted or not dealt with adequately in the early stages and it can become out of control leading to a panic attack. As the precipitant of a panic attack is usually shortness of breath it is not surprising that many people with COPD have these attacks. Anxiety symptoms often lead to repeated presentations for hospital admission at a significant financial cost.

Studies have shown that the prevalence of depression and anxiety in COPD can range between 40-90% compared to 8-20% in the general population. These psychological disturbances can compound the disability faced by people with COPD leading them to withdraw from society that in turn enhances the psychological symptoms and a vicious cycle develops.

People who receive education and psychosocial support show greater improvement in more aspects of health-related quality of life than those who receive education without ongoing support. One way to provide such education and support is through patient support groups that aim to empower COPD patients to take a more active role in the management of their healthcare and reduce the psychosocial impact of their disease.

Pulmonary rehabilitation including health education has been shown to improve the coping ability and psychological functioning of carers as well as those with COPD. The primary goal of pulmonary rehabilitation is to restore the person with COPD to the highest possible level of independent functioning, the benefits of which are wide-ranging with minimal risk.

People with chronic illness who participate in self-management strategies also have better outcomes including reduced healthcare costs. In COPD, behavioral education alone is effective, although less effective than integrated pulmonary rehabilitation programs that include an exercise component.

In summary depression is common in people with chronic illness and COPD is no exception. Identifying individuals at risk of clinical anxiety and developing effective interventions should be priorities.

Pharmacological treatment of depression in COPD may be hampered by poor tolerance of side effects such as sedation, which may cause respiratory depression and aggravate sleep disturbances.

In addition to usual clinical assessment the presence and impact of anxiety and depression may be reliably predicted with several validated questionnaires.

References:

The Australian Lung Foundation and the Thoracic Society of Australia and New Zealand: *The COPD-X Plan: Australian and New Zealand guidelines for the management of Chronic Obstructive Pulmonary Disease 2004*

The Australian Lung Foundation, 2000: *Psychological Consequences of Respiratory Diseases and the need for Patient Support Groups*

Senior Territorians participating in an aqua aerobics class

Publication of
The Chronic Diseases Network

Self management:
Key ingredients for life style change

'Real patients are more complex than pure diagnoses: real patients often have comorbid diseases … A comorbid approach will facilitate the links between treatment of various disorders and enhance compliance and adherence to treatments …'

World Health Organsiation, 2006 [1]

Carolyn presenting the stay strong plan

Dr Tricia Nagel
Menzies School of Health Research

The AIMhi project has been seeking to improve outcomes in Indigenous mental health through an action research framework incorporating three main approaches: a story telling project, a relapse prevention project and a service provider training project. The five-year AIMhi project has focused on communication and empowerment of Indigenous clients and carers through partnership with AMHWs. The project also aimed to link the care of those with mental illness to care provided to people with physical illness.

The AIMhi partnerships have expanded since the project began in 2003. There are now regular conversations between the AIMhi project and primary care practitioners, chronic disease nurses and diabetes educators. The key issues of compliance, life style change and motivation are shared priorities across these specialities and there is increasing recognition that relapse prevention in any setting requires similar skills and approaches.

Compliance and adherence to treatment plans is an important component of improved outcomes in health. In a 2003 systematic review of 30 randomised controlled trials (RCTs) Haynes concluded that the full benefits of medications cannot be realised at currently achievable levels of adherence, that current methods of improving adherence for chronic health problems are 'mostly complex and not very effective' and that innovations to assist patients to follow medication prescriptions are needed [2].

Practitioners in the NT remote setting are thoroughly aware of the contrast between ideal management plans and the reality of adherence in the real world. Such contrasts are particularly vivid in the setting of mental illness. Author M. Nose systematically reviewed clinical interventions in psychoses and found around one in four patients with psychosis fail to adhere to treatment programmes [3]. A key challenge to education and to compliance in the Indigenous setting is communication. An early AIMhi NT Remote Service Provider (RSP) survey identified compliance with mental health treatment as an important issue and RSPs linked noncompliance and lack of understanding of illness with relapse [4].Three studies from Arnhem Land have suggested that miscommunication between Aboriginal patients and non-Aboriginal health professionals may contribute to patients' inability to comply with medical advice and that non-Indigenous staff struggle to find appropriate strategies for sharing information [5-7].

In addition to communication and information-sharing, it is likely that the development of a relationship between the client and the treating team is also important. One of the studies explored factors related to compliance with rheumatic fever prophylaxis for Indigenous people in a remote NT community. The study found that trust and relationship with service providers was more important than having an understanding of the scientific principles behind the treatment plan [6].

The above studies suggest that both communication and trust are important strategies for promotion of

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compliance. There has been little practical guidance available for practitioners, however, in strategies to promote understanding, relationship and compliance in the setting of remote Indigenous health.

Meanwhile there is also a need to take further steps toward empowerment of individuals with chronic conditions. There is a need to ensure that rather than being passive and 'compliant' recipients of care that they are active collaborators, able to make day-to-day decisions about their illnesses. Training patients with chronic diseases to self-manage their disease increases functioning, reduces pain, and decreases costs [8].

Despite important advances in self management there is still little research to guide practitioners in the strategies that are effective in Indigenous health care. Once again, there remains a gap between the evidence and the practice in the real world. The AIMhi project sought to fill that gap and to develop strategies that promote communication and trust, as well as self management and motivation. It particularly aimed to develop brief and practical interventions which recognised the resource-poor settings of remote communities and maximised the opportunities provided by one-off client assessments.

The AIMhi 'story telling project' contributed to a range of education and intervention tools. These assessment and treatment tools were then tested in the relapse prevention project [9]. This was a randomised controlled study which was recently completed [10]. It provided insight into Indigenous perspectives of mental health and new information about the experience of chronic mental illness in the remote Indigenous setting. The study achieved high rates of recruitment and retention of study participants and also described a successful model for individual and family engagement in treatment.

The study showed improved client outcomes in terms of: well being and life skills, alcohol and marijuana dependence, and self-management skills. The study also showed that these effects were sustained over time. These findings were particularly notable given the high baseline levels of distress of the participants.

The findings suggest that collaboration with AMHWs, family engagement, and self-efficacy may be important active ingredients in the brief intervention. It shows that a brief intervention in the setting of chronic mental illness and comorbid marijuana and alcohol dependence is effective in improving outcomes. The preliminary findings were incorporated into service provider training which AIMhi has delivered across the NT and around Australia since 2006.

The story telling project, the relapse prevention trial and the service provider training project have all provided important new information in the area of compliance, life style change, self managment and motivation [11].

The assessment, education and treatment tools developed for mental health through these projects translate to any setting that requires a brief intervention. The essential intervention is 4 steps:

1. Review of supportive family
2. Review of strengths
3. Review of stressors
4. Goal setting

The intervention incorporates problem solving and motivational interviewing principles with three key differences: a focus on family, pictorial tools and a holistic approach. The AIMhi team offers training in Indigenous mental health, cross cultural assessment, and the brief intervention. The resources are available for all to access and use through the website www.menzies.edu.au/AIMHI. We are particularly interested in the translation of the tools to different settings and welcome and invite your feedback and inquiries.

AIMhi Story telling

Yeah! My mother and grandmother used to teach everything what they were taught before by their mothers – that how I want to teach my kids, my grandchildren, to do the same … because back in those times, like to me it was strong, we didn't have this mental health problem … because at that time we had good life … we've enjoyed everything.

Aboriginal Mental Health Worker

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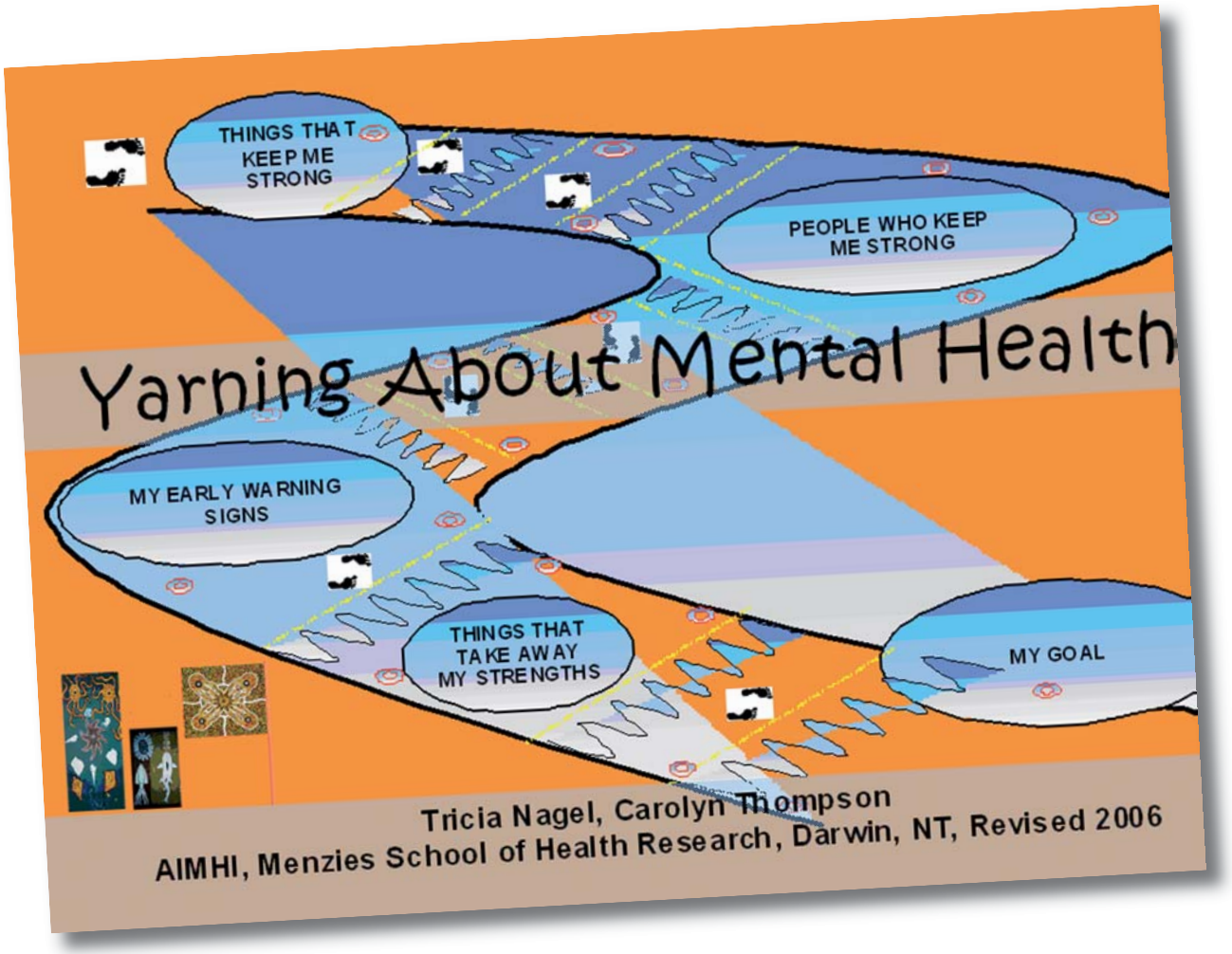
Cover of the AIMHI Yarning about Mental Health Flip chart



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3. Nose M, et al., *Clinical interventions for treatment non-adherence in psychosis: meta-analysis 1*. Br J Psychiatry, 2003. 183(3): p. 197-206.
4. Nagel T, *The need for relapse prevention strategies in Top End remote indigenous mental health*. Australian e-Journal for the Advancement of Mental Health (AeJAMH), 2006. 5(1): p. 1446-7984.
5. Bryce S, *Lessons from east Arnhem land. Improving adherence to chronic disease treatments*. Aust Fam Physician, 2002. 31(7): p. 617-21.
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9. Nagel T and Thompson C, *AIMHI NT 'Mental Health Story Teller Mob': Developing stories in mental health*. Australian e-Journal for the Advancement of Mental Health (AeJAMH), 2007. 6(2).
10. Nagel T, *An approach to management of psychotic and depressive illness in remote indigenous communities*. Australian Journal of Primary Health Care, 2008. 14(1): p. 17-24.
11. Jordan J and Osborne R, *Chronic disease self-management education programs: challenges ahead*. MJA, 2007. 186(2): p. 84-87.

New AOD initiatives

Jeff Brownscombe
NTER AOD Clinical Director

Under the Northern Territory Emergency Response (NTER) a variety of initiatives have occurred in the Alcohol and Other Drugs (AOD) sector. These recognise the need to couple legislative changes and law enforcement with enhanced clinical and support services.

