Bicultural Diabetes Support Officers for Italian & Vietnamese People with Type 2 Diabetes in the Inner City & Swan Health Services (March 2001- June 2002)

Evaluation Report

Metropolitan Health Service
Government of Western Australia

East Metropolitan Population Health Unit

In collaboration with the Italo-Australian Welfare and Cultural Centre Inc., and Diabetes Australia Western Australia.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
BAT	Be Active Together
CALD	Culturally and Linguistically Diverse
CPS	Community Physiotherapy Services
DAWA	Diabetes Australia Western Australia
DE/DEs	Diabetes Educator/s
DSO/DSOs	Diabetes Support Officer/s
EMHS	East Metropolitan Health Service
EMPHU	East Metropolitan Population Health Unit
GDM	Gestational Diabetes Mellitus
GP/GPs	General Practitioner/s
HPO	Health Promotion Officer
IAWCC	Italo-Australian Welfare and Cultural Centre Inc.
ICIDCP	Inner City Integrated Diabetes Care Project
JDF	Job Description Form
MOU	Memoranda of Understanding
RPH	Royal Perth Hospital
RTO	Registered Training Organisation
SHS	Swan Health Service

1.0 EXECUTIVE SUMMARY

A needs assessment identified that people from Italian and Vietnamese backgrounds experienced difficulty accessing and using mainstream diabetes services which can help prevent the development of diabetes–related complications (Di Francesco, Gillam et al. 1999). A contributing factor was the lack of culturally appropriate diabetes services available to these communities. A recommendation was to utilise bicultural and bilingual diabetes support officers (DSOs) to provide information and support services to Italian and Vietnamese people with Type 2 diabetes.

Health services do not have the capacity within their existing structure and resources to provide appropriate care to people from diverse communities. A pilot program was therefore implemented to respond to this identified need in the Inner City and Swan health services. The essential elements identified for health service infrastructure outlined by the Capacity Building Framework (NSW Health Department 2001) were implemented to support the program. These included building partnerships, dedicating resources, organisational development, workforce development and leadership (NSW Health Department 2001).

As part of the program Italian and Vietnamese DSOs were recruited and trained to deliver diabetes services in their own languages from two sites: one from an existing health service (Swan Health Service (SHS), the other from an ethno-specific consumer organisation (Italo-Australian Welfare and Cultural Centre Inc. (IAWCC).

An extensive evaluation was conducted upon completion of the pilot program. Discussion groups were conducted to gain consumer feedback on the impact of the service and service providers were surveyed to assess their level of awareness and use of the service. These qualitative data were analysed manually using thematic analysis. Quantitative data collected via the HCARe data system and monthly reports were analysed to describe the consumers who accessed the service and to measure the extent of service provided by the bi-cultural DSOs.

The evaluation found that a total of 106 Italian and 77 Vietnamese consumers attended one to one consultations with their respective DSO. 121 Italian and 106 Vietnamese people attended group activities during the pilot period. 1,048 individual occasions of service were provided to the Italian and Vietnamese people combined.

More than 50% of the Italian consumers were over the age of 70 years and had complex needs. Approximately 15% of the consumers from the Vietnamese community were young women with history of Gestational Diabetes Mellitus (0-40 years) who have a significant risk of developing Type 2 diabetes in the next five years.

Consumers cited the importance of receiving the information in their own language because most did not speak English well. Program partners and consumers reported significant improvements in consumers' capacity to self-care as a result of the information and support they received from their respective DSO. This included improved awareness and knowledge, weight loss, improved diabetes control and improved self-efficacy. Service providers who utilised the service also provided positive feedback.

The final evaluation report highlights that the service is highly valued by both service providers and consumers, thus supporting the need for its continuation. If implemented, the recommendations in this report will help to enhance service delivery for Italian and Vietnamese people with Type 2 diabetes beyond the pilot phase and further integrate the program into regular service delivery for the key organisations involved.

2.0 RECOMMENDATIONS

2.1 Program planning and development

It is recommended that:

- The program is continued beyond the pilot phase;
- In light of the new health service restructuring, the program is extended to all Italian and Vietnamese consumers with Type 2 diabetes and health service providers based in the East Metropolitan health service (EMHS);
- The DSOs continue to accept referrals from consumers living outside EMHS, however the situation be closely monitored and that the main priority remain for consumers residing in EMHS;
- New promotional materials are produced to raise awareness about the program amongst consumers residing in EMHS and service providers, in particular with pharmacists as minimal promotion has occurred with them to date. Any newly developed promotional materials targeting service providers should outline the advantages of using bilingual and bicultural DSO. This will help to enhance referrals from allied health practitioners, including those who have access to interpreter services;
- As a longer term strategy the East Metropolitan Population Health Unit (EMPHU), in collaboration with the Department of Transport and other sectors, advocates the need for healthier transport systems to overcome transport barriers faced by consumers. In the interim consumers accessing the program should be encouraged to find avenues and means to attend the program and consultations at the service site. At the same time the DSOs continue to conduct home visits to consumers with identified special needs (eg. have co-morbidities);
- Consumers continue to be consulted in all components of service delivery;
- Program partners review the program's target group to ascertain whether it should be broadened to include all Italian and Vietnamese people (ie. consumers with and without diabetes). Existing objectives and resources will need to be taken into consideration and whether new partnerships can be formed with organisations providing prevention services.

2.2 Promoting access to other services

It is recommended that:

- The DSOs continue to refer consumers to a multidisciplinary team of health service providers as required. In particular they should continue to work closely with general practitioners who are the recognised case managers and have a central role in coordinating medical management, education and counselling for adults with diabetes;
- The DSOs continue to act as advocates to link consumers to mainstream diabetes services as required. Advocacy related activities outside diabetes would require the DSOs ensuring consumers were linked to relevant welfare services.

2.3 Future training

It is recommended that:

- Future programs offered to DSOs use training facilitators who will be closely connected to the program, both as initial facilitators and as mentors;
- Future diabetes related competency based courses (eg. Health Worker Training Program in Diabetes Prevention and Control) continue to be delivered in partnership with RTOs;
- The DSOs be invited to participate in relevant future training programs available to health professionals within the EMHS diabetes network or training identified by their respective management;
- As a longer term strategy, program partners consider the feasibility of providing situational and consumer-specific cultural awareness training to mainstream service providers.

2.4 Data collection

It is recommended that:

- A mechanism is considered to audit and monitor existing program and service data collection. This would ensure that services are being reported in a meaningful way that will inform health service planners on appropriateness, efficiency and effectiveness of service provision to Italian and Vietnamese people beyond the pilot phase.

3.0 INTRODUCTION

This report presents the results of the evaluation of the Pilot Program for Italian and Vietnamese People with Type 2 Diabetes in the Inner City and Swan Health Service. The pilot program, which began in March 2001, was conducted over 15 months and concluded in June 2002. The program represents a joint initiative between Diabetes Australia Western Australia (DAWA), East Metropolitan Population Health Unit (EMPHU), Italo-Australian Welfare and Cultural Centre Inc. (IAWCC) and Swan Health Service (SHS).

As part of the program Italian and Vietnamese Diabetes Support Officers (DSO) were recruited and trained to deliver diabetes services in their own languages from two sites: one from an existing health service (SHS), the other from an ethno-specific consumer organisation (IAWCC). The aim of the pilot program was to reduce the risk factors for developing diabetes-related complications in Italian and Vietnamese people. The results of the evaluation will be used to determine future service development and the continuation of the program beyond the pilot phase.

4.0 BACKGROUND & RATIONALE

The program was developed from a needs assessment, conducted by EMPHU in 1999 (Di Francesco, Gillam et al. 1999), as part of the Inner City Integrated Diabetes Care Project (ICIDCP)[1]. The needs assessment included an extensive literature review, an audit of available and culturally appropriate services and consultations with service providers and consumers of diabetes services. The needs assessment focussed on Italian and Vietnamese communities because they represented the two largest cultural communities in the Inner City health service. Data from the 2001 Census revealed that of the 59,860 people residing in Inner City, there were 3,082 Italian speaking and 841 Vietnamese speaking residents (Australian Bureau of Statistics 2002) (ABS). Together this represented 6.5% of the total Inner City health service population.

The needs assessment found that people from culturally and linguistically diverse (CALD) backgrounds experienced difficulty accessing and using mainstream services. Very few culturally appropriate diabetes services were available to Italian and Vietnamese people in the Inner City health service (Di Francesco, Gillam et al. 1999). Consumers relied on general

[1] The ICIDCP was a pilot program that occurred between 1998-2001. It aimed to enhance and integrate diabetes services at all levels in the Inner City health service.

practitioners (GPs), mainly those who spoke their first language, and made only limited use of the range of allied health and educational services that can assist in preventing diabetes-related complications. This was due to problems relating to:

- Cultural and language differences;
- Consumers' low level of awareness of available services;
- Problems experienced by mainstream service providers in providing appropriate education for self-management;
- Lack of integration and co-ordination of services (Di Francesco, Gillam et al. 1999).

A recommendation from the needs assessment was to establish a pool of bi-cultural health workers able to deliver culturally appropriate diabetes services in partnership with mainstream and consumer based organisations. Accordingly, a pilot program was developed to respond to this identified need. During the planning process the geographical boundaries of the program were however extended to include the Swan health service due to its significant Italian and Vietnamese population. Data from the 2001 Census revealed that approximately 7,978 Italian speaking and 4,701 Vietnamese speaking people resided in this health service (Australian Bureau of Statistics 2002).

5.0 PROGRAM AIM

To reduce the risk factors for developing diabetes-related complications in Italian and Vietnamese people in the Inner City and Swan health services.

6.0 PROGRAM OBJECTIVES

6.1 To provide Italian and Vietnamese people with Type 2 diabetes access to culturally appropriate diabetes services in the Inner City and Swan health services.

6.2 To improve the knowledge of and skills in self care amongst Italian and Vietnamese people with diabetes in the Inner City and Swan health services.

6.3 To pilot the use of a capacity building framework to guide the development, evaluation and maintenance of a culturally appropriate diabetes service within an existing health service and an ethno-specific consumer organisation.

7.0 TARGET GROUPS

7.1 Primary Target Group

Italian and Vietnamese people with Type 2 diabetes in the Inner City and Swan health services.

7.2 Secondary Target Group

Organisations/individuals in contact with the primary target group who are in a position to refer them to the program (eg GPs, diabetes educators (DEs), podiatrists, migrant resource centres, community leaders).

8.0 PROGRAM DESCRIPTION

8.1 Capacity Building Framework

Capacity building is a conceptual framework that supports health service development. The components of capacity building outlined by the NSW Health Department (2001) include building partnerships, resource allocation, organisational development, workforce development and providing leadership (Appendix 1). The model acknowledges the importance of the *context* within which capacity building occurs. Context refers to the:

> *physical, economic, political, organisational and cultural environments within which the program (or individual or organisation or community) sits.*
>
> (NSW Health Department 2001).

Health services do not have the capacity within their existing structure and resources to provide appropriate care to people from diverse communities. The capacity building framework was therefore used to assist with the planning and development of the pilot program and to ensure sufficient infrastructure to deliver culturally appropriate diabetes services to Italian and Vietnamese people. The components which make up the capacity building framework are briefly described below.

8.1.1 Partnerships

The program represents a joint initiative between EMPHU, SHS, IAWCC and DAWA. The forming of partnerships with these organisations occurred over a 12 month period. It was preceded an in-depth process of identifying and meeting with potential partners, consulting relevant stakeholders to develop business cases for prospective partners to consider, and

follow up meetings with relevant organisations to modify the business case according to the needs of the organisations. The outcome was to form a partnership with an ethno-specific consumer organisation not traditionally involved in the delivery of diabetes services, was consistent with the research conducted by Di Francesco, Gillam et al. (1999). Participating allied health practitioners stated that partnerships between diabetes service providers and ethno-specific organisations would enable the service delivery to be guided by people who understand the cultural context in which people with diabetes from CALD backgrounds live (Di Francesco, Gillam et al. 1999). This was complemented by the experience of many of the consumers in the needs assessment who reported that the mainstream diabetes services they accessed were inappropriate because they did not fit with their beliefs and values (Di Francesco, Gillam et al. 1999).

Memoranda of understanding (MOU) were developed to formalise the partnership arrangements with each organisation. The MOU clearly outlined the roles and responsibilities of each organisation to facilitate shared planning and implementation.

Regular project meetings between partners were scheduled throughout the course of the pilot program. The meetings were designed to provide a forum for program partners to review project progress, discuss emerging challenges and to reach consensus on decisions as required.

8.1.2 Resources

Financial resources were allocated through the ICIDCP budget to meet the costs of:

- Advertising and recruitment of the Italian DSOs;
- FTE for the DSO positions, including travel and on-costs;
- The mentoring program;
- Initial and ongoing professional development training;
- Diabetes educational materials;
- Diabetes equipment and supplies for the Italian DSO based at the ethno-specific consumer organisation;
- Development of promotional materials.

As a requirement of the MOU, each partner organisation provided the organisational infrastructure for the program. A health promotion officer (HPO) coordinated the program with support from the Diabetes Regional Coordinator. Both these staff were employed by EMPHU.

