This Community Storybook celebrates the Riverland Aboriginal Chronic Disease Support Group, and shows how Aboriginal people from the Riverland in country South Australia are taking an active part in managing their long-term illnesses in partnership with health professionals. It tells how and why the group was formed, some achievements and benefits to date, and several stories and tips from individual members. It also describes how the Riverland Community Health Service is involved, some related activities in the region and how this work fits into a larger research project about chronic condition management strategies in Aboriginal communities. We hope this Community Storybook inspires and encourages Aboriginal people to take control of their health, and to live well despite their health challenges.

Yvonne Helps and Inge Kowanko
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Members of the Riverland Aboriginal Chronic Disease Support Group
Riverland Towns and Aboriginal Community Members of Barmera, Berri, Gerard, Glossop, Loxton, Lyrup, Renmark, Waikerie, Winkie.

Riverland Community Health Service Staff
Ms Jenny Boyd
Ms Emily Tinning
Ms Judy Riley
Ms Kate Blowes and Ms Trish Hancock
Ms Evelyn Theodorokakis, Ms Libby Birkmyre, Mr Nick Frangos, Ms Andrea Thomas and Ms Tania Hahn
Mr Heath Pillen and Ms Chantelle Hislop
Mr Francis Lovegrove
Mr Oscar Abdulla, Ms Natasha Lehane and Ms Michelle Wise

Chronic Disease - Healthy 4 Life Registered Nurse
Aboriginal Health Services Manager
Diabetes Educator
Senior Dieticians
Podiatrists
Dieticians
Transport Officer
Aboriginal Health Workers

Invited guest speakers
From the Aboriginal Health Council of South Australia, Flinders University of South Australia, Riverland Community Health Service, Country Health SA

Research team
Mrs Yvonne Helps
Dr Inge Kowanko, Associate Professor Peter Harvey and Professor Malcolm Battersby
Mr Alwin Chong
Mrs Kathy Chisholm
Mr Oscar Abdulla

Project Officer, Aboriginal Health Council of South Australia
Chief Investigators, Flinders University
Senior Research and Ethics Officer, Aboriginal Health Council of South Australia
Riverland Community Link person
Riverland Community Health Service Aboriginal Health Worker Link person

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### ABBREVIATIONS

- **AHCSA**: Aboriginal Health Council of South Australia Inc.
- **GP**: General Practitioner
- **HbA1C**: The HbA1C test gives an average blood glucose level over the previous 10–12 weeks from your sample.
- **LIFE**: Living Improvements For Everyone
- **RACDSG**: Riverland Aboriginal Chronic Disease Support Group
- **RCHS**: Riverland Community Health Service
- **RN**: Registered Nurse
- **Type II Diabetes**: Is a disease where the body has high levels of sugar in the blood and not enough insulin is produced or the body can’t respond adequately. It often runs in families, obesity is a major risk factor.
Inconsistent health service provision, poor coordination between services, and lack of staff capacity are ongoing challenges in the Riverland, despite the strenuous efforts of dedicated health professionals. Consequently Aboriginal people with chronic diseases have not always received the health care they need, with impacts on their quality of life and families. Early health service discussions indicated needs for better engagement with Aboriginal clients, chronic condition management training, and more peer support for people with chronic conditions. A community consultation conducted by Kate Blowse, Riverland Community Health Service senior dietician, in 2009 confirmed the desire for a support group. Consequently the RCHS Aboriginal health team, particularly Chronic disease and Healthy for Life Registered Nurse Jenny Boyd and Aboriginal Health Worker Oscar Abdulla, began plans to develop and maintain a client support group.

From 14 people attending the first meeting in May 2009 at Glassey Park community sports complex in Berri, the RACDSG has met monthly, achieving their 2nd birthday in 2011. Members decide on discussion topics (Table 1) and activities, such as cooking, jewellery making, weaving. The RCHS staff arrange visiting speakers, provide transport, hire the venue, prepare or order lunch and supply resources. Attendance numbers have steadily increased, with 39 people having attended the group over time.

Table 1 Health topics discussed at RACDSG meetings

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What makes the RACDSG successful

Unusually, the community wished the group to be open to men and women, with any chronic condition (not just diabetes), and be community-driven. Kathleen Sansbury, a founding member of the group, gave a presentation about it in February of 2010 in the SA Health forum ‘Only the Beginning Chronic Disease Self Management Support Beyond June 2010’ in Adelaide, identifying factors contributing to the group’s success: interesting speakers, transport, member input, learning to take control of their health, shared resources, community and health professionals interacting in a neutral environment. Comments from participants and staff confirm this view:

“You meet a lot of people, and you do a lot of talking, and you listen to the people’s stories. You communicate and you’re not sort of isolated.” - Yvonne Koolmatrie

“We just need to know when the meetings are and what’s going on then we can attend. …Part of what’s good about that group, you can do what suits you… You’ve got speakers and that, and you either listen to them or not, you know what to expect, so, it’s good in that way.” - Kathleen Sansbury

“It certainly helps the networking, and making sure that clients are getting that co-ordinated care and getting those referrals on and stuff like that, and just making, just helping with that follow through to happen for clients. Because we are… health is a bit of a mine field really, when you try and, you know, access different services, and you’ve got to jump through this hoop to do that, and all the rest of it.” - Jenny Boyd

Relationship to research

This Community Storybook was developed as part of a larger research project titled ‘Chronic Condition Management Strategies in Aboriginal Communities’, funded by the Cooperative Research Centre for Aboriginal Health over 2008-2011, and conducted by a team of researchers from Flinders University and the Aboriginal Health Council of South Australia. The overall goal of the project was to develop and demonstrate effective, transferable and sustainable chronic condition management strategies for Aboriginal communities.