AOD initiatives under NTER include workforce development, improved withdrawal management pathways and education and training.

Staff have been provided with resource kits, including flipcharts, assessment and screening tools around AOD and mental health issues. Some of these are undergoing translation and modification in consultation with local people. These are available for wider circulation.

Early on, AOD staff have focused on community liaison and education. They are looking to develop new models of care to sit alongside conventional clinical services. Staff are encouraged to contribute to diversionary activities, including community projects and participating in bush trips. A pilot program in massage therapy is about to commence under the guidance of three RNs with qualifications in this field. An understanding of traditional Aboriginal medicine is being sought and incorporated into treatment paradigms.

Table 1: New AOD positions within primary health care

Organisation	Number of Professional Workers	Number of Aboriginal Consultants
Central Australian Aboriginal Congress	4	8
BRADAAG/Anyinginyi	2	2*
Wurli Wurlinjang	2	2
Katherine West Health Board	1	1
Danila Dilba Health Service	1	2
Miwatj Health Service	1	2

**Not funded by NTER*

The major NTER initiative is expanding AOD workforce capacity within primary health care. Each of the Aboriginal Medical Services (AMSs) in the five regional centres have added AOD workforces to their organisation's activities. The first worker commenced in late February 2008 and new staff are still commencing. For various reasons, these initiatives have not occurred in DHCS clinics.

These "AOD projects" typically consist of a team of AOD professionals (mainly nurses, but also including Aboriginal health workers and social workers) working with community-based Aboriginal consultants. They operate on an outreach model and include visits to remote communities.

The AOD projects have a strong mental health focus, consistent with AMSANT's recently released policy document "A model for integrating alcohol and other drug, community mental health and primary health care in Aboriginal Medical Services in the Northern Territory". This calls for both AOD and mental health services to be delivered seamlessly through primary health care. Projects tend to be placed within Social and Emotional Wellbeing (SEWB) Units and involve liaison with mental health services.

NT hospitals have also received assistance.

In September 2007, acute medical teams were placed in Katherine and Tennant Creek to enhance capacity to manage alcohol withdrawal. Whilst a sudden increase in withdrawal presentations did not occur, the teams increased awareness and skills amongst hospital staff, leading to improved treatment for many people with alcohol-related presentations.

The initiatives of funded "detox" beds and specialist AOD staff in hospitals continues and may be part of future models of improved withdrawal management. A supportive local hospital can be a great asset to a community-based AOD program.

Several training initiatives are planned for the near future. The Dulwich centre from Adelaide will be delivering narrative therapy workshops in late June/early July. These utilise storytelling to promote healing. There will be education sessions around dual diagnosis, withdrawal management and youth AOD issues. These will be available to all interested people, including primary health care, AOD, mental health and other staff.

A number of community education activities have also taken place through organisations such as Central Australian Aboriginal Alcohol Program Unit (CAAAPU), Council for Aboriginal Alcohol Program Services (CAAPS, Darwin) and Wurli Wurlinjang Aboriginal Health Service.

A Working Group, comprising DHCS, AMSANT and OATSIH representatives, is overseeing these initiatives. They are currently funded until June 30 2008, though it is hoped they will attract recurrent funding. They are being co-ordinated with similar, longer term initiatives under COAG.

Summary Points

- There has been a rapid expansion in AOD workforce within the AMS sector funded by NTER
- Initiatives within hospitals will hopefully lead to better withdrawal management approaches
- New AOD training initiatives will be circulated shortly to all interested staff
- Progress is being made in bringing together AOD and mental health knowledge and skills at the level of service delivery

Case study: Miwatj Health Service, Gove

Mike Fenton is an RN from Bunbury, WA, with a background in mental health and AOD. He was recruited through the NTER pool. Shortly after arriving at Miwatj, he was joined by local workers Binmala and Nungki Yunupingu. The team has worked on adapting the 13-point IRIS questionairre, which combines AOD and mental health, for use amongst Yolgnu people. The team has attended community meetings and activities. Mike arranged a meeting of service providers in the Gove region around AOD issues, leading to improved links. Discussions are progressing with Gove hospital about ways to facilitate referral and management of people requiring alcohol withdrawal. The AOD team provides ongoing input into Miwatj's longer term plans to develop a sustainable, evidence based AOD service.

Case study: Central Australian Aboriginal Congress (CAAC), Gerard Waterford, Social Worker CAAC

Congress has been given funding of $644,000 through Office of Aboriginal and Torres Strait Islander Health to provide assessment and treatment services for indigenous residents of Central Australia. As part of this we will seek to explore with local communities what they see are the locally based solutions for supporting improvements in alcohol and other drug behaviour. The project will focus on how best to;

- Operationalising the assessment and treatment teams,
- Developing the community partnerships required for the project,
- Developing a reference/advisory group and an evaluation framework, and
- Developing the assessment tools, other educational and treatment resources, and a data collection and analysis framework that best meet longer term needs in the AOD assessment and treatment area.

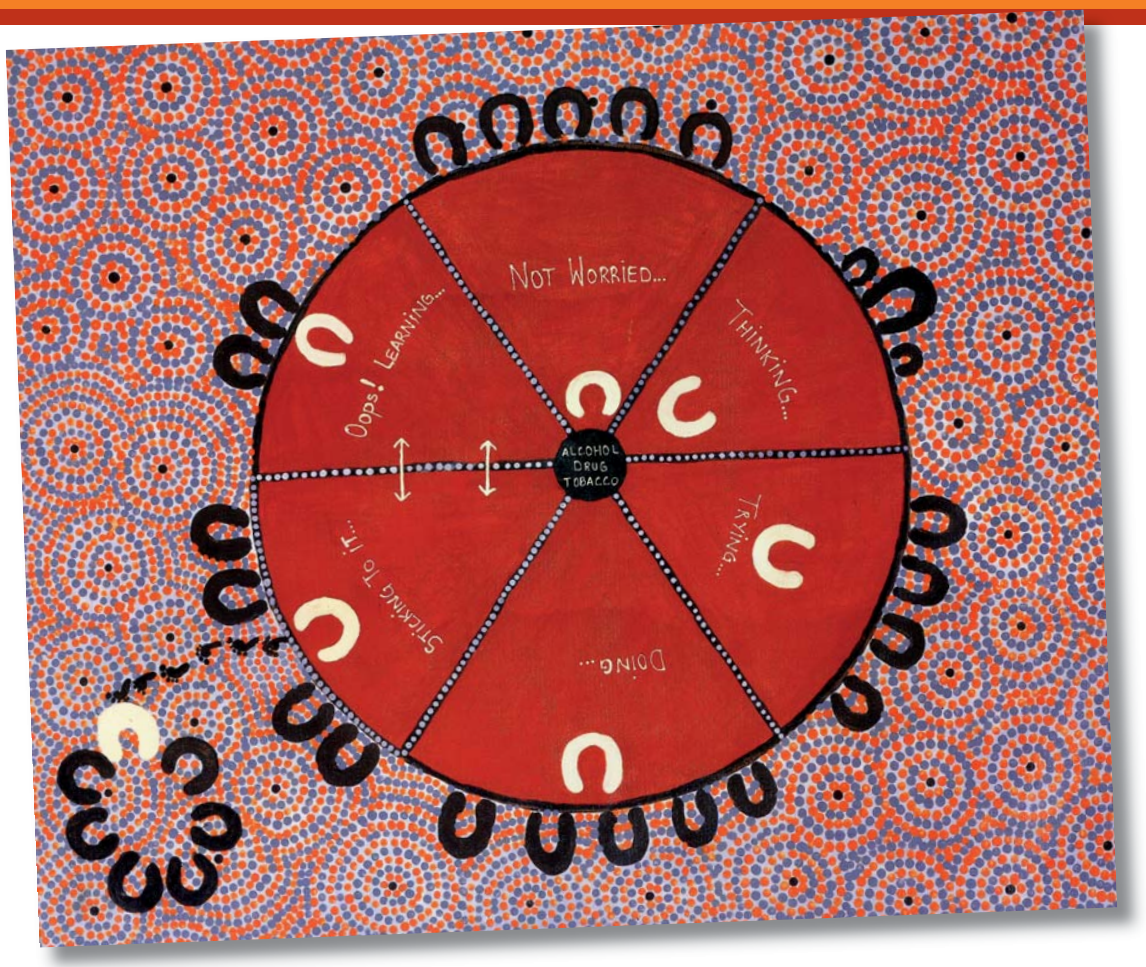
CAAC is working with a broad range of remote communities in CentralAustralia as well as services in Alice Springs.

For further information contact:

Jeff Brownscombe 0n 0429 999 472

Resource:

Dulwich Centre website (providers of narrative therapy): http://www.dulwichcentre.com.au/



The 'Cycle of Behaviour change'

Not worried... (pre contemplation)

The alcohol, tobacco or drug use has become a problem for the person in the circle (∩). The person in the circle is close to the alcohol, tobacco or drug. The person close to the alcohol, tobacco or drug isn't worried about troubles or family, they want to stay close to the alcohol, tobacco or drug.

But the family (∩∩∩∩∩) at the edge of the circle are worried for the person close to the alcohol, tobacco or drug. The family wants the person to change, but the person in the circle 'can't listen' and tells them to go away and leave them alone.

Thinking... (contemplating)

The person using the alcohol, tobacco or drug (∪) starts to think and understand that not everything is good about alcohol, tobacco or drug use. The person is now thinking that there is some sorry and shame with alcohol, tobacco or drug use. The person in the circle has started to listen to what the family - wife, husband, children - are saying and wonders how life could be without the sorry and shame alcohol, tobacco or drug brings. The person in the circle may need some further support to change.

Trying... (planning)

The person in the circle is halfway between the alcohol, tobacco or drug and their family. The person wants to change and starts making plans to cut down or stop using the alcohol, tobacco or drug. The person in the circle starts trying different things like only using the alcohol, tobacco or drug on a few days, finding safer ways to use, having health checks, drinking mid strength or light beer only, trying new hobbies or fun things to do without the alcohol, tobacco or drug. Remember, any change requires good planning and support. Changing alcohol, tobacco or drug use is not just about giving up, it is a life change which needs a well thought out plan to tackle the 'ups' and 'downs' for success.

Doing... (action)

The person in the circle has made up their mind to change and has moved closer to family and friends for support. The person has now stopped or cut down their alcohol, tobacco or drug use. It is early days but a good plan has helped make the changes easier to do. The family are happy and support the person in the circle to change.

Sticking to it... (maintenance)

The person in the circle no longer has a problem with alcohol, tobacco or drug use and has broken out of the circle. The person is free from the alcohol, tobacco or drug problems and is sticking to the good plan that was made. The person is now able to move back to their family.

Oops! Learning... (relapse)

The person who broke out of the circle has stopped using alcohol, tobacco or drug but has trouble saying 'no' and being strong when alcohol, tobacco or drug is around. The person may start using the alcohol, tobacco or drug again. The person is learning new ways to stay strong and say no. The person and family need to think about what was learnt from this experience and what they would do next time. The family is helping the person to change and may look at what other things the person wishes to include in the plan to help the person become stronger.

Note: Changing alcohol, tobacco or drug behaviour takes time. Not everyone has to go through all the stages in the same order. Some stages can be missed, others can be repeated.

Publication of
The Chronic Diseases Network

Responding to hardship and trauma

Narrative ways of working with groups and communities

When faced with significant hardship and trauma in communities, how can health care professionals respond in ways that are not only hopeful, but also acknowledge and respect the steps that individuals and communities are already taking?

This is one of the key questions that informs the work of the Dulwich Centre Foundation, which is based in Adelaide, and is soon to commence work with communities and offer training for health professionals in the Northern Territory. Members from Dulwich Centre, including senior Indigenous team member Barbara Wingard, will be visiting the Territory in late June, early July.

The work of the Dulwich Centre Foundation is based on what has come to be known as narrative approaches to counselling and community work. Narrative approaches centre people as the experts in their own lives and view problems as separate from people. Narrative approaches assume that people have many skills, competencies, beliefs, values, commitments and abilities that will help them to reduce the influence of problems in their lives. The word 'narrative' refers to the emphasis that is placed upon the stories of people's lives and the differences that can be made through particular tellings and retellings of these stories. Narrative approaches involve ways of understanding the stories of people's lives, and ways of re-authoring these stories in collaboration between the worker and the people whose lives are being discussed. It is a way of working that is interested in history, the broader context that is affecting people's lives and the ethics or politics of this work.

