

DRO

Deakin University's Research Repository

Lawn, Sharon, Battersby, Malcolm, Harvey, Peter, Pols, Rene and Ackland, Arlene 2009, A behavioural therapy approach to self-management: the Flinders Program, *Diabetes voice*, vol. 54, Special issue, pp. 30-32.

This is the published version.

©2009, International Diabetes Federation

Article originally published in *Diabetes Voice*, vol. 54, Special issue, pp. 30-32. Reproduced with permission of the International Diabetes Federation.

Available from Deakin Research Online:

<http://hdl.handle.net/10536/DRO/DU:30083832>

A behavioural therapy approach to self-management: the Flinders Program

Sharon Lawn, Malcolm Battersby, Peter Harvey, Rene Pols, Arlene Ackland

Chronic diseases, including diabetes, represent the most prevalent problem in healthcare today. They are the most common cause of disability and consume the largest part of health expenditures internationally. Most diabetes care is provided by people with diabetes and their family or supporters. Therefore, understanding how to enhance diabetes self-management is of primary importance in addressing this growing burden. The effective self-management of type 2 diabetes is closely linked to environmental factors and a person's lifestyle. In this article, the authors describe the Flinders Chronic Condition Self-Management Program, which highlights the person's perspective, and provide an example of its practical application in an Aboriginal population in South Australia.

Self-management is concerned with maximizing quality of life, avoiding unnecessary complications, and maximizing informal and formal supports, such as community social networks and input from healthcare providers. People with diabetes are entitled to opportunities to acquire the information, education and skills that enable them to participate in their diabetes management. Indeed, this is essential to successfully manage the condition and avoid unnecessary complications. For people to be actively

involved in their care, they must understand the condition, its effects and how to manage it. Good communication is essential – both between the person and healthcare providers, and among healthcare providers.

The World Health Organization has highlighted the importance of good communication and a close relationship with healthcare providers and other supports – categorized as 'collaborative management' – when a person attempts

to self-manage chronic conditions like diabetes. This collaborative management includes four main elements:¹

- collaborative problem definition – what the person sees as their main problem, not just what the healthcare provider thinks is the main problem
- targeting, goal-setting and planning – getting organized, knowing what steps to take to self-manage, having a plan and goals that the person sees as important, willing and able to achieve

- a continuum of self-management training and support services – services and personnel that know their role in providing support and work together to effectively support the person with a chronic condition
- active and sustained follow-up – being proactive, not waiting for new problems to occur.

Tools for supporting self-management

Diabetes treatment recommendations include a range of advice and information about diet, foot care, exercise, eye care and regular monitoring. However, this is no guarantee that the person with diabetes understands this advice or follows it. An innovative behavioural approach, known as the Flinders Chronic Condition Self-Management Program, seeks to understand a person's health status from the person's perspective, to understand the strengths and barriers that influence the way people approach their diabetes management and the way they engage with health services that offer self-management support. Often, these have less to do with the condition and much to do with the person's health-related values, their belief in their own capacity, as well as environmental factors. Understanding and addressing these underlying factors will influence self-management effectiveness and health outcomes.

The Flinders Human Behaviour and Health Research Unit developed the Flinders Program, a generic set of tools enabling health workers and people with diabetes to undertake a structured process that allows assessment of self-management behaviours and collabora-

tive identification of problems and goal-setting. These lead to the development of individualized, client-owned care plans to support self-management. The Flinders approach accepts that understanding and supporting motivation for behaviour change is essential. The tools include:

- the 'Partners in Health Scale', where the person self-rates their self-management capabilities
- a cue and response interview, in which the person and healthcare provider discuss those capabilities, and any barriers and strengths can be realized and motivation assessed
- a problem and goals assessment, where the person's main problem is identified and an agreed specific, measurable, achievable, realistic, timely (SMART) goal is set – creating a partnership between the healthcare provider and the person with diabetes in which the person is the decision-maker and the healthcare provider is facilitator, coach, and advisor
- a care plan, documenting the agreed issues, agreed aims, tasks to be undertaken, the person responsible for them, review date and progress.²

The Flinders Model is based on six internationally recognized principles for effective self-management:

- Have knowledge of your condition.
- Follow a care plan agreed upon with your healthcare providers.
- Actively share in decision-making with your healthcare providers.
- Monitor and manage signs and symptoms of your condition.
- Manage the impact of the condition on your physical, emotional, and social life.
- Adopt lifestyles that promote health.

The Partners in Health Scale and cue and response interview explore each of these in detail.