RCHS was one of the project sites, along with Port Lincoln Aboriginal Health Service and Nunkuwarrin Yunti in metropolitan Adelaide. Briefly, the research project explored issues and contexts behind the chronic condition management strategies in use in each of three sites, found out what works well and identified barriers and enablers. Additional chronic condition management strategies were offered or supported through the project, depending on local priorities and capabilities. The processes, impacts and outcomes were assessed using multiple methods including interviews with clients and service providers. At RCHS the chronic condition management strategies provided through the research project included facilitating the RACDSG and providing training for staff in chronic disease self management.

Where possible, opportunities not usually within their reach to benefit clinic staff or the client community were facilitated through the project. As well as Kathleen Sansbury’s dynamic forum presentation, Aboriginal Health Worker Oscar Abdulla was mentored to submit an abstract, and subsequently co-present the story of the evolution of the RACDSG at the 6th Healing Our Spirit Worldwide 2010 Conference in Honolulu, Hawai’i.

The idea for this Storybook came from community members attending initial meetings of the RACDSG, where they were shown a range of leaflets and booklets about chronic conditions. One booklet in particular was of great interest: ‘Look, Think, Act: Indigenous stories about living with diabetes’ developed by researchers, health workers and Aboriginal Elders living in Port Lincoln. There were several requests from RACDSG members for a similar booklet to be produced as part of the current research project, to give a voice to the Riverland Aboriginal community living with chronic conditions. People signing informed consent to participate in the project were very keen to have their stories recorded, and the research team has worked closely with participants on the design and content of the Storybook.

Kathleen Sansbury is a no nonsense, tell it straight kind of person. She is also a kind person, a help in her community in many ways. She lives in Winkie, a beautiful little secret on the road to Gerard settlement, with husband John.

‘‘…our neighbours are kangaroos, magpies and lizards, it’s lovely it’s peaceful. We’ve got a goanna, a couple of goannas, and little ones because I’ve seen their tracks, and we’ve got those shingle back lizards…At the moment we’ve got a family of magpies that comes for breakfast, lunch and dinner!’’

In the past, Kathleen had not felt comfortable with the health professional helping her with her diabetes; the information was patchy and generic, not tailored to her.

What would be the things that work well, work best for you?

‘‘I go and see the podiatrist, and I go and see the people that do the mammograms. I make my own appointments. I think being trained as a nurse puts you in perspective of things too. It makes you aware everything what’s going on in your body.’’

‘‘…and you said before that the two of you are driving still, so transport’s easier for you and you’re able to access appointments…’’ ‘‘I think that’s the biggest thing in the Riverland, transport. A lot of people haven’t got transport.’’ ‘‘Do you think that the Peelies Bus sort of helps by going to the towns?’’ ‘‘It does, it does, for the people who haven’t got transport, and the people who aren’t confident enough to go to their doctor…’’

I asked Kathleen what things she does to control her diabetes, how she approaches looking after herself and John.

‘‘He eats what I eat, he’s happy with that. …I’ve worked out what’s good for me and what’s not. I eat a lot of veggies and a lot of salad stuff…I don’t mind shopping because I only go for certain things and that’s it. There’s some things have three lots of sugar in them, and I say to John, look at that, it’s got sucrose and glucose and whatever…fructose’’

‘‘I do a lot of gardening, and I like walking, I take my dogs for walks. I like being outside doing things. You know, out where we are, we’re on rain water and we haven’t got a hot water system, so I love going with the dogs, the wheelbarrow and going getting some wood…Sometimes when we need water we go down to Redbank, that’s near Gerard, and we go for an early morning swim…It’s beautiful down there, I like swimming.’’

Kathleen has had sadness from the loss of close relatives recently. I wondered how she manages to keep going in these times, and working at the local school as well.

‘‘I think the diabetes is keeping me mentally going. I know that sounds funny…’’

‘‘So I guess, it’s mainly things that you can’t have control over are probably the things that make life hard for you, but when those things come up you tend to focus more on your diabetes and try to get a bit of mental strength out of that?’’ ‘‘Yes.’’ ‘‘So that seems to be a strategy, but at the same time, I think you’ve already said to me that you recognise that it’s okay to have those times for grieving, so that’s a natural part of things.’’
“Oh yeah, then you got to pick yourself up and get going [because] it’ll come again.”

As well as looking for a positive angle on things, Kathleen loves her work with the children at Winkie Primary School. Their school motto is ‘Nurturing Children for Tomorrow’, and that’s something Kathleen enjoys and does well.

“That’s right, you’ve got to have a positive attitude (she laughs), I think that’s the main thing, a positive attitude….and I find my work is really good for me….hmm. And it gives me my space away from my husband, and he can have his space, and I can have my space (laughs), yeah, work is a big thing for me.” Work strengthens her sense of identity as well; “No, when I’m at work, I’m Aunty Nattie… at school.”

