diabetes

Diabetes in Italian and Vietnamese communities: An assessment of service needs in the inner city area of Perth

A joint initiative of
Eastern Perth Public and Community Health Unit
And
Inner City Diabetes Services

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GLOSSARY OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
CALD	Culturally and Linguistically Diverse
DAWA	Diabetes Australia Western Australia
EPPCHU	Eastern Perth Public and Community Health Unit
GP	General Practitioner
IAWCC	Italo-Australian Welfare and Cultural Centre Inc.
ICIDCP	Inner City Integrated Diabetes Care Project
LAC	Local Advisory Committee for Diabetes
NESB	Non English Speaking Background
NIDDM	Type 2 Diabetes
NMHS	North Metropolitan Health Service Population Health Unit
RPH	Diabetes and Endocrine Unit and Podiatry Department, Royal Perth Hospital
WADS	Western Australian Diabetes Strategy

FOOTNOTE

In this report, the term *bi-culturally sensitive* is interchangeable with *bi-culturally appropriate.*

CONTENTS

ACKNOWLEDGEMENTS **1**

EXECUTIVE SUMMARY **6**

RECOMMENDATIONS **7**

RECOMMENDATION 1. REDUCE THE EFFECT OF LANGUAGE AND CULTURAL DIFFERENCES 7
RECOMMENDATION 2. IMPROVE EDUCATION PROGRAMS AND MATERIALS 7
RECOMMENDATION 3. INCREASE THE INTEGRATION AND CO-ORDINATION OF SERVICES 9

INTRODUCTION **10**

AIM AND OBJECTIVES **10**

METHODOLOGY **11**

3.1 THEORETICAL FRAMEWORK AND DESIGN 11
3.2 LITERATURE REVIEW, SERVICE AUDIT AND CANVASSING OF EXPERT OPINION 12
3.3 SOURCES OF QUANTITATIVE AND QUALITATIVE DATA 12
3.4 RECRUITMENT OF CONSUMERS 13
3.5 RECRUITMENT OF SERVICE PROVIDERS 14
3.6 QUANTITATIVE DATA COLLECTION 14
3.7 QUALITATIVE DATA COLLECTION 14
3.8 TOOLS FOR COLLECTING QUALITATIVE DATA FROM CONSUMERS 15
3.9 TOOLS FOR COLLECTING QUALITATIVE DATA FROM SERVICE PROVIDERS 16
3.10 ANALYSIS OF THE DATA 16
3.11 INFORMATION DISSEMINATION AND ACKNOWLEDGEMENT FOR PARTICIPANTS 16
3.12 ETHICAL CONSIDERATIONS 17

LITERATURE REVIEW **17**

4.1 PREVALENCE OF DIABETES IN WESTERN AUSTRALIA 17
4.2 PREVALENCE OF DIABETES IN CALD COMMUNITIES 17
4.3 PREVALENCE OF DIABETES IN OLDER AGE GROUPS 18
4.4 THE AGE STRUCTURE OF THE ITALIAN AND VIETNAMESE COMMUNITIES 18
4.5 COST OF DIABETES 19
4.6 SERVICE PROVISION AND USAGE 19
4.6.1 Culturally-specific services *19*
4.6.2 Interpreter Services *20*
4.6.3 General practitioner and allied health services *20*
4.7 FACTORS WHICH REDUCE ACCESS TO SERVICES 21
4.7.1 Cultural and structural barriers *21*
4.7.2 Health beliefs *22*
4.7.3 Resources and materials *22*
4.7.4 Knowledge of the causes and management of diabetes *23*

DEMOGRAPHIC PROFILE OF THE ITALIAN AND VIETNAMESE COMMUNITIES OF THE INNER CITY PERTH AREA **24**

5.1. THE ITALIAN COMMUNITY IN INNER CITY AREA OF PERTH AREA 24
5.2 THE VIETNAMESE COMMUNITY OF THE INNER CITY AREA 25

DEMOGRAPHIC CHARACTERISTICS OF NEEDS ASSESSMENT SAMPLE **25**

ITALIAN CONSUMERS 25
VIETNAMESE CONSUMERS 26

RESULTS **26**

6.1 DESCRIPTION OF SERVICES CURRENTLY PROVIDED 26
6.1.1 General practitioners *26*
6.1.2 Community-based service providers *27*
6.1.3 Royal Perth Hospital *28*
6.1.4 Multicultural Access Unit *29*
6.2 USE OF CURRENT SERVICES 29

6.2.1 Services used *29*
6.2.2 Referral from general practitioners to other services *30*
6.3 ISSUES FOR SERVICES PROVISION 30
6.3.1 Language and cultural differences *30*
6.4 EDUCATION FOR SELF-MANAGEMENT 36
6.4.1 Education materials *36*
6.4.2 Support groups and education programs *38*
6.5 INTEGRATION AND CO-ORDINATION OF SERVICES 40
6.5.1 Referral processes *40*
6.6 ISSUES FOR SERVICE USAGE 41
6.6.1 Knowledge of causes and complications of diabetes *41*
6.6.2 Knowledge and skills for self-management of diabetes *43*
6.6.3 Support and education for self-management *50*
6.6.4 Knowledge of existing services *55*
6.6.5 LANGUAGE AND CULTURAL DIFFERENCES 56
6.6.6 Transport to services *57*
6.6.7 Preference for services provided by general practitioners *58*
6.6.8 Satisfaction with services other than those of general practitioners *59*
6.7 INTEGRATION AND CO-ORDINATION OF SERVICES 60

DISCUSSION **61**

7.1 PREVALENCE 61
7.2 SERVICE PROVISION AND USAGE 62
7.3 THE IMPACT OF LANGUAGE AND CULTURAL DIFFERENCES 62
7.4 USE OF INTERPRETERS 62
7.5 PERCEPTIONS OF HEALTH AND ILLNESS 63
7.6 OVERCOMING THE EFFECT OF LANGUAGE AND CULTURAL DIFFERENCES 63
7.6.1 Partnerships between service provider organisations and ethno-specific organisations *63*
7.6.2 Increasing the supply of culturally appropriate health staff *64*
7.7 IMPROVING EDUCATION FOR SELF-MANAGEMENT 65
7.7.1 Consumer readiness for self-management education *65*
7.7.2 Using support groups as an education tool *65*
7.7.3 Improving resources and materials for self-management education *66*
7.8 IMPROVING INTEGRATION AND COORDINATION OF SERVICES 66
7.8.1 Improving the referral process *67*
7.8.2 Transport *68*
7.8.3 Location services in accessible places *68*
7.8.4 Cost of services *69*

CONCLUSION **69**

RECOMMENDATIONS **71**

RECOMMENDATION 1. REDUCE THE EFFECT OF LANGUAGE AND CULTURAL DIFFERENCES 71
RECOMMENDATION 2. IMPROVE EDUCATION PROGRAMS AND MATERIALS 71
RECOMMENDATION 3. INCREASE THE INTEGRATION AND CO-ORDINATION OF SERVICES 73

REFERENCES **74**

APPENDIX ONE **77**

LOCAL ADVISORY COMMITTEE MEMBER ORGANISATIONS 77

APPENDIX TWO **79**

ORGANISATIONS INCLUDED IN THE DATA COLLECTION PROCESS 79

APPENDIX THREE **81**

RECRUITMENT MATERIALS 81

APPENDIX FOUR **84**

ORGANISATIONS WHICH ASSISTED WITH RECRUITMENT OF CONSUMER FOCUS GROUPS 84

APPENDIX FIVE **86**

SURVEY FORM FOR COLLECTION OF DEMOGRAPHIC DATA ON CONSUMERS 86
APPENDIX SIX 88
DATES AND TIMES OF CONSUMER FOCUS GROUPS 88
APPENDIX SEVEN 90
SCHEDULE FOR INTERVIEWS WITH CONSUMER FOCUS GROUPS 90
APPENDIX EIGHT 94
SCHEDULE FOR INTERVIEWS WITH GENERAL PRACTITIONERS 94
APPENDIX NINE 96
SCHEDULE FOR FOCUS GROUP AT RPH 96
APPENDIX TEN 98
SCHEDULE FOR FOCUS GROUP WITH COMMUNITY BASED SERVICE PROVIDERS 98

EXECUTIVE SUMMARY

People from culturally and linguistically diverse (CALD) communities are at greater risk of complications from diabetes because they have difficulty accessing and using mainstream diabetes care services for treatment and self-management of the condition.

The needs assessment reported here examined the reasons people with diabetes from the Italian and Vietnamese communities of inner city Perth have difficulty accessing and using services, and how these difficulties may be overcome. The project focused on the Italian and Vietnamese communities because these are the two largest CALD communities in inner city Perth. However, many of the findings will be relevant to smaller CALD communities in the inner city and in Western Australia as a whole.

The prevalence of diabetes is higher in older people and the Italian community than in the mainstream community. The Italian community has a greater proportion of older people than the mainstream community. The rate of diabetes in Vietnamese people in the 74-79 year age group is around nine times higher than in the same age group in the mainstream population.

The needs assessment was part of the Inner City Diabetes Integrated Care Project (ICIDCP) being conducted by the Eastern Perth Public Health Unit (EPPCHU) in collaboration with the Local Advisory Committee (LAC) of the ICIDCP.

The needs assessment included a review of current literature, an audit of diabetes care services in inner city Perth, the canvassing of expert opinion, and the gathering of quantitative and qualitative information from providers and consumers of diabetes care services.

Focus groups and structured interviews were used to collect the qualitative information. Separate focus groups were held for Italian and Vietnamese people and service providers. The general practitioners were interviewed individually.