8.1.3 Organisational development

DSO Job description form

During the initial planning phase, some mainstream service providers questioned whether the educational interventions of bi-cultural health workers would be of the same standard as credentialled diabetes educators (DE). They recommended that the DSO Job Description Form (JDF) clearly defined their role as being different, but complementary, to that of DEs. Representatives from the partner organisations agreed that the main role of the DSO was to:

- Provide basic culturally appropriate information and support to consumers;
- Facilitate consumers' access to essential clinical and allied health services as required (eg. GPs, podiatrists, DEs).

It was anticipated that the majority of the DSOs' work would occur with consumers on a one to one basis however, time permitting, they would be encouraged to implement group interventions such as information seminars.

The DSOs' JDF was therefore developed with due consideration of the above factors (Appendix 2).

Formal recruitment

A formal procedure was undertaken to recruit the Italian DSOs. These positions were advertised in the West Australian Newspaper during December 2000. The need for excellent language skills, in both Italian and English, and established networks with the Italian community were two of the essential criteria (Appendix 3). The interviews occurred at each employment site to begin the process of embedding ownership of the program. An Italian GP (closely connected to IAWCC), a DE from SHS, the Regional Diabetes Coordinator from EMPHU and the Managing Director from IAWCC were represented on the selection panel. The IAWCC provided additional support during this phase by implementing a language test to assess applicants' Italian verbal and written language skills.

As a result of the recruitment process, two Italian DSOs positions were substantiated, one for the IAWCC to address the needs of the Italian community in Inner City, and the other, for the SHS, to address the needs of the Italian community in Swan.

The generalist Vietnamese health worker employed by the SHS for over 20 years was recruited as the Vietnamese DSO following her expressed interest in the program. Management agreed to redefine her role and work locations, and ensure that health service staff were informed about her new specialised role in diabetes. She was based at the North Perth Child Health Centre two days per week to work with the Inner City Vietnamese community, and at the Lockridge Community Health Centre two days per week to work with the Swan community. One day per week continued to be devoted to child health at the North Perth Child Health Centre.

Integration into diabetes team

Particular efforts were made to integrate the DSOs into local diabetes teams to ensure that they did not work in isolation and were recognised as legitimate members of the diabetes network. The DSOs employed by SHS became members of their existing Diabetes Team, which comprised two DEs, two dietitians, a physiotherapist and two podiatrists. As there is no infrastructure for service provision in Inner City, the Italian and Vietnamese DSO in the Inner City were connected to a Dietitian/DE at DAWA through the mentoring initiative (see 8.1.4 Workforce development).

8.1.4 Workforce development

Initial training

The DSOs were trained using a revised version of DAWA's existing, nationally accredited course for Aboriginal health workers. This course, titled *A Course in Diabetes Prevention and Management for Bicultural Health Workers*[2] was modified and piloted with health workers from diverse cultural backgrounds, including Italian and Vietnamese.

[2] Information about the course, including relevant resource materials, can be obtained by contacting DAWA.

The training occurred over five weeks, two days per week, between January and February 2001. Bicultural health workers who were not directly involved in the pilot program, but who were considered that they may benefit from the training, were invited to participate. In total, nine people representing the SHS, IAWCC, Derbarl Yerrigan Health Service, North Metropolitan Health Service Population Health Unit (NMHS PHU) and The Vietnamese Community of Western Australia participated in the training. The Regional Diabetes Coordinator and Nutritionist/DE, both from EMPHU, and a Dietitian/DE from DAWA facilitated the training in partnership with J-Five Health Services, a registered training organisation (RTO)[3].

The training program, which was competency based, consisted of five modules with related learning outcomes. A range of assessment strategies were utilised to assess participants' competence including written assessment (eg. multiple choice tests, short answer tests, verbal questioning) and demonstration of skills (eg. role plays).

An orientation day and graduation ceremony were held at the commencement, and completion of the training respectively.

Mentoring

A structured mentoring program was implemented to provide additional support to the DSOs following their initial training. Within the context of this program mentoring is defined as:

> *A one to one relationship between a more experienced person (*mentor*) and a less experienced person (*mentee*).… It is based upon encouragement, constructive comments, openness, mutual trust, respect, and a willingness to learn and share.*
>
> (NSW Health Department 2001)

> *Mentoring is characterised by the adult nature of the relationship in contrast to traditional student and apprentice relationships. Problem solving techniques and reflective thinking are developed through the dialogue with the mentor in which experiences and researched knowledge are shared. Effective mentoring facilitates the*

[3] RTOs provide a range of training services (eg. training delivery, skills recognition) and/or training products (eg. accredited courses, training programs or short courses).

> *transition from learner to an autonomous practitioner who is accountable for their own practice.*
>
> (Dietitians Association of Australia 1996)

The mentees (DSOs) were matched up with a mentor with whom they were required to meet for up to four hours each week during work hours. Two DEs from SHS were allocated time and funding to mentor the DSOs in Swan. It was decided that a Dietitian/DE from DAWA was better positioned to mentor the DSOs in Inner City because of the organisation's local knowledge of Inner City diabetes services through its involvement in the ICIDCP. She was also involved as a co-facilitator during the initial training of the DSOs.

Mentoring guidelines[4] were developed and distributed to all program partners[5]. The guidelines encouraged the mentees and mentors to set up a contract prior to commencing their relationship. This was a strategy to clarify roles and expectations, formulate mutual goals and learning objectives and to determine the frequency and structure of meetings (eg phone/fax/face to face). The guidelines also outlined a procedure for the relationship to be terminated if problems arose.

In addition to the guidelines, program partners attended a briefing meeting, which provided an opportunity to clarify questions about how the mentoring component of the program would operate.

Journals

The DSOs were encouraged to write a journal over the course of the pilot program to reflect on new skills learnt, identify areas that required further development and to report on success and problem areas. It was also intended as a tool for recording information that could later be used to facilitate discussions between mentors and mentees. This strategy was extended to the DEs following their expressed interest to also maintain a journal.

[4] The guidelines were developed drawing on various sources, including relevant literature, existing mentoring programs and the input received from program participants. The guidelines were intended for internal use only and are not available for distribution.

[5] Within the context of this program, program partners refers to the line managers, DSOs, DEs, the HPO and Regional Diabetes Coordinator directly involved in the planning and implementation of the pilot program.

Ongoing training opportunities

Ongoing training opportunities were built into the program to consolidate the competencies the DSOs acquired during the initial training and to keep them informed of new developments and technologies in diabetes care and education.

Orientation visits

Orientation visits to relevant diabetes services were scheduled as part of the program. These visits were designed to assist the DSOs to build their professional networks and to raise their awareness of essential diabetes services they could refer consumers to.

8.1.5 Leadership

Within a capacity building context leadership relates to:

> *…the development of leaders who conceptualise and integrate work across the organisation in addressing health equality, are committed to building programs to address inequity, are responsive to consumer and community needs and who can act as teachers in challenging the system to reflect on ways in which equity can be addressed.*
>
> (Bowen, Harris et al. 2001.)

Leadership was demonstrated by each partner organisation's willingness to address the health service delivery needs of its local and diverse community affected by diabetes. At an organisational level management support assisted with the process of engaging, mobilising and inspiring relevant staff members to become involved in the program.

9.0 METHODOLOGY

The evaluation of the pilot program included the gathering of qualitative and quantitative data using multiple methods and sources which are described below.

9.1 HCARe

Consultations with primary health care managers confirmed that the HCARe database, traditionally used to monitor community nursing services, could be used to collect relevant data for the pilot program. HCARe could be used to provide a broad description of consumer groups and measure the occasions of service, presenting health issues, services provided and

service results. The DSOs were required to complete the HCARe forms on a weekly basis and forward these to the Data Processor at EMPHU to be entered into a database. Reports generated from the raw data were presented at project meetings for review and discussion.

During the evaluation phase, a meeting was held between the HPO and the DSOs to verify the inter-rater reliability of the raw data gathered from HCARe. The need for the meeting arose due to the inconsistent way the data had been recorded over the duration of the pilot program. Discussions revealed that this initial inconsistency was the result of limitations in the HCARe database, unclear instructions and differing interpretations about which codes could be used. This highlighted the need for a mechanism to be considered to audit and monitor existing program and service data collection. This would ensure that services are being reported in a meaningful way that will inform health service planners on appropriateness, efficiency and effectiveness of service provision to Italian and Vietnamese people beyond the pilot phase.

9.2 Monthly reports

A brief tool was developed to collect additional relevant information not captured on the HCARe database (Appendix 4). This included number of referrals received and referral sources, referrals made by the DSOs, and details of intangible work such as planning seminars and strategies implemented to promote the program to consumers and/or service providers. The DSOs forwarded the completed reports to the HPO to collate at the end of each month.

During the evaluation phase a similar process as described above (9.1 HCARe) was undertaken to check the inter-reliability of the data collected from the monthly reports. This was to ensure it could be used as an accurate basis for analysis and evaluation.

9.3 Survey disseminated to community & tertiary based service providers

A brief survey was disseminated to all diabetes care service providers to whom promotional information about the program was sent (Appendix 5). A draft version of the survey was pilot tested with a sample (n=6) of diabetes service providers. The final version was either faxed or posted to 140 tertiary and/or community based diabetes service providers representing:

- DEs;
- Dietitians;
- GPs;
- Community Physiotherapy Services (CPS);

- Podiatrists contracted to provide primary diabetes podiatry services in Inner City as part of the ICIDCP;
- Occupational therapists;
- Optometrists who had identified special interest and skills in fundal examination for detection of diabetes related diabetes (eg. retinopathy);
- Silver Chain Nursing Association.

9.4 Discussion groups with consumers

A letter was sent to invite all Italian and Vietnamese consumers who attended a consultation with the DSO to participate in a discussion group (Appendix 6). The IAWCC and SHS translated the letters from English into Italian and Vietnamese respectively to minimise language barriers.

Four discussion groups were conducted in total (two for each community in both health service areas) with each approximately one and a half hours in duration. An interview schedule was developed to guide the interviews (Appendix 7). The HPO conducted the discussion groups using accredited interpreters accessed through Royal Perth Hospital's (RPH) Language Services Department. A note taker, who was present at each discussion, had sufficient time to record detailed notes because the interpreter was only able to listen and interpret one response at a time. As a back up strategy, consumers were asked for permission to record the discussion groups in order to clarify or add to the data collected by the note taker.

A short questionnaire was used to collect demographic data from participants prior to the commencement of each discussion group (Appendix 8). The interpreter and note taker assisted with this process. Data were collected on:

- Gender;
- Postal address;
- Year of birth;
- Length of residency in Australia;
- Year diagnosed with diabetes;
- Language predominantly spoken at home;
- Other languages spoken;

- Self reported level of spoken English proficiency.

9.5 Consultations with program partners

An interim evaluation comprising discussion groups and semi-structured interviews was held with program partners in December 2001. The HPO conducted the group discussions using an interview schedule (Appendix 9). Due to time and resource constraints the interviews were not audio-taped, the HPO simply took notes which were later used for the data analysis. Each meeting lasted approximately one hour.

A similar process of consultations with program partners was repeated as part of the final evaluation. The final evaluation report therefore combines data collected from these consultations during the interim and final evaluation phases.

10.0 ANALYSIS

The qualitative data were analysed manually using thematic analysis[6]. The quantitative data were analysed using a statistical software package (SPSS version 10.0).

11.0 ETHICAL CONSIDERATIONS

The purpose of the evaluation was explained to all participants before the data were collected from them. The names of participants have not been used in any written documents resulting from the evaluation. Each participant had the right to withdraw from the data collection process at any time.

12.0 RESULTS

12.1 HCARe

12.1.1 Individual consultations

In total 106 Italian and 77 Vietnamese consumers attended one to one consultations (Table 1)[7].

[6] This form of qualitative analysis relates to analysing data according to patterns or themes suggested by the data.
[7] These figures do not include consumers who attended a group activity (eg. information seminar). See 12.2.3 Group Activities, for information regarding the number of consumers who attended group activities.

Table 1. Number of consumers who accessed the service

Health Service	Italian	Vietnamese
Inner City	59	27
Swan	47	50
Total	106	77

12.1.2 Occasions of service & service provided

Italian consumers

The Italian DSO delivered a total of 473 individual occasions of service to Italian consumers in both health areas. This equates to 4.4 occasions of service per consumer. The main service provided in both health areas was health education/promotion[8] (n=440, 93%) (Table 2).

Table 2. Individual contacts by service provided (Italian)

Service Provided	Number	Percentage
Health Education/Promotion	440	93.0
Advocacy/Liaison[9]	26	5.5
Equipment Provision/Instruction[10]	7	1.5
Total	473	100.0

Vietnamese consumers

The Vietnamese DSO delivered a total of 575 individual occasions of service to Vietnamese people. This equates to 7.4 occasions of service per consumer. The main service provided was health education (n=350, 60.9%) followed by advocacy (n=104, 18.1%) (Table 3).

[8] Health Education/Promotion relates to education on a specific health issue or health promotional activities to promote/maintain/improve health for client in relation to diabetes management (Health Department of Western Australia 1999).