Kathleen is in a position where she can influence the children with education, and the belief that they can make differences themselves, to push away that barrier of thinking ‘I’m going to get diabetes anyway.’

“We could be getting them before they get to that stage: All the young people, there’s a lot of them out there that could have a better life. You can go out and do things that you want to do and eat moderately, and exercise and all that…but some people just give up.”

Kathleen was diagnosed with diabetes in 1996, and mostly her health needs have been met by the private clinic near her home. Her doctor started her on a care plan, but frequent staff turnover and long wait times for appointments at the clinic have been frustrating. Until fairly recently, Kathleen hadn’t had much contact with the Riverland Community Health Service and, like others in the community, she was not clear about the role of RCHS Aboriginal team.

“There’s a big misconception out there as to what these people are doing.”

Then she heard about a new group starting up to cater for Aboriginal people living with chronic diseases (the Riverland Aboriginal Chronic Disease Support Group).

“But we’re starting to use them now. I’ve joined a chronic diseases club, and I took John along also – he’s started to feel comfortable. We just need to know when the meetings are, and what’s going on.”

During the course of the Chronic Disease Management Strategies in Aboriginal Communities Project, Kathleen gave a seven minute presentation on the evolution and benefits of the RACDSG to a very receptive audience of Department of Health staff and health consumer group representatives. Kathleen was the only community member on the program, and her talk was the only one describing a client/patient’s perspective of living with chronic disease. Aunty Nattie, you’re a star!

**Riverland Aboriginal Chronic Disease Support Group Community Storybook | 5**

**You’re the Boss**

Take control – be a partner in your health

Use your local services – there are lots available for your needs

Be aware of ‘hidden’ sugars, like fructose, glucose, sucrose, lactose, honey, maltose

Grief and loss affects everyone – people cope & care in different ways

Education and moderation

Be there for the children

Prevention is better than cure
Cora came back to the Riverland around 26 years ago, and lives in Gerard. At the time we talked, she was having some time out in Renmark with Joseph, one of her sons. Cora had been in and out of hospital, and just needed some time to pick herself up before returning home to Gerard.

Cora is in her 60’s now, and has been living with chronic health problems all her adult life. She was diagnosed with lupus at twenty years of age, and other long term health problems including diabetes, kidney and liver problems developed later.

“I was thinking to myself, well, that’s what my sister had, that’s what my father had, and I’ve got them now. I didn’t have them a couple of years back.”

She manages with support from her son and others.

“My son is my carer. … I’ve got a worker that comes here once a week to help me.”

Cora’s sons look after getting her to health appointments, and she often has transport supplied by the Aboriginal Health Workers;

“They’re very good, they don’t leave me alone. They try telling me what to do, too!”

When I met Cora, sorrow and grief were overwhelming her; and in particular, funerals were very hard for her to cope with. Cora has seen so many of her close family pass, and the death of her husband in 2008 came in the midst of the loss of other family members.

“And I used to look after all of them. After they went I just didn’t want to live any more. I knew that my sister and my husband were sick, but I thought they’d pull through and it was just a shock when they didn’t pull through. When my husband died, I think it was the hardest time in my life, because I fell in love with him when I was nine, but I didn’t get stuck down with him until I was sixteen. We waited until we were about eighteen and then we lived together for two years before we got married. I think that was the hardest time in my life.”

Cora’s health went downhill, and chronic conditions were compounded by her seeking refuge in drinking and solitude. However, she found the strength and will power to stop drinking and attend to her health, for the sake of her children and grandchildren.

“It was just after my husband died, I think, when I started to drink. I was trying to kill myself, you know, I didn’t care until my kids all started going crazy at me, so I just gave it up. …… I’m not drinking alcohol [now]… It’s there where I can see it all the time just to say no. … I’ve got something to live for now.”

I asked Cora if there was a landmark in time, or something that triggered her to make the decision to stop drinking:
“I just started crying one day and had a look myself, what am I doing. I'm killing myself. And then I wanted to, but I didn't want to. As I said, I've got to make sure I get up. I go down but this time I went down, but I didn't want to go where I went before.”

Cora also makes efforts to think about her diet, because mobility is more difficult for her these days, and with less exercise it's harder to keep weight off. She's also keeping up with her medications and checking her bloods and sugars.

“I try to cut the fat off and have lean meat, and bought this thing [cooker] for myself, it takes all the fat out. I used to have a lot of fat, it's like I couldn't go without it, but now I have one piece of meat and that's it.”

When she's at home, Cora attends the Gerard clinic, and when she stays with her daughter in Berri, Cora goes to the Peelies Bus. Her children have her to stay so they can look after her, and although she doesn’t want to get in their way, she does enjoy her grandchildren.

“Oh I love to help with the grandkids, they're lovely, especially my two new grandchildren.”

Cora lost a much loved grandchild, with whom she and her husband had been very close, and they had helped bring him up. It was a harsh blow for both of them. Later on, another grandson was born.

“I've got two now, my son has a boy and my daughter's got the younger one. My son's got five girls too. I'm so happy. I know I've done some damage to myself but I still look forward to their upbringing and I hope, I pray, that I'm around until they reach about ten or something. Longer than that, I hope.”