If you are interested to know more about these ways of working that have been engaged with in Indigenous communities and also in the Palestinian Territories, South Africa, Uganda, Rwanda and many other contexts, then you may like to attend workshops that will be taking place in the Northern Territory soon.

These training events will focus on narrative approaches to counselling, group work and community work relevant to Drug and alcohol, mental health, grief and loss, and trauma. They will be conducted by a team of both Aboriginal and non-Aboriginal trainers and will include stories and examples of narrative practice particularly developed in Indigenous contexts.

The training will be developed so that it is relevant both to those working in clinical (one-on-one counselling) settings and those who are engaged more in the community. Special care will be taken to ensure that the training is relevant to a wide range of participants in terms of background, educational experience, community experience and so on. The focus of the training will include work with adults, young people and children. The methods of work that will be taught are based on the latest approaches while remaining deliberately accessible and able to be put into practice by local workers.

TRAINING DATES

June 23rd - 29th:
Central Australia (Alice Springs / Yuendumu)

June 30th - July 4th:
Darwin

FOR MORE INFORMATION

For more information about the workshops in Alice Springs and Darwin, please contact Jeff Brownscombe, via email: Jeff.Brownscombe@nt.gov.au

For more information about the Dulwich Centre Foundation or narrative approaches please see: www.dulwichcentre.com.au

Responding to hardship and trauma:

the use of collective narrative practices

Dulwich Centre International training/supervision program

Suitable for counsellors, health workers, therapists, educators, psycho-social support workers, group facilitators and community workers

Seeking expressions of interest

Dulwich Centre has recently been approached by a number of practitioners in different parts of the world who are trying to respond to people who have experienced significant hardship and/or trauma. These may be women for instance who have experienced violence, or groups of vulnerable children, or working with those in prison, or those struggling with physical illness, or broader communities who are struggling with the effects of grief, poverty and/or colonisation. These practitioners have asked whether it would be possible for us to develop a narrative training program specifically focusing on ways of working that link individuals together and that respond to groups and communities.

This narratively informed program would provide:

- training in practical easy-to-engage methodologies
- supervision and support in using these in your work
- links with practitioners working in similar contexts
- specially tailored program to fit practitioners' particular challenges
- reading and writing program to consistently reflect on practice
- the use of a range of different mediums of practice – conversational, individual, group, community, visual art, song
- ways of working relevant for use within institutions – schools, hospitals, prisons, detention centres, psychiatric units

Each participant will identify a particular project in their own working context that they would like to focus on and the training/supervision program would then become a context where this work would be highly supported. The program would be shaped so that it fitted the particular requirements and interests of those who attended. Collective narrative work that Dulwich Centre has been involved with in a wide range of countries and contexts will be shared. And participants will be trained in a range of easy-to-engage narrative collective methodologies such as Collective documents, the Tree of Life, Team of Life, Collective timelines and The River of Memories/River of Dreams. These are methods of working that utilise narrative ideas and can be used with individuals, groups and communities who have experienced significant hardship and/or trauma.

On-line component

One aspect of the training/supervision program will involve reading papers and writing reflections which will then be responded to by Faculty members. This will occur via email. Other on-line components will include e-lists, group discussions. Conversations with participants will occur through Skype or by phone.

Face-to-face component

The program will also consist of one or two face-to-face teaching blocks. These could occur either in Australia or USA or a location where we have been engaged with community practitioners – for instance Bangladesh, Africa, Israel/Palestinian territories. The location of the teaching blocks will depend upon the preferences of those who attend the program.

Project

A considerable part of the program will be based around supporting practitioners in engaging with a project in their local context. This could be work with a particular group, or linking a number of individuals who are facing similar issues, or work in a school or community. The options for the sort of projects that participants may choose to engage with are endless.

We are now seeking expressions of interest in this training program. If you are interested in attending, please write to Virginia Leake c/o dulwich@senet.com.au

Publication of
The Chronic Diseases Network

'Living Hope'

Suicide Bereavement Support Training Program

Leonore Hanssens
Mental Health Project Officer
Top End Mental Health Services (TEMHS), DHCS

The Salvation Army Bereavement Support Services recently hosted the pilot of the 'Living Hope' Suicide Bereavement Support Training conducted by Leonore Hanssens TEMHS DHCS. This training is the realisation of a vision to develop a practical training course by Salvation Army Envoy Alan Staines OAM who was a recipient of the Order of the Founder Salvation Army in 2007. The roll out of the 'Living Hope' training throughout Australia is part of the Salvation Army's "Hope For Life" national program based in Sydney NSW and funded by the Commonwealth Department of Health & Aging and the National Suicide Prevention Strategy community grants funding 2006 - 2009.

Major John Friend, Salvation Army Darwin, was instrumental in drawing together the highly qualified and experienced Salvation Army personnel to receive the training and participate in the pilot training program. It was a highly successful workshop with eight participants who are now forming a Northern Territory wide bereavement support network and service. They are also involved in the further development of the training program by participating in the evaluation of the pilot conducted by Edith Cowan University, Western Australia.

Participants provided a variety of services and support including: a women's shelter in Darwin; a community outreach in Katherine; an alcohol rehabilitation in Alice Springs; prison ministry services in Darwin; a Flying Padre who covers the whole of the Northern Territory and Ministers of Religion.

The training will equip the Salvation Army Officers with the skills to provide help and care to those people and families who have lost loved ones to suicide. It will provide a referral pathway to support networks, support groups and agencies. The "Living Hope" training program will also support Indigenous communities with the Indigenous Postvention Response and Suicide Safe Community model completing the comprehensive model of bereavement support in these communities.

The young man from the Tiwi Islands featured in the article told his story to video journalist Angela Bates SBS Living Black about the loss of his brother to suicide and the acute grief he felt after this tragic event. He also spoke about his own personal suicide risk of imitation and familial contagion his grief provoked in him. He also says how his love for his family protected him through the bereavement stage. He was then able, with the help of his family and community, to overcome his own suicidal feelings. He now promotes life and supports others in his community.

At the same training the "Information and Support Pack for those bereaved by suicide and other sudden death" 2007 was launched by Leonore Hanssens and distributed to participants of the training. The "Info Pack" is now available for distribution by the Mental Health Directorate, Suicide Prevention Coordinator. This pack gives essential information on the coronial process and referral to agencies and support groups in the Northern Territory. It also provides culturally sensitive information for Indigenous people through "Grieving Aboriginal Way" a.

My thanks to the Salvation Army Alan Staines, John Friend, Peter Wood, the "Living Hope" national trainers and the Edith Cowan University.

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left to right back row: *Janet Seden; Gary Taylor; Shirley Baker; David Buckle; and Peter Wood.*

left to right front row: *Jennie Shrimpton; Sue Benedetti; Joan Buckle and Leonore Hanssens ('Living Hope' Train the Trainer)*

A young Indigenous man from the Tiwi Islands tells his story to SBS Angela Bates:

"I had … my own brother… he passed away a couple of years ago. He committed suicide. And that's when I saw Mum, how she reacted when my little brother passed away; he's the youngest of our family. So I sort of reflect back to those days when I lost my brother and it makes me think a lot, you know, if I do take my life away, you know, my mum will have no kids left".

The Crisis Intervention Committee coordinates the prevention, intervention and postvention activities at a local community level and incorporates primary, secondary and tertiary interventions, support and referral pathways. Concerned Indigenous people and volunteers, who are willing to support others and undertake training, generate the response.

INDIGENOUS POSTVENTION RESPONSE AND SUICIDE SAFE COMMUNITY

CRISIS INTERVENTION COMMITTEE – COORDINATES	PRIMARY (WHOLE OF COMMUNITY)	SECONDARY (MONITOR AT RISK GROUPS)	TERTIARY (HIGH RISK INDIVIDUALS IDENTIFIED)
PREVENTION (POPULATION APPROACH: BROAD COMMUNITY EDUCATION, PROMOTE HELP SEEKING)	**BROAD EDUCATION FOR COMMUNITY:** NIGHT PATROL, YOUTH GROUPS, SCHOOLS, CLINICS, PRISONS, PROBATION & PAROLE, COMMUNITY GROUPS & CHURCH GROUPS.	**IDENTIFY GROUPS AT RISK & WORKERS REMAIN ON SUICIDE RISK ALERT:** ABORIGINAL (MENTAL) HEALTH WORKERS, ABORIGINAL COMMUNITY POLICE OFFICERS, YOUTH WORKERS, TEACHERS, NURSES, and DOCTORS.	**CLEAR PROTOCOLS FOR RISK ASSESSMENT & ADMISSION:** FOREMERGENCY DEPARTMENT STAFF, AMBULANCE OFFICERS, POLICE OFFICERS, CLINICAL PSYCHIATRIC NURSES, DOCTORS & ALLIED HEALTH STAFF.
INTERVENTION (SKILLS TRAINING UNDERTAKEN FOR COMMUNITY MEMBERS AND PROFESSIONAL GATEKEEPERS)	**SUICIDE AWARE TRAINED:** COMMUNITY MEMBERS, GROUPS, AGENCIES, ORGANISATIONS,VOLUNTARY GROUPS AND CHURCH GROUPS.	**APPLIED SUICIDE INTERVENTIONS SKILLS TRAINING** (ASIST) ABORIGINAL (MENTAL) HEALTH WORKERS, ABORIGINAL COMMUNITY POLICE OFFICERS, YOUTH WORKERS, TEACHERS ETC	**CLINICAL SUICIDE RISK ASSESSMENT SKILLS:** EMERGENCY DEPARTMENT STAFF, CLINICAL PSYCHIATRIC NURSES, AMBULANCE, POLICE,PSYCHIATRIST, PSYCHOLOGIST.
POSTVENTION (SUPPORT FOR BEREAVED WITH SORRY CAMPS, HEALING CIRCLES, SUPPORT GROUPS OR OTHER BEREAVEMENT SERVICES – SALVATION ARMY BEREAVEMENT SUPPORT	**GENERAL BEREAVEMENT** INFORMATION, SUPPORT, TRAINING IN LISTENING SKILLS FOR COMMUNITY SUPPORTERS AND CRISIS INTERVENTION COMMITTEE MEMBERS	**ACTIVE SUPPORT** FOR THE BEREAVED FROM ABORIGINAL MENTAL HEALTH WORKERS AND ABORIGINAL COMMUNITY POLICE OFFICERS - GIVE ASSISTANCE AND REFERRAL IF NECESSARY	**REFERRAL PATHWAY** TO AGENCIES FOR BEREAVED FAMILIES WITH COMPLICATED GRIEF; SUICIDE WATCH AND RISK ASSESMENT IF NECESSARY FOR THOSE 'AT RISK' OF SELF-HARM.

(Adapted from the Top End Life Promotion Program TEMHS DHCS 1999 – 2006 Northern Territory) (Hanssens 2007)

For further information on the:

Hope for Life website: www.suicideprevention.salvos.org.au

Information & Support Pack for Bereaved www.mcsp.org.au/bereavement

Hanssens L. (2008) Clusters of Suicide: The need for a comprehensive postvention response in Indigenous communities in the Northern Territory. Aboriginal & Islander Health Worker Journal. Vol. 32. Issue 2. March / April.

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Publication of
The Chronic Diseases Network

Top End Division of General Practice Allied Mental Health Team

A Small Mental Health Team Servicing Katherine and Beyond

TOP END DIVISION
OF GENERAL PRACTICE

Background

One out of every five Australians will experience some form of mental illness every year. In November 2006 the federal government released the Better Access to Mental Health Initiative as a response to this serious problem. This initiative aims to increase access to mental health services through general practitioners, psychiatrists, clinical psychologists and other allied mental health professionals. The Better Access to Mental Heath Initiative has engaged in an inducement policy where general practitioners and allied health professionals can claim new item numbers through the Medicare Benefits Schedule (MBS). A recent evaluation of the MBS data reveals that the uptake of Better Access has been strong in urban areas, but in rural and remote areas the uptake has been poor. The major reason for this poor uptake is the lack of quality mental health services and professionals in rural and remote areas.

The Service

All people who are living with a mental illness have a right to access quality mental health services. The Department of Health and Ageing has funded the Top End Division of General Practice under Stage One of the Mental Health Services in Rural and Remote Areas Program. The aim of this program is to increase access to allied mental health services in rural and remote areas by engaging Psychologists, Mental Health Nurses, Mental Health Social Workers, Aboriginal Mental Health Workers, Aboriginal Health Workers and Mental Health Occupational Therapists in direct service provision. This program aspires to fill the gap left by the lack of MBS funded mental health services in rural and remote areas.