Different approaches to self-management support

The Flinders Program is one of a number of self-management support approaches. It is a one-to-one process with a healthcare provider. The Stanford course is a six-week, peer-led group programme run by trained peers or healthcare providers. However the two are entirely complementary. A person has an individual Flinders assessment with a healthcare provider in order to establish their short- and long-term goals, agreed tasks and education requirements. Once the person agrees that he or she requires a range of skills to assist with self-management, referral to a Stanford course is a common outcome of the care-planning process.

“Different approaches to providing self-management support engage people in considering self-management in different ways.”

Once a person has completed their six-week Stanford course, the tasks and goals established on the care plan and the skills learned during the course can be reviewed and supported by the healthcare provider over the next six to 12 months. These different approaches to providing self-management support involve and engage a person with diabetes in considering self-management in different ways.

Each approach has specific strengths and weaknesses. Improved understand-

ing of these can help healthcare providers to decide what may work best for their clients by considering the agency, its location and the people it serves. Peer-led group programmes can be run in the community or within community health service or hospital settings, depending on the needs of the person with diabetes.

Self-management care-planning approaches represent a highly effective means of communicating and organizing care where there are a range of healthcare providers within and across various service sectors. They can also serve as a useful process for constructing agreed plans between people with diabetes and healthcare providers who work largely autonomously, and where case-management approaches are the standard.

Using the Flinders Program with an Australian Indigenous population

The prevalence of type 2 diabetes among Australian Indigenous people is 3.4 times higher than in the non-indigenous population. In the recent 2004-2005 National Aboriginal and Torres Strait Islander Health Survey, one in 16 Aboriginal people were found to have high blood glucose or diabetes.³ These figures reflect broader concerns for health status and social disadvantage among these populations.

In 2001, the South Australian Department of Human Services (now 'SA Health') funded a 12-month Aboriginal Chronic Condition Self-Management pilot project on Eyre Peninsula, a remote region of South Australia, targeting diabetes.⁴ The core partners were Port Lincoln

Aboriginal Health Service, Ceduna Koonibba Aboriginal Health Service and Eyre Peninsula Division of General Practitioners. The Flinders Human Behaviour and Health Research Unit provided training and ongoing project support for Aboriginal health workers in these primary healthcare centres to conduct client-centred, self-management assessment and care planning using the Flinders Program tools.

“The most significant outcome was a reduction in average HbA_{1c} over 12 months – representing an overall reduction in risk of complications.”

After a three-month consultation process with the communities, each site recruited 30 Aboriginal people with type 2 diabetes. After assessment using the Flinders tools, the Aboriginal health workers then assisted the people to access support services and achieve their goals over the following months.

The most significant outcome of the use of the tools and the associated collaborative work between workers and people with diabetes was a clear reduction in average HbA_{1c} from 8.7 to 8.1 over all reduction in risk of complications. It was concluded that a diabetes self-management programme provided by Aboriginal health workers is acceptable, improves self-management and is seen to be useful by Aboriginal communities.

Sharon Lawn, Malcolm Battersby, Peter Harvey, Rene Pols, Arlene Ackland

Sharon Lawn is a senior lecturer at the Flinders Human Behaviour and Health Research Unit, Flinders University, Adelaide, Australia.

Malcolm Battersby is director of the Flinders Human Behaviour and Health Research Unit.

Peter Harvey is a senior lecturer at the Flinders Human Behaviour and Health Research Unit.

Rene Pols is deputy director at the Flinders Human Behaviour and Health Research Unit.

Arlene Ackland is education and training team manager at the Flinders Human Behaviour and Health Research Unit.

Visit <http://som.flinders.edu.au/FUSA/CCTU/default.htm> for more information on the Flinders programmes.

Visit <http://patienteducation.stanford.edu/programs/> for more information on the Stanford course.

References

- 1 Wagner E, Austin B, Von Korff M. Organizing care for patients with chronic illness. *The Milbank Quarterly* 1996; 74: 511-42.
- 2 Flinders Human Behaviour and Health Research Unit. *The Flinders Chronic Condition Management Program*, 2009. FHBHRU. Adelaide, 2009. (http://som.flinders.edu.au/FUSA/CCTU/self_management.htm)
- 3 Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Health Survey 2004-2005*. ABS. Canberra, 2006. (www.abs.gov.au/ausstats/abs@.nsf/Lookup/C36E019CD56EDE1FCA256C76007A9D36).
- 4 Battersby M, Ah Kit J, Prideaux C, et al. Implementing the Flinders Model of Self-management Support with Aboriginal People who have Diabetes: Findings from a Pilot Study. *Australian Journal of Primary Health* 2008; 14: 66-74.