[9] Advocacy/Liaison relates to actively supporting client and includes consultation with other persons/departments/agencies (Ibid).

[10] Equipment/Provision/Instruction relates to the provision of any item or equipment designed to benefit the client (Ibid).

Table 3. Individual contacts by service provided (Vietnamese)

Service Provided	Number	Percentage
Health Education/Promotion	350	60.9
Advocacy/Liaison	104	18.1
Review/Reassessment[11]	79	13.7
Equipment Provision/Instruction	39	6.8
Practical Assistance[12]	3	0.5
Total	575	100.0

12.1.3 Age of consumers

Italian consumers

Approximately 50% of the occasions of service were delivered to Italian consumers aged over 71 years of age (n=236, 49%) and 40% (n=192) were aged 61-70 years. No services were provided to Italian consumers in the 41-50 years age group. Table 4 below shows the proportion of Italian consumers in each age category for each health service area.

Table 4. Ages of Italian consumers

	Swan and Inner City		Inner City		Swan	
Age Group	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
31-40	2	0.4	1	0.5	1	0.4
51-60	38	8.0	33	15.5	5	1.9
61-70	192	40.6	67	31.6	125	47.9
71+	236	50.0	110	51.9	126	48.3
Unknown	5	1.0	1	0.5	4	1.5
Total	473	100.0	212	100.0	261	100.0

[11] Review/reassessment relates to documented physical/social/emotional/environmental reassessment after an agreed period of time (Ibid).
[12] Practical assistance relates to a service which is structured to provide practical assistance (Ibid).

Vietnamese consumers

Occasions of service most commonly delivered to Vietnamese consumers were aged 61-70 years (n=196, 34%), followed by those aged over 71 years (n=102, 17%) and 41-50 years old (n= 101, 17%) (Table 5).

Table 5. Ages of Vietnamese consumers

Age Group	Number	Percentage
0-30	44	7.6
31-40	42	7.3
41-50	101	17.6
51-60	89	15.5
61-70	197	34.3
71+	102	17.7
Total	575	100.0

12.1.4 Service sites

Italian consumers

Most occasions of service were delivered to Italian consumers in the DSO's place of employment, that is, at the IAWCC (n=156, 33%) and at the SHS (n=198, 41%). Approximately 25% of the service sites were home visits[13] and telephone consultations[14] (Table 6).

Table 6. Individual contacts by service site (Italian)

Service Site	Number	Percentage
SHS	198	41.9
IAWCC	156	33.0
Home Visits	69	14.6
Telephone Consultations	50	10.5
Total	473	100.0

[13] Home visits are defined as occasions of service carried out in consumer's homes.

[14] Telephone consultations are defined as an occasion of service provided to a consumer over the telephone. It does not include brief/general inquiries such as making an appointment.

Vietnamese consumers

Most service sites for the Vietnamese community were home visits (n=201, 35%), followed by services conducted at the Lockridge Community Health Centre (n=155, 27%). A similar number of telephone consultations (n= 103, 17.9%) and services conducted at the North Perth Child Centre (n=102, 17.7%) were reported (Table 7).

Table 7. Individual contacts by service site (Vietnamese)

Service Site	Number	Percentage
Home Visits	201	35.0
Lockridge Community Health Centre	155	27.0
Telephone Consultations	103	17.9
North Perth Health Centre	102	17.7
Community Location[15]	9	1.5
Swan District Hospital	5	0.9
Total	575	100.0

12.1.5 Consumers' place of residence

Italian consumers

For the Italian community the most common place of residence was postcode 6056 (n=110, 20%). A total of 102 (21%) occasions of service were delivered to Italian consumers residing outside the Inner City and Swan health services (Table 8).

[15] Community location refers to services delivered in community venues (eg. private GP surgery, Morley Recreation Centre).

Table 8. Italian consumers' place of residence

Postcode	Suburb	Number of occasions of service	Percentage
6056	Baskerville/Bellvue/Herne Hill/Boya/Greenmount/Helena Valley/JaneBrook/Red Hill/Stratton/Swan View/Koongamia/Middle Swan/Midland/Midvale/Viveash/ West Midland/Wexicombe	110	23.3
6006	North Perth	42	8.9
6062	Embleton/Morley/Noranda	41	8.7
6055	Caversham/Guildford/East Guildford/South Guildford/Hazelmere/Henley Brook/West Swan	36	7.6
6053	Bayswater/Meltham	28	5.9
6000	Perth	20	4.2
6060	Joondanna Yokine	19	4.0
6016	Mount Hawthorn Glendalough	18	3.8
6059	Dianella	18	3.8
6081	Parkerville Stoneville	15	3.2
6066	Ballajura	12	2.5
6074	Sawyers Valley	11	2.3
Other[16]		103	21.8
Total		473	100.0

[16] Other includes all other postcodes that had less than ten occasions of service.

Vietnamese consumers

The majority of Vietnamese consumers resided in postcode 6062 (n=112, 195), followed by postcodes 6054 (n=72, 12%) and 6066 (n=45, 8%). A small number of occasions of service (n=34, 6%) were delivered to Vietnamese consumers residing outside the Inner City and Swan health service (Table 9).

Table 9. Vietnamese consumers' place of residence

Postcode	**Suburbs**	**Number of occasions of service**	**Percentage**
6062	Embleton/Morely/Noranda	112	19.5
6054	Ashfield/Bassendean/Eden Hill//Kiara/Lockridge	72	12.5
6066	Ballajura	45	7.8
6003	Northbridge/Highgate	40	7
6053	Bayswater/Meltham	39	6.8
6063	Beechboro	36	6.3
6006	North Perth	31	5.4
6050	Coolbinia/Menora/Mount Lawley	26	4.5
6059	Dianella	25	4.3
6000	Perth	22	3.8
6016	Glendalough Mount Hawthorn	15	2.6
6005	West Perth	13	2.3
6007	Leederville/West Leederville	13	2.3
6052	Bedford/Inglewood	12	2.1
6060	Joondana/West Minister	11	1.9
6107	Beckenham/Cannington/East Cannington/Kenwick/Maniana/ Queens Park/Wattle Grove/Wilson	10	1.7
Other		53	9.2
Total		575	100.0

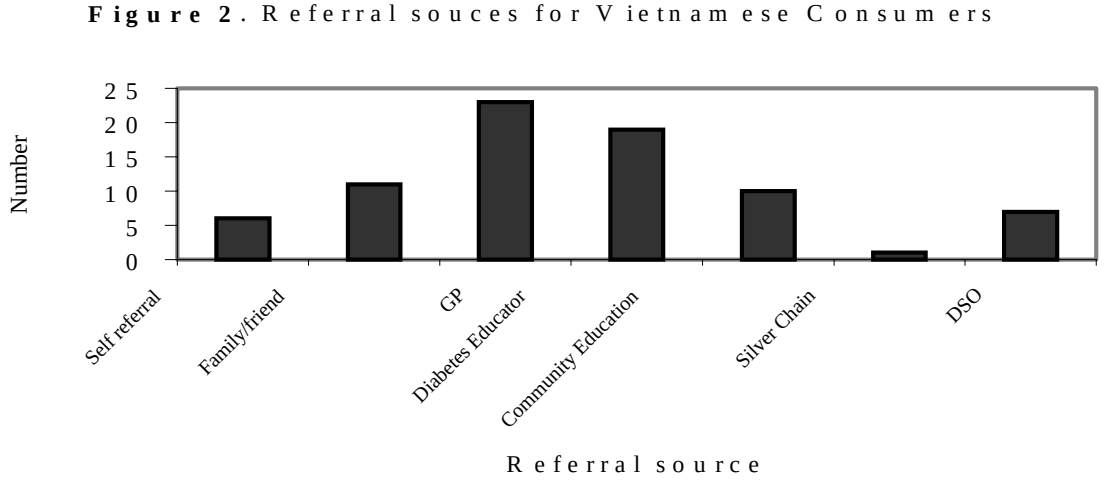
12.2 Monthly Reports

12.2.1 Referrals received

A review of the monthly reports revealed that over the duration of the pilot program:

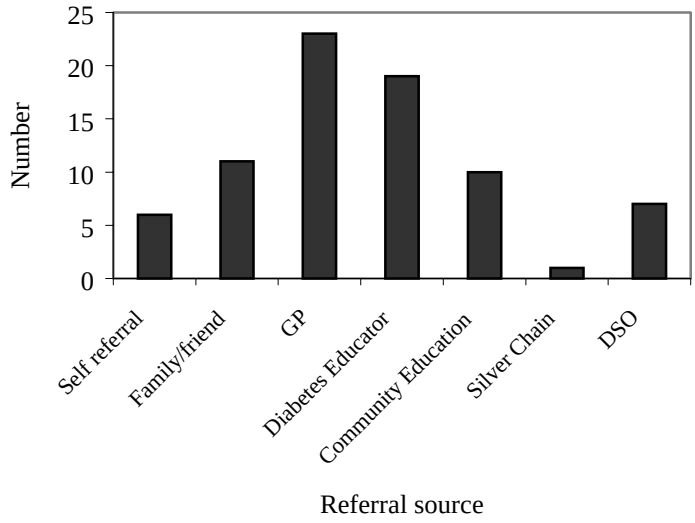
- For both cultural groups most referrals were received from GPs;
- A notable number of self referrals[17] were made to the Italian DSO in Inner City (Figure 1);
- The Vietnamese DSO received nineteen referrals from DEs. Furthermore the Vietnamese DSO indirectly referred participants to the program as a result of promoting the service at a group seminar (Figure2).

Figure 1. Referral sources for Italian community



[17] Self referrals included consumers who learnt about the program via written materials or radio announcements or who were advised to attend the service by a service provider but there was no confirmation from the service provider.

Figure 2. Referral sources for Vietnamese community



12.2.2 Referrals made to other services by the DSOs

A review of the monthly reports revealed that:

- For both cultural groups, most referrals were made to GPs, followed by podiatrists.
- The Vietnamese DSO made 25 referrals to a physical activity program specifically targeting Vietnamese people;
- The Italian DSO made several referrals to 'other' (mostly non-diabetes) care services. In Inner City this included Home Help, Women's Health Care House, DAWA, City of Bayswater for domestic help and transport and Family and Children's Services. In Swan this included Cancer Foundation, SHS Social Worker, Pharmacist and Home Help.

Please refer to Figures 3–4 referrals made to other services by the DSOs.

Figure 3. Referrals made by Italian DSO

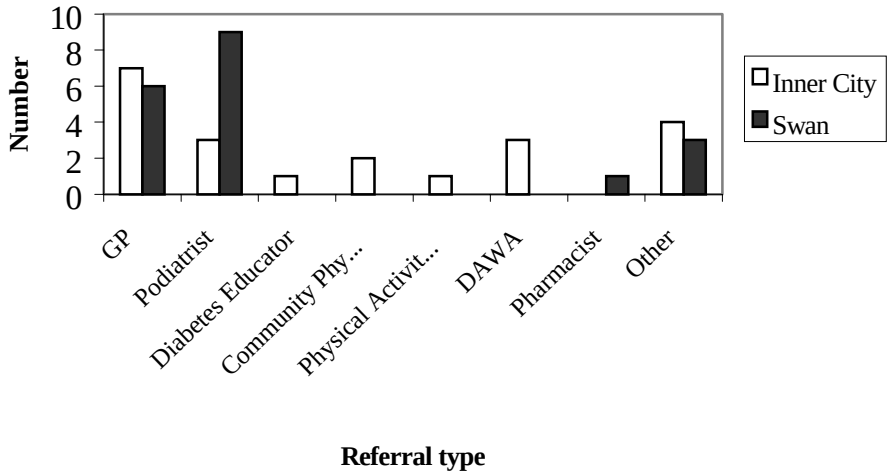
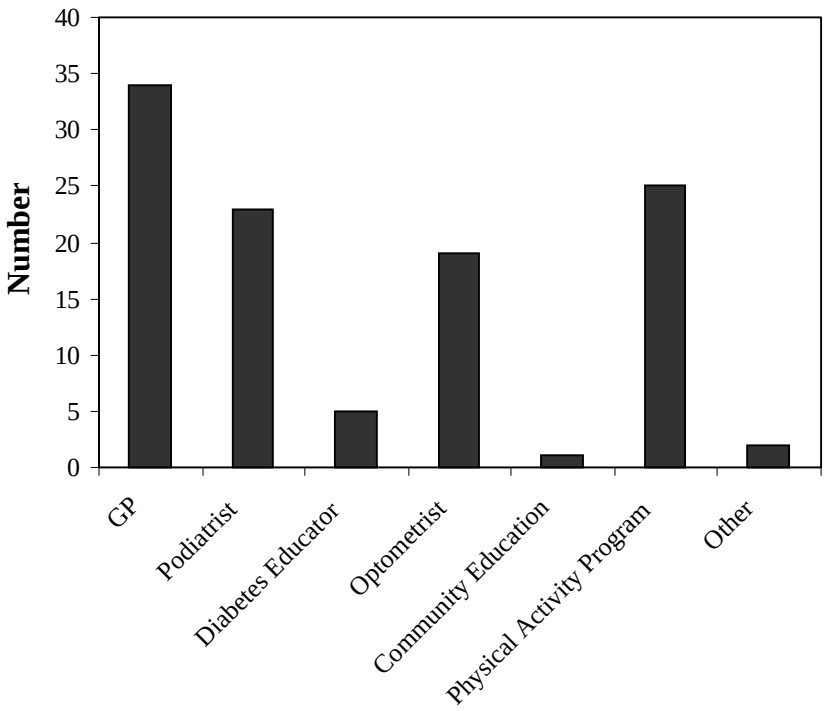


Figure 4. Referrals made by Vietnamese DSO



12.2.3 Group activities

In addition to delivering individual consultations the DSOs conducted a number of information seminars for consumers over the course of the pilot program. Written evaluations were distributed to consumers at the end of each seminar for their feedback. A total of 121 Italian and 112 Vietnamese people attended these seminars (Tables 10 and 11). The DSOs reported that:

- The seminars were extremely well received from both communities;
- Information seminars were effective in reaching larger populations and offered an alternative service to consumers to whom one on one consults did not appeal;
- Information seminars presented an opportunity to further promote the program amongst their respective communities;
- Planning and implementing information seminars could be time consuming and detracted from other work commitments such as conducting individual consultations;
- Conducting evaluations was difficult and time consuming with Italian and Vietnamese people due to a range of factors such as poor eye-sight and/or poor literacy levels in the vernacular.