Very few culturally specific diabetes services are available to Italian and Vietnamese people with diabetes in inner city Perth. Consumers relied mostly on general practitioners, mainly those who spoke their first language. There were estimated to be four Italian-speaking and four Vietnamese-speaking general practitioners practicing in the inner city. Participants made only limited use of the range of allied health and educational services which can help to prevent complications arising from diabetes. This was due to problems related to cultural and language differences, problems in providing appropriate education for self-management, and lack of integration and co-ordination of services.

RECOMMENDATIONS

Recommendation 1. Reduce the effect of language and cultural differences

Establish a working party to devise and implement strategies to increase the number of bicultural allied health professionals and bicultural health workers available in the inner city area and to ensure that workplace-based, situation and client-specific cultural awareness training is available for health professionals who want to use it.

The working party should consist of representatives from organisations in the inner city area, including:

- Ethno-specific community organisations
- Consumer groups
- Perth Division of General Practice
- Diabetes-specific organisations
- Community-based health service organisations
- Professionals organisations representing relevant allied health professions
- Royal Perth Hospital (RPH).

Specifically the working party should examine the feasibility and estimate the cost of:

1.1 Providing incentives for bicultural allied health professionals to:

- Obtain accreditation as language-specific service providers for clients from similar cultural background to their own
- Register as sessional service providers for clients from similar cultural background to their own
- Provide services to clients from similar cultural backgrounds at appropriate locations chosen on the basis of the recommendations of the working party on integration of services (see *Recommendation 3*).

1.2. Increasing the pool of bicultural health workers by:

- Training bicultural health workers as diabetes educators to Australian Diabetes Educators' Association and credentialling standards through the National Training Accreditation Council
- Providing information to general practitioners, allied health professionals and specialist service providers on the role of bicultural workers in diabetes care for patients and clients from CALD communities and how they can be accessed.

1.3. Policy change by health service organisations, where necessary, so that health professionals can receive situation and client-specific cultural awareness training if they request it

Recommendation 2. Improve education programs and materials

Establish a working party to identify strategies to increase the availability and improve the quality of education programs and materials for people with diabetes in CALD communities.

The working party should consist of:

- Ethno-specific community organisations
- Consumer groups

- Perth Division of General Practice
- Diabetes-specific organisations
- Community-based health service organisations
- Professionals organisations for relevant allied health professionals
- RPH.

The working party should examine the feasibility and estimate the cost of:

2.1. Further developing diabetes education programs for CALD communities in inner city Perth and implementing these in partnership with designated ethno-specific organisations

Options the working party should consider when determining who will deliver the program include:

- Bicultural allied health professionals with a similar cultural background to the participants
- Bicultural health workers trained as diabetes educators
- Diabetes educators with cultural awareness training and support available.

Options for media to deliver the programs should include face-to-face education sessions, ethnic radio programs, audio materials and audio-visual materials.

The range of programs to be considered should include:

- A series of education sessions on causes, complications and self-management of diabetes for **newly diagnosed** people with diabetes
- A series of education sessions for people **with long-term diabetes** who wish to update their self-management skills
- One-off sessions provided in response to requests from partner organisations or consumer groups.

2.2. The establishment of ethno-specific diabetes support groups for people from CALD communities.

In particular the working party should consider:

- Formalising of partnerships, roles and responsibilities between diabetes-specific and relevant ethno-specific community organisation for the purpose of establishing support groups
- Quality assurance mechanisms for support groups
- Provision of facilitators with appropriate cultural background and training for the role of support group leader.

2.3. Establishing a system and agreed lines of responsibility for producing and disseminating educational materials, including written and audio-visual materials

In particular the working party should consider:

- Designation of responsibility, and allocation of funding, for identifying, reviewing and disseminating educational materials in language other than English at the local level

- Designation of responsibility, and allocation of funding, for maintaining a catalogue and collection of available educational materials and disseminating information on resources to service providers
- Designation of responsibility for funding and preparation of new materials where materials already developed either locally, nationally, or in other states, are not considered by the reviewing organisations to be appropriate to local needs.

Recommendation 3. Increase the integration and co-ordination of services

Establish a working party to develop strategies to promote referral of patients and clients between general practitioners, allied health professionals and other bicultural health workers, and examine the feasibility and cost of those strategies.

The working party should consist of representatives of:

- Perth Division of General Practice
- Organisations that provide allied health services to inner city Perth
- RPH
- Local government authorities
- Consumer organisations.

In particular the working party should consider:

- Adopting the strategies developed by the working party on reducing language and cultural differences (see *Recommendation 1*)
- Identifying the causes of differences in perceptions of referral rationales and practices between general practitioners, allied health professionals and consumers
- Developing a scheme that promotes consumers' requests for referrals from their general practitioners to allied health professionals and bicultural health workers and supports them in taking up those referrals
- Examining the value of, and sources of funding for, designated bicultural health workers who can act as the link between services and facilitate consumer access
- Examining the options, responsibility and sources of funding for case management
- Examining the options for reducing problems associated with transport to services
- Examining the options for co-location of services using a variety of strategies centred around the provision of localised services in places that are familiar and comfortable for people with diabetes from CALD communities (see *Recommendation 1*).

INTRODUCTION

In 1998 the Eastern Perth Public and Community Health Unit (EPPCHU) established the Inner City Integrated Diabetes Care Project (ICIDCP). The purpose of the project is to pilot an integrated model of service delivery which provides comprehensive care services at the primary, secondary and tertiary levels, for people with diabetes living in the inner city area of Perth, Western Australia.

To conduct the pilot project the EPPCHU has established partnerships with diabetes service provider organisations in the public and private sector. These include Royal Perth Hospital (RPH), Mercy Hospital, Swan Primary Health Service, Diabetes Australia of Western Australia Incorporated (DAWA), professional organisations representing allied health practitioners, and the Perth Division of General Practice.

The project is managed by a Local Advisory Committee (LAC) which represents the eleven key stakeholder organisations (Appendix 1). All organisations represented on the LAC provide services to people with diabetes in the inner city area. In 1998 the LAC identified the lack of services appropriate to the needs and location of culturally and linguistically diverse (CALD) communities as a barrier to the provision of comprehensive, integrated care for residents of inner city Perth. CALD communities are at greater risk of complications from diabetes because they have difficulty accessing and using mainstream diabetes care services for treatment and self-management of the condition.

As a result of the concerns expressed by the LAC, the EPPCHU, in consultation with the LAC, conducted an assessment of the diabetes service needs of the Italian and Vietnamese communities in 1999. The assessment focused on the Italian and Vietnamese people with diabetes because they are the largest CALD groups in the inner city population. However, it is anticipated that the findings and recommendations will be relevant to most CALD people with diabetes in the area. Recommendations that are not relevant to other CALD people with diabetes may be refined in consultation with representatives of those communities at a later date.

This report presents the findings of the needs assessment and the recommendations for future action. By acting on the recommendations the stakeholders in the project will be able to achieve their aim of improving access to, and use of, diabetes care services among Italian and Vietnamese communities in the inner city area, and thereby contribute to their overall aim of providing a comprehensive and integrated service to people with diabetes living in the area.

AIM AND OBJECTIVES

Aim

The aim of the needs assessment was to identify existing services and priority services required for people from Italian and Vietnamese backgrounds with diabetes. An additional aim was to identify strategies to promote preferred services and to increase access to the range of services available to people with diabetes from Italian and Vietnamese backgrounds in the inner city health area.

Objectives

1. To identify existing services used by people with diabetes from Italian and Vietnamese backgrounds
2. To identify priority services required for people with diabetes from Italian and Vietnamese backgrounds in the inner city area
3. To identify those factors which reduce the ability of Italian and Vietnamese people to access diabetes services
4. To identify strategies to enhance and promote existing preferred services for people in the inner city area with diabetes from Italian and Vietnamese backgrounds
5. To identify strategies to increase people with diabetes from Italian and Vietnamese backgrounds' knowledge on the range of diabetes and health services available in the inner city area
6. To identify strategies to increase access to self-management education for people with diabetes from Italian and Vietnamese backgrounds.

METHODOLOGY

3.1 Theoretical framework and design

A health promotion framework was used to plan and implement the needs assessment (Green and Kreuter, 1991; Degeling, Hawe and Hall, 1990). The design included a literature review, an audit of diabetes care services provided in inner city Perth, the canvassing of expert opinion on the content of the data collection tools, and the gathering of quantitative and qualitative data from providers and consumers of diabetes care services.

Literature describing factors which may influence access to, and use of services by people with diabetes from CALD communities and interventions developed to improve access to, and use of services, was reviewed. An audit of services available to people with diabetes from the Italian and Vietnamese communities was conducted. Expert opinion on barriers faced by Italian and Vietnamese people with diabetes when accessing and using diabetes care services was canvassed (e.g. Multicultural Access Unit). The literature review and canvassing of expert opinion were conducted prior to the collection of quantitative and qualitative data and the results of these procedures were used to inform the development of the data collection tools. Data were collected from Italian and Vietnamese consumers and providers of services for people with diabetes of the inner city area. The results of the service audit were used to augment data collected from service providers where necessary.

Participants who could provide insights into the problems associated with access to, and use of services by people with diabetes from the Italian and Vietnamese communities of inner city Perth were selectively sampled (purposive sampling) for the study. Data were collected from Italian and Vietnamese consumers of diabetes services and from various types of service providers representing both community-based service provider organisations and Royal Perth Hospital (RPH) Diabetes and Endocrinology Unit and Podiatry Service.

The internal validity of the study was established through face validity and construct validity. Face validity was developed by reviewing current literature to determine the categories of information to be sought and by incorporating feedback from experts in diabetes services and Italian and Vietnamese representatives when finalising the data collection tools. Construct validity was achieved by comparing data from various sources (triangulation) and demonstrating that the same themes emerged from data provided by consumers and a wide range of service providers. External validity was not needed as the results were only intended to be used with the

Italian and Vietnamese communities or in applications where the problems experienced by the communities are common in other CALD communities.

