It's good to talk: Using conversation maps in diabetes education

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Article points

1. Structured education is an essential part of diabetes care; education programmes should be flexible and responsive to individual need and must fulfil NICE criteria.
2. A 3-month study was set up to trial the use of the Conversation Map tools; evaluations were mainly positive.
3. DESMOND is widely used in the community; it may not meet the needs of all local populations. The Conversation Map tools is an alternative educational programme that was used with positive benefits in Enfield.

Key words
- Conversation maps
- Structured education
- Type 2 diabetes

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Structured education is an integral part of diabetes care. DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) is the most familiar education programme in use. However, in Enfield DESMOND did not always provide flexibility to cater for the diverse educational needs of local ethnic minority groups. This article describes the author's experiences of using the conversation map tools to provide type 2 diabetes education to the local population of Enfield.

Type 2 diabetes is a chronic, progressive condition, which, if not managed correctly, can lead to serious complications such as lower limb amputation, blindness and renal failure; it also carries an increased risk of cardiovascular disease. The person with diabetes needs to be able to self-manage their condition, making informed choices about their care such as medication, dietary decisions, activity and monitoring. To do this people with diabetes require information and support from healthcare professionals. (Department of Health [DH], 2001; Diabetes UK, 2006).

Education is a fundamental part of diabetes care. It should improve knowledge and skills, allowing people with diabetes to take control and integrate self-management into their daily life

The National Service Framework (NSF) for diabetes standard 3 (DH, 2001) encourages the empowerment of people with diabetes and the provision of services that encourage decision-making and support in managing their condition in "an appropriate language and format". NICE (2003) recommends that structured patient education is made available to all people with diabetes at the time of diagnosis and on an ongoing basis. NICE also recommends that the education provided should reflect the principles of adult learning and should be provided by an appropriately trained multidisciplinary team.

Structured education programmes, while planned, should be flexible and responsive to individual needs (NICE, 2003). The Department of Health and Diabetes UK (2005) identified key criteria that should be met to fulfil the NICE requirements. Programmes should:

- Have a patient-centred philosophy.
- Have a structured curriculum.
- Have trained educators.
- Be quality assured.
- Be auditable.

Background

Education programmes before 2003 did exist, but there was no evidence or guidance as to their effectiveness. The NSF (DH, 2001) and NICE (2003) guidance led to the setting up of the DESMOND (Diabetes Education and Self Management for Ongoing and

Newly Diagnosed) Collaborative group. The DESMOND programme launched in 2004, and is currently the most familiar education programme provided in the UK. It includes a training and quality development programme and meets the requirements of NICE (2003) and the NSF for diabetes (DH, 2001).

DESMOND is delivered by two trained educators, usually healthcare professionals such as practice nurses, DSNs or dietitians. The educational session takes place over 6 hours – either two half-days or one full day. It is delivered in the community to a maximum of 10 people who can choose to bring a friend or family member. It has a theoretical basis with a written curriculum and clear philosophy that ensures consistency. Since the success of the DESMOND programme, a foundation programme for people with established diabetes and a programme that is culturally appropriate for the South Asian community has been developed.

Local experience

In 2006, to fulfil the NICE (2003) guideline, the author's PCT chose to implement the DESMOND programme. However, after informal evaluation it was found that this programme had disadvantages. The sessions were very costly in terms of ongoing running costs and staff time. It required two trained members of staff (usually a dietitian and DSN) to attend for a whole day; this reduced the time available to provide direct patient care and run patient clinics. There was also a very high non-attendance rate. The course itself, due to the standardised curriculum was inflexible, and did not allow for changes to cater for the needs of the local population, which includes high numbers of ethnic minority groups including people of Turkish, Black African/African–Caribbean, Somali, South Asian and Greek origin.

Conversation Map

The Conversation Map is an educational tool that has been used and well received in Canada and the US since 2006, and became available in the UK in March 2008.

The tool consists of four large colourful pictures that are placed on a table around which the participants sit; the facilitator guides the group around the Map. It is designed to engage a group of 3–10 people with type 2 diabetes in meaningful, informative and open discussion. The conversation is guided by a trained facilitator but led by participants. The participants learn from each other and it is hoped this will be enable participants to improve their decision-making. At the end of each session participants are invited to set their own goals and complete an action plan.

Theoretical background

The theories on which the programme is based include:

- Bandura's Social Learning Theory (people learn from each other by observation, imitation and modelling [Bandura, 1977]).
- Levanthal's Common Sense Model (encouraging people to explore the beliefs they have about their condition in the hope that this will inform and change behaviour [Levanthal et al, 1998]).
- Pask's Conversation Theory (learning occurs by one person teaching another person what they have learnt, leading to agreement and understanding [Pask, 1975]).

