

SECTION 7

Community groups with specific needs

Rural and remote communities

In Australia 34% of the population live in either a rural or remote area.¹ The disadvantages for rural and remote South Australia (SA) occur in two areas.

1. People living outside the metropolitan areas have higher rates of mortality and morbidity than people living in metropolitan areas.²
2. Recruitment and retention are problematic for those health professionals with specialist skills.³

In addition, South Australian data also highlights that;

- In 2007, SA had 82,500 adults (age 16 years and over) living with diabetes in country areas.⁴
- Comparisons done between metropolitan Adelaide and country SA in 2005 found the prevalence of diabetes to be significantly higher in country areas – 10.2% compared to 7.8%, a 2.4% difference.⁵
- There are 191 children living in country areas who have type 1 diabetes, 29 of these are on insulin pump therapy.⁶
- There are 127 young adults between the age of 18 and 25 with type 1 diabetes living in country SA, with 64 of these on insulin pump therapy.⁶
- 44% of people with diabetes in SA have high cholesterol levels.⁷
- Persons living in rural and remote regions generally have worse health, in terms of mortality, hospitalisation rates and risk factors compared to those living in metropolitan areas.⁸

Caring for people in a rural or remote setting brings with it all the challenges of distance, isolation and limited access to specialist support services. Strategies such as developing networks at a local, regional and state-wide level can help to overcome some of the barriers.

Major rural centres generally have a core range of health professionals eg diabetes educators, dietitian, podiatrist, physiotherapist, optometrist or ophthalmologist. For health professionals working in smaller health services within a larger cluster of health services, virtual teams can be set up to facilitate access to specialist support and information / education for people with diabetes in their communities.

Rural and remote areas are home to people with all types of diabetes. It is important that diabetes services in rural and remote areas are cognisant of the fact that they play an important role in providing and facilitating best practice in diabetes education.

For example, in a rural area there may be people with type 1 diabetes, children and adolescents with type 1 diabetes and at times some with type 2 diabetes. The geographical area may also have women with gestational diabetes and women with pre-existing type 1 or type 2 diabetes who are pregnant. It is important that education services do not ignore the education and support needs of these groups. If education services do not have the expertise to provide education in these areas it is essential that the service facilitate access in some way (eg distance technologies) to ensure access to education and support for all people living with diabetes in rural and remote areas.

Indigenous communities

Diabetes is a significant cause of excess morbidity and mortality among Aboriginal and Torres Strait Islander people.⁹ Type 2 diabetes occurs at a higher rate and at a younger age than that of non-Indigenous people.¹⁰

- South Australia has the most geographically isolated Aboriginal communities in Australia.¹¹
- 45% of Aboriginal communities live more than 250kms away from a health service.¹¹
- Diabetes shows up some 10 years earlier in Indigenous people than non-Indigenous.¹²
- Diagnosis of diabetes in Indigenous people in 2004-05 were double that of the non-Indigenous population.¹²
- In 2006/07 the crude hospitalisation rate for diabetes was 3.3 times higher for Aboriginal people compared to non Aboriginal people.¹¹
- In 2006/07 the crude hospitalisation rate for renal disease was 8 times higher for Aboriginal people as compared with non Aboriginal people.¹¹
- Ischemic heart disease and type 2 diabetes are leading causes of premature mortality in Aboriginal people.¹¹

Many of the complications from diabetes can be prevented with the appropriate community based primary health care interventions.¹³ Structured approaches are needed if outcomes of Indigenous Australians are to be improved. A structured approach consists of a shift from reactive care to proactive care. Aboriginal health services require systems of care which ensure early detection and care planning with clients. Registers and recall systems which are linked to appropriate action are integral to this process.¹³

The Strategy for Aboriginal & Torres Strait Islander people;¹⁴

- To implement regionally coordinated knowledge management processes.
- To develop collaborative diabetes implementation plans.
- To provide coordinated ongoing workforce development programs.
- To develop and implement effective organisational capacity building initiatives.

In Australia, State funded health services provide services to the whole community. In some areas the Aboriginal Community Controlled Health Services (ACCHS) are also providing primary health care services specific to Indigenous communities. Which ever service is available, it is essential that regional and ACCHS work together to ensure access and equity of service.

The roles of Aboriginal Health Workers (AHW's) within the community health teams of both state funded services and Aboriginal Community Controlled Health services is integral when working with Aboriginal people with diabetes. Some AHW's are also trained as diabetes educators and should provide the majority of education and support. AHW's assist with providing culturally appropriate care.

There are many resources available which are specific to Indigenous communities.

- Diabetes Australia – Northern Territory
www.healthylivingnt.org.au
- Diabetes Australia – Victoria
www.diabetesvic.org.au
- Diabetes Australia – New South Wales
www.diabetesnsw.com.au/about_diabetes/indigenous_introduction.asp
- Australian Indigenous Health Information Net
www.healthinonet.ecu.edu.au/chronic-conditions/diabetes

Culturally and linguistically diverse communities

Many culturally and linguistically diverse (CALD) community groups have a high prevalence of type 2 diabetes compared with the non-Indigenous Australian-born population. A combination of genetic, biological, behavioural and environmental risk factors are thought to be related to this higher incidence.