Reliability was assured by using standardised interview schedules to ensure that data on the same topics were collected from each data source, by using the same facilitator or interviewer where schedules had to be administered to different groups or individuals; by tape-recording the focus group interactions; and, in the case of the bicultural facilitators, by training two facilitators simultaneously in the purpose and administration of the schedules.

A preliminary report of the findings was prepared and circulated to representatives of all key stakeholder organisations for comment and revision. Feedback was either incorporated into the final report, or omitted after agreement was reached between the stakeholders and researchers. Italian and Vietnamese consumers were represented in the feedback process by their ethno-specific cultural organisations.

3.2 Literature review, service audit and canvassing of expert opinion

Medline and Internet literature searches were conducted. Relevant literature identified from these sources was included in the review. Published and unpublished documents recommended by stakeholder organisations and diabetes experts were also included in the review. The coordinator of the ICIDCP guided the audit of services and identified the experts from whom opinions should be sought, based on her knowledge of the range of services available in the inner city.

3.3 Sources of quantitative and qualitative data

Data were collected from two sources:

1. Consumers: Italian and Vietnamese people with diabetes

2. Service providers: Representatives of the diabetes care service provider organisations and ethno-specific cultural organisations operating in the inner city health area.

Consumers were drawn from two sources:

1. Members of the diabetes support groups which operate specifically for Italian and Vietnamese people with diabetes in the northern suburbs of Perth. The support groups were administered by the North Metropolitan Health Service Population Health Unit (NMHS PHU)

2. Italian and Vietnamese people who had diabetes but had not attended a support group specific to their cultural group.

Community members who had not attended a support group were drawn from the Italian and Vietnamese residents of the inner city area of Perth. The members of the support groups who contributed to the data collection were residents of the north metropolitan area. They were included in the data collection process because their membership of an ethno-specific support group gave them a perspective on diabetes care services that was considered valuable to the needs assessment.

The service providers who participated in the data collection process had specific expertise in diabetes and/or CALD groups and were drawn from organisations in the public and private sectors and from RPH (Appendix 2). The following professions were represented:

- Bicultural health workers

- Ethno-specific social workers
- Community health nurses
- Diabetes nurse educators
- Dietitians
- Physiotherapists
- Podiatrists
- Pharmacists
- Optometrists
- General practitioners (GPs)
- Medical specialists.

Ancillary services such as Silver Chain Nursing Association and alternative health care providers, were not included as a data source because the researchers did not realise how they might inform the study at the time that it was designed. EPPCHU acknowledge that this is a limitation which has made it difficult to fully describe the consumers' service usage patterns.

3.4 Recruitment of consumers

A key strategy for the recruitment of consumers to the focus groups was the forging of partnerships with community organisations representing Italian and Vietnamese residents of inner city Perth. This strategy was adopted not only because it would assist in conducting the needs assessment in a culturally sensitive manner, but also because it would enable them to determine whether they wished to take part in any interventions which evolved from the needs assessment and to decide what role they might take in those interventions.

Partnerships were established with the Italo-Australian Welfare and Cultural Centre Inc. (IAWCC) and The Vietnamese Community in Western Australia and the assistance of these organisations proved invaluable in recruiting consumers for the focus groups. They provided guidance on cultural considerations, appropriate times and days, and catering requirements thus ensuring that the data collection process was culturally sensitive. They employed a range of recruitment strategies including:

- Articles in community and ethnic newspapers
- A series of announcements and interviews on ethnic radio
- Distribution of over 100 translated pamphlets per community to venues used by potential participants (e.g. bicultural GP clinics, churches, temples, leisure/recreation clubs etc.).

Additional initiatives undertaken by the IAWCC were the distribution of flyers to 34 organisations on their mailing list and encouraging volunteers to assist with recruitment.

Italian participants in the project reported that they had heard about it from four main sources: their social group or club (n = 16), an Italian radio program (n = 7), a friend or relative (n = 5) or a flyer (n = 4). For Vietnamese participants the most common source was their religious leader (n = 19) and their social group or club (n = 5).

Focus group participants who were members of Italian and Vietnamese support groups were recruited by their group facilitators. The Project Officer coordinating the needs assessment sought permission from the NMHS PHU to meet with support group members and request their participation in the data collection process.

A copy of the recruitment materials is presented in Appendix 3. A list of the organisations whose assistance has made it possible to recruit and organise the focus groups with consumers is in Appendix 4.

3.5 Recruitment of service providers

Service providers other than GPs were recruited using a list of potential participants developed by the ICIDCP coordinator and a snowball sampling technique in which each contact person was asked to suggest another person who could be contacted.

GPs were recruited through the Perth Division of General Practice which provided names and contact details of GPs who spoke either Italian or Vietnamese, or had a special interest in diabetes.

3.6 Quantitative data collection

A short questionnaire was used to collect demographic data from the participating consumers. These data were used to compare the characteristics of the sample to those of the communities from which they were drawn. Data were collected on:

- Gender
- Suburb of residence
- 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.

Data were also collected on how participants found out about the project and whether or not they would like to be contacted in the future in relation to the project.

The questionnaire was administered in one of two ways depending on administrative constraints (Appendix 5). A staff member from the relevant ethno-specific organisation administered the questionnaire by asking the participant the questions over the telephone when the latter telephoned to volunteer for the focus groups. If the data were not collected then, the questions were presented orally in the participant's first language, either Italian or Vietnamese, prior to the commencement of the focus group.

3.7 Qualitative data collection

The qualitative methods used were focus groups and in-depth interviews.

Focus groups were used to collect data from consumers and services providers from community-based organisations and RPH. Some participating service providers were from organisations outside the inner city catchment area, but were included because of their valuable experience in providing services to people from CALD backgrounds. One bicultural pharmacist who could not attend the relevant service providers' focus group was interviewed by telephone because her perspective as a bicultural service provider in private practice was considered important. The focus group schedule for community-based service providers was used to elicit information from her.

Ten focus groups were conducted as follows:

- 3 focus groups for Italian people with diabetes who had not attended a support group
- 1 focus group for members of the support group for Italian people with diabetes
- 3 focus groups for Vietnamese people with diabetes who had not attended a support group
- 1 focus group for members of the support group Vietnamese people with diabetes
- 1 focus group for service providers from community-based service organisations, the allied health professions, community health nurses, bicultural health workers and an ethno-specific social worker
- 1 focus group for service providers from the RPH.

The dates and times of consumer focus groups are presented in Appendix 6.

Focus groups for consumers were conducted in the first language of the participants, either Italian or Vietnamese. The facilitators were bicultural workers who had been recommended by the ethno-specific organisation for which they worked. The EPPCHU provided training for the facilitators on focus group facilitation and briefing on the purpose of the needs assessment prior to the data collection.

Each consumer focus group ran for approximately two hours. The number of participants ranged from 4 –14. Light refreshments were provided for participants at the conclusion of each session.

The focus group for community-based service providers was conducted over two sessions with a total duration of three and one half hours. The second session was held because the schedule of questions had not been completed by the close of the first focus group and some participants wanted to respond to the remaining questions. Eleven participants attended the first session and five of those returned for the second session. The allied health professionals from the private sector (optometrist, podiatrist and pharmacist), the two bicultural health workers and a nurse educator were not able to attend the second session. The focus group for service providers from RPH had four participants.

Individual interviews were used to collect data from GPs. Five GPs were interviewed, rather than holding a focus group, because it was not possible to organise a time at which all could attend. The interviews were of approximately one half to one hour's duration.

Service providers and organisations not represented on the LAC were offered remuneration to participate.

Each focus group session was audio-taped and then transcribed. The data from consumers were translated from the original language into English after transcription. These transcriptions were used for all data analysis. Due to practical constraints the in-depth interviews were not audio-taped. Instead the researcher made notes during the interviews and these notes were used for the data analysis.

3.8 Tools for collecting qualitative data from consumers

The focus group schedule used for consumers who had not attended support groups was designed to gather consumers' perceptions of their needs in relation to accessing and using services (ie. their felt needs). Specifically, it sought to promote discussion on the following topics:

- Knowledge of the causes and complications of diabetes
- Problems with self-management of diabetes
- Knowledge of existing diabetes services

- Use of existing diabetes services and accessibility
- Barriers to accessing and using existing diabetes services
- Satisfaction with existing diabetes services
- Strategies to improve existing services
- Other services required
- Appropriate strategies for disseminating information on diabetes to consumers.

The same schedule was used for consumers who had attended a support group with additional questions on their opinions on the value of support groups (Appendix 7).

The coordinator of the ICIDCP and personnel from DAWA provided feedback on the schedules during their development.

3.9 Tools for collecting qualitative data from service providers

The focus group and in-depth interview schedules for service providers were designed to gather information on the needs of service organisations providing care to people with diabetes from CALD communities, as defined by expert opinion (ie. normative need) (Hawe, Degeling and Hall, 1990). Specifically the purpose was to gather information on:

- Services provided for clients with diabetes from a CALD community and specifically for Italian and Vietnamese people
- Problems encountered by GPs in providing services for Italian and Vietnamese people
- How those problems are, or could be, overcome
- Gaps in current diabetes care service provision to CALD communities, and specifically to Italian and Vietnamese people
- Strategies to overcome the gaps identified
- Information dissemination strategies.

Representatives of the Perth Division of General Practice provided feedback on the interview schedule for general practitioners during the developmental phase.

Copies of the schedules for the focus groups and in-depth interviews conducted with service providers are presented in Appendices 8, 9 and 10.