Facilitator training

Before facilitating the Conversation Map sessions, facilitators undertake a half-day training session. This session introduces them to the concept of what the map tools are and enables them to participate in a trial session with a lead trainer. At the end of the

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2. The course itself, due to the standardised curriculum was inflexible, and did not allow for changes to cater for the needs of the local population, which includes high numbers of ethnic minority groups.
3. The Conversation Map is an educational tool that has been used and well received in Canada and the US since 2006, and became available in the UK in March 2008.

Table 1. Numbers of attendees at each session.

	First session	Second session	Third session
April 2009	8	9	8
May 2009	8	9	8
June 2009	10*	12	9

* One individual who attended this session was hard of hearing; it was arranged that he should have one-to-one education; he did not attend the remaining two sessions.

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1. It was decided that as the DESMOND (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) programme did not seem to be meeting the needs of the local population with type 2 diabetes, the Conversation Map tool would be trialled.
2. Following much discussion, sessions were held on Tuesday mornings starting at 9 am, usually lasting between 2 and 2.5 hours, and participants were encouraged to attend all three sessions.
3. Each session is designed to be engaging and interactive. As the sessions are consecutive, the participants get to know each other which helps to break down barriers and improve group dynamics.

session participants are given their own kit, which includes all that is needed to initiate Conversation Map sessions.

The toolkit

There are four Conversation Map tools, which can be used as a series or stand-alone sessions.

Managing my diabetes

This session facilitates discussion around what diabetes is and the importance of self-management to achieve good outcomes.

Diabetes and a healthy lifestyle

This session facilitates discussion around the importance of a healthy diet and increased activity to help to achieve good control of diabetes; participants are encouraged to identify lifestyle changes that they could make.

Experiencing life with diabetes

This session focuses on the progressive nature of type 2 diabetes and possible complications if not adequately controlled; it also looks at different treatments that are available.

Starting insulin

This session is designed to facilitate discussion around insulin therapy. This session has not been used in Enfield, but will be used for group initiation of insulin therapy or for people using insulin who may need an update around insulin therapy.

Evaluation

It was decided that as the DESMOND programme did not seem to be meeting the needs of the local population with type 2 diabetes, the Conversation Map tool would be trialled. The Conversation Map tool was presented to the local Diabetes NSF Group to seek endorsement. The diabetes team (nurse consultant, three DSNs and a dietitian) underwent the necessary training, and in April 2009 a 3-month trial period was started. Initially it was decided to facilitate the first three sessions running consecutively over 3 weeks.

Following much discussion, sessions were held on Tuesday mornings starting at 9 am, usually lasting between 2 and 2.5 hours, and participants were encouraged to attend all three sessions. However, if they were unable to attend one of the sessions, they were invited to attend the following month's session.

There have been many advantages to using Conversation Map tools: there is better use of staff time; it requires one member of the diabetes team to facilitate each morning session allowing more time for direct patient care; it also allows more flexibility – if for any reason a member of staff is unable to facilitate a session, another trained facilitator can cover the session.

In terms of finance, cost is minimal. Tea and coffee is offered at each session and some hand-outs are provided, most of which are photocopied by the administrator.

The sessions provide more flexibility for the needs of Enfield's diverse population than DESMOND. The questions that are included in the facilitator guide prompt participants to discuss certain topics, but allow them to learn at their own pace and learn from each other. Each session is designed to be engaging and interactive. As the sessions are consecutive, the participants get to know each other which helps to break down barriers and improve group dynamics. At the end of the third session friendships have often been made and names and addresses exchanged.

Although the non-attendance rate remains high, numbers have improved, and most people who come to the first session attend all three sessions, finding it easier to take a morning away from work rather than to attend for a whole day.

Facilitating these sessions is very challenging as the role itself does not use traditional teaching skills. The aim is to get participants discussing and answering questions between them, and the facilitator needs to guide the group in keeping focused on the topic and encourage every one to take part; the facilitator should be listening rather than talking. Healthcare professionals may be used to leading teaching sessions, therefore it can be very difficult to adjust to this type

of teaching method. Initially, the author found herself doing most of the talking as participants assume that the facilitator will answer all questions.

Method

An evaluation form was given to each participant at the conclusion of each of the sessions. Those who were unable to read or write in English were taken through the form by one of the facilitators who noted down their answers. The evaluation form comprises the following questions and a space for additional comments:

Q1. Did you find the room comfortable?
Q2. Did you find the content of the session is what you expected?
Q3. Were the course organisers friendly and approachable?
Q4. Did you feel you learnt the skills necessary to manage your diabetes?
Q5. Was the course was relevant to your needs?

Questions were scored from one to six, (1=poor, 6=excellent; see *Table 2* for results.

Results

To accommodate an expected high non-attendance rate, and ensure seven or eight participants per group, the authors invited 20 people to the first session. Most who attend the first session attended the subsequent two sessions (*Table 1*).

The first session can be difficult to facilitate as participants may be apprehensive about the course and group dynamics need to be formed.

In the author's experience, the second session on lifestyle appears the most popular, particularly with the discussion of what constitutes a healthy diet.