The Team

The Top End Division of General Practice Allied Mental Health team operates from a 'hub and spoke model' and is based in Katherine. This team is currently providing mental health services to Katherine Town, Ngukurr, Beswick, Minyerri, Timber Creek and Yarralin. TEDGP Allied Mental Health Team consists of Steven Raymond, (Aboriginal Health Worker) Ella Carmichael (Aboriginal Mental Health Nurse) and Sam Lloyd (Psychologist). It is expected that all people that are referred to this service will have a diagnosed mental illness and a medical practitioner must have ongoing clinical oversight.

Co-Morbidity Issues

Current estimates indicate that up to 75 percent of people presenting with alcohol and drug problems also have additional mental health problems. The TEDGP Allied Mental Health Team has noticed similar

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TEDGP Allied Mental Health Team Steven Raymond, Sam Lloyd and Ella Carmichael

trends in the Aboriginal Communities that they visit. The following example provided by our team leader Steven Raymond demonstrates how a quality mental health service can help clients with both mental health problems and substance abuse issues.

Client based in Beswick, who for some time kept coming into Katherine by mini bus(taxi) to spend his money on alcohol. He was getting around $480 per fortnight and the taxi ride would cost him $200 each way.

Family had concerns that he was neglecting his wife and children because of this.

The team sat down under a shady tree with the client, his wife, his mother and uncle/father. The client was adamant that this was ok, we spoke about how he was giving more money to the taxi driver then to his family who should come first, but he stated that you can't drink "hot stuff" here, meaning spirits. We were informed that there was a canteen in Beswick which sold light beer lite for around $5 a can. We spoke about the saving's that he would make if he made fewer trips to Katherine and would be able to feed/clothe himself and his family.

We returned some time later to find a different person, who not only stopped coming into Katherine but someone who got a job, looks well and the family seems more happier now and he has stated that he can have a few cans at the canteen sometimes and has more money to spend on his children.

This example highlights the importance of family and kin relationships for Aboriginal people. TEDGP Allied Mental Health Service recognises the importance of family and social contacts when providing mental health services in Aboriginal Communities. In addition, TEDGP Allied Mental Health Team believe in a strength based approach to service provision, which embraces values such as empathy, compassion, respect, hopefulness and honesty when working with people who have mental health problem and their families.

Referrals

Direct referrals can be made to the TEDGP Katherine Mental Health Team by phoning 08 8971 0629. Please contact Tony Cowie from Top End Division of General Practice if you would like to hear more about this service on 08 8982 1004 or email him at tcowie@tedgp.asn.au

Reference

Bland, R. (2001) *'Social Work Practice in Mental Health'* in Alston, M and McKinnon, J. (eds) Social Work: Fields of Practice. South Melbourne: Oxford University Press.

Drug Use in the Family, ANCD Report, 2007.

Mental Health and Wellbeing: Profile of Adults, Australia 1997, Australian Bureau of Statistics.

New Medicare Data on Mental Health Service, The Hon Nicola Roxon MP Minister for Health and Ageing: Media Release, 2008.

Publication of
The Chronic Diseases Network

What is the role of a Aboriginal Mental Health Worker and how to access them

TOP END DIVISION
OF GENERAL PRACTICE

Marrpalawuy Marika
TEDGP

My name is Marrpalawuy Marika. I am married and have four children and seven grandchildren.
I have worked as an Alcohol and other Drugs (AOD)/ Mental Health Worker within the Top End Division of General Practice around three years.
I have an office based here at Yirrakala, with another aboriginal worker training in this job. This new job was what I had in mind, as the effects of alcohol and other drugs as well as mental health issues have affected my family and also.

I've seen changes (happen) slowly, slowly. - miracles won't happen over night. The long term of AOD/Mental health issues need to be dealt with at a grass roots level, with ngapaki and yolngu working side by side to work for the solutions rather than for the problem.

Marrpalawuy Marika presenting

Delegates at the Anglicare News Week Conference

Now other yolngu people are seeing the benefits of having AOD/Mental Health workers in their communities, especially one who comes from that particular area and that knows the language, the land and everyone living within that community.

The best yolngu solutions and how to access them for ngapaki visiting any yolngu community is to contact the local Aboriginal AOD/Mental Health workers, as there are people working in remote areas and in rural areas. We try to build bridges between two worlds Yolngu world values and Ngapaki world values as well.

For further information please contact Marrpalawuy Marika on (08) 89872609

The Chronicle

Collaborations for Life: Helping GPs Manage Suicide Risk in General Practice

TOP END DIVISION
OF GENERAL PRACTICE

Kelly-lee Hickey
TEDGP

Suicide is a major public health issue in Australia, claiming more lives than the road toll each year. General Practitioners are the most frequently consulted professional by people with suicide risk. The Top End Division of General Practice has been working on a project called "Collaborations for Life" over the past six months which has developed a set of resources and training designed to help GPs in the Greater Darwin area identify and respond to suicide risk.

The Collaborations for Life project has produced four resources; a risk assessment tool, a response tool, a service directory and three sets of small cards containing information about suicide risk assessment and response. The Collaborations for Life resources are available to GPs in printed and electronic format.

The Collaborations for Life project held two training sessions for GPs and allied health professionals. Both sessions were well attended by a range of health professionals including GPs, psychologists, psychiatrists and Aboriginal Health workers. The first training session, 'Managing Suicide Risk in General Practice' focused on suicide risk assessment and management in the General Practice environment. This session was presented by Top End Mental Health Services staff Dr Robert Parker, Anthony Guscott and Sarah O'Regan and GP Dr Sarah Giles.

A second training session, the 'Collaborations for Life Suicide Prevention Hypothetical' was held at 'Men, Mars and Medicine, ' the Top End Division's annual Continuing Professional Development Conference. This session utilised a GP and actor to present a case study on suicide risk, and included a panel of representatives from community, government and mental health services. The session aimed to increase GPs understanding of suicide risk management, and awareness of referral sources and methods in the Darwin area.

The Collaborations for Life resources were developed after extensive consultation with key stakeholders. The Top End Division of General Practice consulted with government, NGOs and private practitioners to identify possible referral pathways available to GPs and find out about individual stakeholders needs.

As well as conducting one-on-one consultation with individual stakeholders, the Collaborations for Life project held a social mapping forum with government and NGO stakeholders. During this session, participants mapped referral pathways for a person with suicide risk. This exercise highlighted the need for clinical and non-clinical services to work together to ensure that patients received ongoing care that suited their individual needs and risk factors.

A key finding from the Collaborations for Life consultation was the need for improvement in referral quality and follow up processes. GPs consulted wanted a resource that was simple and easy to use, and wanted more information on referral pathways for people with suicide risk. These findings are reflected in the resource which is clear, concise and contains information on how to refer to a variety of government, community and private service providers.

Collaborations for Life resource and training have been well received by GPs. The detailed consultation process that informed the production of the resource is a key factor in the projects success. The Division will be evaluating the resource using quantitative and qualitative data to gauge the usefulness of the resource in General Practice and whether it has improved the quality and diversity of referrals.

Electronic and print copies of the resource are available from the Top End Divisions website www.tedgp.asn.au. Results of the scoping study and consultation are also available online from the Top End Division website. If you would like more information about the Collaborations for Life project, please phone Kelly-lee Hickey at the Top End Division of General Practice on 89 821043.

Publication of
The Chronic Diseases Network

Just Another Step on Road Recovery

Pat Bradley
CNM, TEMHS Inpatient Unit

Mental illness like all illnesses can become chronic. People who live with chronic illness spend the vast majority of their lives independently in the community with the support of case managers, non-government organisations and carers. Many never experience an inpatient admission. Of those who do, most have a short admission and many have only one. Even those people who experience many admissions still spend only a fraction of their lives in hospital.

Australian mental health inpatient units today are very different from the image often held by the general public and that which is portrayed in the media. Most inpatient units are located in general hospitals – like the ward in Alice Springs. Others, like Cowdy and the Joan Ridley Unit (JRU) in Darwin are co-located on a general hospital campus. This is in line with the national policy of mainstreaming mental health services which aims to ensure optimal mental & physical health care for those diagnosed with mental illnesses.

In the Inpatient Unit at TEMHS, we are working hard to ensure that the admission experience is as positive as possible and that continuity of care between hospital and community is maintained. For people experiencing chronic mental illness this is crucial as it provides structure to the day, assurance of knowing who to call when a crisis occurs, and maintains support for carers. Mental health inpatient units in contemporary mental health care are positioned as key specialist service delivery areas within the broader spectrum of community based mental health care. As such they deliver only tertiary based services and develop high levels of expertise in supporting people who experience acute episodes of mental illnesses.

The TEMHS Inpatient Unit is actively seeking to establish itself as a centre of excellence within the framework of National and Territory Mental Health agendas. In particular the endeavours in this area include –

- A change in the model of practice used by staff within the ward, moving toward the full implementation of the Tidal Model. The Tidal Model is recovery based and person focused; it requires real partnership between the client, carers and specialist staff.
- An emphasis on cultural security by ensuring Aboriginal Mental Health Workers are actively involved in assessing clients' needs and supporting non-aboriginal staff to fully appreciate cultural norms and behaviours. This will also involve workshops for staff and wherever possible extension of culturally secure space. Additionally, research is being undertaken with the Northern Territory AIMhi team to further identify and explore other possible cultural resources and processes for use in the Inpatient Unit.
- Refocusing practices within the ward to provide a positive environment in which people are assisted to recover and in which treatment of "Dis-ease" is uppermost. This will also focus on crisis management plans and personal safety plans.

AIMING FOR EXCELLENCE

The Mental Health Inpatient Unit is currently one of eleven federally funded Beacon sites for seclusion reduction and a national pilot site for the implementation framework associated with the National Practice Standards for the Mental Health Workforce. This involves a focus on discrete aspects of staff practice with the view that developing staff knowledge and skills will have a subsequent positive impact on client outcomes.

Staff initiatives have included the appointment of a Community Liaison Nurse whose role is to effect a smooth and comfortable transition of clients experiencing complex problems from the unit to their home or to supported accommodation or other agencies. This involves significant networking across agencies, communities, disciplines and families. The Liaison Nurse works extensively with clinics and carers in remote communities facilitating continuity of care.

The Unit has also appointed a Social Worker who assists in ensuring financial and accommodation arrangements are satisfactory, and who works positively with Northern Territory Non-Government Organisations to facilitate continuing contact, recovery and support for clients and carers.

The Unit's Occupational Therapist has established a core activity program and this is augmented by recreational activities. This assists in establishing further connection with Non-Government Organisations and carers.

All this activity aims to enhance outcomes for people with mental illnesses, and to ensure that hospitalisation causes the least possible disruption to their lives – we aim to provide just another step on the road to recovery.

The Chronicle

Advanced Care Planning, not if, but when?

Territory palliative care

John McMahon
Territory Palliative Care

'Advanced care planning is everyone's business. It is the needs of the consumer, not the health system or service that are represented and served by the process.'

PCA E-Bulletin Feb 2008

Why is it Important

Advance Care Planning is directed at improving quality of care, facilitating patient autonomy (or self-determination) and reducing unwanted and unwarranted medical treatments and hospitalisations. By respecting every person's right to autonomy, dignity and fully informed consent, health professionals can assist individuals to reflect upon, choose and communicate their wishes regarding their current and future health care. "Respecting Patient Choices Implementation Guidelines 2008"

The aged population in Australia is increasing every year, this combined with the new medical technologies and procedures, has extended the life expectancy of Australians. These new technologies do not always equate to quality of life or quality care, but most importantly they are often not desired by patients and their families.

Advance Care Planning is a consultative and ongoing process that enables patients to choose future health care options, which meet their personal lifestyle goals. Health care providers, family members and other significant people in the lives of patients can collaborate in this process.

During the1990's a major shift in focus of advance care planning occurred. Relatively simple refusal of treatment options developed into more complex options of partial treatment, treatments with time limits attached, or some specific treatments but not others. Accommodating these complex plans required a cultural and systemic change within the health care sector.