3.10 Analysis of the data

The qualitative data were analysed manually using thematic analysis. Themes were identified and then related back to the objectives and the information obtained from the literature review, service audit and expert opinion. The demographic data were analysed using a statistical software package (SPSS version 8.0).

3.11 Information dissemination and acknowledgement for participants

The report will be launched publicly and all participants in the data collection process will be invited to attend, together with representatives of all stakeholder organisations and other interested groups. The executive summary of this report will be translated into Vietnamese and Italian and made available to participants on the day of the launch. Copies of the report will also be disseminated to key stakeholders and to other interested groups and organisations across Australia. A series of announcements will be made on ethnic radio to thank the Italian and Vietnamese communities for their contributions once the project is complete.

3.12 Ethical considerations

The purpose of the needs assessment 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 project, except with their permission. Each participant had the right to withdraw from the data collection process at any time.

Consumers were offered the option of having the audio-tapes and transcripts of their focus groups returned to their ethno-specific organisations at the completion of the project. Either the coordinator or project officer for the ICIDCP was present at each of the consumer focus groups and undertook to answer any questions about diabetes at the end of the session or to obtain the answers after the session if they could not answer them immediately.

LITERATURE REVIEW

4.1 Prevalence of diabetes in Western Australia

Type 2 diabetes accounts for 85-90% of cases of diabetes in the Australian community (Health Department of Western Australia, 1999). Between 1989 and 1995 the prevalence of diabetes doubled in Western Australia (Ridolfo and Codde, 1997). This has been attributed to an increase in the proportion of the migrants and the increasing age of the general population (Commonwealth Department of Health and Aged Care, 1999).

The true prevalence of diabetes is likely to be higher than the available data suggests for two reasons. Firstly, for every diagnosed case of diabetes it has been estimated that there is one undiagnosed case in the community (Health Department of Western Australia, 1999). Secondly, rates of hospital separation for diabetes do not include cases admitted due to the complications of diabetes, such as cardiovascular disease, renal failure, or amputation of a lower limb, because diabetes is not recorded as the principal diagnosis in such cases.

4.2 Prevalence of diabetes in CALD communities

A number of recent reports have highlighted the fact that diabetes is more common in CALD communities than in the Australian-born community (Arkles, 1997; Colagiuri, 1998; Commonwealth Department of Health and Aged Care, 1999). The Commonwealth Department of Health and Aged Care (1999) reported that 3% of the overseas-born population of Australia has diabetes compared to 2.1% of the Australian-born population. McCarty, et al. (1996) reported that, in Australia, approximately 11% of Italian-born residents and a very high rate of Asian-born residents had diabetes. Gestational diabetes, which predisposes women to Type 2 diabetes in later life, is higher in some ethnic populations, including migrants from Southern Europe, than in the general population (Arkles, op cit.).

Data from the Western Australian Hospital Morbidity Data Base for 1995/96 (see Table 1) demonstrates that, in comparison to the Australian-born, non-Aboriginal community, the age-standardised rate of hospital separation for diabetes was:

- 1.3 times higher in the CALD community
- 1.5 times higher in the Italian community
- Similar in the Vietnamese community to the Australian-born non-Aboriginal community.

The higher prevalence of diabetes in the CALD communities is considered to be due to a combination of genetic factors and adoption of a more Western lifestyle after migration (Colagiuri, op cit., Reid and Trompf, 1990).

TABLE 1: Age-standardised rates* of hospital separation for diabetes, for selected populations and age groups, Western Australia, 1995 - 1996

Age	Aust-born non-Aboriginal	CALD	Italian	Vietnamese
65 - 69	333.3	530.6 (1.7)	854.1 (2.6)	0.0**
70 - 74	612.2	801.7 (1.3)	565.8 (0.9)	0.0
75 - 79	355.2	752.9 (2.1)	618.9 (1.7)	3225.8 (9.0)
80 - 84	763.4	1386.6 (1.8)	1013.0 (1.3)	0.0
85 +	513.4	1140.4 (2.2)	1302.1 (2.5)	0.0
Total	**288.3**	**363.5 (1.3)**	**424.5 (1.5)**	**290.0**

Source : WA hospital morbidity data base, extracted from HealthWiz (Prometheus, 1999)
* Rates per 100,000 for principal diagnosis only, calculated on population aged 45 years or older
** Numbers too small for rates to be calculated
Figures in parentheses are rate ratios calculated against the rates for the Australian-born, non-Aboriginal population.

4.3 Prevalence of diabetes in older age groups

The majority (83.4%) of people with diabetes are 45 years or older (Ridolfo and Codde, op cit.). Some CALD populations have higher age-standardised rates of hospital separation in their older age groups than the older age groups in the Australian-born non-Aboriginal population.

For example, data from the Western Australia Hospital Morbidity Data Base (see Table 1) for 1995/96 indicate that, compared to the Australian-born non-Aboriginal population of people over 65 years of age, age-standardised rates of hospital separation due to diabetes are:

- From 1.3 to 2.2 times higher in the non-English-speaking population
- From 1.3 to 2.6 times higher in the Italian population
- 9 times higher in the 75-79 age group in the Vietnamese population (the only age group for which numbers were sufficient for rates to be calculated).

4.4 The age structure of the Italian and Vietnamese communities

The Italian community of inner city Perth has an older age structure than the general population of the area. People aged 40 years or older constitute 66.5% of the Italian population of the area compared to 42% of the general population (ABS, 1997). Because the Italian community has an older population and a higher prevalence of diabetes among its older people, it will have proportionately more people who need diabetes services than in the Australian-born non-Aboriginal community.

The Vietnamese population of inner city Perth is younger than that of the general population. Only 30% are aged 40 years or older compared to 42% of the general population (ABS, 1997). However, the age-standardised hospital separation rate for diabetes in the 75-79 age group was nine times higher for the Vietnamese population than for the Australian-born non-Aboriginal

people in the same age group in 1995/96. This suggests that, although the Vietnamese community does not have large numbers of people needing diabetes services at present, as the number in Western Australia increases and the age of the Vietnamese-born population increases, the burden of diabetes will begin to impact greatly on the Vietnamese community and the health care system.

4.5 Cost of diabetes

Diabetes causes many serious health problems, mainly because it damages the blood vessels. Heart disease and diseases of the circulatory system and kidneys often occur in people with diabetes. Loss of vision, the need to amputate lower limbs, foot neuropathies and renal failure are all relatively common outcomes. The cost of these outcomes to the health care system, individuals and their families and friends is enormous. The social cost, in terms of lost productivity, reduced contribution to community life and disruption to family life is immeasurable. The financial cost has not been fully estimated but may be gleaned from estimates for certain procedures required. For example, the cost of renal dialysis for one year is estimated to be $57,000 (Health Department of Western Australia, 1999).

Although the cost of diabetes for specific populations has not been calculated it is likely to be higher for the CALD community because of the greater prevalence in that community and longer hospital stays. For example, older Italian and Vietnamese people who are admitted to hospital with diabetes tend to stay in hospital longer on average than Australian-born non-Aboriginal people (Prometheus, 1999). In 1995/96 the length of stay was:

- 3.4 times longer (30 days compared to 8.8 days) in Italian people aged 70-74 years
- 1.25 days longer (16 days compared to 12.7 days) in Vietnamese people aged 74-79 years.

4.6 Service provision and usage

4.6.1 Culturally-specific services

The lack of culturally specific interventions for CALD communities has been reported in several studies. Giglia (1996), in her study of diabetes in the Western Australian Italian population highlighted the gaps in health service provision for this community and its implications for the community and health care system. The author reported:

> *Today the Italian community remains isolated in its lack of culturally appropriate health care needs…Their high genetic risk to NIDDM (Type 2 diabetes), absence of culturally appropriate health services and resources, and an ageing population make them a principal target group for the prevention of costly NIDDM complications and further increases in the prevalence of NIDDM (p20).*

Lego (1999), in an audit of existing diabetes services for CALD communities in the Perth, South-Eastern Division of General Practice found that there was no dedicated service for people from CALD backgrounds, and that although interpreter services were available to GPs, DAWA, hospitals and community health centres, they were not easily accessible. The extent to which bicultural GPs provided diabetes services to different language groups was unknown. Lego (p5) further stated, *there are no prevention or management strategies specifically organised to target these high risk communities and proportionally there are low usage rates of mainstream services.*

4.6.2 Interpreter Services

Arkles (1997), in her review of the literature on interventions available to CALD communities across Australia, consistently found a lack of culturally relevant approaches in mainstream education and support services for CALD communities. In reviewing a study involving Italian, Greek and Vietnamese people with diabetes in South Australia, she noted the lack of available interpreters during consultations in private practice and public hospitals, causing many patients to use relatives or friends as interpreters. Gagliardi's (1991) study of Italian people with diabetes in Sydney similarly showed low use of interpreters, with 85% of respondents (n=63) stating that a professional interpreter was not present during their visit with a health professional. Of the 72% of respondents who stated that an interpreter was unnecessary, the majority were seeing an Italian-speaking GP.

4.6.3 General practitioner and allied health services

The Perth, South-Eastern Division of General Practice (1996) reported that there is a scarcity of data available on health service usage in Australia by Asian migrants. The National Health Strategy (Dollis, et al., 1993) stated that investigation into the utilisation of health services by CALD communities is complex and the available data do not allow conclusions to be reached about access to services. Despite these limitations, the National Health Strategy stated it is possible to infer from existing data, that people born in non-English speaking countries are more likely to visit GPs, emergency departments and outpatient clinics and conversely, are less likely to use community-based services and preventative services compared to their Australian-born counterparts.