One DSO reported that she supported additional group activities such as conducting nutrition tours and establishing physical activity groups for her community. The latter included recruiting people to the physical activity programs by actively promoting the programs through her community networks.

Table 10. Group seminars conducted for Italian community

Venue	Topic	Facilitator	Number of participants
IAWCC	Overview of diabetes	DSOs	43
IAWCC	Understanding Diabetes Footcare	DSO Podiatrist	45
Swan Italian Club	Understanding what is Diabetes	DSOs	23
Swan Italian Club	Overview of diabetes	DSOs	10
Total			121

Table 11. Group seminars conducted for Vietnamese community

Venue	Topic	Facilitator	Number of participants
Loftus Community Centre	What is diabetes?	DSO	20
Lockridge Community Health Centre	Foot-care	DSO DE Podiatrist	16
North Perth Day Centre	What is diabetes?	DSO	22
Private GP Surgery	What is diabetes?	DSO DE	13
Supermarket	Supermarket Tour: Nutrition advice	DSO	6
Lockridge Community Health Centre	Diabetes and the Eyes	DSO Vietnamese speaking Optometrist	16
Lockridge Community Health Centre	Diabetes and Dental Health	DSO Vietnamese speaking Dentist	19
Total			112

12.2.4 Resources

Educational materials

Over 20 different educational resources were provided to the DSOs in order to inform them about diabetes and/or where appropriate to disseminate to clients. These resources included:

- Posters (eg. Diabetes Eye Health (Italian and Vietnamese version), National Physical Activity Guidelines for Australians, The Australian Guide to Healthy Eating);
- Brochures (eg. Riverside Gardens Walking Trails, Italian and Vietnamese specific diabetes brochures);
- Booklets (eg. Walk Friendly in WA –A Resource for Walkers, Diabetes What You Need to Know);
- Newsletters (eg. Be Active Together (BAT) newsletters).

Over the course of the program, the DSOs were encouraged to seek out their own resources or *tools of trade*. This included utilising household items (eg. collecting used food containers to demonstrate what constitutes a balanced diet to consumers) or acquiring resources through their professional networks.

Promotional materials

Various promotional strategies were implemented to raise the primary and secondary target groups' awareness about the program. These included:

- Brochures for service providers;
- Wallet sized cards detailing information both in English and Italian or Vietnamese;
- Publicity generated through various publications[18] (eg. local newspapers, ethnic newspaper) and ethnic radio;
- Meetings with service providers to inform them about the program;
- Publicising the program at conferences[19] targeting service providers.

An analysis of the promotional strategies implemented is presented in Table 12.

Table 12. Promotional strategies implemented

Promotional strategies implemented	**Approximate Numbers**
Service provider brochures disseminated	370
Wallet sized cards disseminated	1300
Announcements on ethnic radio	Ongoing
Articles published (local newspaper, ethnic newspaper)	32/Ongoing
Presentations at Conferences	4/Ongoing

[18] Articles were published in Midland Reporter, Punto D'Incontro (ie. IAWCC Newsletter), Il Globo, Healthview, The Voice of the Vine and Connective Issue.

[19] Information about the program was presented at the ADEA (WA) Conference (16th November 2001), DoH Diabetes Symposium (17th May 2002), Population Health Unit (11th June 2002) and at the National Health Promotion Conference (17th June 2002).

12.2.5 Workforce development

Ongoing professional development

In total, five professional opportunities were delivered as part of the program following the DSOs initial training. These included:

- Diabetes Show and Tell for supplies and equipment for self management (displays set up by various pharmaceutical companies);
- Nationally accredited basic foot assessment course (Facilitated by RPH Podiatry Unit);
- Public speaking tips (Facilitated by DAWA);
- Physical activity local services and interventions (Jointly presented by the EMPHU, City of Bayswater, City of Swan and CPS;
- Food Cent$ budgeting program (Facilitated by EMPHU).

The DSOs participated in additional training opportunities organised and/or supported by their employing organisation. This included the 2001 Australian Diabetes Educators Association Western Australia State Conference, a weight control seminar and information updates provided by pharmaceutical companies.

Orientation visits

In total four orientation visits were scheduled to the following organisations:

- Podiatry Clinic (RPH);
- Diabetes Clinic (RPH);
- Perth Hills Division of General Practice (formally Perth Division of General Practice);
- King Edward Memorial Hospital (Diabetes Clinic).

During a physical activity training event held for the DSOs, the BAT project officers from the City of Swan and City of Bayswater, and a senior physiotherapist from CPS presented information about their respective services, and how consumers could be referred to their programs. As a result of this training event, the DSOs were placed onto the BAT newsletter mailing lists in order to receive their own copies in the future.

12.3 Survey disseminated to community & tertiary based service providers

12.3.1 Survey response rate

Out of the 140 surveys sent out, 44 were returned completed and two were returned unopened, thus giving an overall response rate of 33%.

12.3.2 Awareness of service

Eighty nine per cent (39/44) of respondents indicated that they were aware of the service provided by the DSOs.

12.3.3 Referral to service

When asked whether they had referred consumers to the service, 48% (19/40) of respondents reported they had referred clients to the service whilst 52% (21/40) indicated they had not referred clients.

Thirty three percent (8/24) of respondents who had referred clients to the service reported they were very satisfied with the level of communication they had with the relevant DSO whilst 30% (7/24) reported being satisfied. Twelve percent (3/24) reported being neutral and a further 25% (6/24) reported that communication with the DSO was not applicable.

Seventy one percent of the respondents (12/17) reported receiving positive feedback from consumers who had been referred to the service. Only one respondent reported receiving mixed feedback (6%). Four respondents indicated they had not received any feedback from their clients (23%).

12.3.4 Barriers to referral

When asked what prevented service providers from referring consumers to the DSOs, 52% (10/19) of respondents listed having minimal contact with Italian and/or Vietnamese clients and 26% stated they could access accredited interpreters (5/19)[20]. Less frequent responses included being able to manage clients without additional support, perceived lack of interest from clients and the DSO role being unclear (Table 13).

[20] Respondents could provide more than one answer.

Table 13. Barriers to referring consumers to DSO

Reasons	**Number**	**Percentage of respondents**
Minimal contact with Italian and/or Vietnamese clients	10	52
Access accredited interpreters	5	26
Other[21]	4	21
I can manage clients without service	3	16
Clients declined offer for additional support	3	16
Information about the service not readily accessible	2	10
Perceived lack of interest from client	2	10
I speak Italian and/or Vietnamese	2	10

One respondent commented that they were unlikely to refer to the service because:

> *We have access to a lot of services as a tertiary hospital so it is rarely necessary for our clients.*

Another respondent reported that they were likely to refer consumers to the service after observing a recent increase in the number of Italian and Vietnamese consumers accessing their service. Another respondent reported they *would be very happy to use this service* when the opportunity arose.

12.3.5 General comments

Some general comments and suggestions were put forward including:

> *Need fliers to give to patients.*
> *In North Perth we could do with another support officer speaking in Slav.*

> *Have referral pad printed with all details of service providers – address details etc.*

[21] Other includes responses listed only once (eg. client referred to diabetes clinic, mostly under control of GP already, forgetting about existence of service, not aware of service).

One respondent advocated the need for the program to continue beyond the pilot phase, stating that:

> *After getting the service up and running I feel it is very important for it to continue and not be dropped at the completion of the pilot. I have found it to be a very valuable service.*

12.4 Discussion groups with consumers

12.4.1 Demographic characteristics of consumers who participated in the discussion groups

Italian participants

A total of 18 Italian consumers participated in the Italian discussion groups. Their mean age was 72.7 years and just over half the group were men (55.6%, n = 10).

The mean length of time that the Italian participants had been in Australia was 45.8 years. All people (100%, n = 18) reported that they predominantly spoke Italian or Italian dialect at home. However, just under half (44.4%) reported that they also spoke English. Only five (27.8%) consumers reported that they spoke English well. Over two thirds reported either that they did not speak English well (66.7%, n = 12) or that they did not speak English at all (5.6%, n = 1).

The mean length of time since diagnosis of diabetes was 10.7 years. Approximately a fifth (22.2%, n = 4) had been diagnosed with diabetes within the past two years, only 2 consumers (11.1%) had been diagnosed between two and five years ago, 16.7% (n = 3) had been diagnosed between six and ten years ago, and the remaining half (50.2%, n = 9) had been diagnosed more than ten years ago.

Two thirds (66.6%, n = 12) of the participants lived in four postcodes – 6000 (11.1%, n = 2), 6006 (22.2%, n = 4), 6054 (11.1%, n= 2), 6056 (22.2%, n = 4). The most commonly reported suburbs or suburban areas were North Perth (6006), Midland and Swan area (6065), Perth City (6000) and Bassendean/Lockridge area (6054).

Vietnamese participants

A total of 22 Vietnamese people participated in the focus groups for Vietnamese consumers. Their mean age was 61 years and half the group (n = 11) were women.

The mean length of time for which participants had been living in Australia was 15.1 years. All but four consumers (81.8%, n= 18) spoke Vietnamese at home. Of the remaining four, three reported speaking Chinese at home and one did not specify the language used. Just under a third (22.7%, n = 5) of the consumers reported that they also spoke English. Of those who reported on their fluency in English, only two (9.1%) consumers reported that they spoke English well. Approximately one half (54.5%, n = 12) reported that they did not speak English well and 31.8% (n = 7) reported that they did not speak English at all.

The mean length of time since diagnosis was 5.9 years. Just under a third (27.2%, n = 6) of the consumers had been diagnosed with diabetes within the past two years. A further third (27.2%, n = 6) had been diagnosed between 2 and five years previously and the remainder had been diagnosed for more than five years.

More than half (68.2%) the Vietnamese participants lived in three postcodes - 6054, 6062, and 6063. The suburbs or suburban areas in which they were most likely to live were the Bassendean/Lockridge area, Dianella/ Morley area and Beechboro.

The demographic characteristics of the participants are presented in Table 14.

Table 14. Demographic characteristics of Italian and Vietnamese participants

Demographic Characteristics	Italian	Vietnamese
Mean age	73 years	61 years
Mean length of time in Australia	46 years	15 years
Speak first language at home	100%	82%
English spoken	44%	23%
Do not speak English well or not at all	72%	86%
Mean length of time since diagnosis	11 years	6 years
Total number of participants	18	22

12.4.2 Participants' referral source

Italian participants

The majority of Italian participants reported being referred to the service by their GP. Other referral sources included:

- DEs;
- Podiatrists;
- Tertiary specialists.

Vietnamese participants

Most Vietnamese participants reported that their GP, who in the majority of cases was also Vietnamese, had referred them to the DSO. Some participants however reported being referred by a/an:

- DE;
- Eye specialist;
- Friend or relation.

One participant mentioned they found out about the program after attending an information seminar the DSO conducted at her GP surgery whilst another mentioned hearing about the service in a community notice.

12.4.3 Participant satisfaction

Participants expressed a high level of satisfaction with the service they received from their respective DSO. The majority of participants expressed the appeal and importance of receiving the information in their first language as many did not understand or speak English well.

Italian participants

> *I am very happy with {*Italian DSO*}. He explains everything in Italian.*

> *They {*service provider*} asked me if I want more information in Italian or English. I said Italian so they sent me to {*Italian DSO*}.*

> *It is important that he {*Italian DSO*} can speak Italian…sometimes when we see an English person, we understand some but not everything…now we can understand everything…*

Vietnamese participants

> *It is very important to us that she {*Vietnamese DSO*} can explain to us about diabetes in Vietnamese.*

> *I can speak English too. But when she* {Vietnamese DSO} *explained things to me in Vietnamese I can understand it better.*

> *My doctor sent me here because he knows I don't understand English well enough…*

When asked what they liked most about the service, consumers cited the amount of time DSO spent providing them with information and support about diabetes. Some consumers noted that time constraints prevented GPs from being able to provide the same quality of care.