We talked about what it would be like to go back to Gerard, how Cora might keep healthy and look forward to life with her family, children and grandchildren.

“I'm just going to meet it head on and do whatever it takes to make myself better. I guess I want to say, I'll try and help myself. I have an action plan – to help me stay sober. I look at my action plan, it's up in my room. I look and say, good one, you've done alright today.”

Take your tablets
Don't drink alcohol, even if everyone else does
Life is worth living
Love your family
Enjoy your food, but cut down on fat
Kingsley has been using the RCHS Aboriginal Health Unit services for a couple of years, and prefers to come into Berri (he lives with family in Gerard). Transport isn’t an issue for him; he has his own late model vehicle. He didn’t consider he had a chronic disease when Oscar and I spoke with him, although he did take medication for hypertension (high blood pressure), and he was fatalistic about developing diabetes:

“I don’t have any (chronic conditions), my dad has, not me. My family’s got a history of diabetes”

“So you don’t have diabetes yourself?”

“No, not yet. But I’ll get it later on down the track, I suppose. I’m actually doing quite well, I think.”

Lots of things need to be taken into account when looking at preventing diabetes. Kingsley’s mum, Sue, was diagnosed with diabetes in the past year, and she usually cooks at home for him. This could probably help Kingsley in avoiding developing Type II diabetes, but working night shift makes regular meal times difficult.

The security work involves a lot of walking, which is good for Kingsley’s fitness, weight control, blood pressure and overall feeling of wellness. All of these efforts are important, and it’s also important for Kingsley to keep motivated to continue to eat well and lose weight. He is aware that his weight has gotten away from him, and he needs to keep conscious of his size.

Kingsley felt that his work and community council commitments contributed to his elevated blood pressure.

“Are there any particular things that you do to set yourself up for being well, for being on a good balance with things?”

“Like sometimes I’ll go shooting just to relieve tension… kangaroos, rabbits, tracking something else…”

“Sleep and organising yourself for work is pretty important… Are you missing out on a lot of social things because you’re working at night, or do you still fit some of that in before you go to work at 11 pm?”

“Sometimes I’ll fit it in if I’m around the place, most of the time I just miss out because most of the activities, people do on Friday night and Saturday, but I’m normally working Friday and Saturday, so…”

We talked a bit about accessing health services, particularly in Gerard. Kingsley has his own transport, so he is not so reliant on the clinic there as some other community members.

“I’m just wondering how you feel about the mix of health workers here, and whether it coordinates well for you?”
“It’s a good little mix, but they just need to be more consistent when they go out to clinics. They need to be regular, ’cause when they have a break [like over Christmas], it breaks their routines, they [the clients] keep turning up.”

Kingsley already copes with hypertension, and believes he is a candidate for Type II diabetes down the track. He does have checkups, regularly has his blood pressure measured and other blood tests, and tries to stick to his mother’s good food. Kingsley does struggle with weight, stress and exercise, but having awareness of his health and where he needs help is really important in improving his condition and avoiding onset of Type II diabetes.

Your Aboriginal Health Team is there to help with checks, testing and advice, and can refer you to specialists in allied health areas to give you the best care for your condition. There are specialists in diabetes education, podiatry, diet, exercise and many other areas that you can access, and self help courses too. Booking in for an Adult Health Check with the RCHS Aboriginal Health Team is a good way to start, and you can be assessed for a Care Plan if that is appropriate.

Will I get diabetes later on?

Know and believe that you are worth looking after
You can take steps to prevent diabetes, or to prevent insulin dependence
Keep in regular contact with your health service
Keep a check on your blood sugar levels and other warning signs
Choose to eat a good balance of food
Make a decision do some physical activity at least 10 minutes a day

Living Improvements for Everyone (LIFE)

Is a training course to benefit Aboriginal people living with a chronic condition. It helps people to set goals, shows them ways to achieve those goals, and builds their confidence and ability to manage their condition better. The course also equips people to be leaders and peer supports to other people around them. It doesn’t matter what chronic condition you are living with, the program helps you as a person.
GROUP TALK

“Useful information, activities”

Mixing with people, just getting together, you know – Doris

Good to get out, instead of being stuck home. Having a joke, and that – Rex

Never give up hope! There’s always hope for you – Pat

“I’ve learnt a lot from others and getting to know people and learned a lot by getting together”

I wish more men would come along, to talk with the men that do come – Natalie

“It’s great, you learn a lot about yourself”

I like giving cheek to everybody! Anybody and everybody, no-one in particular – Maureen W

“I enjoy the healthy shared lunches (no salt!)”

I liked all the information, I haven’t been before – Dora

“I had a very good time”

I like getting out of the house and meeting people – Major

If you choose not to drink, you don’t have to hide. Take a special fancy glass with you. You’re a star, so shine!