As people migrate to a country like Australia (western culture) they may start to adopt some of the lifestyle behaviours eg eating a greater proportion of high-energy dense foods or reducing exercise levels. Such changes can lead to excess weight gain, thus increasing their risk for type 2 diabetes.¹⁵ Furthermore research highlights that migrants are at a high risk of diabetes complications due to the many barriers that they face when accessing health services. Barriers include:¹⁶

- language
- literacy (in English and native language)
- stigmatisation
- lack of access to culturally specific care
- religious beliefs and cultural practices.

It is important to recognise that religious beliefs and / or cultural practices can affect the person's ability or desire to self manage. There may be different perceptions of what actions will have a positive effect on health across various cultures.

Diabetes health care should be:¹⁶

- culturally specific
- incorporate the diet, beliefs and attitudes of the cultural group
- foster increased understanding, interest and participation.

Health professionals need to be aware of special circumstances that could be a risk for the client eg Muslims wishing to fast during Ramadan. Health professionals will need to work with clients to ensure that safety is maintained during this period.^{17, 18}

Culturally specific resources can help with these situations and Diabetes Australia does provide a national Multilingual Internet Resource for consumers and health professionals.¹⁹

In Australia organisations such as the Migrant Resource Centre can be invaluable when working with people from CALD backgrounds.

Children and adolescents

Type 1 diabetes is one of the most common diseases of childhood and adolescence. Results for the period 2000–2006 on the incidence of type 1 diabetes show the rate is increasing in Australia at almost 3% per year.²⁰ Type 1 diabetes in children and adolescents is a serious, life-long disease that causes a major health, social and economic burden for individuals with the disease, their families and the community.^{20, 21} There is also an increasing prevalence of type 2 diabetes in children²¹ but at present there are considerably less children with type 2 than type 1 diabetes.

Current guidelines recommend that children and adolescents should have access to care by a multidisciplinary team trained in childhood and adolescent diabetes.²¹ In rural and remote areas the local team should work in a shared care arrangement with the appropriate tertiary level diabetes service.

Children

Children with type 1 diabetes require insulin from diagnosis and insulin requirements will change as they grow into adulthood. It is becoming more common for children to be on an insulin pump or on multiple dose injections (MDI) from a very young age.

In children with type 2 diabetes, lifestyle education remains the foundation of management. All education should be done as a whole of family approach.

Adolescence

The management of diabetes during adolescence can be difficult for a myriad of reasons. Firstly, puberty is associated with insulin resistance and so many young people require more insulin than what is usually needed for their weight. Other issues such as alcohol and illicit drug use, dating, sex, contraception, driving, employment, study and sport must be discussed in a non judgmental way.

All children and adolescents in school or child care must have a care plan that has been developed in consultation with the paediatric service, parents and school staff. For more information, visit www.decs.sa.gov.au (Department of Education and Children's Services).

Transition to adult services

Young adults with diabetes pose a challenge because they fall outside the focus of the paediatric and the adult clinics. Many of these young adults are at risk of 'falling through the gaps' which puts them at high risk of acute and long term complications.²²

Young people with diabetes need support to stay connected to their diabetes health professionals. Resources such as www.realitycheck.org.au can be invaluable for young people as the website is written by young adults who have type 1 diabetes. The website has many stories and real life accounts of what it is like to live with type 1 diabetes 24/7.

People with mental health / illness issues

Individuals who live with psychotic disorders and other mental illness have a higher prevalence of type 2 diabetes as compared with the rest of the population.²³ This higher prevalence relates to the illness itself, poor dietary habits, lack of exercise and the direct or indirect effects of antipsychotic and other psychotropic medications.^{23, 24} A diagnosis of diabetes has also been shown to double the odds of depression.²⁵ Conversely a diagnosis of depression can double the risk of developing type 2 diabetes. Depression can also increase the chance of developing complications. It is important to provide people with the appropriate supports and resources. BeyondBlue has a fact sheet called 'Depression and diabetes' at www.beyondblue.org.au and SANE Australia has also produced a resource called 'The SANE guide to good mental health'. For more information, visit the website at www.sane.org.

Medications used in mental illness

Second generation antipsychotic (SGA) medications are widely used in conditions such as schizophrenia, bipolar disorder, dementia and psychotic depression. The use of SGA medications have been associated with reports of dramatic weight gain, type 2 diabetes and changes in lipid profiles.²⁶ It is for this reason that all people taking antipsychotic medication should be regularly screened for diabetes and its associated risk factors.²³

There is also a possibility of diabetic ketoacidosis in clients taking SGA medication and clients need to be assessed for and aware of the signs and symptoms of hyperglycaemia.²⁶

Education and support

People who live with a mental illness need ongoing support and education. Diabetes knowledge has been demonstrated to be lower in populations with mental illness as compared to the general population.²⁷ Frequent repetition of important information is beneficial for all people with diabetes but it is critical for clients with a psychotic illness.

Health professionals who care for clients with mental illness should encourage healthy nutrition and activity as these can improve metabolic parameters even when there is no weight loss.²³

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