Italian participants

> *I have been to many English and Italian-speaking doctors. {*Italian DSO*} has helped me more because he tells me things over and over again. He makes me understand....explains things more clearly.*

*He {*Italian DSO*} really explains everything…doesn't let you go unless he's sure you understand everything.*

Vietnamese participants

The doctors have limited time to explain things to us.

One Vietnamese participant further commented that the DSO was accessible for follow up support when required.

*When we have a problem we just ring {*Vietnamese DSO*}.*

12.4.4 Increased knowledge and skills for self management of diabetes

Participants cited the following areas where they had acquired the most diabetes information and support:

- Lifestyle management advice;
- How to monitor and access diabetes supplies and equipment;
- Medications and insulin;
- Information about relevant diabetes services.

Italian participants

Exercise…he {Italian DSO*} showed me how to do it.*

*I already had a machine {*blood glucose monitor*}. {*Italian DSO*} asked me how I was doing the test...He asked me to bring my machine in to see exactly what I was doing.*

*He {*Italian DSO*} also referred me to a podiatrist.*

Vietnamese participants

*She {*Vietnamese DSO*} tells us to be careful when we cut our toes and that it's better not to cut it too deep.*

*{*Vietnamese DSO*} explained about diet, insulin, and medications.*

She {Vietnamese DSO} *told me where to buy the machine. It usually costs $100 but she told me where to buy it for $60.*

Participants identified that the information they had received from their respective DSO had, in turn, increased their level of knowledge about diabetes.

Italian participants

*He {*Italian DSO*} has helped me a lot and taught me new information.*

Vietnamese participants

*Before seeing {*Vietnamese DSO*} I really didn't know much.*

*We are more aware about our feet, toes, shoes, eyes, teeth. Through {*Vietnamese DSO*} we found all this out.*

*{*Vietnamese DSO*} gave me a lot more information about diabetes and she supports me a lot.*

Before we didn't know how to choose our own diet.

All participants reported implementing lifestyle management strategies to varied degrees based on the information they had received.

Italian participants

I've changed my diet completely. I have eliminated things like fat and dividing my meat into 40g portions...pasta into 50g portions...instead of having a big plate.

I now walk 4kms everyday...

*I used to eat, for example, two lamb chops …after he {*Italian DSO*} explained to me I stopped eating them…*

Vietnamese participants

*She {*Vietnamese DSO*} has given me advice for food so I can know what to eat.*

We do exercises more than before. We walk 35 minutes every morning and 35 minutes every evening.

All the Vietnamese consumers in one discussion group said that they were eating healthier.

As a result of the lifestyle changes they had implemented many consumers reported notable positive differences including weight loss, improved diabetes control and feelings of self efficacy about managing their diabetes.

Italian participants

I don't have headaches any more and I'm not dizzy any more.

I feel more in control.

Before coming here my sugar level was 10 or 12 or 15… now my sugar level is about 7 and I also lost a bit of weight.

My friend who suffers from diabetes tells me I don't look like it because I am so healthy.

Vietnamese participants

I feel more confident now.

*We were scared… we thought were going to die before {*seeing Vietnamese DSO*}.*

*{*Vietnamese DSO*} has helped her to improve. Before her blood sugar was 13 and now she is improving. It has gone from 13 to 8.7 to 7.8 {*comment made by one participant's husband*}.*

We check our blood sugar and now it is stable.

My diabetes control is better.

Despite the level of support provided, some Italian participants reported difficulty in implementing lifestyle changes because of health problems, time constraints, stubbornness and/or lack of motivation to perform the necessary self-management tasks.

Italian participants

> *We all know what we shouldn't eat but we still make some mistakes.*
>
> *I do not have time to exercise but my children keep me busy in the house.*
>
> *I am Calabrese {*southern region of Italy*} and stubborn!*
>
> *…But when I ate according to the suggestions I started being hungry more often and so I find it hard to follow the diet.*

12.4.5 Barriers to accessing service

Participants cited the following barriers they believed prevented consumers from accessing the service:

- Lack of transport, especially amongst the elderly;
- Lack of time (*too busy with other commitments such as caring for other family members*);
- Lack of education about the importance of managing diabetes.

Italian participants

> *I have a friend whose husband had a stroke and she cannot attend because she is looking after him.*
>
> *There are a lot of people, and they would like to come but have no transport.*

Vietnamese participants

> *For the younger people it's easier…For the older people they prefer {*Vietnamese DSO*} to visit them because they cannot drive.*

Some Italian participants identified additional reasons why some people chose not to access the service, including:

- Privacy concerns;

- Fear of the lifestyle changes people with diabetes may need to make;
- Not being able to accept that one has diabetes.

They don't want people to know they have diabetes.

I heard from some people they don't want to see a dietitian because they are scared they will have to go on a strict diet.

Some people don't want to acknowledge they have diabetes.

12.5 Consultations with program partners

12.5.1 Cultural appropriateness of service

Program partners reported that the DSOs were able to give clients appropriate information because they:

- Were of the same cultural background as their clients;
- Could speak the same language as their clients;
- Could work with consumers at their own pace.

Being of the same background meant the DSOs were able to draw on their tacit knowledge of their consumers' culture to tailor messages accordingly.

Being Vietnamese, I know what kind of food they cook at home. Some of the food, we cannot translate into English. So, when they speak to an Australian doctor, or an Australian dietitian, they would say they eat meat, fish, vegetables etc. But when they talk to me they tell me the names of dishes (which you could not find on the menu of Vietnamese restaurants) and then I would know how salty, how sweet, how fatty they are…

*With the Italian community I achieved this {*being able to communicate messages to consumers*} by being able to speak the language and understand their customs and their thinking process.*

They further identified that providing the information in the consumer's own language was imperative because most consumers did not speak English well.

> *One of the major issues affecting my clients, is lack of effective communication…Although many Italian people have been living in Australia for many years, many of them are not proficient with the English language, which hinders them to understand how best to self manage their diabetes.*

One of the DSOs noted however that he did not always understand the dialect some consumers spoke. He cited spending additional time asking *consumers to clarify what they meant in a manner that did not embarrass them* to overcome this problem. He further stated that time constraints may prevent interpreters faced with the same problem from being able to communicate effectively with consumers.

Working at consumers' own pace was related to:

- Spending extra time with consumers who struggled to understand key concepts;
- Being aware and/or able to ascertain consumers' level of education;
- Utilising various educational methods and strategies to deliver lifestyle management advice.

> *After tactfully ascertaining if clients are literate, as there are a number that are illiterate, we reinforce the message with the use of Italian written pamphlets, that clients can then take away with them…Or conversely we give illiterate clients visual information in a picture format.*

> *On my first visit I need to find out how much they know about diabetes and their levels of education so that I can choose an appropriate way to deliver our message. Some {*of my clients*} did not go to school… With these people, there is no point talking about pancreas, hormones, insulin, glucose, cells.. They would not be able to understand. I need to use simple terms, pictures, analogies.*

12.5.2 Improved capacity to self care

Program partners observed the positive impact the service has had on consumers, including improved self-efficacy, knowledge and awareness and improved access to diabetes equipment and supplies.

> *Consumers now have a sense of empowerment…they are more confident and understand the laboratory results and can now interpret blood glucose readings.*

> *Consumers were not aware of sub-agents that they could access instead of having to go to DAWA.*

> *As a result of the program all consumers are placed onto the NDSS {ie.* National Diabetes Service Scheme}.

> *They don't need to arrange an appointment to see their doctors to test their blood. They can do it themselves at home.*

The DSOs noted however that promoting optimal self management amongst consumers was affected by a number of factors, including:

- Lack of motivation to perform the necessary self management tasks;
- Tendency to rely on Western medication and/or alternative therapies to manage and/or *treat* their condition;
- Perception that their condition was not life threatening because they did not feel unwell;
- Stress arising from personal problems.

They reported utilising a number of strategies to motivate clients to achieve lifestyle changes, including:

- Assisting clients to set realistic and achievable goals;
- Providing clients with follow up support;
- Engaging family members for support;
- Being available to listen to and, where possible, help clients address some the stresses affecting them. This process required *building confidence with clients, demonstrating empathy and good people skills*.

*Getting them to change their lifestyle is hard… We don't push them {*consumers*} one iota. I tell my clients I am only suggesting for you to decide if it is a good idea to {*do some walking*}.*

You can not assume just because you have provided all the information they will remember what to do. Many of my clients were registered with NDSS to buy cheap supplies but forget to use the card. I have to remind them.

I ask the client's spouse to come along to all groups. I encourage them to exercise together so they can support each other.

*I had one client who was living on her own. She had BGL {*blood glucose level*} double digit figures. I got her daughter to check on her and what she was eating on a regular basis.*

…stress can impact on diabetes management. For the old people, language is the biggest problem. They are isolated, stuck at home, feeling homesick. We are helping them to overcome the stress in their lives. To learn ways to deal with it.

12.5.3 Home visits

Some program partners reported that home visits were necessary for consumers who were unable to attend consultations at the DSOs service site. These problems related to consumers:

- Relying on family members for transport;
- Lack of confidence and/or experience negotiating public transport due to limited English skills;
- Living outside the public transport route;
- Having co-morbidities which reduced their mobility;
- Caring for elderly or sick family members.

Participants supported the need to continue to make home visits available to consumers who lacked access to transport. They commented however that, where possible, consumers should be encouraged to explore avenues to attend consultations at the service site.

12.5.4 Resources

Promotional materials and marketing strategy

Despite the level of publicity generated participants cited various barriers as to why some consumers did not access the service. One participant commented that many Italian people her organisation had contact with did not perceive the need for a culturally specific service because they had lived in Australia for many years and could speak English reasonably well. Another participant commented that many Vietnamese people affected by diabetes chose not to access the service because of their:

- Satisfaction with the quality of care provided by their GP, who was usually Vietnamese speaking;
- Preference to keep the number of people who knew about their diabetes to a minimum;
- Lack of understanding in the community about her new specialised role in diabetes.

Seasonal factors were also cited as barriers impacting upon both communities uptake of the service. For example, few Italian referrals were received over summer, during the Swan Valley wine making season. Program partners noted that many Vietnamese people travelled to Vietnam during the Chinese New Year (between January to June) and consequently few presented to the service at that time.

Some participants suggested that enhanced promotional efforts were needed given the minimal number of referrals received by some mainstream allied health practitioners. This included raising awareness amongst pharmacists as minimal promotion had occurred amongst this group during the pilot phase.

12.5.5 Organisational development

JDF

When asked about the initial hesitations felt by some service providers about the need to clearly define the DSO role as being different but complementary to that of the DE had been overcome, one DE commented that this had adequately been addressed by the JDF.

One of the DSOs, who was formerly a generalist health worker, identified that having specialist training skills and time dedicated to diabetes had enabled her to better assist her community:

> *I really enjoy my new role. It gives me the opportunity to help my people to make changes in their lifestyle to live a longer and better quality life.*

Integration into local teams

One DSO reported rescheduling his dates so that he could attend the monthly diabetes team meetings held at the health service. He described being able to attend these meetings was *most beneficial* because it helped him to *feel more part of the team* and to hear first hand the outcomes of decisions likely to impact upon their work, as opposed to waiting to be informed at a later date.

Program partners reported that the DSOs had successfully integrated into their respective teams, citing various examples of how they worked together. One DE commented that she was *called into consultations* when the DSO was working with clients with complicated care requirements. She reported that a case conferencing or multi-disciplinary approach helped to achieve a better outcome for these clients. This was supported by another DE who stated that as a result of the effective integration that had occurred, she was able to rationalise her workload accordingly:

> *I have been freed up to work with consumers with complicated care as the DSO can now meet the needs of consumers requiring basic information and care in their own language.*

One participant noted however that collaborating with other health professionals located within the health service was easier to initiate for the DSO on site as they had direct access to health professionals and a geriatrician. She noted several benefits of this, including the ease to which the DSO could discuss client issues and have them addressed efficiently and the *familiar face for easy referrals*.

Participants observed that the DSO based within the ethno-specific consumer organisation had similarly integrated successfully into the organisation's existing Welfare Team. They reported that the DSO attended the Welfare Team meetings and worked closely with the Welfare Officer. They met regularly to case conference mutual clients and, over the course of the pilot, jointly implemented educational and promotional strategies (eg. prepared articles about the program in their organisation's newsletter, the Welfare Officer acted as an interpreter for a guest speaker at a diabetes information seminar).

Integration with other services

Program partners reported that although the DSOs referred consumers to essential diabetes services, transport problems and lack of confidence arising from language barriers compromised some consumers' ability to take up those referrals. One DSO however noted that she was able to refer consumers residing in the north metropolitan health service to the Vietnamese Health Worker employed to cater for Vietnamese people in that area. The other DSO reported that because there was no equivalent culturally appropriate service available he was not able to refer consumers residing outside the Inner City or Swan health service to other bicultural service providers.

The DSOs reported acting as a link to services and/or programs to improve consumers' use of other services. For example, one DSO reported that she sometimes met consumers at DAWA to show them what services were available at this consumer organisation. Similarly she had met consumers at the commencement of a physical activity program (eg. Tai chi, walking group) to introduce new clients to program coordinators and other participants. She further commented that working within this capacity also included making appointments to other service providers on behalf of consumers who spoke little or no English.