Scenes from the April 2011 RACDSG meeting
“It’s good to come, I enjoy it — there are people worse off than me”

“Learning not to wait, speak up sooner” — Cheryl

“This group is good” — Flo

“I’ve slowed down — it’s good to come and learn and get motivated”

“I think it’s wonderful the group is expanding. We always get interesting stuff to think about” — Kathy

“They’re all good people”

“This is my first time at the group. A lot of positive learning today” — Pauline

“Keep exercising, no alcohol, physical activity, walking the dogs” — John

“It was good to come and listen to Nick about feet”

“I had stents in recently. I liked the information about calcium” — Dorothy

“It’s good, everyone being together” — Viola

Scenes from the April 2011 RACDSG meeting
Kathy was diagnosed with diabetes in about 2005. It didn’t come as a big shock because it runs in her family.

“Well, to be honest I was sort of expecting it because my mum had diabetes, my aunties had diabetes, my uncle, it’s in the family a fair bit . . . Not knowing any different and trying to understand I just thought, well it’s an automatic process . . . I’ve got a sister on [insulin] needles.”

Through her own efforts and questioning, Kathy has learned a lot about her health conditions, and is more in tune with her body and what it needs.

“I’ve learned now you can look after yourself more and avoid the insulin”

She has made big changes to her lifestyle in recent years, such as eating habits.

“Yeah I just eat when I want, but I know what I’ve got to regulate. Occasionally I forget . . . I used to eat cream buns, maybe one or two every day, because I worked it was the first time I had money, was near a cake shop, and that was just brilliant. Always went to bed with a coke and packet of chips at night . . . Now I drink Coke zero. I don’t take food to bed though, not anymore.”

Kathy attends appointments with her GP, and she appreciates how allied health services like podiatry can help with the side effects of diabetes.

“[The podiatrist] has a recall system, I go every six months.”

She is active in her community, and a council member at AHCSA, making for a busy life. Nevertheless, she is mostly managing her medications quite well, but sometimes gets out of routine, due to travel commitments.

“And if my routine changes in the morning, if I don’t do what I have to do before anyone comes I forget about morning tablets. Just throws me completely.”

Sometimes she has to take time out alone, for rest and quiet.

“So yeah I love silence, love my grannies. I look after myself and my grannies”

“I’ve got to be honest with myself. Some days I feel fine, but I have my bad days, miss my husband a lot. Still curse him now and again for going, but what can you do. I’m still growling, I’ll bring him [his photo] out Christmas Day, he can have dinner with me.”

I asked Kathy how she was going with measuring her blood sugars each day. When she’s feeling good she does well with her checking but when things get too much it upsets her to see the readings, and her anxiety probably makes it worse.
“I haven’t done anything for a while because when I was taking them [readings] it was I just going higher and higher and I was getting more agitated. So I thought no, stop it. So I stopped taking it and I haven’t had any dizzy spells or whatever. I know when I’m feeling crook, I go and have a sandwich.”

She sets herself challenges and feels more confident each time she has a win.

“And that’s the way I do things, I buy cream buns now and again, sometimes eat straight away or take them home and put them in the fridge and forget about them. I’ll keep them here and it’s how strong I got to be as to how long they last. I’ll have that later, and then I find it two days later, and I chuck it out, and I don’t consider that a waste of money. To me, that’s me being strong, and I really didn’t need it… And if I eat them I take out most of the cream.”

Kathy found information about diabetes was not always available, or was not well explained, by health professionals.

“Nobody explained … Our aunties were sick or something, but nobody said anything about diabetes. And when I did learn I just thought, well that’s the way I’m going to go.”

“Sometimes you go to people and they talk, and you think, what did they mean by that? Nobody wants to feel constantly silly, saying what does that mean? You walk out the door thinking, well, what does that mean? With my feet I’m finding out, every time I go to the podiatrist she tells me bits and pieces.”

Kathy has some good ideas about how health professionals might help people understand better.

“They need to tell you more about nitty gritty stuff. I’m finding out slowly from different people the effects that diabetes can have on you.”

“If they’ve got a new patient they need to diagnose, they need to talk to the patient a bit longer, explain a bit more stuff. I honestly think we need to have a group of Aboriginal people talking to the dietician, not with non Aboriginal [clients], because then we can ask the questions that we think are silly. Like they was raving on about when you go into the supermarket and read the labels, well a lot of people don’t read.”

Clearly, Kathy is managing her own health and setting herself up for long and active involvement in with her grannies and community.

“I want to see them grow up a bit more, another six seven years you know. I want to be around as long as I can do for myself. As soon as I’ve got to get someone to wipe my bum, that’s it. I want the lights put out.”

Kathy with her Riverland Aboriginal Female Elder of the year award, 2011.

Riverland Aboriginal Chronic Disease Support Group Community Storybook
Yvonne has lived in the Riverland since 1984, and has seen a lot of changes in the provision of health services over that time. To start with, she had to go to mainstream doctors and clinics, because there were no health services specifically for Aboriginal people.

“…there was nothing really in place you know, before it was really hard, you had to go mainstream, sort of do a lot of things on your own, you know. To get appointments done, and to get to them… I think a lot of Aboriginal people suffered through that with their diabetes and a lot of old people didn’t know what they had. But now we’ve got this service, it’s a good service [the Aboriginal Health Unit at the Riverland Community Health Service].”

Her own health care needs have also changed over the years. The introduction of the Peelies Bus, and its evolution from travelling eye care clinic to primary health care clinic has been a positive in her opinion, offering improved access to services as well as health education for Aboriginal clients.

