The Better Living Diabetics Project

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In 2001 Goondir Aboriginal and Torres Strait Islander Corporation for Health Services based in Dalby (Queensland) in collaboration with the University of Southern Queensland in Toowoomba received funding from the Australian Government Department of Health and Ageing for the Better Living Diabetics project. The funding was allocated for projects with a Chronic Disease Self-Management focus under the Sharing Health Care Initiative (SHCI), being one of four national Indigenous SHCI projects. The following article is a consolidation of the progress of the project thus far with particular focus on the strategies and tools used, which have had positive outcomes.

The Better Living Diabetics project focuses on Aboriginal people who suffer from diabetes, with particular emphasis on non-insulin dependent people from all age groups. The project team works with diabetics and their families within the Goondir service region. Goondir Health Services has medical centres in Dalby, St. George and Toowoomba, with a health worker also based in Miles. The service area covers north-west to Miles, south–west from Miles to Bollon, south to the NSW border, east to Goondiwindi and north–east to Toowoomba. This area has an approximate Aboriginal and Torres Strait Islander population of 10,000 people. One important health issue identified within the client group in this area is that of Non-Insulin Dependent Diabetes Mellitus (NIDDM). As many health workers working in Indigenous health are acutely aware, diabetes is having an immense physical, social and emotional impact on Indigenous people right around Australia. Figures show that the incidence of diabetes is almost four times that of Non-Indigenous people [1].

The Better Living Diabetics project came about as a result of a small study undertaken in 2001 [2]. This study explored Indigenous people's experiences with diabetes and looked at what they believed would help them most to manage their illness. The Better Living Diabetics project is based on the findings of that study and incorporates not only the health care needs identified by the participants, but most importantly, uses an approach that is culturally appropriate. In short, this project provides what the clients said they wanted, in the way they said they wanted it, and we believe that this is the key to its success.

The goal of the project is to reduce the health impact of diabetes by educating sufferers and their families and facilitating change in relation to diabetes and lifestyle. Approximately 50 men and women with diabetes from Toowoomba, Dalby, Miles, Tara, St.George and Dirranbandi have been taking part in the project and are showing some improvement not only in relation to their diabetes, but their general wellbeing.

The strategies implemented in the Better Living Diabetics project can be categorised into two areas: 1. Education and 2. Clinical Support. Education occurred on two levels: education of project participants; and education and training of health workers and diabetes project staff. Most project participants expressed an interest or need to enhance their knowledge about their condition and how to manage it. Project staff needed to look at delivering such information in a way that was attractive and meaningful to the participants and empowered them to help themselves. In order to maintain good communication between the various communities and project staff, one willing participant from each location became the Diabetes Liaison Officer (DLO). The DLO's are a vital link between project participants and project staff as they take on a variety of tasks such as contacting participants when project staff are visiting, as well as organising various activities such as exercise groups or craft classes. DLO's were also involved in a number of training sessions on programs outlined further in this article.

One of the first ways of making contact with participants and delivering information about the project was via a newsletter entitled *Sweet Gossip*. *Sweet Gossip* is a monthly newsletter published by project staff and contains recipes

suitable for diabetics, any messages regarding the project, words of encouragement, special points of interest and other relevant diabetes information. The newsletter has been very well received by all participants and helps to provide information and education on a regular basis as well as keeping people abreast of the progress of the project. Another successful activity has been the introduction of regular cooking demonstrations. These are conducted by project staff on a bi-monthly basis and involve showing how to cook healthy, low fat meals using easily available ingredients and each participant receives a copy of the recipes. Following the cooking demonstration the food is shared among all participants and a lot of talk about food takes place during that time. Eating together enhances a sense of community and provides a good forum to talk about healthy food choices and exchange ideas.

The training and education of project staff, health workers and participants in relation to managing illness was conducted through the Flinders Chronic Disease Self Management Program. The Flinders Program encourages self-management of chronic diseases in conjunction with health care professionals through individualised plans that evoke change in health related behaviours. Initially health workers and project staff were trained in the application of the Flinders program thus being able to use the tools and skills learned in their communities. The training provided health care staff with a holistic perspective on chronic disease management as well as sound interviewing skills. A number of tools in the form of questionnaires and rating scales are used to identify health behaviour issues and areas that need to be addressed. The development and implementation of a care plan in partnership with the client, project staff and their general practitioner helps clients and health care staff to work toward set individual goals. These goals are reviewed on a regular basis and are altered if needed to suit changing needs. A symptom action plan is also used in order to help clients to understand their condition and take action if they are experiencing symptoms relating to their diabetes. The Flinders Program benefits clients directly by being able to identify areas where they lack understanding of their condition and looking at ways to overcome them. The care plans also serve as a partnership contract between the participants and health care staff, thus supporting participants in their journey to improve their health.