Program partners reported that acting as a link required frequent liaison with other mainstream service providers of mutual clients. They reported sending progress reports routinely to GPs, who were consumers' recognised primary case manager. One DSO described an occasion when he liaised with a pharmacist to assist a client who forgot to take his medications.

> *One consumer constantly forgot to take his medications until we {*DSO and Diabetes Educator} *introduced him to a "Webster Pack" which is filled weekly by his pharmacist thus making it easier for the consumer to take his medications on a regular basis, which in turn, influenced his well-being.*

Another DSO described an occasion when one of her clients could not remember the advice initially provided to him through an interpreter service. She responded by informing the service provider of the difficulties her client was experiencing in managing his diabetes as a result. In this instance, advocating on behalf of the client meant the DSO was able to provide follow up support to her client by reiterating the advice he had previously forgotten that had

been provided by the mainstream service provider. Furthermore the DSOs cited occasions when they needed to advocate in areas outside health in order to address some of the wider social and/or personal problems their clients faced. This included linking consumers to a broad range of welfare services such as local councils and home help services.

12.5.6 Workforce development

Initial training

Of the three training facilitators, only one was allocated time to continue her involvement in the broader program as a mentor. Program partners identified that the two other mentors not involved in the initial training were disadvantaged because they were unfamiliar with the competencies the DSOs had acquired. This was overcome however by providing them with copies of the training course.

Mentoring

All participants reported that the mentoring program was an extremely important factor in the program's overall success. The mentees commented that mentoring allowed them to problem solve emerging issues, case conference and consolidate the skills they acquired during their initial training. One mentee explained that her mentor routinely forwarded any relevant diabetes information to her and organised several training seminars with pharmaceutical representatives. Another mentee explained that the mentoring was particularly crucial during the *first three months* of the program as it was during this time they were still orientating themselves to their new positions and workplace. This was supported by another mentee who added that she felt *psychologically safer* knowing that there was *someone to turn to for support and to discuss issues* as she was working in a new area.

The mentors reported enagaging in a number of mentoring activities such as assisting the mentees to liaise with other service providers, *how to advocate on behalf of clients* and orientating the DSOs to their organisational culture. They noted several positive outcomes from their involvement in the program. These included the opportunity for reciprocal learning, in this case, *learning more about different communities* and the satisfaction of observing the personal and professional growth of mentees over the course of the project. One mentor with prior experience working with the Vietnamese community commented that the mentoring had *cemented what I already knew*. The mentor previously involved in the initial

training as a co-facilitator commented that mentoring provided an opportunity to *follow up on issues which were rushed in the training*.

The majority of participants felt confident raising issues for discussion with their mentor/mentee and identified various reasons for this. One participant explained that *spending time at the beginning to set parameters* (eg. stipulating meeting days, times and purpose) helped the *mentoring process to run smoothly*. Some highlighted the importance of trust being needed for the mentoring relationship to work, whilst others mentioned being matched with a compatible person. One mentor cited the importance of the mentor *not being seen as having a line manager role but more for the professional development in diabetes* as an essential characteristic of an effective mentoring relationship. Another mentor commented that her involvement in the recruitment process may have played a part in the rapport that developed between her and her mentee.

Despite the positive feedback received, some challenges were noted. One mentee explained that she was unsure *how far to divulge* information and discuss issues with other service providers when her mentors were not available. One mentor reported that one of her mentees rarely initiated contact to meet with her. She further commented that as a mentor she felt obligated to prompt meetings because it was a requirement of the program and that time and funds had been allocated to support this initiative. Another mentor commented that additional training set aside specifically for the mentors may have been beneficial in terms of enhancing their skills and competence as mentors.

Participants commented that the most common form of contact maintained over the course of the pilot program was face to face, followed by telephone and sometimes e-mail. They further reported that the amount of time spent on mentoring and the frequency of meetings reduced over time from one to two hour weekly meetings to a need basis as a result of their mentees' growing confidence. One mentor explained:

> *As far I am concerned {*mentee*} has such good insight that I do not make any special time to check on her. She has the confidence to contact me if she feels the need.*

She further noted that much of the time previously spent on mentoring was now spent on program development such as jointly planning and facilitating information seminars which in turn enhanced the DSOs integration into the team.

> *We have set aside time to discuss our {*clients with*} GDMs and plan to bring them in for an afternoon to have a healthy life style chat.*

Another mentor similarly noted that the relationship with her mentee had changed to one on more even terms – *as colleagues* and that being available to provide support was not necessarily about mentoring per se but more about effective team functioning.

The mentees reported that they had scheduled meetings on a monthly basis between themselves. These meetings enabled them to provide each other with peer support, review challenging cases and share information.

Participants suggested that a flexible mentoring program be adopted beyond the pilot phase that enabled the mentees to access other people for support and guidance, not only the mentor they were initially matched with. Participants identified that the DSO based in the health service had opportunistic and/or immediate support to *bounce ideas off* qualified diabetes specialists. They therefore suggested that DSOs who were not part of an existing diabetes team be encouraged to meet with their mentors face to face, albeit less frequently, to ensure they did not become isolated. All participants agreed that management support was required for any form of mentoring to operate effectively within working hours.

Journals

The discussions revealed that only one participant had maintained a journal. The participant commented that this strategy provided an effective record of events as a reference as well as a tool for reflection. Another participant stated that they had not recorded the information as intended but kept a record of progress notes instead, including information learnt from attending conferences or professional training events. Time pressures were cited as a major barrier preventing participants from keeping a journal.

12.5.7 Leadership

Program partners reported the numerous benefits of the program in the community and their respective organisations. One participant commented that the program had increased the profile of Type 2 diabetes, particularly amongst the elderly who were most at risk. Another person commented that the service *fills a gap* in service delivery to special need groups, further identifying that the program had extended their organisation's capacity to access new consumers.

The organisations' readiness to plan new and innovative activities beyond the pilot phase, and in the case of the health service, to commit continued funding, demonstrated their sustained support for the program.

Various suggestions were put forward by participants on how the program could be enhanced. They suggested that:

- Community consultations, which embrace the principles of a community development approach, be held to identify gaps and in turn determine future service development. This will promote community ownership of any new initiatives (eg. walking groups, support groups);
- Future activities be planned and implemented with relevant allied health professionals (eg. dietitians, podiatrists) to enhance collaboration between service providers. This may include working with new partners outside the health sector (eg. liaising with local government to support walking groups for consumers);
- Future initiatives be planned within a set program as opposed to *one off* and/or adhoc events (eg. calendar of events);
- The program be broadened to include Italian and Vietnamese people without diabetes and therefore focus on healthy lifestyles and diabetes prevention. This was based on the high prevalence of diabetes amongst CALD communities.

Participants identified that management support was imperative to ensure that time was allocated for planning new events and initiatives which, in turn, may reduce their availability to conduct one on one consultations.

13.0 DISCUSSION

13.1 Objective 1

To provide Italian and Vietnamese people with diabetes access to a culturally appropriate diabetes service in the Inner City and Swan health services.

13.1.1 Program reach

The short time frame of the pilot program has not allowed the service to reach its full capacity. It was envisaged that the first priority of the pilot was to increase the health services capacity through organisational change, workforce development and reorientation of service delivery into mainstream infrastructure. However, the actual throughput of service delivery was impressive, and indicates that the program was reaching its intended primary target audience (ie Italian and Vietnamese people with Type 2 diabetes). Furthermore it is worth noting that as the throughput of a new service is usually less than well established ones, program partners can expect that the number of consumers who access the service will increase in the future.

13.1.2 Age categories

Although the biggest age group for each community group was over 71 years of age, Italian consumers represented an older group overall and few or no occasions of service were recorded for consumers aged 0-30, 31-40 and 41-50 years. On the other hand a more even spread of age groups was noted amongst the Vietnamese consumers. This is in accordance with ABS (1996) statistics which revealed that the Italian community (of Inner City) has an older age structure than the general population of the area (cited in Di Francesco, 1999:13). By comparison the Vietnamese population (of Inner City) is younger than that of the general population (cited in Di Francesco, 1999:13).

The HCARe data also showed that 14.8% of occasions of service were delivered to Vietnamese consumers aged between 0-30 and 31-40 years respectively. Discussions with the Vietnamese DSO revealed that most of these occasions of service were delivered to Vietnamese women who have or had a past history of GDM. This would tend to concur with the research which shows that the prevalence of GDM among CALD populations, particularly those from India, Asia and the Pacific Islands is reported to be up to 20% higher than in Caucasian women (Commonwealth Department of Health and Aged Care 1999).

13.1.3 Consumers' place of residence

HCARe data revealed that consumers who accessed the program were primarily from the intended catchment area (Inner City and Swan health services). The pilot site for the program did not include the whole of the East Metropolitan Health Service (EMHS). There is a need– *beyond the pilot phase* – to extend the service to consumers and health service providers in the EMHS in light of the restructuring of health services.

An analysis of the data revealed that consumers residing outside EMHS were also accessing the service. Where appropriate, the Vietnamese DSO was able to refer consumers living in the NMHS to the NMHS Vietnamese DSO, however this was not possible for the Italian community, as there is no existing equivalent service available. This may account for the greater number of occasions of service which were delivered to Italian people living outside EMHS compared to the Vietnamese population (21% and 6% respectively). This program stems from local needs assessment data which identified a lack of culturally appropriate services available for Italian and Vietnamese people. It is therefore clear that the DSOs need to continue to accept referrals from consumers irrespective of where they live, however limited resources requires that the situation be closely monitored and that the main priority remain with consumers residing in EMHS.

13.1.4 Service sites

Program partners identified that home visits were offered to consumers who were unable to attend consultations at the DSOs' place of employment mainly due to lack of access to transport and/or being affected by reduced mobility. Although the health sector does not have direct responsibility for transport, lack of transport impacts directly on consumers' capacity to access services and programs, and therefore warrants close monitoring by program partners. EMPHU, in collaboration with the Department of Transport and other sectors, should continue to advocate the need for healthier transport systems as identified in their 2001-2003 Strategic Plan (Eastern Perth Public and Community Health Unit 2001). In the interim, clients should be encouraged to find avenues and means to attend the program and consultations at their respective service site. At the same time it is important that home visits continue to be offered to consumers with identified need as appropriate follow up and assessment is vital for people with diminished ability to self manage their condition.

13.1.5 Language proficiency

Consumers and program partners reiterated the importance of having bilingual workers deliver the information in their own language because most did not speak English well. This was despite the fact that the mean length of time spent in Australia was 46 years and 15 years for the Italian and Vietnamese groups respectively. The fact that one participant noted that some consumers with proficient English skills may not perceive a need for the service simply highlights that consumers from CALD backgrounds are not a homogenous group, and that those with no or basic English skills will benefit the most from the service.

13.1.6 Promoting access to essential services

Part of the DSO's role included facilitating consumers' access to allied health and specialty services which complemented their own. The evaluation highlighted that although referrals were made, language barriers and transport problems compromised some consumers' ability to take up those referrals. Despite these barriers, the DSOs demonstrated that they did not work in isolation. Rather they liaised closely with other mainstream service providers at various levels such as acting as a physical link to services/programs, case conferencing and advocating on behalf of clients as required, sometimes in areas outside health.

An audit of available services supported the fact that few culturally appropriate services are appropriate for people with diabetes from CALD backgrounds (Di Francesco, Gillam et al. 1999). In the absence of bicultural health professionals, it may be worth investigating whether the DSOs can provide cultural awareness training to mainstream service providers to assist service providers to better understand the needs of individual clients. The suggestion is in line with one of the recommendations to emerge from the 1999 needs assessment which was to provide opportunities for situational and consumer-specific cultural awareness training to mainstream service providers (Di Francesco, Gillam et al. 1999).

13.2 Objective 2

To improve the knowledge of and skills in self care amongst Italian and Vietnamese people with diabetes in the Inner City and Swan health services.

13.2.1 Health education/promotion

The needs assessment conducted by Di Francesco, Gillam et al. (1999) found that people from CALD backgrounds were at greater risk of developing complications because of their lack of

access to appropriate services and incomplete knowledge about how to self manage their condition. Participating mainstream service providers recognised they were unable to provide follow up support for clients to problem solve, review practice and answer questions or concerns raised by the client after one to one education sessions. Rather they could only provide consumers with initial advice and guidance (or *survival information*) which was insufficient to facilitate effective self-management. This was in contrast to the level of support consumers who accessed the DSO's service received.

On average Italian consumers received 4.4 occasions of service and Vietnamese consumers received 7.4 occasions of service. Program partners reported that because the DSOs spoke either Italian or Vietnamese and were of the same cultural background as their clients they were able to build a rapport with consumers, give clients appropriate information, provide follow up support and work with them *at their own pace*. Consumers who participated in the discussion groups also provided positive feedback. Despite the fact that most consumers had long term diabetes (ie. they had been diagnosed with diabetes for more than five years), all consumers reported significant improvements as a direct result from the information and support they had received.