“…it’s quicker to go to the Peelies bus and get an appointment done through that way because, if it comes from mainstream you’ve got to wait about three or four weeks to see a doctor. But it’s good that we got the Peelies bus, and we got people like you, you know, coming and having discussions with us [at the Support Group], and its educating, which we need… education. The right foods to eat, how much sugar is in this and how much sugar is not in there if it’s salty. I used to have sugar in my tea, but now I have Equals. I have Weetbix in the mornings with nothing on it, just milk, or maybe I put a piece of fruit.”

Yvonne was diagnosed with Type II diabetes in 2009. We talked in December that year. I asked Yvonne how she felt earlier in the year, when she got the diagnosis of Type II diabetes.

“I just thought to myself, well I’ve got it and I’ve got to learn about it, what is diabetes? So then I started reading up, and seeing what food to eat, and how to keep it under control, so I never really panicked. I just thought to myself, it’s up to me to control it. I take my reading in the morning and if it’s not bad, then I’ll take another reading and I’ll compare the two readings. I like it to be around…not a double number.”

As much as eating the right foods, Yvonne realised that it’s also about how much of each food group you eat.

“Everything in moderation. You know, you can have a piece of chocolate, in moderation. You don’t eat the whole chocolate, you know.”

There have been a lot of tragedies in Yvonne’s immediate family, a lot of sadness. Over the years she has kept going for her children when they were young, and now also for their young children.

“…it’s very important for children to go and get educated, and have a bit of schooling, because that’s the most important thing for Aboriginal people, because later in life, they can’t function. A lot of them will go to drugs and alcohol, they can’t get employed because they haven’t got the qualifications. I sat [lived] in one place for sixteen years to educate my kids, never consumed alcohol in my life – it was horrible what I seen alcohol done to people around me. And I wasn’t interested in alcohol, that’s the secret. I just make the best of my life, like I said, alcohol is a ruination.”
Anniversary dates are particularly difficult, but the love and company of other family members help during those times. Yvonne remembers experiencing long, low times when her children were very young, and now deals with feelings of loss and grief in ways that keep her positive and calm — before, her feelings made her mind numb and normal life was a struggle. Every time she faces a challenge learning to live with and manage her diabetes, Yvonne thinks back over traumatic events in her life and about how she has gotten by, even grown stronger. With all that life experience, she said;

“You think I can’t cope with diabetes?”

Yvonne is a master weaver, and has pieces on display in the South Australia Museum in Adelaide, and has exhibited internationally. Weaving is a therapy for her, and other people who learn to weave through her workshops find it therapeutic too. This activity really lends itself to sitting and yarning, looking at the sedges and taking time with your thoughts.

“Yes, weaving has helped me a lot. I’m creative, but then I get ‘deep’. When I’m weaving, I run workshops, and in those workshops you meet a lot of people, and you do a lot of talking, and you listen to the people’s stories. You communicate and you’re not sort of isolated, you’re not sitting there, and just dwelling on the past, you move on, so you’re talking to other people who have gone through similar experiences what you did. It just made me strong, it’s just made me stronger, you know?”

Yvonne, along with several other community members, took part in the Flinders Program of chronic disease management training for 10 RCHS staff, volunteering to be a case study. This meant that the health workers could practice their learning on real clients, and also achieve the first stage of creating care plans for chronic condition clients in their care. Yvonne’s daughter in law Michelle is an Aboriginal Health Worker, and brought her along. What happened for Yvonne through that process?

“… this is all new to me, it was all new to me and I was still learning, you see. The goals — it taught me to reach goals now. Which just gives me a better understanding that I didn’t have before … and it’s good to come in to learn about your self, you know, our health and all that. There is goals that I do want to reach, you know. I don’t know if I will or not, you know, but I’m a strong person so when I make up my mind ….”

I asked Yvonne whether going through the care planning process had made other services more available to her:

“That is true. I didn’t know there was services that was available, now I find that there is a lot of services out there. I’ve done everything by myself until, you know, recently, and when I come in now, I know that there are other services that I’m starting. All those years … [now] I’m starting to use those services.”

Strong you

Making ‘good’ time for yourself
Lead and support children
Encourage reading and school
Keep learning and understanding about your health
Accept it, deal with it, control it
Everything in moderation
Eat well, avoid alcohol
The Peelies Bus was launched in October 2002 as a travelling eye clinic, ‘Peelies’ being the local term for eyes. This initiative took several months to implement, and was initiated through the identification of barriers to accessing services in the Riverland, in particular, the Families SA partnered Vision Impairment Prevention and the Yanninminden (wellbeing) projects established in 1999, and the Ngarrindjeri Ngangkari project in 2000. In 2003 the Riverland Division of General Practice and the Riverland Regional Health Services Inc. joined Families SA in a service agreement to maintain and operate the bus. The continuity and consistency of the services offered have changed over time, mainly due to funding and staffing difficulties, but remains as the major ‘shopfront’ access to health services for the Riverland Aboriginal community. The service travels on a regular roster to Loxton, Barmera, Berri, Renmark and Waikerie, and operates in Gerard community, making use of the purpose built clinic in lieu of the bus.

A Day in the Life, Tuesday, 4th November, 2008

The bus is kept in a yard at Rosenthal Automotive at Berri, and today Yvonne Helps is riding along to see first hand how the service operates.