The Federal Government recognised this need for systemic change and funded the Respecting Patient Choices Program at the Austin Hospital in Victoria in 2002. It has since extended to other hospitals and Aged Care Facilities in Victoria and to at least one other hospital in each state. (RDH Wards 4A & 4B in 2006/2007)

The Federal Government is now looking at ways of implementing the program on a national level. Palliative Care Australia has a view that Palliative Care Programs are ideally suited to implementing Advance Care Planning and will be lobbying for involvement and funding. Whichever way is chosen to implement the program, it will be implemented, and all health care providers will be expected to incorporate Advance Care Planning into their practice at some stage in the future. It is not a matter of if, but when.

The Respecting Patient Choices Program has done extensive work and research on how best to implement an Advance Care Planning program into an organisation. The main aims for a successful implementation of the program are;

- **Aim 1** To initiate conversations about advance care planning with all adults.
- **Aim 2** To skilfully facilitate advance care planning with appropriate individuals.
- **Aim 3** To ensure that Advance Care Plans are clear to all involved and specific to each person.
- **Aim 4** To ensure that all Advance Care Plans are available when needed.
- **Aim 5** To follow Advance Care Plans in a thoughtful and respectful way.

What is happening in the Territory?

After the Respecting Patients Choices Pilot Program in 2006/2007 the key recommendations were,

"Adequate funding needs to be provided to support the normalisation of Advance Care Planning into clinical practice and culture".

"Advance Care Planning should largely be in the community rather than the acute setting "

"A review of the existing legislation, The Natural Death Act, be undertaken"

The Territory Government has made a commitment to review the existing legislation and a Steering Committee of community stakeholders is being formed and will be convened by mid year.

Funding has been made available and a position created at Territory Palliative Care to help in implementing the program in the community setting.

Community education will also be attempted, it is not until the consumer is aware, and familiar with the concept of ACP, and the benefits to their health care ,that real change will ensue.

Eventually all the Health Care Sector, Government, NGOs, GP clinics, and remote health, will be expected to incorporate Advance Care Planning into their practice and culture. It will not go away; it is not a fad that will pass. The Federal Government is committed to its introduction on a national scale. We all need to review our current practices and determine how we can introduce Advance Care Planning into our systems and culture.

EASA
COUNSELLING • TRAINING
MEDIATION • CONSULTING

Toolbox Training

EASA provides counseling, training, mediation and consulting to Government and non-Government organisations throughout the Northern Territory.

One of a myriad of services that EASA offers is toolbox training. Training is brief with duration between 10 to 30 minutes. Toolbox Training provides clients with a practical intervention designed to provide information and teaching of functional skills

Popular toolbox sessions include:

- Work life balance,
- Time management,
- Communication,
- Relaxation,
- Stress management.

Advantages of toolbox training

- Assist to pinpoint and address workplace issues
- Enhance client coping by developing skill base
- Clients feel support is being provided by employer

Toolbox training is brief training that can be tailored to meet specific client needs, what might be of benefit to your team?

To book a toolbox training session, ring EASA to discuss your needs on

1800 193 123 or 08 8941 1752

Some comments from participants:

"The sessions provided good verbal and hard copy information to staff as well as an on-the-spot relaxation session where participants would learn to relax through visualisation and listening to the counsellor talking them through it……. All staff who attended the sessions were really positive about the benefits and some verbalised a desire for similar sessions to be conducted by the Team Leader at the end of each shift. The techniques used by the EASA staff were easily remembered and could be transferred to become a 'quick fix' for easing tension in home and work life".

(Sharon Haste, Child Health and Wellbeing Executive Officer Health Services, RDH)

headspace Top End:

new youth mental health and substance use service in the Top End

We know that most mental health concerns begin between the ages of 12 and 25. We also know that during this period there are considerable barriers to accessing help. Surveys conducted in Australia indicate that young people don't access help because they feel embarrassed, concerned about confidentiality, don't know where services are, or what type of health professionals they may need to see. This situation often leads to longer term complications that may result in young people being isolated from family and friends when support is most needed.

headspace is the new Australian Government funded National Youth Mental Health Initiative. Leading up to the 2004 Federal election the issue of mental health amongst young Australians received bipartisan recognition as being of leading concern. Following the election headspace's National office was created in Melbourne along with an advisory board comprising of leading researchers and professionals within the youth sector. Nationally, headspace is working to build the capacity of the community to recognise and respond to young people at risk from mental health and substance use issues through collaboration with governments, health professionals, families and young people themselves. Currently, there are 30 headspace offices funded across Australia.

According to Youth Activist Kat Byron for a service to successfully engage young people it needs to involve them in decision making so they feel they have some ownership over the service. Kat became a valued member of the Headspace National Youth Reference Group after, "being mentored by supportive project officers who made me feel able to go on and participate". headspace has a commitment to responding to youth issues that are important for, and are identified by, young people themselves.

Anglicare NT is the lead agency of a local consortium charged with running headspace Top End. The consortium also includes Danila Dilba Aboriginal Medical Service, Top End Division of General Practice and the NT Department of Health and Community Services. Headspace Top End is also in partnership with 13 Link Agencies which are currently engaged in the provision of youth services in the Top End. These Link Agencies include consumer/carer groups, local councils, secondary schools, alcohol & other drug services, youth services, employment services and mental health service providers.

headspace Top End has three major area's of focus, across all of which we aim to maintain the highest standards of cultural and age sensitivity. Firstly we look at how best to utilise and improve existing youth services. Secondly we look at how to increase accessibility to these services for young people. Finally we offer youth specific training to service providers and information and awareness to the broader community.

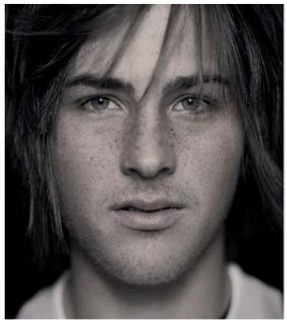
headspace Top End offers assessment, information and referral to young people aged between 12 and 25. The headspace office has psychological services available by appointment as well as General Practitioners and a variety of other youth health services.

headspace Top End will be opening in May in the Palmerston Oasis Shopping Complex

If you would like to know more about headspace you can visit the national website at: www.headspace.org.au,

email us at headspace@anglicare-nt.org.au

or phone us on (08) 89315999 or 1800 659 388.



Mental Health training for remote Health Professionals

Jeanette Boland
Educator
Preventable Chronic Disease Program, DHCS

The annual mental health workshop was run in Darwin 3rd to 7th March 2008. This workshop coordinated by Clinical Learning team and Mental Health services from the Department of Health and Community Services is offered to all health professionals in the Top End but specifically targets remote health professionals.

The content of the training included:

- 2 days ASSIST training from Anglicare, this module is first aid training in the early detection and prevention of suicide.
- Reviewing proposed changes to the mental health act
- Mental illness what is it?
- Assessment, classification and risk of mental illness in clients using problem based case scenarios.

Mental health services provided a range of presenters throughout the week with the bulk of the training delivered by Anthony Guscott, a very experienced mental health trainer from Top End Mental Health Services DHCS. His engaging interactive approach to teaching was refreshing, enabling all participants with a vast range of backgrounds to actively learn throughout the week.

The range of health professionals that attended the week included community based aboriginal health workers, nurses, drivers, educators, a social worker and a health support officer. This reflects the nature of community-based services, with a wide range of individuals who deal daily with clients with mental health issues. All participants expressed positive feedback on the workshop.

Mental health training for community based service providers is essential to ensure we are providing holistic care to clients. With an increasing number of clients who have multiple disorders, a basic mental health assessment within the primary health care assessment of clients is essential to ensuring appropriate care.

Mental health training for health professionals will continue to be offered within the Top End.

For training requests contact Jeanette Boland on 08 8922 6990

Second NT ADEA Branch Conference A Big Hit!

The Northern Territory Branch of Australian Diabetes Educators Association (ADEA) held its 2nd annual conference in Darwin on 18-19 April 2008 at the Healthy Living NT office. Compared to the rest of Australia, the NT branch of ADEA is a small one with members performing diverse roles: educators in Darwin and Alice Springs Hospitals, community educators, private consultants and roles as public health nurses in remote Aboriginal communities. Thirteen members of ADEA attended the conference with extra attendees on one of the days. It was an interesting and varied program with guest speakers and presentations from ADEA members. Some highlights included networking with other members from their varied and diverse roles and regions and hearing more about what is occurring on a local level.

Dr Ashim Sinha, Director of Diabetes and Endocrinology Cairns Base Hospital and Diabetes Centre James Cook University, gave a fascinating presentation on the latest developments in diabetes.

Dr Mark Shephard, Director and Senior Research Fellow, Community Point of Care Services, Flinders University Rural Clinical School, Flinders University, talked about 'point of care testing' (POCT) which is occurring in many clinics throughout Australia. POCT and will soon be rolled out in the NT (and other regions).

Julie Croft, Wellbeing Manager from Outback Stores introduced an Australia-wide initiative to make healthy food choices easier in remote community run stores, channelling profits directly back into the communities.

Bhavini Patel, Director of Pharmacy at Royal Darwin Hospital and NICS- HCF Foundation Fellow, presented a case study that challenged all participants regarding medication management for clients with diabetes.

Dr Trish Nagel, Consultant Psychiatrist and Senior Lecturer at Flinders University/Menzies School of Research presented on the ongoing progress of her research into Depression and Mental Health Care Planning. Dr Nagel spoke at our inaugural conference in 2007. It was wonderful to see how work by her team had progressed and the potential for greater use in a chronic disease context.

Penny Brown from the Oral Health Promotion Unit kept everyone focused at the end of the day on dental care and the challenges of working in remote settings.

Chrissie Ingliss, from Healthy Living NT gave up her Saturday morning to give an excellent talk on diabetes and cardiovascular disease, debunking myths and providing the latest evidence and development regarding advice and care.

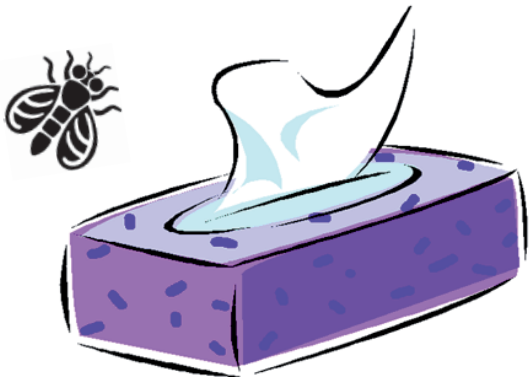
The rest of the conference was spent with ADEA members presenting the work they are currently involved in, followed by a branch meeting.

Whilst there are regular teleconferences held for ADEA business and ongoing professional learning, face to face conferences such as this one highlight the importance of meeting and networking in person to discuss the complexities of our work. Evaluations from the 2008 conference have been excellent with many suggestions for speakers and topics for next year already being suggested. Thanks goes to the pharmaceutical companies for providing support for the conference, demonstrating products over lunch and the wonderful conference dinner.

ADEA is an Australia's peak professional organisation in diabetes education. It is a multi skilled, multidisciplinary organisation which "actively promotes education to ensure optimal health and well being for all at risk and affected by diabetes." Accrediting courses, developing evidence based guidelines and policies and advocacy for equitable services are some of the activities of ADEA.

For More Information regarding ADEA or to join ADEA,
Contact: NT Branch Chair Linda Rennie
on (08) 8927 8488
or visit the website at www.adea.com.au

The Canteen Creek Snot Campaign:
An Innovative Approach to Trachoma



Trachoma is one of the leading causes of preventative blindness, and remains endemic in many remote communities (1). Canteen Creek is a small Indigenous community in the Barkly Region of Northern Territory, with a population of approximately 300. A community wide trachoma screen in April showed alarming statistics: Canteen Creek had a 73% incidence of trachoma, one of the highest rates in the world.

Screening for the disease was the easy part. The challenge has been what to do next.

As per Northern Territory Guidelines, a community wide treatment program was implemented immediately following the screening. This was done in consultation with the local Council, and had support of the entire community. Clinic staff (comprised on one Remote Area Nurse & one Apprentice Aboriginal Health Worker) went door to door over a period of two days, in an attempt to attain the highest possible treatment coverage. The community responded very positively to this door-to-door campaign, and expressed eagerness in assisting wherever possible.

Some of the fantastic posters from senior primary poster competition

Health promotion initiatives were started simultaneously with the community treatment program. Photos and information related to trachoma were shared at each household during the treatment period. The Remote Area Nurse discussed health strategies related to trachoma at a Council Meeting, and was also given the opportunity to speak at a community wide meeting.