It is therefore envisaged that in the long term, with improved self-management and self-efficacy of diabetes amongst consumers who access the service, there is likely to be a reduction in hospital admissions for acute and chronic complications associated with poor diabetes control.

13.3 Objective 3

To pilot the use of a capacity building framework to guide the development, evaluation and maintenance of a culturally appropriate diabetes service into an existing health service and ethno-specific consumer organisation.

13.3.1 Partnerships

The program represents a unique partnership arrangement between a health service, public health unit and consumer based organisations. Various strategies were implemented to enhance the level of collaboration and communication between the partner organisations, including regular project updates, decision making by consensus and the development of MOU. The MOU was pivotal as it outlined each partner organisation's responsibilities and

formally acknowledged their commitment to the program. The negotiation process commencing prior to the implementation took 12 months and ensured that both the recipient communities and service organisations all shared a common goal and were equal partners in the program development. Sheddiac-Rizkallah and Bone (1998) considered this a key factor in sustaining programs post pilot period.

13.3.2 Resources

Cost effectiveness of service

A number of resources were allocated to the pilot program. The setting up costs for the program includes one off costs that will not be required to sustain the program. The ongoing cost is employment of the already trained and skilled DSOs. Furthermore, the bilingual and bi-cultural competencies of the DSOs negate the need for utilising interpreters.

The total cost of maintaining the service is $68,117. This includes 0.8 FTE salary per DSO with $2,000 each for other goods and services. The cost for each occasion of service provided by the DSOs is $20.60 per hour. If the same service was provided through interpreters and mainstream services it would equate to $105.80 plus travel costs per hour. The direct service cost for providing the 1623 occasions of service which was provided by the DSOs in the pilot program was less than $33,433. If this level of service had been provided through the alternative existing service it would cost at least $171,433. The efficiency and effectiveness of this service that has been based on formative research with the recipient communities is very worthwhile adjunct to existing services. Thus the analysis has shown that the total cost of maintaining the service is more cost effective compared to the costs of utilising DEs to deliver information in conjunction with accredited interpreters. Furthermore, the use of DSO's compared to traditional service delivery for CALD groups is more likely to increase CALD communities capacity to self manage their condition.

The initial funding for the pilot program was provided as a component of a three-year pilot program investigating the feasibility and effectiveness of integrating diabetes services in the Inner City health service. Since the completion of the pilot program, services have been maintained through interim funding from existing budgets within EMPHU for the period between July and December 2002. This transitional funding has allowed the pilot evaluation to be conducted and the evaluation report to be collated, which was needed to inform health service management's decision to continue the service post pilot program. The service was

developed in response to the recipient communities identified the need. If the program discontinued it could be perceived that community consultation had been ignored, that the partner organisations had built up false expectations in the community and the inequity in health service access would remain not met.

Referral to service

The evaluation revealed that one reason some service providers did not refer their clients to the DSOs was because they were able to access accredited interpreters. Whilst the use of accredited interpreters is a recognised recommended practice, research conducted by Di Francesco, Gillam et al. (1999) highlighted some of the limitations service providers experienced using interpreters to communicate with consumers. Consumers and service providers found that interpreters slowed the delivery of service and reduced confidence on the quality of service. Extra promotions reinforcing the advantages of using bilingual and bicultural DSOs and their capacity to work closely with allied practitioners to foster a multi-disciplinary approach may therefore be needed to enhance referrals from allied health practitioners, including those who have access to interpreter services. Another reason service providers cited was lack of contact with the targeted communities. Research has shown that many CALD people's primary source of information and support are GPs who speak their own language (Di Francesco, Gillam et al. 1999). Additional efforts promoting the program amongst Italian and Vietnamese GPs may therefore be warranted, including pharmacists as they have regular contact with consumers and minimal promotion has occurred with them to date.

In view of the expansion of the program to Bentley and Kalamunda, new resource materials and promotions are needed to raise awareness about the program in these health services.

13.3.3 Organisational development

The evaluation revealed that as a result of the organisational development strategies implemented the DSOs were not working in isolation. Their roles were clearly defined and communicated to all staff and those based within the health service were immediately integrated into the local diabetes team. The mentoring program was also cited as a significant factor assisting the process of integrating the DSOs into their diabetes team (see 13.3.4, Workforce development). The DSO employed at the consumer organisation had similarly

integrated well into the organisation and the program did not exist as a separate entity. This was evidenced by the effective working relations with other staff within the organisation.

Sheddiac-Rizkallah and Bone (1998) describe two forms of integration, vertical or stand alone types and horizontal. Horizontal integration involves adaptation to local needs and the program being orientated into the standing operating factors of the service providers or organisation. The horizontal integration of this program has facilitated the development of the local Diabetes Coordinator's role in providing the ongoing support and management of the DSOs in the context of a diabetes team and enhancement of communication between the local health service and ethno-specific organisation in line with the new EMHS infrastructure. This provides infrastructure to accommodate the transition from the pilot program to sustainable service delivery and:

- Ensuring the DSO based within the consumer organisation is connected to a local diabetes team;
- Allowing EMPHU's central coordination role of the program be diminished;
- Standardising service protocols which will ensure seamless diabetes care services across all services in EMHS.

13.3.4 Workforce development

Initial training

The initial training program was modified from an existing nationally accredited course and delivered in a partnership arrangement with a RTO. The partnership ensured quality assurance processes, including monitoring the quality of training delivery was achieved. The benefits for participants were that their training led to a nationally recognised qualification, which could articulate with other vocational education training courses. The mentors who were not involved in the initial training expressed feeling disadvantaged because they were unfamiliar with the competencies their mentees had gained from the course. Although this was overcome by providing them with relevant course materials, future mentors may benefit from delivering training initiatives to their prospective mentees. Allowing them to co-facilitate the training may have added benefits such as providing the opportunity for the mentoring relationship to develop before the mentoring program officially begins and promote local ownership of the program.

Ongoing professional development

The time and effort invested in the initial and ongoing training of the DSOs ensured they were competently trained to deliver specialised diabetes services to their respective communities and kept updated about new developments and technologies. Nevertheless providing training events specifically targeting the DSOs are not feasible beyond the pilot phase. It is suggested that the DSOs be invited to participate in relevant future training programs available to health professionals within the EMHS diabetes network or training identified by their respective managers. This does not preclude the DSOs from actively seeking out additional professional development opportunities from relevant networks or RTOs.

Mentoring

A structured mentoring program was established as part of the program. The evaluation confirmed that the mentoring represented a legitimate and effective workforce development strategy. Program partners noted several benefits for the mentees, mentors and organisations.

Program partners identified that the mentoring relationship between mentors and mentees had evolved to one on more even terms as a result of the mentees' growing confidence. They suggested that other forms of mentoring, which were less structured and enabled the mentess to access other people within their network be encouraged beyond the pilot phase. This included *situational mentoring* (ie. The right help at the right time provided by someone when a mentee needs guidance) (Outside the Square Solutions 2001: 13) and peer mentoring which was already taking place. Despite the less structured approach being advocated, participants suggested that DSOs who were not part of an existing diabetes team be encouraged to meet with their mentors face to face, albeit less frequently, to ensure they did not become isolated.

Journal use

The evaluation revealed that only one participant utilised a journal as intended. Program partners cited time barriers as the main reason they did not maintain a journal. Discussions with academics highlighted that keeping a journal did not appeal to all people. Thus the use of journals should remain optional to those who may find it a valuable tool beyond the pilot phase.

13.3.5 Leadership

Leadership was demonstrated by the participating organisations at various levels, including their readiness to address the current inequity in diabetes health service delivery to special populations, seek out opportunities to diversify and expand the program and, in the case of the health service, to commit continued funding beyond the pilot. Their commitment to sustain the program is in keeping with the regional operational plan for the EMHS Strategic Direction for Diabetes Management 2001-2004 (Unsworth 2002).

Program partners supported the need to focus on one on one education, however suggested that renewed community consultations be undertaken. This will help to identify gaps in the service, facilitate planning and further enhance community ownership of the program. In keeping with EMHS Strategic Direction for Diabetes Management 2001-2004 (Unsworth 2002), it is recommended that all future programs or new initiatives be evaluated, and standardised where possible. It was further stated that service delivery for CALD groups should be based on systematic regional needs and planned according to recognised standards and evidenced based systems of care.

One suggestion was made to incorporate a prevention focus and by doing so extend the program to Italian and Vietnamese people without diabetes. This suggestion warrants further investigation given the high risk of developing Type 2 diabetes in Vietnamese women with a history of GDM and the high prevalence of Type 2 diabetes amongst CALD populations. CALD communities generally have higher levels of some of the risk factors that predispose them to the development of diabetes and its complications, particularly being overweight or obese and physical inactivity (cited in Di Francesco, 1999:13). Incorporating a prevention focus would entail implementing intervention strategies which promote healthy lifestyles and raise the community's awareness of the modifiable and non-modifiable risk factors associated with the development of Type 2 diabetes.

14.0 CONCLUSION

The evaluation has demonstrated that the program objectives were met. Italian and Vietnamese people with Type 2 diabetes from the intended catchment area accessed the service and reported notable improvements in their capacity to self care as a result of the support they received from their respective DSO. The benefits of using bilingual and bicultural DSOs over and above the use of interpreters was also highlighted, in particular their

ability to provide culturally appropriate information, provide follow up support when required, work with consumers at their own pace and complement the services offered by mainstream specialty service providers. Furthermore a cost analysis of the efficiency of the program compared to the existing alternative service provision through employing interpreters and mainstream allied health professionals highlights that the pilot program is significantly the most efficient. Furthermore, the evaluation demonstrated how, utilising a capacity building approach, innovative services can be built into an existing health service and consumer organisation to bridge the barriers created by cultural and linguistic diversity. The evaluation reinforced the need for a comprehensive approach to work towards the implementation of services that are sustainable.

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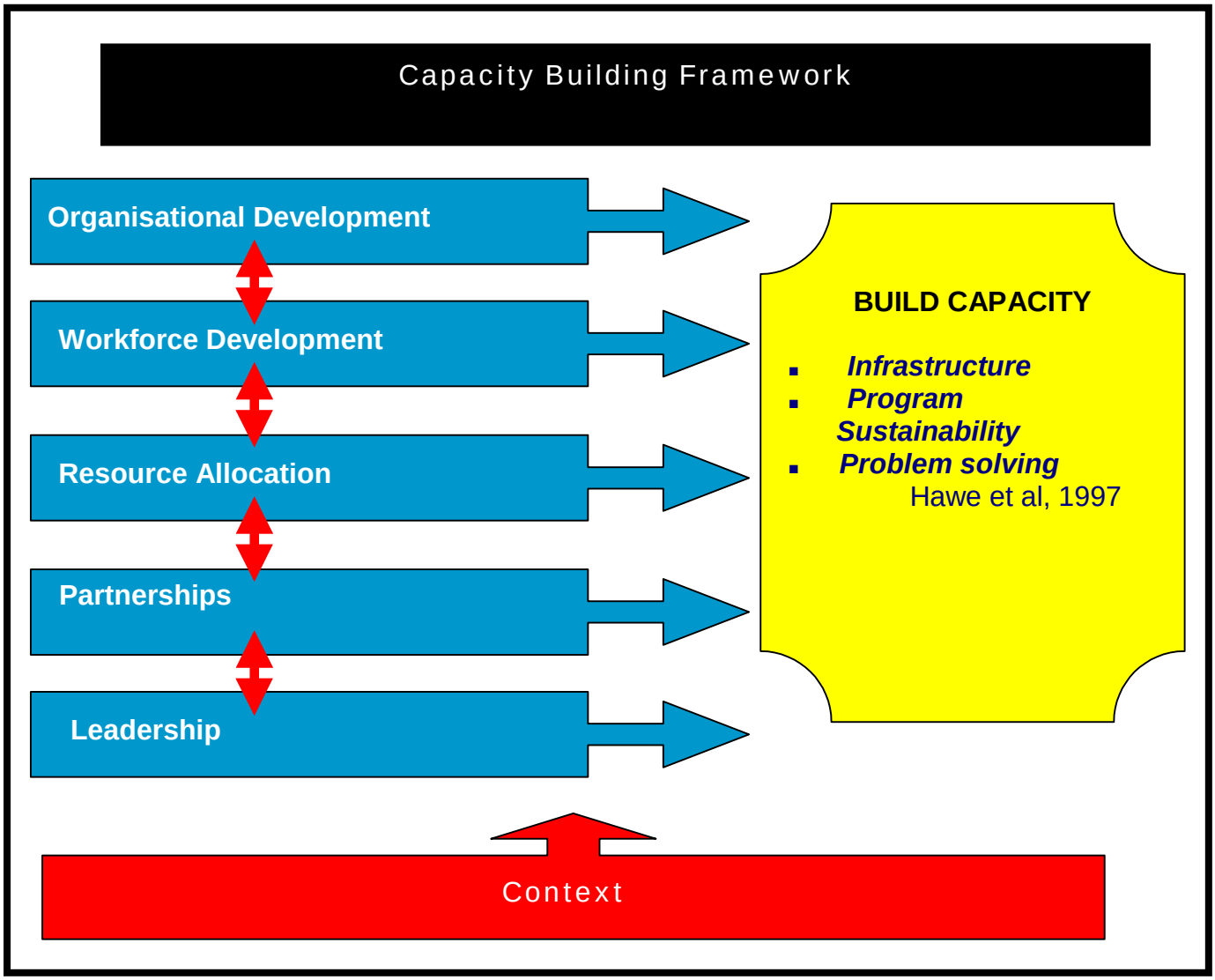
APPENDIX ONE

CAPACITY BUILDING FRAMEWORK



APPENDIX TWO

DSO JDF

Client Services

1.1 Responsible for providing immediate and ongoing generalist diabetes information, support and referral services to Italian and Vietnamese people with diabetes over the telephone and/or in person or in appropriate community settings.