The third session is usually a lively and more open session than the previous two. On some occasions participants have become very tearful as the reality of what it means to live with diabetes, and the possible long-term complications, is explained.

Discussion

The evaluations were mixed but mainly positive, and they improve in the later months, which the author believes reflects an increased confidence and ability in the facilitators. The comfort of the room was outside the author's control as room bookings were frequently changed.

Regarding the content of the course, the lower initial marks may reflect that participants were not expecting to sit at a table looking at what appeared to be a very large board game. The letter inviting participants to the education sessions has since been changed and this may be reflected in the improved scores in later sessions.

Comments were generally positive, and included:

"It was user-friendly and made practical sense."'

"Good and informative."

Page point

1. To accommodate an expected high non-attendance rate, and ensure seven or eight participants per group, the authors invited 20 people to the first session. Most who attend the first session attended the subsequent two sessions.

Table 2. Responses to post-session questionnaires.

Question	First session						Second session						Third session					
Score	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
April																		
Q1	-	-	-	1	6	1	-	-	-	3	3	1	-	-	-	1	1	6
Q2	-	-	1	3	2	2	-	-	-	1	4	2	-	-	-	-	2	6
Q3	-	-	-	1	2	5	-	-	-	1	2	4	-	-	-	-	-	8
Q4	-	1	1	3	2	1	-	-	-	1	5	1	-	-	-	-	2	6
Q5	-	1	-	1	4	2	-	-	-	-	5	2	-	-	-	-	1	7
May																		
Q1	-	1	-	1	3	3	-	-	2	1	1	5	-	-	1	1	-	6
Q2	-	-	1	1	4	2	-	-	1	2	2	4	-	-	-	1	1	6
Q3	-	-	-	1	3	4	-	-	1	-	2	6	-	-	-	1	1	6
Q4	-	-	2	3	1	2	-	-	1	2	3	3	-	-	-	3	2	3
Q5	-	-	1	3	2	2	-	-	-	2	4	3	-	-	-	3	2	3
June																		
Q1	-	1	-	-	-	7	-	-	-	2	1	7	-	-	-	1	1	6
Q2	-	-	-	-	-	8	-	-	-	-	3	7	-	-	-	-	2	6
Q3	-	-	1	-	-	7	-	-	-	-	-	10	-	-	-	-	-	8
Q4	-	-	1	-	1	6	-	-	-	1	2	7	-	-	-	-	2	6
Q5	-	-	1	-	1	6	-	-	-	-	3	7	-	-	-	-	1	7

Questions were scored from 1–6 where 1=poor and 6=excellent.

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1. In Enfield, evaluations from participants have been positive.
2. The author had hoped to be able to measure for improvements in HbA_{1c} levels following attendance at these sessions, but as most participants are under the care of their GP it was difficult to obtain these results.
3. The author has found that the Conversation Map tools provide greater flexibility in catering for the diverse educational needs of people in Enfield with type 2 diabetes.

"Very informative and thought provoking."
"Very comprehensive given a mixed audience."
"I found the course very helpful and it has answered some of my queries regarding diet."
"This course has been an eye opener for me. There are many things about my body and diabetes that I have learnt and am willing to put into practice."
"I have found the course most helpful. I am more aware of my diabetes and what I have to change."
"I have learnt to be more confident about my situation and I hope to apply all the knowledge."

There were, however, two negative comments:

"I prefer to be taught similar to school system, i.e. using blackboard and standing and speaking."
"The map would have been better on the wall to enable everyone to see it better."

A formal research study programme to evaluate the value of the Conversation Map tools is ongoing in the US, and is due to report in 2012. There is also a similar study taking place in Germany and Spain.

In Enfield, evaluations from participants have been positive. However, these evaluations were completed at the end of the session and handed to the facilitator, which may have influenced the result. The author would like to repeat the questionnaire at a later date and review whether learning and lifestyle changes had been maintained. The author had hoped to be able to measure for improvements in HbA_{1c} levels following attendance at these sessions, but as most participants are under the care of their GP it was difficult to obtain these results.

Conclusion

The Conversation Map tools provide greater flexibility in catering for the diverse educational needs of people in Enfield with type 2 diabetes who come from a variety of ethnic backgrounds. It is user-friendly and people with diabetes enjoy participating in the learning process. They also value the support from others in the group who may have experienced similar problems.

In financial terms it is less costly to run than DESMOND, requiring only one member of staff with minimal ongoing costs. Some participants have also commented that it is easier/preferable to take a morning from work on three consecutive weeks rather than to attend for one whole day.

It is a requirement of the NSF for diabetes that education is available for everybody with type 2 diabetes. At present, DESMOND is the most widely used programme available in the community setting, however this may not meet the needs of every local population. The Conversation Map tools may be an alternative or additional tool that could be used. In Enfield these have been used with success. The author is aware of work that has been ongoing to ensure that this method of education is fully compliant with the NICE criteria and is keen to implement this as soon as it is available. ■

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