Qualitative research conducted by the Perth, South-Eastern Division of General Practice (1997) into the patterns of self reported use of GPs and other health care community services by Vietnamese, Chinese and Cambodian people found:

- 70% of respondents consulted a GP
- Consumers were very satisfied with GP services
- Consumers' knowledge and utilisation of other health services was low (e.g. nearly 60% of the Vietnamese respondents were not aware of DAWA and almost 95% of all respondents did not use its services).

Gagliardi's research project into the diabetes health needs of Italian and Tongan communities in Sydney found that participants relied on GPs as their main source of treatment, advice and support and used allied health services infrequently, although almost two thirds of participants were managed by more than one practitioner. The results for the Italian sample (n=63) revealed that of the professionals seen for diabetes:

- 38% were GPs
- 32% were medical specialists
- 10% were dietitians
- 9% were podiatrists
- 2% were ophthalmologists
- 1% were community nurses.

Gagliardi reported that 58% of Tongan participants (n=16) saw a GP for their diabetes, whilst the remainder saw no health professional. Sixtyeight percent of the Tongan respondents indicated that their GP was helpful, but in contrast, satisfaction amongst Italian respondents with the services provided by GPs and allied health practitioners was low. Reasons for low satisfaction

included not being provided with adequate information and not being appropriately referred to a range of other services.

Gagliardi (ibid) and Arkles (op cit.) reported a perception by allied health professionals that GPs were reluctant to refer their patients to other services. Nguyen's (1999) consultations with Vietnamese general practitioners as part of a needs assessment into the diabetes health needs of Vietnamese communities in Melbourne provided some support for these claims. The results showed that only a small proportion of GPs referred their patients to other services (e.g. diabetes educator, dietitian, podiatrist and endocrinologist). Transport problems, language barriers and a perceived lack of knowledge of Vietnamese foods and culture among dietitians, were reasons cited for their reluctance to refer patients to outside services. Other reasons for the low levels of use of allied health practitioners by the CALD community cited by Arkles and Nguyen (op cit.), following consultations with consumers and service providers alike, included the high regard in which GPs were held by consumers, consumers' lack of awareness of other services and low levels of understanding of the need and importance of regular follow up checks with specialists.

In summary, there has been very little provision of culturally appropriate diabetes interventions for CALD communities. People from a CALD background mainly use general practitioners for treatment, education and support more than any other service provider. The extent to which consumers are satisfied with the services received seems variable amongst different CALD communities. Furthermore, low levels of allied service provision by consumers results mainly from a lack of awareness of existing services and lack of referral and co-ordination of services.

4.7 Factors which reduce access to services

4.7.1 Cultural and structural barriers

Alcorso and Schofield (1992), in their summary paper on the National NESB Women's Strategy, reported on the shortcomings of service provision to CALD women and the difficulties migrant women face in obtaining access to high quality mainstream services. They reported that the main factors affecting migrant women's access to health care services were:

- Communication barriers and existing inadequacies within the health care system, largely owing to ethnocentric practices and culturally insensitive structures implicit in health service delivery
- Migrants' lack of tacit system knowledge
- Barriers such as a lack of access to transport and child-care facilities.

Language problems and costs of services and equipment were barriers to services cited by Vietnamese consumers living in the Western Metropolitan Region of Victoria. Where transport and mobility problems were rejected as possible barriers by some participants, further probing revealed that the same participants were dependent upon family members to access services (Nguyen, 1999).

According to Blackford (1997), cultural and linguistic barriers that prevent equitable access to health care services for people from CALD communities have been identified in numerous areas including women's health, acute care settings and district nursing services. Blackford (1997) reported there is a notable percentage of the Australian population whose capacity for autonomy and decision making in health is compromised because many people experience cultural and communication difficulties. Blackford (1997, p15) explained that *nursing use of an interpreter service is an essential component of practice in a multicultural community*, and cited Macintyre and Dennerstein (1995), who advocated a hospital policy stating clearly that only professional

interpreters were acceptable, because the use of 'unofficial' interpreters was frequently problematic.

Factors which impact upon health and access to health services as identified in the literature include: poor English proficiency; cultural and religious beliefs related to health; and other barriers to accessing key social resources (e.g. lack of transport).

4.7.2 Health beliefs

Orwin (1996) stated an understanding of the patient's health beliefs and customs is needed before a health practitioner can expect to deliver an acceptable standard of care to patients. Cultural, religious, spiritual and supernatural dimensions to health which may impact upon the use of services by CALD communities are reported in several studies. Hamilton (1996) reported that a person who believes in fate, or believes that spirits and supernatural forces are involved in illness, is unlikely to believe that lifestyle changes can affect outcomes.

Hamilton (1996) and the Multicultural Access Unit (1996) explained that many Vietnamese people believe in the principle of balancing 'yin' - (female, negative and cold) and 'yang' (male, positive and hot) for health, with illness resulting from an imbalance between the two. According to Orwin, a health belief in the balance or in-balance of certain elements may predispose many Asian people to the use of traditional medicine. The Multicultural Access Unit (1996) and Goldflam and Lymon (1998) further stated it was not uncommon for Vietnamese people to use a three tiered health system, involving the professional health sector (e.g. GPs); popular or lay sector (e.g. ailments remedied by family and friends) and the 'folk' sector (e.g. traditional healing and/or advice prescribed by the elderly). Nguyen's (op cit.) research findings confirmed this community's preference for alternative remedies and distrust towards Western medicine. The majority of her sample (n=30) perceived that prolonged use of Western based treatments lead to further medical complications (e.g. stomach and kidney problems) and many had returned to Vietnam to seek alternative diabetes treatment.

Furthermore she reported that in Vietnam the responsibility for health lies mainly with individuals and families, and as such, problems are more likely to be dealt with by the family rather than by seeking outside or professional assistance.

In summary, the research demonstrates that a consideration of the myriad of factors, including clients' values, customs and belief systems is necessary for the provision of culturally appropriate services to CALD communities.

4.7.3 Resources and materials

Wallace (1996) reported on the difficulties faced by Asian women with diabetes who are precluded from seeking information or advice from usual sources (e.g. brochures) as many are unable to speak or read English (Wallace, 1996). According to Wallace, where translated brochures are available, the material is written from a Western perspective, and in most cases is culturally irrelevant to consumers' needs. The value of written translated materials for people who are illiterate in any language is questioned by Orwin (op cit.), who instead advocated disseminating information through other media, such as audio-visual materials and video tapes to overcome the problems of illiteracy common to many CALD populations. Orwin stated that whilst written and audio-visual resources are readily available to the English-speaking population, there is little accessible information to people from a CALD background.

Research conducted by Arkles (op cit.) similarly identified a need to develop resources in languages other than English as what was available was poorly translated, or occasionally

contained incorrect information. She reported that there is insufficient use of audio-visual material and ethnic media, in particular ethnic radio, and acknowledged that the low levels of English proficiency and illiteracy in the vernacular was common in Australia's migrant population.

4.7.4 Knowledge of the causes and management of diabetes

The literature suggests that many CALD clients have a poor understanding of the causes of diabetes. For example, in a study involving Sixty three Italian participants, one third (31%) cited 'shocks', 'nerves' and 'sorrows' as causes for their diabetes thus demonstrating an incomplete knowledge of the disease. However, the same study found that participants had a good knowledge of diabetes-related complications (Gagliardi, 1991).

Poor control of diabetes is evident in many CALD communities. For example, Nguyen (op cit.) found that the majority of participants with Type 2 diabetes in her study did not regularly self monitor their blood glucose levels, have regular foot or eye checks or understand the different requirements for proper management. Some participants reported deliberately choosing not to self monitor to avoid the knowledge of high glucose levels. Some feared taking the blood themselves. A common belief held amongst participants was that the use of insulin injections meant the final stage of their life.

CALD communities generally have higher levels of some of the risk factors that predispose to the development of diabetes and its complications, particularly overweight, obesity and physical inactivity (Colagiuri, et al, 1998). These risk factors may be due to lifestyle changes after migration since migrants generally have better health and lower levels of lifestyle diseases when they arrive in Australia than do Australian-born residents (Alcorso and Schofield, op cit.).

Kushi, Lenart and Walter (1995) reported that many southern European-born people shifted away from the traditional Mediterranean diet, characterised by an abundance of plants foods, fresh fruit, olive oil and moderate consumption of fish and poultry, to a more Australian diet after migrating to Australia. The South Australian Dietary Survey revealed that Vietnamese respondents had increased their consumption of meat and snack meals and decreased their consumption of fish, vegetables and dietary fibre intake after arrival in Australia. Seventy two percent of Vietnamese women reported weight gain after migration (Reid and Trompf, op cit.).

Tzimas (1997) reported that people from CALD communities had lower rates of participation in physical activity than Australian-born persons and migrants from English speaking countries. The 1995 WA Health Survey found that Asian and European populations in Western Australia had higher proportions of sedentary people than the general population. Asian women were more sedentary than their male counter parts (Milligan, 1998).

In addition to the risk posed by dietary changes and physical inactivity, people with diabetes from CALD communities may be at greater risk of complications and psycho-social effects because of the sometimes conflicting advice by professionals, coupled with the difficulty accessing and using mainstream diabetes education and support services. They need to develop self-management skills (McCartey et al., 1996; Wallace, op cit.).

Evaluation of an education program for the Vietnamese and Cantonese communities in Melbourne revealed that monitoring of health was regarded as the role of the health professional and that self monitoring was an alien concept for most consumers (Arkles, op cit.). This study also found that educating some CALD communities was difficult because the high regard given

to teachers and people in high positions in society often resulted in individuals with diabetes agreeing that they understood information which they did not really understand.

In summary, the self care management practices of CALD communities with diabetes are compromised by their incomplete knowledge about the disease, coupled with lifestyle risk factors, such as obesity and physical inactivity, brought about by the migratory experience. All of these factors are conducive to the development of complications.