12.00pm Murray Harvey, the driver from Townsend’s Transport, arrives to prepare the bus for the run, this time to Loxton. With everything in good order, it’s time to go.

12.30pm We head off in the shiny white bus, gaining a lot of looks at the Aboriginal art painted on the sides, and the eyes with attractive long eyelashes painted on the front. Along the outskirts of Berri and over the bridge, what a view. Bowling along, people wave as they pass us in the overtaking lanes on the steep inclines on the approach to Loxton.

12.55pm In the town traffic Murray negotiates the bus neatly into its place, marked out by the council with orange witches hats between sections of the plantation separating the lanes. Murray collects the key from the council to hook up power, and stabilises the bus. While I give the floor a sweep, Murray cleans down the surfaces. The outside shade goes up, ready for the Aboriginal Health Workers and clients.
01.15pm Lyn from the Berri office of Medicare arrives, followed closely by Aboriginal Health Workers Oscar Abdulla, Michelle Wise and Natasha Lehane. Now it’s up to the clients to come and make use of the service. Lyn talks to clients as they wait to see a health worker, checks their Medicare details, registers them if they don’t have a current card. To start the process, she helps clients to complete an Aboriginal and Torres Strait Islander enrolment form, which is required for proof of identity for Medicare. Lyn can also reissue lost cards, helps to sort out lost cheques, adds new babies to family cards, can record Aboriginal and Torres Strait Islander status to existing records, and performs general checks and updates. If a client has no card, as a Medicare agent Lyn can fill in a form to present to the chemist to ensure they get their prescriptions at the subsidised price.

Point of Care tests by Aboriginal Health Workers on the Peelies Bus can be the first alert to a client that they may have indications of a chronic condition. For example, they are able to take and analyse a blood sample to measure glucose levels, which can help a person with Type II diabetes keep on track, or may flag a client who is undiagnosed, or at risk of the disease. Other tests can also be performed, with results entered into the on board computer for doctor reference. The Aboriginal Health Workers assess each client’s needs, make appointments for doctors, allied health services, x-rays and scans, and can also arrange transport. If a GP or RN is on the bus, the Aboriginal Health Workers can also give immunisation for Gardasil, triple antigen and influenza.

04.00pm At the end of the allotted time, the Peelies is packed up and wiped down again. The Health Workers return to Berri to complete their records, and the Bus returns to Rosenthal’s, ready for the next run.
Not having a permanent clinical shopfront, the Aboriginal Health Unit works from the Riverland Community Health Service in Cornwall St, Berri, and their main points of contact with clients are through home visits, attendance at Gerard clinic, attendance on the Peelies bus at one of the 5 major Riverland towns on its schedule, and hospital visits. Perhaps because of the structure in which they work, the staff of the Aboriginal Health Unit are becoming innovative in promoting access to services and uptake of programs.

The Aboriginal Health Unit staged the Moorundie (river) Ruwe (country, or land) Nunga Health Expo on Wednesday, May 12th 2010 at Glassey Park, Berri. It was a well organised and highly collaborative undertaking, and congratulations go to the organisers for the professional yet approachable way in which they engaged with Aboriginal clients and families. Aboriginal Health Worker Oscar Abdulla made a special point of emphasising the enormous volume of co-ordination and networking that was involved in successfully staging this event, with most of the credit due to Registered Nurse Jenny Boyd, whose special talent is being able to bring out the best in the team and stretching them to aim high, all with no fuss, down to earth attitude.

Eighteen different stalls or ‘stations’ showcased the staff and services who care for Aboriginal clients in the Riverland, at which visitors could get checkups and sample the types of things available through the Riverland Community Health Service. Everyone came away with a show bag of samples and information to mull over at home.

While at a glance it may have appeared to be a casual affair, it was in fact, a highly organised interactive event, with health benefits for all participants. Upon arrival, attendees were registered before entering the building to access the first checkpoints. Registration entitled all Aboriginal persons aged 15 years and up to an Adult Health Check. This was explained and consent to proceed from each individual was gained. The information enabled the attendees to be registered as clients of the Riverland Community Health Service, if they were not existing clients. Some health checks were mandatory, and some were optional, so clients were aware up front and could choose to go ahead or not.

As the clients proceeded through the various checkpoints, they completed a checklist with a qualified worker in that area of health, who could then identify and record the client’s needs and problems, goals, required treatments and client actions, and could also recommend referrals for specialised treatment. For each health area there was also a page handout explaining different facets of care and where appropriate, self check information.
As you would expect, eye, ear, bladder, diabetes and the usual health areas were all represented, what you might not expect was on the spot immunisation, comprehensive hearing testing, vision testing, and dental checks carried out by an attending dentist and dental nurses. The inclusion of not only emotional health, smoking, physical activity and nutrition, but carer’s support, alcohol and other drugs, and a financial health check was impressive.

It really was a one stop, top to toe and all inclusive health assessment. It is likely that many people who made use of some of these services would probably not have the opportunity to do so elsewhere, and certainly not in the safety of the environment created and maintained by the combined health providers on the day. Whether it was information and assistance to help deal with a relative’s problem, or to directly improve their own health, there seemed to be a level of confidence in the professionalism of the health workers, and a commitment to action, or partner in health from the clients.