Another important training component involved the Healthy Weight program. This weight management and healthy lifestyle program has been developed by Queensland Health and caters for Aboriginal and Torres Strait Islander people who are over 18 years of age. The program covers a variety of topics which include low fat cooking and reducing fat in the everyday diet, shopping and physical activity[3]. To deliver the program to project participants, a number of health workers attended a 'train the trainer' workshop, which provided them with a competency certificate and the ability to deliver the program to Indigenous clients. Currently participants from Dirranbandi have attended the Healthy Weight program and responses have been positive. Participants expressed particular interest in food label identification and choosing appropriate food portions.

The clinical component of the Better Living Diabetics project encompasses a number of strategies. Evidence suggests that regular health screening decreases the risk of diabetes sufferers developing complications associated with their condition, such as blindness and foot ulcers [4]. To attend to the need of regular foot and eye check ups, allied health professionals were sought to assist with the project. Eye health of the participants was tested by the Eye Team of the Aboriginal Medical Service from Charleville. This team travels throughout Queensland once a year and provides free eye assessments for all Indigenous people. In order to promote foot health the project team arranged to set up a schedule of visits for participants to have regular check ups by a podiatrist. It was initially difficult to attract a podiatrist to travel to the rural areas, but eventually persistence paid off. All participants who wish to see a podiatrist can do so on a 3 monthly basis free of charge. During the visit participants receive a full assessment of their feet, treatment if needed and valuable education on how to keep their feet in good condition. The podiatrist visits have proven to be very successful, with good attendance and positive clinical outcomes. One participant commented that she was unable to exercise prior to the podiatrist visits due to the bad condition of her feet, but they have greatly improved and she is now able to go on regular walks.

An important part of the process was the support provided by project staff and health workers. Participants were initially informed of the dates the specialists were available, suitable appointments were made, reminder telephone calls undertaken just prior to the pending date and transport was provided for people who had access difficulties. This support enabled a greater number of participants to attend and ultimately helped to improve aspects of their health.

Another area of clinical interventions included the regular testing of HbA1c, which provides information on how effectively the individuals' diabetes is controlled [5]. The testing is traditionally done via a blood test at a pathology laboratory. At the beginning of 2004, the company Bayer provided one of their portable testing machines (DCA 2000) free of charge to the project. This machine can be taken anywhere and enables trained project staff and health workers to get testing results within minutes. Another important tool in the area of clinical analysis has been the purchase of a 'Cholestech' machine. Trained health workers can operate this machine and only a finger prick blood sample is needed to get immediate test results for a full lipid analysis (HDL, LDL, glucose, total cholesterol and triglyceride).

Since the implementation of mobile testing, project staff have been able to collect a much larger amount of data, as clients can be tested in the clinic or their home. The results can also be discussed with the participants thus providing instant feedback on how the participant is progressing. If participants show testing results that fall outside the recommended range, health workers will recommend that participants see the General Practitioner at the clinic as soon

as possible. The transportability and ease of use of both of the machines enables more frequent testing, with on-the-spot results. Additionally, participants can now be tested every three months, rather than the usual 12 month interval. During clinic visits participants are also weighed to establish their Body Mass Index, have their blood pressure taken and Blood Sugar Level tested. The combination of regular screening and health checks has greatly improved the participants' ability to control their diabetes in conjunction with their health professional and enabled them to gain a better understanding about their condition.

The Better Living Diabetics project is now nearing its end under the current funding arrangement. It has been a steep learning curve for everyone involved. Project staff were able to build extensive networks with a variety of organisations and health professionals throughout the last two years. This has fostered sharing of information and mutual learning. Without the support of a large number of people and organisations, in particular all the participants, the staff of Goondir Aboriginal and Torres Strait Islander Corporation for Health Services and the financial support from the Australian Government Department of Health and Ageing, this project would not have had the success it is enjoying today.

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