DEMOGRAPHIC PROFILE OF THE ITALIAN AND VIETNAMESE COMMUNITIES OF THE INNER CITY PERTH AREA

The inner city area of Perth forms part of the east metropolitan region of Perth, Western Australia. It comprises the local government areas of City of Perth and the Town of Vincent and includes the following suburbs: Perth, East Perth, West Perth, Leederville, Northbridge, North Perth, Glendalough, Mount Hawthorn, Coolbinia, Menora, Mount Lawley, Bedford, Inglewood, Meltham, Bayswater, Maylands and Highgate. The postcodes covered by the area are 6000, 6003-6007, 6016 and 6050-6053 respectively.

Together, the people of the Italian and Vietnamese communities in the inner city of Perth constitute just over 13% of the population or about one in every 12 residents of the area (The Office of Multicultural Interests, 1998). At the 1996 Census, inner city Perth had a considerably higher proportion of people born in non-English speaking countries (28%) and a higher proportion of people who reported they spoke English poorly or not at all (27%) than in the east metropolitan area of Perth as a whole (20%) (ABS, 1997).

The City of Perth has a higher proportion of people born in a non-English speaking country than any other local government area in Western Australia. The Town of Vincent has a higher proportion of people who speak a language other than English at home than any other local government area in Western Australia (The Office of Multicultural Interests, 1998).

5.1. The Italian community in inner city area of Perth area

The Italian community is the largest CALD community in Perth with 22,342 residents who constituted 1.8% of the Perth population at the 1996 census (ABS, op cit.).

At the 1996 census, in the inner city area of Perth:

- Italy ranked first as the country of birth for residents born in a non-English speaking country
- Italian was the language most commonly spoken at home by people who reported speaking a language other than English at home
- Italian people constituted 8.2% of the population with 1,810 Italian residents in total (The Office of Multicultural Interests, op cit.).

Italian people began migrating to Australia around the time of the World War II, and many originally settled around North Perth and Northbridge, predominantly on Lake, Palmerston and Roe Streets. Italian people also settled in Leederville, West Perth and Bayswater. Anecdotal information provided by the Italo-Welfare Cultural and Welfare Centre Inc. indicates that, from the late 1970s to the early 1990s, younger members of the Italian community, born in Western Australia, have tended to reside on the outskirts of the inner city or in the northern suburbs such as Osborne Park, Tuart Hill, Morley and Bayswater. Thus Italian people remaining in the inner city are mostly older people who are unlikely to move to other suburbs.

5.2 The Vietnamese community of the inner city area

In the last two decades people migrating to Australia from Asia have formed an increasing proportion of the total population of new arrivals. In Western Australia the Vietnamese population increased by 23% between the 1991 census and the 1996 census (ABS, 1997). At the 1996 census, there were 52,843 residents who were born in South East Asia living in the Perth - Mandurah region, representing 4.5% of the total population and 13.5% of the migrant population (Konrath, op cit.). Amongst the Indo-Chinese population of Western Australia, Vietnamese people are the largest migrant group. Thus Vietnamese migrants are a substantial and growing proportion of the population of Western Australia.

At the 1996 census, in inner city Perth:

- Vietnam was the second most common country of birth for residents born in a non-English speaking country
- Vietnamese was the third most commonly reported language spoken at home by people who spoke a language other than English at home
- Vietnamese people constituted 4.9% of the population, with 1,006 Vietnamese residents in total (The Office of Multicultural Interests, op cit.).

Many members of the Vietnamese community migrated to Australia under the refugee - humanitarian program or the family reunion program (Nguyen, op cit.), following the demise of South Vietnam under the North Vietnam government in 1975 (Goldflam and Lymon, 1999). According to Konrath (1997), many Vietnamese people initially settled in central Perth suburbs, especially around Highgate and North Perth. However the trend in later years has been to settle in outer suburbs such as Ferndale, Balga and Wanneroo (Hopkins, 1987).

DEMOGRAPHIC CHARACTERISTICS OF NEEDS ASSESSMENT SAMPLE

The demographic characteristics of the consumers who participated in the study are presented in Table 2.

Italian consumers

A total of 39 Italian community members participated in the focus groups for Italian consumers. Their mean age was 73.8 years (SD = 8.6) and three quarters were women (75%, n = 27).

The mean length of time that the Italian consumers had been in Australia was 45.9 years (SD = 9.4). All but four people (90%, n = 35) reported that they spoke Italian at home. However, approximately two thirds (62%) reported that they also spoke English at home. Of those who reported on their fluency in English only 8 (23%) spoke English well. Three quarters reported either that their English skills were poor (21%, n = 7) or that they did not speak English at all (56%, n = 19).

The mean length of time since diagnosis with diabetes was 12.5 years (SD = 11.1). Of the 35 who reported the length of time since they had been diagnosed, less than 20% (n = 7) had been diagnosed with diabetes within the past two years, approximately one fifth, 23% (n = 8) had been diagnosed between two and five years ago, 11% (n = 4) had been diagnosed between six and ten years ago, and the remaining half (46%, n = 16) had been diagnosed more than ten years ago.

Just over half (54%, n = 21) the consumers lived in four postcodes - 6006, 6021, 6059, 6060. The most commonly reported suburbs were North Perth, Balcatta, Tuart Hill and Mount Lawley.

Table 2: Demographic characteristics of Italian and Vietnamese consumers who participated in the needs assessment

	Italian	**Vietnamese**
Mean age	74 years	64 years
Mean length of time in Australia	46 years	11 years
Speak first language at home	90%	95%
English spoken at home	62%	2%
Speak English poorly of not at all	77%	82%
Mean length of time since diagnosis	12 years	5 years
Total number of participants	**39**	**39**

Vietnamese consumers

A total of 39 Vietnamese people participated in the focus groups for Vietnamese consumers. Their mean age was 64 years (SD = 9.7) and two thirds (65%, n = 22) were women.

The mean length of time for which consumers had been living in Australia was 10.7 years (SD = 4.5). All but two consumers (95%, n= 37) spoke Vietnamese at home. Of the remaining two, one reported speaking English at home and one did not specify the language used. Only six (16%) consumers reported that they spoke English well. One third (n = 13) reported that they spoke English poorly and 49% (n = 19) reported that they did not speak English at all.

The mean length of time since diagnosis was 4.85 years (SD = 5.85). Just under one half (40%, n = 15) of the consumers had been diagnosed with diabetes within the past two years. A further one third (35%, n = 13) had been diagnosed four to five years previously and the remainder had been diagnosed for more than five years.

More than half (56%) the Vietnamese consumers lived in four postcodes - 6006, 6052, 6061 and 6064. The suburbs in which they were most likely to live were Balga, Ballajura, Bedford, Girrawheen, Highgate, Marangaroo and North Perth.

RESULTS

6.1 Description of services currently provided

6.1.1 General practitioners

Types of services provided

Most participating GPs reported that they provided a variety of services including:

- Diagnosis
- Management
- Follow-up
- Information on self monitoring of blood sugar levels
- Counselling on diet
- Advice on prevention of complications
- Language or culturally specific education materials.

Through-put

Most of the GPs interviewed reported that they provided services to between one and ten Italian or Vietnamese clients with diabetes per month. An interviewee from a large Perth practice reported that the practice saw 30 to 40 clients with diabetes from CALD background per month despite having a predominantly young client population. One general practitioner saw only Italian clients and another saw only Vietnamese clients. Both spoke the relevant language fluently.

Participating GPs reported providing services to clients from various other CALD communities including Czechoslovakia, Ukraine, Poland, Balkans, Eastern European, Burma, and Cambodia. They stated that clients were willing to travel a considerable distance to see a GP who spoke their first language.

Most participants reported that their practices were working towards computerised records and would eventually provide a recall system for clients with diabetes.

Use of interpreters

Participating GPs reported that they did not use interpreter services for several reasons. These included either they could speak the first language of their clients, their clients could speak English, or their clients used a family member to interpret. One GP with limited Vietnamese language skills reported using her Vietnamese speaking secretary to communicate medical concepts to her clients.

Education materials and programs

Interviewees reported using some education materials in languages other than English. One GP reported using information in English only. Another reported that he provided most of the education himself as he has a particular interest in diabetes. He sees each newly diagnosed client for a one hour appointment twice per week until he has covered all aspects of diabetes care with them.

Referral to other service providers

Participating GPs identified a range of services to which they normally refer clients. These included:

- Allied health professionals
- Specialist service providers at RPH
- A GP with skills in diabetes management
- DAWA
- Community health services
- A support group for Vietnamese people.

6.1.2 Community-based service providers

Types of services

Participants in the focus group for community-based service providers reported that their organisations provided a range of services. These included:

- Counselling, education and assessment by bicultural service providers such as pharmacists, optometrists and podiatrists
- Individual assessment, counselling and education through an interpreter
- Assistance from a bicultural Vietnamese health worker to access services
- Ethno-specific support groups (not in the inner city area)

- Education seminars presented in the first language of participants using a bicultural health worker or interpreter
- Interpreter services
- Yearly routine eye examinations
- Language specific reminder letters for annual eye screening
- Access to equipment and supplies
- Physical activity programs
- Language specific brochures.