The provision of a brief but formal assessment by professionals in several areas, including dental, emotional wellbeing, alcohol and other drugs and smoking, has the potential to literally change and improve the way clients will be able to live. Moreover, the service support can help enable them to meet goals they have set for themselves, but were struggling with through lack of knowledge about and access to services.

Not ignoring the creature comforts on what turned out to be a breezy and chilly day, hot pumpkin soup, tea and coffee were available throughout, as well as a substantial lunch.

The finally checkpoint was set up inside the Peelies Bus, which is used as a mobile unit in the five major Riverland towns. At this point, a health worker checked that the mandatory stops were completed, and answered any queries. The client was then consulted by one of two participating GPs, and referrals were signed off on.

What a massive undertaking, with huge co-ordination and effort from all involved. It is estimated that over 70 people attended the event, with 58 being registered for adult health checks. Of those, 17 were signed off by a GP on the day. The real test on Riverland regional resources now will be working through all the referrals and follow ups generated from the Moorundie Ruwe Nunga Health Expo. Go Aboriginal Health Unit, Riverland Community Health Service and the Aboriginal community, amazing effort!
There is no Aboriginal community-controlled health service in the region, and Aboriginal clients rely on ‘mainstream’ services such as local GPs and the Riverland Community Health Service (RCHS), a part of Country Health SA, for their day-to-day health needs. The RCHS head office in Berri houses a small Aboriginal Health Worker team, a Chronic Disease/Healthy for Life Registered Nurse and some allied health staff. General practitioners work from surgeries located in the various Riverland towns, most GPs are associated with the Riverland Division of General Practice. The Peelies Bus is a mobile clinic for Aboriginal people, open two days per month in each of the major Riverland towns in turn. The Gerard Community clinic also operates two days per month. Aboriginal Health Workers and others from RCHS assist clients with chronic conditions to access services.

Interviews with staff and Aboriginal clients of the RCHS were conducted as part of the research project ‘Chronic condition management strategies in Aboriginal communities’ in order to explore the way that long-term illnesses are identified and managed in the region, to identify problems and implement potential solutions. The interviews highlighted that Aboriginal people with chronic conditions have not always received the health care they need, affecting their quality of life and impacting on their families. The main problems relate to inconsistent health service provision (e.g., there were several months when Gerard clinic and the Peelies bus were not operating), poor coordination and information-sharing between services (especially between the RCHS and GPs), lack of staff capacity and training.

Jenny Boyd is a Registered Nurse working with the Aboriginal Health Team at the RCHS since early 2009. She has responsibility for chronic conditions and the ‘Healthy for Life’ program in the Riverland. When we first interviewed Jenny she explained some of the problems she encountered in identifying and keeping track of clients with chronic conditions, and her plans for improvement.

“I am assessing how things are being done at the moment, trying to improve the way things are being done, and trying to get better continuity of care for clients around their chronic disease, to try and improve their outcomes, because at the moment things seem to be a bit ad hoc and opportunistic … I think we need to start with the basics first in regards to cleaning the data, making sure that everything is up to date, getting the recall system and that happening. And then I think after a few months look at the chronic disease management plans, and any assistance or ideas in regards to what you might see in other services and what forms and processes they might take … So it’s about improving our processes with documentation and stuff like that, to be able to report on it, and hopefully develop systems that have better outcomes for clients. That’s the idea in the long run.” Jenny Boyd

Some staff took part in the Living Improvements for Everyone (LIFE) course, a peer support program specifically for Aboriginal people with chronic conditions, offered through Country Health SA during 2009. LIFE complements the Flinders Program of Chronic Disease Management, and helps clients take control of their health.

Staff trained in the Flinders Program of Chronic Disease Management, a strategy known from previous research to be successful was undertaken through the project in October 2009. This is being rolled out nationally via Closing the Gap agreements.

The training equips health professionals to develop care plans in partnership with clients, focusing on individual client’s problems and goals. Ten RCHS staff took part, including nurses, allied health and AHWs, with clients volunteering, initiating their care plans. Few staff completed the training, lacking time and confidence.

Recognising that comprehensive care planning might be difficult to achieve in the Riverland at present, Jenny Boyd has developed an Action Plan template based on the above programs. Clients who are willing and confident to take an active role in managing their chronic conditions work with a member of the health team to set an achievable long term goal, specifying a monthly action plan (shown opposite). So far there are 2 clients progressing with action plans, and more are thinking about starting. They are already proving to be helpful, for example;

“I’ll try and help myself. I have an action plan … I look at my action plan, it’s up in my room. I look and say, good one, you’ve done alright today.” Cora Sumner
Long Term Goal and Monthly Action Plan

Long Term Goal
Over the next 6-8 months I will ____________________________________________________________
______________________________________________________________________________________
My confidence level is ________________________________________________________________
(0 = not at all confident; 10 = totally confident)

Monthly Action Planning
In writing your action plan, be sure it includes:

- What are you going to do
- How much you are going to do
- When are you going to do it
- How many days a week you are going to do it

For example: this month, I will walk (what) around the block (how much) after lunch (when) three times (how many) per week

This month I will:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

How confident are you?
_____________________________________________________________________________________
(0 = not at all confident; 10 = totally confident)

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