A main focus of the health promotion has been school health. Facial cleanliness has been identified as a critical component in relation to trachoma prevalence. Previous studies have suggested that improvements in overall facial cleanliness when combined with community wide antibiotic treatment were more effective than antibiotic treatment alone (2). Armed with this information, a unique health promotion program was developed: the SNOT campaign. The premise is relatively simple: children learn that mucous/snot make their faces dirty and sticky, which helps to spread the bug that causes trachoma. Further, children discover how 'boogers' are like lollies for a fly; and flies help spread trachoma as well. Thus, keeping faces clean and 'snot free' means less dirt on faces, and less flies around faces. "Snot talks" at the school (involving homemade 'snot' science experiments) have helped to demonstrate this. A successful poster competition amongst the primary school aged children has resulted in creative displays throughout the community identifying how 'flies love snot' and the virtues of tissues & facial cleanliness. A senior school poster competition is also planned. To complement the health promotion education, a face washing campaign has been initiated at the school, with disposable face washers provided to each classroom.

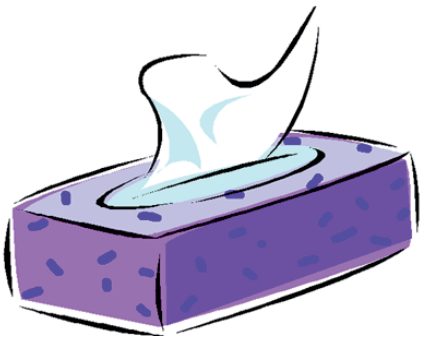
>>>

Delvan Beasley (with brother Rowan) showing off his snot free nose

'Snot blitzes' have proven to be a huge success as well. Health staff have been sporadically blitzing the community and school, rewarding 'snot-free' faces with prizes (cheese sticks, stickers, tattoos). Older children & teens observed to be assisting young children to blow their noses/wash their faces are given rewards as well. Blitzes are also occurring at the women's health centre, & are planned to occur at the store in the near future (with parents of 'snot-free' kids receiving small rewards).

Finally, a Clean Faces Display at the Clinic (photos are taken of children with clean faces, and displayed on posters) has been hugely successful. Children and parents/guardians alike have been delighted upon the discovery that their photo/child's photo has been displayed for all the community to see!

Needless to say, facial cleanliness and snot free faces are only a small component of decreasing trachoma incidence. The health team is working in consultation with Council members about the importance of improving environmental conditions (overcrowding, rubbish, etc.) However, the Snot Campaign has provided the community with a fun way of working towards improving trachoma incidence, as well as keeping trachoma in the spotlight.



The response to the Snot Campaign has been fantastic thus far, with a noticeable improvement in facial cleanliness already. Other community stakeholders have even started to get involved. The local Council office now has a 'no dirty faces allowed' policy, and keeps facial wipes just inside the door for parents to wipe their children's faces before entering. The Canteen Creek shop (an Outback Stores managed facility), and the Australian Government Business Manager have graciously donated prizes for the snot blitzes.

The Snot Campaign officially concluded on 30 May. It is hoped that the health promotion messages surrounding the importance of facial cleanliness will be sustained within the community and that a decreased incidence of trachoma will be observed at the next screening, scheduled for August, 2008.

Reference: Couzos, S., Taylor H., & Wright, H. (2008). Trachoma. In *Aboriginal primary health care: an evidence-based approach*. 3rd edition. Ed. S.Couzos & R.Murray. Oxford University Press: South Melbourne. Pp. 708-731.

Tamika Corbett - prize winner during a snot blitz for having a clean face

Community Involvement

Influenza Vaccination Week in Areyonga

From 31st March – 4th April 2008 Areyonga Clinic (in Central Australia) facilitated a special HEALTH WEEK for the community.

The main aim was to offer Influenza vaccine before the start of the Flu season. The idea of a special health week was born when the E-Health Team indicated that they had to see every client in the community to sign them up and the clinic wanted to see everybody for their Flu needle. It was decided to join efforts and have a special "Health Week".

Preparations

FLUVAX

The health team in Areyonga decided to offer influenza vaccination to all residents of the community, including all children, for which the needle is not funded by the Government. This was welcomed by the community. In preparation, the population list was updated and FluVax lists for the different age groups generated.

PNEUMOVAX

The clinic staff with the help of the NT Immunisation Database went through all the adult health records to determine who was due or overdue for a Pneumovax. A list was generated, with the aim to give due and overdue Pneumovax needles as well.

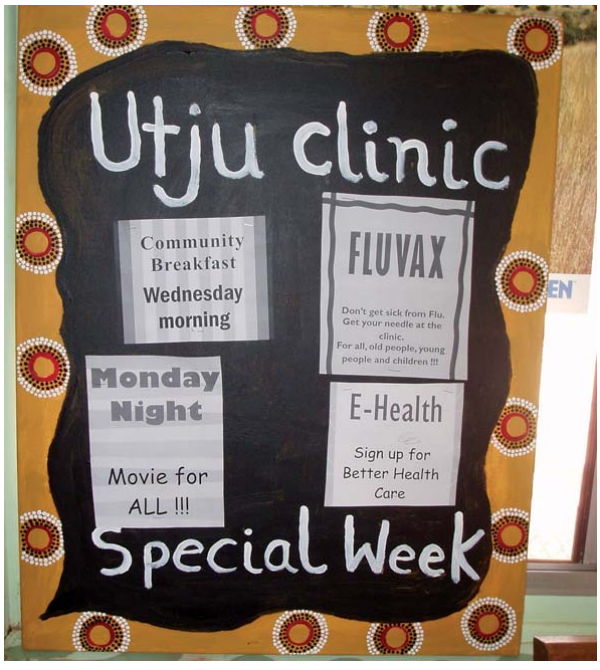
IMMUNISATION TARGET

Out of these preparations the following targets for the immunisation week were set:

FluVax	0- 14 years	15-49 years	50 + years	TotalFluVax	PneumoVax15+ years	Total NeedlesFluVax &PneumoVax
Target	51	131	35	217	48	265

ADVERTISING

2 local artists designed a notice board and the different activities for the week were advertised. Just letting the community know that the vaccine was available and would be given during the week was promotion enough. There was a huge turn up and people lining up to get their vaccines.



Notice board created by 2 local artists

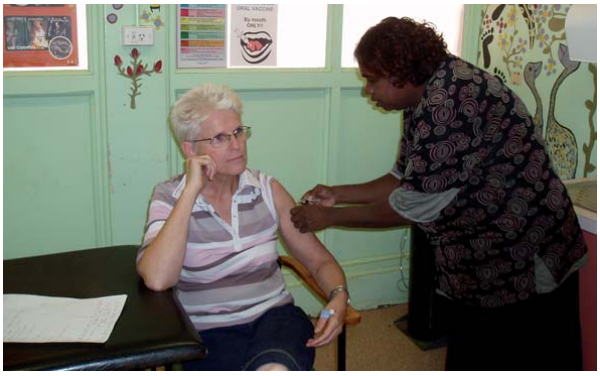
continued next page >>>

The Health Week

Immunisation Givens

The clinic files were pulled for all clients while at the clinic and immunisations recorded in files and ticked off on the population list. By the end of the week all 236 immunisations given had been reported to the NT immunisation database and were recorded on Communicare.

Girls supporting each other



Health team needs their needles too

Mum's bringing their kids in

E-Health

The E-Health (formerly known as Health Connect) team managed to sign up around 150 people from the community. They also supplied funding for the community breakfast.

Bringing in people to sign up for E-Health

Community Movie Night

The movie "The Whale Rider" was shown on Monday night with a data projector and big screen on the basket ball court. This was a way of inviting and informing the community about the health week. This event was attended by around 50 people.

Men's Night and Women's Night

It was planned to have a special men's and women's night on Tuesday. Due to ongoing cultural business and some youth week celebrations it was not possible to run these activities.

Healthy Community Breakfast

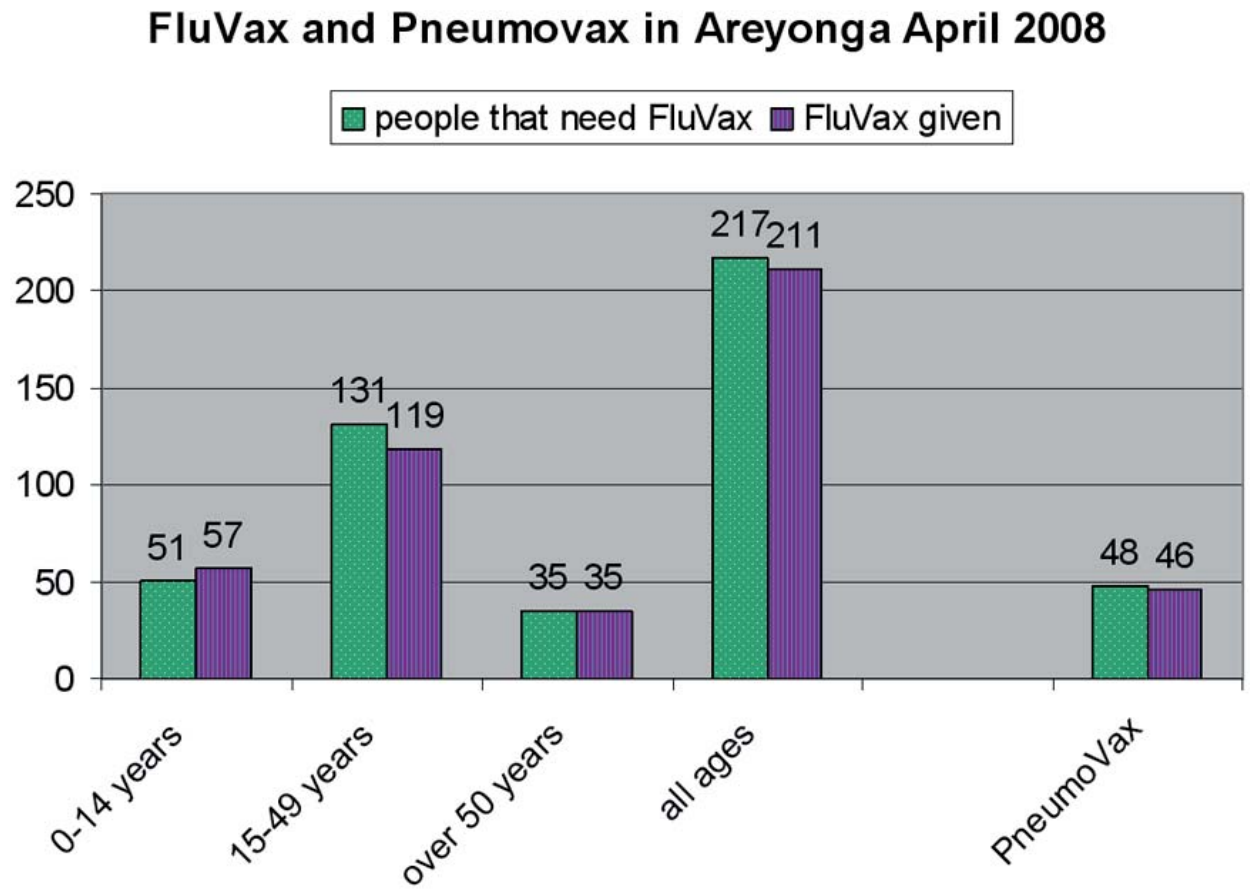
Promotion of healthy nutrition was incorporated during the week with healthy fruity snacks and "Veggie Man" visiting. With the help of the DHCS nutrition team, 5 community members and sponsorship from e-health, a "Healthy Community Breakfast" was provided on Wednesday morning. This was seen as a way of celebrating the achievements of the week and was taken up by around 100 community members.

Sarah (AHW) talking to community members at the breakfast

Tamika Corbett - prize winner during a snot blitz for having a clean face

Vege Man

The Health Week



This special Areyonga Health week has been extremely successful. The community participated and enjoyed the activities.

By end of April (including 3 weeks after the Health Week) a

97% coverage for Influenza vaccine and a

96 % catch up rate for adult PneumoVax was achieved. This included a few visitors.

Everybody involved in this exercise can be very proud of the work done. It was wonderful to see how the community responded with an overwhelming turn up. The very good relationship between the clinic, staff and community members greatly contributed towards the success. It is the plan to repeat a similar exercise for next years FluVax season.

The immunisation Team at Areyonga: Genevieve (RAN), Judy (RAN), Sarah (AHW), Inge (PHN

Close the Gap Day

Normie Grogan
Menzies school of health research

As part of the national Close the Gap Day initiatives, a joint event was hosted by the Chronic Diseases Network and Menzies School of Health Research in Darwin on April 22.