The service audit revealed that other than the North Perth Community Health Centre, there is a lack of access to a multidisciplinary community health centre in the inner city area. Thus it is not possible to refer patients from both the mainstream and CALD community to allied health services. Allied health service provision is limited to the services mainly offered by DAWA, Silver Chain, North Perth Community Health Centre or allied health practitioners in private practice. Limited primary care services offered by a multidisciplinary team are provided by RPH (*see below*). The limitations of these services are:

- Community health, based at North Perth Community Health Centre provides general migrant health services mainly to new migrants, and specific diabetes services to people who do not speak English are not currently provided. This is provided by a community nurse and bicultural health worker.
- Whilst DAWA is the main service provider in the inner city and provides a comprehensive diabetes service with access to a dietitian and diabetes educator, resources are limited and there is a three week waiting period
- Ongoing services for Silver Chain patients following discharge are restricted (Lego, op cit.)
- Community Physiotherapy, RPH, provide a statewide specialised advice and education service on exercise (e.g. how to exercise effectively) for people with type 2 diabetes. They also act as a resource for other physiotherapists. Funding for the provision of land and water-based exercise programs is not specifically for people with type 2 diabetes. However these people are encouraged to attend.

6.1.3 Royal Perth Hospital

Types of services

Participants in the focus group for RPH reported that a range of diabetes services were provided by the Diabetes and Endocrinology Unit and Podiatry Department. RPH works in close liaison with other hospital departments, including Psychiatry, Social Work, Ophthalmology and Physiotherapy. Whilst the main role of RPH is to provide a tertiary service for the whole State, some primary care services are also provided because of the limited resources in the primary care setting. These include:

- Initial and ongoing medical assessment
- Ambulatory stabilisation
- Individual assessment and education through an interpreter for inpatients and outpatients alike
- Statewide telephone service providing advice and information
- Professional development and training (staff education, consultation service to other services, including other hospitals and universities)
- Some language specific information sheets.

Through-put

Participants in the RPH focus group reported that Italian clients were the largest single CALD group attending the hospital, making up approximately 10% of all clients at RPH. Most participating specialists felt that the proportion of Vietnamese clients at the clinic was smaller at present, however the number was growing.

Participating specialists reported a survey of 200 patients conducted by RPH revealed that up to 33% of clients were from a CALD background. RPH which was used by small numbers of clients from a variety of other countries such as Yugoslavia, Croatia, Turkey, Lebanon, Spain, Cambodia, Saudi Arabia, Ethiopia, French Mauritius, Greece, and Chinese-speaking countries.

Use of interpreters

Participants reported that RPH has a policy to ensure that all CALD clients, including those that speak some English, have the services of an interpreter. Each client's appointments are coordinated to ensure that the interpreter is available for all the service provider visits the client requires at any one time. Podiatry care is booked separately. Diabetes education is provided on an individual basis, according to need, using an interpreter.

The hospital has a policy which prohibits the use of family members as interpreters.

Education materials

Participating specialists reported that the hospital provides a few language-specific written education resources for Italian people, mainly on food and foot care.

Referral to other service providers

RPH works in close liaison with other hospital departments and patients are referred to podiatry, psychiatry, social work, ophthalmology and physiotherapy as required and back to their GPs, but rarely to other education services within the community. Participants reported that this was largely due to the fact that the hospital could provide an interpreter which may not be available to patients who access community services.

6.1.4 Multicultural Access Unit

One participant, representing the Multicultural Access Unit, reported on the range of cross-cultural services that her organisation provided to other service providers. These included:

- One-to-one, situation-specific cross-cultural education
- Ongoing telephone counselling and support
- Training of bicultural health educators
- Interpreter education
- Translated information
- Language phrase cards.

6.2 Use of current services

6.2.1 Services used

Italian consumers

Participants in the Italian focus groups reported that the service provider they used most often was an Italian-speaking GP. Other services which participants reported having used included:

- Podiatrist

- Eye specialist
- Dietitian
- Alternative therapist
- Italian support group
- DAWA
- Community health services
- Hospital clinics and education services.

Vietnamese consumers
Participants in the Vietnamese focus groups (community members with diabetes and support group members) reported that their family doctor was the most commonly used service provider. Other services they reported using included:

- Dietitian
- Diabetes educator
- Community health nurse
- Various specialists, particularly an eye specialist
- Vietnamese support groups
- Hospital clinics and education services
- Community health services.

6.2.2 Referral from general practitioners to other services

Italian consumers
Some Italian participants reported that their GP had referred them to an eye specialist, podiatrist or dietitian at the time of diagnosis, whereas others reported having received referrals only when a problem had arisen.

Vietnamese consumers
Participants reported that they had been referred to specialists and other services by a family doctor or a bicultural health worker. One participant reported being referred to DAWA because it specialises in information for people with diabetes. Another reported having given up her membership of DAWA because equipment and supplies could be obtained from the local pharmacy.

6.3 Issues for services provision

6.3.1 Language and cultural differences

Community-based service providers
Some participating allied health professionals reported that, because they were not of the same cultural background as their clients, they were liable to miss salient information, had more difficulty developing rapport, and were likely to give clients inappropriate information.

> *…I am missing all of that background... being a native speaker is a much better thing.*

> *I mean, it's great to have interpreters and they are wonderful but as far as long-term access to the services is concerned… the sort of local, I can come back to you, you feel confident with, and understand the background to the person, (that's) what I miss most.*

...it is hard to get the message across to people of my own culture and when you have got all the additional problems as well, you usually just resort to telling them what to eat because it is just too hard.

The words are the simplest things to get around. The hard part is getting concepts across because the cultural thinking is so different... that messages just aren't the same. It's like telling jokes in a different language, it just doesn't come across.

I often miss things that are intrinsically part of the culture so I go along and I talk about the risk factors…

Most participating community-based allied health professionals reported that they relied on interpreters or bicultural health workers to communicate with their clients. They identified three main difficulties encountered as a result of the need to use interpreter services:

- An increase in the time required to provide services
- An increase in the cost of providing services
- A loss of flexibility in providing services.

Loss of flexibility was related to the time and cost required to provide services through an interpreter. Participants described three main problems with flexibility:

- The need to book an interpreter two weeks in advance in the case of not-for-profit organisations which are entitled to free interpreter services
- Lack of funds to provide follow-up when clients had questions or concerns after one-to-one education and counselling sessions
- Constraints on providing services when they are needed by a client because of a policy stating that an interpreter can only be used when a group of at least four clients can receive the service together.

Several participants reported that some clients were reluctant to use an interpreter because of the confusion caused by hearing information discussed in both language of origin and English.

They will not use interpreters, especially the older Italians, because they get confused listening to the English version, listening to the Italian version, they misunderstand.

A bicultural health worker reported that, although she was able to interpret for clients whom she took to various services, some organisations provided an interpreter, and that, in that situation, she felt redundant.

…because I'm taking the clients there and they say oh they can do the job without me…

Some participants reported that dietitians and podiatrists with relevant language skills may not use those skills because of:

- The lack of employment opportunities
- There was no mechanism set up to identify and seek out bicultural dietitians
- Their work did not require them to use their language skills
- Because they preferred not to work with CALD communities.

I know a number of (bicultural) dietitians. They're quite happy to work as bicultural dietitians but no one wants them. Their skills are wasted.

It has to be a choice, so that even though you can identify all your Italian psychologists or dietitians, you are not necessarily going to have those people choose to work with the communities.

Several participants reported that the move towards mainstreaming in government policy had limited the funding and infrastructure available to allied health services to provide culturally appropriate services.

More and more we are seeing right from policy at Commonwealth level, they are wanting to mainstream services...they are expecting you and everybody to just deal with the situation but the resources aren't there.

I think we have to make the management aware, because everyone has basically controlled the money and they don't necessarily know a lot about diabetes…accessibility has been a problem because of funding.

Participants suggested a number of ways in which problems due to language and cultural differences could be overcome. Some stated that bicultural health workers were in the best position to assist clients to access and use services appropriately and that the pool of bicultural health workers needed to be increased.

…like a health worker, someone that speaks their language, understands their culture and can be there on a much more consistent basis than I can ever be.

Yes, it's those lead people we don't have. I mean community health has their health workers but there doesn't seem to be a lot of those, but that's the sort of people we need.

…if there could be more bicultural workers, it would be less of a burden on individual ethnic organisations…

For bicultural people like (name of bicultural health worker) *it's a complete cultural comfort... they've taken themselves five steps closer to achieving their professional goal with their clients.*

A Vietnamese bicultural health worker described a comprehensive service which she provides to newly diagnosed clients. The service involves familiarising clients with the full range of services and interpreting for them when necessary.

…normally I (bicultural health worker) *am the one who receives the referral from the doctor or the client rings me himself or herself….I would show them where your* (allied health professional) *service is and help them to buy the machine and organise them to see the educator and things like that. Take them to* (community nurse educator) *and to see the dietitian, see the podiatrist.*

A physiotherapist and bicultural health worker described an exercise program for elderly Vietnamese people which they had developed collaboratively and which had operated successfully for several years. They attributed its success partly to the fact that the activity could

rely on demonstration rather than language to impart information but also to the liaison role played by the bicultural health worker.

> *The physio. is not Vietnamese-speaking, however that doesn't seem to be a huge issue…it is mostly demonstration.*
>
> *I* (bicultural health worker) *was with the physiotherapist for the first few weeks for them* (clients) *to get used to the physiotherapist.*

One participant suggested that language and culture-specific allied health service providers, such as podiatrists, optometrists and pharmacists, needed to be available.

A bicultural pharmacist reported that clients often obtained advice from her because she was readily accessible.

> *… and I find that generally after a week or two they do come back with questions and it is very handy for them because I'm so close.*

One participant reported that another Australian State was able to provide a good quality service to CALD clients because they had a policy of seeking out allied health professionals and health workers from various cultures and training them in specific issues.

Suggestions on how to increase the pool of bicultural allied health professionals were provided by participants. One participant suggested developing a register of bicultural dietitians who were interested in working with CALD communities on a sessional basis, and who could provide professional training to other dietitians. Another participant proposed using bicultural health promotion graduates whose skills could be harnessed to coordinate and deliver diabetes education programs.