1.2 In conjunction with program coordinators and ethno specific organisations actively seeks out opportunities to establish outreach diabetes services as required (eg. demonstrates blood glucose monitoring in client's home) and/or in appropriate community settings.

1.3 In conjunction with program coordinators develops systems of referral to improves clients' access to tertiary care providers by linkage to existing services in inner city and Swan (eg podiatry, ophthalmological examination and tertiary care providers).

1.4 Coordinates the recruitment and referral of Italian and Vietnamese people with diabetes to culturally appropriate education programs offered by the project.

1.5 Conducts basic structured diabetes information programs developed by diabetes specialists for ethno-specific health workers.

1.6 In conjunction with diabetes program coordinator delivers radio interviews using speakers kits developed by DAWA.

1.7 In conjunction with diabetes education teams, assist in the delivery of seminars, risk assessment programs and other relevant lifestyle programs.

Service promotion

2.1 In conjunction with program coordinators and ethno-specific organisations actively promotes the service and how it can be accessed via a range of strategies to Italian and Vietnamese people with diabetes and service providers (eg. attends/speaks at cultural events, open days and religious events, talks on ethnic radio programs).

Administration

3.1 In conjunction with program coordinators participates in quality assurance activity (eg record keeping and monitoring) to evaluate and assess the overall effectiveness of the service being piloted. This includes documentation of client assessment and care plans.

3.2 In conjunction with program coordinators, assists in the preparation and presentation of discussion papers, reports and submissions in relation to diabetes services for people from CALD communities.

Professional development

4.1 Participates in performance management appraisals with line managers.

4.2 Accesses supervision by a qualified diabetes health professional.

4.3 Participates in ongoing professional development opportunities in diabetes education and management identified during performance management appraisals and/or recommended by program coordinators.

4.5 Attends organisation's diabetes team meeting and/or other related meetings.

4.6 Attends relevant networking meetings facilitated by diabetes program coordinator as required, targeting generalised diabetes staff and/or specifically for bicultural health workers.

APPENDIX THREE

SELECTION CRITERIA

ESSENTIAL

- Proficient in Vietnamese/Italian (oral and written)
- Proficient in English (oral and written)
- Good communication skills
- Proven established networks within the Italian/Vietnamese community.
- Proven experience working within a community health and/ or welfare capacity
- Knowledge of Disability Services and awareness of access to health services that affect the clients of this position
- Current knowledge of and commitment to Risk Management, Occupational Health and Safety and Equal Employment Opportunity principles and practices.

DESIRABLE

- Medical/health qualifications.
- Qualified interpreter.
- A and/or E class drivers licence.
- Previous experience in diabetes care or education.

APPENDIX FOUR

MONTHLY REPORTS

PROGRAM FOR ITALIAN & VIETNAMESE PEOPLE WITH DIABETES IN THE INNER CITY & SWAN HEALTH AREAS
MONTHLY REPORT

Report for the month of: _____

1. *Referrals *<u>received from</u> other service providers*

Tally		Total
Self referral		
Family/friend		
GP		
Podiatrist		
Diabetes Educator		
RPH Community Physiotherapist		
Eye Specialist		
Community education		
Other (*please specify*) _____		

***Ensure appropriate referral protocols are followed (eg. follow up communications with referral source).**

2. *Referrals *<u>made to</u> service providers*

Tally		Total
GP		
Podiatrist		
Diabetes Educator		
RPH Community Physiotherapist		
Eye Specialist		
Community education		
Diabetes Support Group		
Physical activity program		
Other (*please specify*) _____		

***Includes referring client back to GP for review and/or to other referring source.**

3. Promotion of service to service providers and consumers

*Promotion Strategies Implemented	**Relevant Details

Please report on strategies undertaken **above those coordinated by EPPCHU. {EPPCHU will target podiatrists, optometrists, ophthalmologists, Divisions of General Practice, tertiary hospitals, Silver Chain, RPH Community Physiotherapists}.*

Promotion strategies include local community paper, distribution of brochures to health professionals, ethnic radio, visit to service providers/migrant centres, consumer organisations (organisations accessed by target group), talk to consumers about the service at a cultural community festival etc.

*** Relevant details for **local media** may include:*
- *Date & title of publication (pls. attach any copies of publicity received by the project).*
- ***Stipulate whether publicity received was paid or unpaid (include costs if paid)***
- *Intended target audience (eg. consumers and/or service providers)*
- ***Approximate audience reach***

*Relevant details for **community event** may include:*
- ***Date, title of community event/festival & venue (pls. attach promotional materials)***
- ***Approximate number of consumers who participated***

- ***Attach names & relevant contact details of service providers contacted by mail or in person***

4. Health education & community development activities implemented

Date	Venue	Program details*	Nos. attended

**Includes title & type of program (eg. supermarket tour). Attach evaluation results where appropriate.*

***5.* *Foot related consultations provided**

Tally	Total

Includes conducting basic foot screening procedures to identify risk factors, providing basic patient education on the prevention of risk factors, establishing links for referral of identified problems and providing appropriate wound care of foot ulceration (Diabetes Support Officers will be able to conduct these tasks following their training in June).

Please complete and return at the end of each month to:
Assunta Di Francesco
C/- EPPCHU
PO Box S1296
Perth 6000

APPENDIX FIVE

SURVEY DISSMENTATED TO SERVICE PROVIDERS

ITALIAN AND VIETNAMESE DIABETES SUPPORT OFFICER EVALUATION SURVEY

1. Are you aware of this service for Italian/Vietnamese people with diabetes? *(please tick)*

☐ Yes ☐ No, please go to Q 8

2. Have you referred any of your clients to this service? *(please tick)*

☐ Yes ☐ No, please go to Q 5

3. How satisfied were you with the level of communication between yourself and the Diabetes Support Officer(s)? (*please circle most appropriate response)*

Very satisfied Satisfied Neutral Dissatisfied Very dissatisfied N/A

4. Was the feedback from clients that you referred to the service positive, negative, mixed or none? *(please tick appropriate response then go to Q 6)*

☐ Positive ☐ Negative ☐ Mixed ☐ None

5. What has stopped you from referring clients? *(please tick **all** boxes that apply)*

☐ Diabetes Support Officer role unclear
☐ Information not readily accessible
☐ I can manage these patients without the service
☐ Client (s) declined offer for additional support
☐ Perceived lack of interest from client (s)
☐ Other, please state _____

☐ Time constraints
☐ I speak Italian / Vietnamese
☐ Service not appropriate
☐ Minimal contact with these clients
☐ I can access **accredited** interpreters

6. **Can you think of ways to improve the services or address any of the above barriers?** *(please state)*

_____
_____
_____
_____
_____
_____

7. Any other comments or suggestions? (*please state)*

_____
_____
_____
_____
_____
_____

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8. If you would like more information about the service offered by Italian and Vietnamese Diabetes Support Officers, please fill in your contact details below. If you wish to remain anonymous, please forward your response to this question separately from the main body of the questionnaire.

NAME:_____
ADDRESS:_____
TELEPHONE NUMBER:_____
EMAIL:_____

Thank you very much for your time and participation.

Please fax attention to: ASSUNTA DI FRANCESCO
Fax No: 9224 1612
By 12th August 2002

APPENDIX SIX

LETTERS SENT TO CONSUMERS (ENGLISH VERSION)

Dear

Our records indicate that you have accessed the new diabetes service we offer to Italian people with diabetes.

We would like you to take part in a group meeting to talk with the organisers about how useful the service has been and whether it needs to be continued. Your opinions are important and will help us look at ways to improve diabetes services for Italian people with diabetes.

The meeting will involve other people who have used the service and will be conducted in Italian. A free afternoon tea will be provided.

The group meeting will be held on {insert date} at the {insert location} between {insert time}.

Your participation is voluntary. All information that you provide will be treated in strict confidence. You can terminate your involvement at any time during the group meeting.

Please telephone {appropriate DSO?) on {insert number} by {insert date} informing us whether you will participate and if you need more information.

Thanking you in advance.

Yours sincerely,

{IAWCC/SHS}

APPENDIX SEVEN

INTERVIEW SCHEDULE FOR CONSUMERS

1. How did you find out about the service/{*Italian/Vietnamese DSO*}?
Did someone refer you to {*Italian/Vietnamese DSO*}?

2. How satisfied are you with the support {*Italian/Vietnamese DSO*} has provided you with? What do you like most about this new service?
Prompts
- Time spent providing information
- Very friendly/approachable
- Providing information in own language
- Listened to concerns
- Opportunity to ask questions
- Explained things clearly

3. What kind of support has {*Italian/Vietnamese DSO*} provided you? What do you do now to manage your diabetes that you didn't do before you accessed the service?
Prompts
- Provided information about how to self care
- Referred me to other services
- Showed me how to use blood glucose monitor and access supplies more cheaply
- Provided follow up care
- Stress management

4. How do you feel now about managing your diabetes compared to before you accessed the service?

5. What are some reasons why some people may not use the service?
Prompts
- Transport problems
- Too difficult to get to venue
- Waiting list/difficult to make an appointment
- People do not want other people to know they have diabetes

6. Is there anything else you would like to add?

Thank you for your time.

APPENDIX EIGHT

TOOL USED TO GATHER DEMOGRPAHIC DATA (ENGLISH VERSION)

1. DATE:_____

2. SEX: M [ ]
F [ ]

3.SUBURB/POSTCODE:_____

4. YEAR OF BIRTH:_____

5. HOW LONG HAVE YOU LIVED IN AUSTRALIA:_____

6. WHEN WERE YOU DIAGNOSED WITH TYPE II DIABETES:_____

7. LANGUAGE PREDOMINANTLY SPOKEN AT HOME:_____

8. OTHER LANGUAGES SPOKEN:_____

9. HOW WELL DO YOU SPEAK ENGLISH?
VERY WELL [ ]
WELL [ ]
NOT WELL [ ]
NOT AT ALL [ ]

10. IS IT OKAY FOR US TO CONTACT YOU IN THE FUTURE IF WE HAVE FURTHER QUESTIONS?
No [ ]
YES [ ]
IF YES, CONTACT TELEPHONE NUMBER:_____

APPENDIX NINE

INTERVIEW SCHEDULE USED WITH PROGRAM PARTNERS

1. The need for bilingual and bicultural DSOs arose from a study which highlighted that Italian and Vietnamese people experienced difficulty accessing mainstream diabetes services.

What are the benefits of using bilingual and bicultural DSOs?

What impact has the service had on consumers?

2. During the initial planning phase, some mainstream service providers questioned whether the educational interventions of bi-cultural health workers would be of the same standard as credentialled diabetes educators (DE).

How was this issue addressed by the program? If yes, in what way?

3. To ensure the DSOs did not work in isolation particular efforts were made to link them to the Diabetes Team at SHS and to DAWA through the mentoring initiative.

Please comment on how well they were linked to their respective local diabetes teams.

4. One of the functions of the DSO was to refer consumers to mainstream service providers which complemented their own.

Please describe the level and type of interaction that occurred between the DSOs and other mainstream service providers.

5. Additional training opportunities were built into the program to keep the DSOs informed on new developments/technologies in diabetes care and education.

Please describe any additional training opportunities the DSOs may have participated in.

6. Considerable time and resources was allocated developing and implementing a structured mentoring program.

How many hours approximately per week was invested in mentoring?

What type(s) of contact did mentor/mentee maintain? (eg. phone, fax, email)

What benefits did mentors/mentees/the organisations involved acquire from the mentoring?
Prompts

- *Increased personal and professional satisfaction*
- *Recognition as an experienced person*
- *Improvement of management skills and interpersonal skills*
- *Access to a role model for support, information and resources*

What are the characteristics of a successful mentoring relationship?

Did you encounter any problems or challenges?

Should the mentoring component of the program continue beyond the pilot phase?

What changes, if any, should be made to the current format?

Could we get the same effects with a different approach?

7. *Have you maintained a Journal? If not, what has prevented you from keeping one?*

8. Various promotional strategies were implemented to raise awareness about the program amongst consumers and service providers.

Are additional promotional strategies required? If so, please suggest appropriate strategies?

What may prevent consumers from accessing the service?

9. Although the main focus was to provide 1-1 consultations, a number of group seminars were conducted.

Were the seminars well attended and what were the benefits of offering these?

What other group oriented activities did you participate in/support?

10. *Please suggest how the program can be enhanced beyond the pilot phase.*

11. *Do you have any further comments or suggestions*?