The crowd was overflowing into the hallway outside the Menzies Seminar Room as the official Oxfam Close the Gap DVD was projected onto the big screen. More than 100 people attended from Menzies, the Chronic Diseases Network, Northern Territory Health Department and the general public.

Most were there to voice their concern about the ongoing state of past, and current, living conditions and death statistics among the nation's Aboriginal and Torres Strait Islander communities.

The event was jointly organised by Hillary Bloomfield from the NT's Centre for Disease Control, and Bilawara Lee from Menzies School of Health Research.

Guest speakers included Professor Shane Houston, Assistant Secretary, Office of System Performance and Aboriginal Policy and Adjunct Professor Health Sciences at Curtain University and Dr Christine Connors, Preventable Chronic Disease Program, Department of Health & Community Services.

On completion of the presentations the attendees later mingled at an afternoon Tea and pledged to support the national movement to Close the Gap on Indigenous life expectancy.

Closing the Gap attendees

Guest Speaker Professor Shane Houston

Hilary Bloomfield introducing guest speakers

Guest speaker Dr Christine Connors

Celebrating

goNT week 28 April – 4 May

goNT Week is a yearly initiative of the Chief Minister's Active Living Council, aiming to raise awareness of the importance of physical activity

This year's goNT week was promoted to the community through newspaper features and radio commercials. DHCS supported goNT week by offering its staff a range of opportunities to be active before work or at lunchtime.

A brisk early morning walk was organised at RDH (Darwin). Participants walked from Block 4 to the Brinkin Cliffs and back again; light refreshments and breakfast were provided. Lunchtime activities included free yoga classes (Darwin and Alice Springs), come'n'try classes at local gyms (Darwin and Alice Springs), walks (Darwin and Alice Springs), car pooling to the pool (Parap Pool) and com'n'try jump rope for heart (Darwin).

Nutrition and Physical Activity (NPA) staff in East Arnhem provided some physical activity professional development sessions for Laynhapuy Homelands teachers at Yilpara School, in order to develop a before-school and after-school physical activity program for students. Sessions involved competitive and non-competitive sports and physical activity games for a broad range of ages

The NPA team also ran an AFL day for children and youth. Boys and girls in Nhulunbuy, East Woody, Ski Beach and Yirrkala participated in modified AFL football rules for their specific ages.

Check out the following web addresses for ideas on how to be active as well as extended information on how to promote and support physical activity.

http://www.nt.gov.au/health/comm_health/food_nutrition/physical_activity/tips_for_all.shtml

http://www.nt.gov.au/health/gont/gont_week_ideas_booklet2008.pdf

http://www.beactive.wa.gov.au/

participants enjoying breakfast

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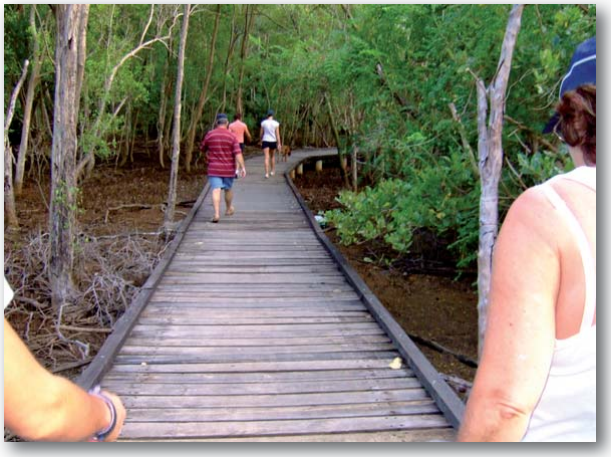

rainforest boardwalk

yoga class

Carrie Turner and Nutrition student Nathan Overbeeke

Ruby Lindberg and Robin Lion

The Chronicle

Complexities of a Screening Test – 1

Dr Madhumati Chatterji
Medical Advisor Screening, HD&OH

Unlike clinical practice in which diagnosis and the decision to treat the diseased is normally based on history, physical findings and laboratory investigations, screening involves the application of a screening test to apparently healthy populations.

Screening is essentially a health service for early detection or reduction of the risk of developing a disease or condition, where individuals in a defined population are offered a screening test to identify those individuals who are more likely to be helped than harmed by further tests or treatment.

Criteria for screening ***(WHO, Wilson & Jungner, 1968)*** can be grouped into four categories – the disease or condition screened, the screening test, the follow up diagnosis and treatment, and program evaluation.

An Acceptable Screening Test

One cannot overemphasise the importance of the 'acceptability' of a screening test. The success of any screening program is based on participation, and individuals who are apparently healthy will only participate if the test or procedure does not inconvenience them, is potentially harmless and does not cost too much. Therefore, to be 'acceptable' to the population, the screening test requires to be simple, rapid, safe, affordable and culturally appropriate.

A Suitable Screening Test - Benchmarking

The screening test can be seen as a sorting process, of those identified to be at risk from those that are not. Depending on the results of a screening test, individuals are therefore categorised into two distinct groups: test positive and test negative. A test positive individual proceeds to a diagnostic or confirmatory test and then as required, to the necessary follow up and treatment.

The first step is therefore the benchmarking. To determine up-front whether the test result should be considered positive or negative, the range and cut-off levels for the 'normal' findings of the screening test must be known. A simplistic example would be in the blood glucose test for diabetes. What blood glucose level should be considered as normal, beyond which the blood sugar test can be considered 'positive'? Again the scenario is made more complex with the type of blood glucose test - random or post-prandial, capillary or venous blood. Should the level differ according to the test? Also, should the level differ for individuals with varying associated factors for diabetes, such as weight for height, physical activity, race or diet?

Benchmarking is usually undertaken at the policy level, based on national and international evidence through research.

Positive and Negative test results – not the whole story

Once the benchmarking for the 'normal' range is set, it seems the problem is resolved! A 'positive test' is then considered one that is outside the normal range and a negative test vice versa. But unfortunately, it is not that

continued next page >>>

World Health Organisation (WHO) Criteria for Screening (Wilson & Jungner, 1968):

The condition:

1. The condition should be an important health problem.
2. There should be a recognisable latent or early symptomatic stage
3. The natural history of the condition, including development from latent to declared disease should be adequately understood

The Test:

4. The test should be acceptable to the population
5. There should be a suitable test or examination

The Treatment:

6. There should be an accepted treatment for patients with recognised disease
7. There should be an agreed policy on whom to treat as patients
8. Facilities for diagnosis and treatment should be available

The Evaluation:

9. The cost of case-findings (including diagnosis and treatment of patients diagnosed) should be economically balanced in relation to possible expenditure on medical care as a whole
10. Case finding should be a continuous process and not a 'once and for all' project

Table: Illustration of Classification of Screening Test Results

Test Result	Disease status		
	Present	**Absent**	**Total**
Positive	a (True Positive)	b (False Positive)	a+b (Total Positives)
Negative	c (False Negative)	d (True Negative)	c+d (Total Negatives)
Total	a+c (Total Diseased)	b+d (Total Non-diseased)	a+b+c+d (Total Population)

straightforward. A positive test result does not always mean that the individual has the disease, and conversely a negative test result does not always mean that the individual is free from the disease.

A positive test result can be a 'true' positive one, where the apparently healthy individual screened does have the disease; or, the result could be 'false' positive, where the individual does not have the disease but has been erroneously tested positive. Similarly, a negative test result could either be 'true' negative, which means the individual does not have the disease, or it could be a 'false' negative one where the individual actually has the disease but is erroneously tested negative.

False positive and false negative results are a part and parcel of any screening test. Reasons could be due to benchmarking, technical or observational effects. 'False' screening test results are a phenomenon that cannot be totally eliminated, but can be kept low through quality assurance and evidence based decision-making.

Thus

Total Positive Screening Test Results = True positives + False positives

Total Negative Screening Test Result = True negatives + False negatives

False Positive and False Negative test results - Implications

Individuals falsely assigned to the positive test category are unnecessarily subjected to time-consuming, unpleasant and potentially harmful subsequent investigations. Occasionally, they are subjected to unnecessary, harmful and expensive treatments. The psychological impact of such false positive tests on individuals can be significant, apart from a wastage of limited resources for the program.

The false negative category presents different problems. Clearly, individuals concerned derive no benefit from the test rather they are harmed. They are falsely assured that they are disease-free. They may thus delay seeking medical help when symptoms subsequently appear.

Given that a screening test is for apparently healthy individuals, and that these healthy individuals are 'offered' screening tests, it is absolutely imperative and ethical that the majority if not most of the screened individuals are not harmed through such false positive or false negative results.

Therefore, for a screening program to be successful and effective at the population level, the screening test requires to be acceptable, and attain high numbers of true positive and true negative results, keeping numbers of false positive and false negative results to a bare minimum.

Conclusion

- No screening program is successful without an acceptable screening test.
- No screening program is effective without a suitable screening test that can differentiate between those who do from those who do not have the disease or condition screened.
- A suitable screening test should have the ability to identify correctly all screened individuals who actually have the disease or condition (true positives), called the *sensitivity* of the test.
- A suitable screening test should have the ability to identify correctly the non-diseased individuals who do not have the disease or condition (true negatives), called the *specificity* of a test.

Reference:

- For a copy of the Nicola Roxon Media statement *Free Bowel Cancer tests* released on the 8 May go to;

http://www.alp.org.au/media/0508/msheag080.php

For further information, contact

Dr Madhumati Chatterji, Medical Advisor Screening, Health Development & Oral Health, Dept. of Health & Community Services;

madhumati.chatterji@nt.gov.au

Next in the series: Complexities of a Screening Test - 2

The Chronicle

Screening versus Diagnostic Mammography

AN INFORMATION SHEET FOR GENERAL PRACTITIONERS & HEALTH PRACTITIONERS

Screening Mammography		Diagnostic Mammography
Asymptomatic 'well' women to detect unsuspected lesions.	**Scope**	To diagnose breast changes or abnormalities that may have been detected through breast self examination/ awareness or clinical check.
Emphasis is on population screening. breastscreenNT is an organised program where recruitment, education, screening, assessment, recall, data collection and evaluation are performed.	**Emphasis**	Emphasis is on the individual.
Women aged 50-69 years.	**Target**	Women or men of any age who have any symptoms or signs.
breastscreenNT provides services at specific sites.Two standard X-ray views of both breasts are taken.	**Service**	General radiology practices and public hospital radiology departments.Specific multiple X-rays are taken of the area of concern.
Free.	**Cost**	Medicare rebatable.
No referral required.	**Referral**	Referral from medical practitioner.
Staff specialise in screening for and assessing impalpable lesions. Two specially trained radiologists independently read all mammograms.	**Staff**	Staff experienced in a range of diagnostic X-ray. Experience in breast cancer mainly with women presenting with palpable lesions/ changes.
Recall for further tests when needed as well as recall for routine screening at recommended intervals (usually two years).	**Recall**	Recall and recommendation for further tests at the discretion of the GP or treating medical practitioner.
Pro-forma results letter to the women and general practitioner (where nominated) within 6 weeks of screening.	**Notification**	Full report to the requesting medical practitioner, usually within a few days.
Systemic data collection for monitoring morbidity and mortality outcomes for the population.	**Data**	GP or treating medical practitioner records data specific to the management of the individual woman.

Breast Screen Rosa Norman

Mammography is a proven method to reduce deaths from breast cancer.

breastscreenNT provides a free screening mammography service, especially targeting women aged 50-69 years but also available to women 40 years and over.

An appointment at breastscreenNT can be made by calling 13 20 50.

RESOURCES

Models in the delivery of depression care: A systematic review of randomised and controlled intervention trials

This paper aims to determine the effective components of depression care in primary care through a systematic examination of both general practice and community based intervention trials. Components which were found to significantly predict improvement were the revision of professional roles, the provision of a case manager who provided direct feedback and delivered a psychological therapy, and an intervention that incorporated patient preferences into care. Certain community models of care (education programs) have potential while others are not successful in their current form (pharmacist monitoring). [Abstract precis by PHC RIS]

Published 5 May 2008-05-12 BMC Family Practice 2008, 9:25doi:10.1186/1471-2296-9-25

See: http://www.biomedcentral.com/1471-2296/9/25

An Analysis of Suicide in Indigenous Communities of North Queensland: The Historical, Cultural and Symbolic Landscape

This is the first systematic and comprehensive examination of suicides in Aboriginal communities in Queensland based on community records and available mortality figures. The data provides a picture, which is notably different from that for suicide generally, in Queensland and across Australia.

http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-a-indigsui

The Australian Institute of Health and Welfare

Rural, regional and remote health: indicators of health status and determinants of health

This report focuses on a comprehensive range of health issues concerning people living in rural, regional and remote Australia. It includes information relating to health status (such as rates of chronic disease, injury and mental health) and determinants of health (such as tobacco smoking, alcohol consumption, nutrition and physical activity) and is the 9th report in the AIHW's Rural health series.

Authored by AIHW.

Published 31 March 2008; ISSN 1448 9775; ISBN-13 978 1 74024 768 9; AIHW cat. no. PHE 97;

http://www.aihw.gov.au/publications/index.cfm/title/10519

http://www.aihw.gov.au/publications/phe/rrrh-ihsdh/rrrh-ihsdh.pdf

News.com.au

Obese inmate sues jail over weight loss

An obese inmate has filed a federal lawsuit after he lost

>>>

more than 45kg over 8 months because of prison food.

http://www.news.com.au/story/0,23599,23608768-13762,00.html

AHHA Think Tank Exchange

A National Health Policy Roundtable, hosted by the Australian Healthcare and Hospitals Association (AHHA) on Monday 21 April, delivered three comprehensive position papers to the Federal Minister of Health & Ageing's office, recommending a broad range of reforms across the spectrum of the health system.

"The three position papers covered the following critical areas for the future of our health system:

- Data and Benchmarking;
- Information Management; and
- Service Integration.

For a copy of the papers and outcomes of the Think Tank Exchange go to:

http://www.aushealthcare.com.au/news/news_details.asp?nid=11183

Public Forums

NHMRC has developed a new online Podcast series *Great minds in health and medical research* where you can download a collection of conversations (audio and transcripts) with some of the leading figures in health and medical research in Australia.

http://www.nhmrc.gov.au/news/podcasts/index.htm

Website links

To access audiocasts and powerpoint presentations from 2 recent public forums:

http://www.med.monash.edu.au/epidemiology/iphu/events/

1. 29/2/08 Depression and Cardiovascular disease: Professor Barr Taylor from Stanford University

http://www.med.monash.edu.au/epidemiology/downloads/barr-audio.mp3

http://www.med.monash.edu.au/epidemiology/downloads/barr-ppt-presentation.pdf

2. Telehealth in CVD, Diabetes etc: Professor Rob Friedman from Boston University

http://www.med.monash.edu.au/epidemiology/iphu/friedman-ppt-presentation.pdf

New Publication

Aboriginal men's health by Brian McCoy

Aboriginal Studies Press has published a new book by Brian McCoy called *Holding Men - Kanyirninpa and the health of Aboriginal men*. Using conversations, stories and art, McCoy explores how Indigenous men understand their lives, their health and their culture, and shows how Kimberley desert communities have a cultural value and relationship described as "kanyirninpa" or "holding".

For more information about the book and an order form, go to

http://www.crcah.org.au/communication/news.html#hmk


Advancing Asthma Where?
Australian Asthma Conference
20-21 October 2008 Sydney
asthmaconference2008.com
We are pleased to invite you to attend the biennial Australian Asthma Conference
When: 20 - 21 October 2008
Where: The Australian Technology Park, Sydney
Theme: Advancing Asthma Where?
The Conference program will review the changing world of asthma in our nation.
We aim to work together to develop ideas and actions which can influence and inform future asthma agendas.
Who should attend: People with asthma, health professionals, scientists, researchers, policy makers and government.
For more Information visit the conference website - www.asthmaconference2008.com - our contact Tour Hosts on Ph: +61 2 9265 0700 or Email: asthma2008@tourhosts.com.au
We look forward to welcoming you to Sydney!
With Regards, Asthma Foundation NSW on behalf of Asthma Foundations Australia.


Northern Territory Government
Quit
The four D's
4 ways to avoid a cigarette
Delay
for at least five minutes, the urge will pass
Deep breathe
breathe slowly and deeply
Do something else
keep your hands busy
Drink Water
take time out to sip it slowly
Call the Quitline
137 848
Counsellors are available to support smokers to Quit.
Benefits of Quitting ...
• Reduced risk of heart attack and stroke
• Quicker healing after an operation
• Better anaesthetic outcome
• Cleaner lungs - reduce risk of cancer
I'm SMARTER than smoking
To refer patients/clients to the NT Quitline for help to Quit a simple referral form is available. To obtain a pad of referral forms call the NT Tobacco Hotline on 1800 588 564.
Department of Health and Community Services
nt.gov.au/health

Professional development

Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health (Community Care)

With specialisation in Primary Health Care, Mental Health and Alcohol and other Drugs.

Applications are being accepted for semester 2, 2008

You can make a difference – this course is being offered at Batchelor Institute

This course will provide information and skills on ways to improve the health of Indigenous peoples and improve community lifestyles.

The Certificate IV in Aboriginal and or Torres Strait Islander Primary Health (Community Care) is the qualification you will obtain after a two year period of study.

Batchelor Institute will assist with your workshop travel and accommodation.

You must be an Aboriginal or Torres Strait Islander person, over 18 years old and live in, or be a resident of, the NT.

For further information contact Freecall: 1800 677095 and ask for

General enquiries: Donna Webb, Dawn Daly or Ann Bolton

Lecturer: Donna Webb

Or **email:**
donna.webb@batchelor.edu.au

Endeavour Awards

The Endeavour Awards is an internationally competitive, merit-based program providing opportunities for citizens of the Asia-Pacific region to undertake study, research and professional development in Australia. Awards are also available for Australians to do the same abroad. A smaller number of awards are available for participants from Europe and the Americas.

The Endeavour Awards provide individuals with a unique opportunity to take the next step in their academic or professional career.

Applications for the 2009 Endeavour Awards are now open. Applications will close 31 July 2008.

Follow the links on http://www.endeavour.dest.gov.au/

Conferences

Population Health Congress

A Global World - Practical Action for Health and Well Being

Brisbane Convention & Exhibition Centre

July 6-9 2008

Major Themes

- Environment and Health
- Social Cohesion, Social Capital and Health
- Food and Health

For further information http://www.populationhealthcongress.org.au/

International Congress on Chronic Disease Self-management - 26th-28th November 2008

"Chronic Disease Self-management: Innovation and evidence of effectiveness."

The University of Melbourne will host Australia's premier conference on Chronic Disease Self-management. Keynote speakers include internationally renowned leaders in the field such as:

- Professor Stan Newman, London University, UK
- Dr Teresa Brady, Centres for Disease Control and Prevention, USA,
- Professor Bob Lewin, University of York, UK.

Conference themes include:

- The workplace – an untapped opportunity for Chronic Disease Self-management
- Innovations in Chronic Disease Self-management program content and delivery
- Optimising the role and impact of primary care
- The needs of indigenous people and those from culturally and linguistically diverse backgrounds
- Chronic Disease Self-management for young people
- Health Literacy: the foundation of self-care and self-management support
- Introduction of innovation - making Chronic Disease Self-management sustainable

To be placed on the early notification email list please email Jodie.North@union.unimelb.edu.au

2008 AHHA Congress REFORM - A New Era

Do you want to know how the Federal Labor Government plans to work with the states and territories to improve our health system and what impact this will have on your working environment?

Australian Healthcare and Hospitals Association (AHHA) 2008 Congress, being held at the Rydges Lakeside, Canberra, ACT 25-26 September 2008.

Congress sessions will include:

- The role of the new National Healthcare & Hospitals Reform Commission;
- Development of a national collaborative approach to healthcare policy;
- What the state/territories are doing to reform healthcare delivery;
- National benchmarking and data;
- Information management (including but not limited to information-communication-technology solutions); and
- Service integration (across settings, between professionals).

For a copy of the Program and Registration please go to:

http://www.ahha2008congress.com.au/

Health at the Heart of Australia Conference

Alice Springs, 13 - 15th August 2008

12th Annual Conference of the Chronic Diseases Network of the NT

18th Annual Scientific Meeting and Exhibition of the Australian Cardiovascular Health and Rehabilitation Association

The 12th Annual Chronic Diseases Network Conference is looking to be an exciting event not to be missed! The 2008 conference is a joint event with the Australian Cardiovascular Health and Rehabilitation Association, (ACRA), and will be held for the first time in Alice Springs.

The theme of the conference: 'Health at the Heart of Australia' focuses on cardiovascular health within the context of chronic disease. Keynote speakers include:

- Professor Garry Jennings Director, Baker Heart Institute,
- Dr Alex Brown Director, Centre for Indigenous Vascular Research, Baker Heart Institute
- Dr Marcus Ilton Cardiologist, NT Cardiac Services.
- Professor Melanie Wakefield Director of the Centre for Behavioural Research
- Dr Robyn Clark Research Assistant, Clinical Pharmacology Royal Adelaide Hospital
- Dr Sepehr Shakib Director of Clinical Pharmacology, Royal Adelaide Hospital
- Dr Nancy Huang Coordinator, National Clinical Guidelines, Heart Foundation.
- Professor Robert Newton Foundation Professor, Exercise and Sport Science, Edith Cowan University.

ACRA
AUSTRALIAN CARDIOVASCULAR HEALTH & REHABILITATION ASSOCIATION

CHRONIC DISEASES NETWORK

SACRA
South Australian Cardiovascular Health & Rehabilitation Association

Conference Registration

We invite you to register now for the conference! Early bird registration offers a discount rate as well as first choice of travel, accommodation and social events at the conference!

Book early to avoid disapointment!

Registration Fees

	Early Bird Registration (paid in full by 14/05/08)	Standard Registration (paid in full after 14/05/08)
Full Registration	350.00	450.00
Day Registration	200.00	250.00
Student Registration	100.00	100.00

Social Events

Conference Welcome Reception

Register early and join us the night before the conference, for an evening hosted by the NT Minister for Health, the Honourable Dr Chris Burns. A unique performance will be will be provided by the Western Desert Renal Choir – not to be missed - and drinks and nibbles will be served.

Date: Wednesday 13th August 2008

Where: Ghan Foyer, Alice Springs Convention Centre

Cost: Free (included in registration fee)

Conference Gala Dinner

Limited numbers are available for this unique dining experience so ***register early!!!***

Located within the Alice Springs Desert Park, Madigans has been built to reflect and include the spectacular surrounding landscape. 180 degree views combined with some of the best Territorian cuisine makes for an unforgettable experience. Madigans menus incorporate many styles of cooking and are designed to reflect the unique location in which the dishes are served. Native foods are combined with the freshest gourmet ingredients to produce a mouth-watering selection of dishes

Date: Thursday 14th August 2008

Where: Madigans - Alice Springs Desert Park

Cost: $130

Clinic Tours

Limited numbers are available for this unique experience so ***register early!!!***

The conference organising committee, Amoonguna, Santa Teresa & Hermannsburg Health Clinics are excited to offer delegates an opportunity to visit these clinics & communities.

Both tours are only available on Wednesday 13th August 2008 and seats are limited. The tours depart Alice Springs at 8.00am returning at approximately 4.30pm (pick up & drop off from hotel accommodation). The cost for each tour is $90.00 & includes transfers, entrance fees & lunch. Please note that cultural conditions apply.

Tour: *Amoonguna & Santa Teresa Health Clinics*

Date: Wednesday 13th August 2008

Cost: $90

Tour: *Hermannsburg Clinic & Mission Precinct Tour*

Date: Wednesday 13th August 2008

Cost: $90

To register – download registration brochure available at:

Chronic Diseases Network:
http://www.nt.gov.au/health/cdc/preventable/conference2008.shtml

Australian Cardiovascular Health and Rehabilitation Association:
http://www.acra.net.au/conference

For further information contact:

The Chronic Diseases Network

T: (08) 892 28280

E: chronicdiseasesnetwork@nt.gov.au

Chrissie Inglis,
ACRA (NT Rep)

T: 0409 697 324

E: murlis@bigpond.com

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

Arthritis & Osteoporosis NORTHERN TERRITORY

healthylivingNT

The Cancer Council Northern Territory

asthma foundation northern territory

mshr menzies school of health research

TOP END DIVISION OF GENERAL PRACTICE

General Practice and Primary Health Care NT

Heart Foundation

ABORIGINAL MEDICAL SERVICES ALLIANCE NORTHERN TERRITORY AMSANT

Central Australian Division of Primary Health Care"

Good Health Alliance NT

Northern Territory Government