Participants were asked to consider the role of cross-cultural awareness training programs in improving services. Most expressed negativity towards the programs currently available to service providers.

> *If you go too generic you run the risk of setting up boundaries which people like myself may not feel comfortable challenging.*
>
> *Too much cross-cultural blanket stuff being done. It has to be situational.*

One participant reported that the Multicultural Access Unit's Resource Officer provides situational cross-cultural training and ongoing support for individuals and small groups.

Some participants felt that allied health professionals and GPs could use assessment tools and brief facts sheets, specific to cultural groups, to overcome some of the difficulties caused by cultural differences. Other participants felt that such tools could lead to stereotyping.

> *If I had some tool that would help me maximise the amount of time both from my point of view and the point of view of my client, then that is probably the best option I could provide being I am not being a bicultural speaker.*
>
> *You need more professional experience before you start dealing with those sorts of tools. It's dangerous in the wrong hands.*

Royal Perth Hospital

Most participants in the RPH focus group reported a lack of knowledge of other cultures as a barrier to providing appropriate services.

> *You've got to have some knowledge of diet in different ethnic groups. They're not the same.*

Some participants reported that the information they gave clients conflicted with what they had received in their own culture and that this made it more difficult for clients to follow.

> *In some Asian countries they have been given advice before they come here and then we give them different advice.*

> *I think it's hard if they are told not to eat rice in Vietnam and then we tell them they can have it.*

However, participants reported that most clients were willing to follow the advice given to them by specialists at the hospital for two reasons. Firstly, the hospital used a team approach in which all the health professionals provided similar information. Secondly, health professionals set realistic and achievable goals for their clients in regard to lifestyle changes.

> *Hopefully it's consistent because it's given by a team.*

> *She doesn't say to an Asian person* 'Don't eat rice'.

Participants reported that RPH had a pool of interpreters organised by a coordinator. They emphasised the value of this service and the needed to be reassured that it will continue. However, they described problems with service delivery caused by the need to use interpreter services.

Most participants reported that having to use an interpreter increased the amount of time needed for consultations and this in turn, increased the cost of providing the service.

> *But with a good interpreter it takes pretty much double the time, I think.*

Some participants reported that trying to work quickly during a consultation to compensate for the amount of time required for interpretation could result in the client becoming confused. This was particularly noticeable when trying to provide clients with information on how to use and access equipment and supplies.

> *The bit that really worries them is the equipment so they concentrate hard on that and then you give them the information about where they are going to get the supplies and they turn up two weeks later and want to buy them from you.*

A few participants reported a concern that their messages might not always be conveyed accurately and appropriately if interpreters had limited knowledge of diabetes or were from a different social class to the client.

> *Whatever their background is, it doesn't cover what you're trying to say, so you've got a problem trying to get it across to the interpreter, and then it's got to go the extra step.*

…with an Italian interpreter who was obviously of a different social standing and you have a bit of a problem relating to the client (through the interpreter) and the problems of poorer standards, and that person relating back.

Several participants described situations in which language differences had made it difficult to provide follow-up services to clients.

If the client decides for some reason that they couldn't come… they can't ring up and tell us and we don't know what's happened and we tend to lose sight of the client because if we send them an appointment they can't read it...

Participants considered that cultural awareness training and support from bicultural health workers might help to overcome the problems caused by language and cultural differences, but were hesitant about both.

If it's going to be done it should be done properly. I mean…if it's not done properly they assume that every Indian person eats curry and rice…

Otherwise, you are going to have them (bicultural health workers) *giving out inappropriate information in a really sort of didactic way which gets people's backs up, because they are not necessarily coming from a proper professional background.*

Although RPH policy prohibits the use of family members to translate for service providers, participants felt that family members were helpful in the process of educating clients and achieving lifestyle changes.

It's good to have the family members there but not to use the family members as the interpreting service.

It's very positive to have family members present and to use them from the point of view of teaching things.

We had quite a big struggle to get her into the right footwear. We had to bring a member of her family in before we could convince her.

General practitioners

Most of the five GPs interviewed reported that they spoke the same language and were of the same cultural background as their Italian or Vietnamese clients with diabetes and therefore did not have significant problems communicating with them. Some reported that they sought the assistance of family members or staff to deal with language difficulties or that clients brought family members to consultations to assist with communication. One reported using the practice's secretary to interpret when necessary.

Several interviewees reported that it was difficult to provide follow up services to clients who did not keep appointments or attended other services where they received different treatments from those prescribed by the GP and were told that there was a cure for diabetes.

Most interviewees felt that more bicultural service providers were needed. Some stated that bicultural service providers should be available on a sessional basis at their practices.

6.4 Education for self-management

6.4.1 Education materials

Community-based service providers

Participants in the focus group for community-based service providers reported that it was difficult to provide good quality written education materials for their clients. This was due to the lack of availability and the fact that translations may not convey the information accurately and that service providers often could not assess the accuracy of the translated materials.

> *When things are translated directly they don't always come out in the language the way they were supposed to come out in English…*
>
> *…and now I don't even have the English translation so I don't know what it says…*

Some participants reported that the funding available to produce and update education materials was very limited.

> *…a lack of funds to actually produce new materials and update what we have already got…*
>
> *…we are providing updated and upgraded information for our English speaking and English literate clients but that information isn't being supported to the same extent for the non-English speaking…*

One participant reported that some Italian people are illiterate in their first language and may not be able to use education materials. Furthermore, participants expressed concerns about the ability of some of their clients to read education materials written in their first language because they used a dialect of that language which in turn had been overlaid with English.

> *…some people have a mix-match of different dialects and bits of English that have been added to it.*

One participant described a process in which health messages are conveyed using concepts relevant to a person's first language.

> *Need to be sure that you're not just translating the English or Anglo-Saxon concept to make the Anglo-Saxon* (health practitioner) *feel more comfortable. It's ensuring that they've* (client) *actually got the concept in a way they can use for themselves.*

Several participants suggested that resources for producing education materials be pooled and a central agency be developed to ensure that the materials were produced in a coordinated and efficient manner. Participants expressed varying views on the benefits of pooling resources at a national level.

> *The more you produce the better* (cheaper) *it is. We could do it on a national basis rather than having one person doing something here and someone else doing something else there.*
>
> *…you are better off to stick to simple messages linked to our own* (local CALD population). *Might not be so flash or as pretty as what you could produce with heaps*

more dollars. But the bottom line is what's the message you're trying to get across? And who are you trying to impact on?

I brought back buckets (of translated brochures from another state) *but what we found was that people said Yes, but that's not the way we do things, we don't use that size syringe, that's not the way we explain things. In the end, I had all this stuff on diabetes that I'm sure I've since thrown out.*

Royal Perth Hospital

Participants in the focus group for specialist health service providers at Royal Perth Hospital reported that they had very few up-to-date and adequately reviewed education materials in languages other than English.

We've got one up-to-date (pamphlet) *now in Italian and in Vietnamese* (that is slightly older).

The Italian one which was produced, when was it produced? Three years ago?

They emphasised the need for simple, culturally appropriate information produced as leaflets and fact sheets and stressed that these should be focus-tested on potential readers and have an English version to accompany them.

You often don't need all the detailed information and background translated.

..it's (the brochure) *more a take home message for them* (clients).

Participants agreed that materials must be kept up to date but had varying opinions on who should be responsible for producing and reviewing education materials.

We can't be using data (ie. resources) that is not up to date.

And more educational materials, which are not necessarily the responsibility of the hospital to produce.

I think it is the responsibility of the hospital to make sure they are right though.

They also had varying opinions on whether the person who developed the brochures needed a medical background.

…it's good if you've got someone who has not got the medical knowledge who can read your hand outs. Absolutely no medical knowledge and say, 'look at this? Do you understand this?

…you need someone who understands where you are coming from, so you know … they understand and can make other people understand.

Participants suggested a national audit of available resources to avoid duplication and stressed the importance of generic materials that could be used at all service sites and meet individual centre styles and care plans.

General practitioners

The five GPs interviewed reported difficulty in obtaining culturally appropriate, easy-to-read education materials for their clients and suggested that education materials be developed in the following formats:

- Booklets and brochures in an easy to read, pictorial style with summaries of key points in their first language
- Entertaining videos in first languages that could be borrowed by clients or shown in GPs' surgeries.

Interviewees were also concerned about how accurate and up-to-date the available materials were. Most felt that general practitioners did not have time to review education materials. Some interviewees suggested a clearing house be established to review educational materials. A diabetes educator was suggested as the appropriate health professional to conduct the review process. DAWA or the Multicultural Access Unit were suggested as appropriate organisations for the clearing house. Some interviewees felt that the Health Department of Western Australia should have overall responsibility for developing and monitoring educational materials.

Most interviewees felt that they needed a catalogue or register of culturally appropriate educational materials. Some reported that the Medical Director software, which most practices were planning to use once it became available, would have information on resources and fact sheets that GPs could recommend or disseminate to clients.

6.4.2 Support groups and education programs

Community-based service providers

Participants in the focus group for community-based service providers identified the lack of homogeneity among cultural groups as a problem when developing education materials and programs.

> *Should we be looking at the group of people who do speak English well but who still wouldn't do so well in the mainstream diabetes education because we're not actually addressing their cultural issues, such as, the sorts of foods they eat or exercise they might prefer?*
>
> *It's important to look at the target groups…Especially with the Italian communities, different age groups have a huge impact in the way they understand information...*

The majority of participants reported that it was inappropriate to translate and deliver education programs designed for English-speaking audiences into other languages without taking the cultural considerations of the group into account. Participants expressed the need to tailor interventions to the client group and suggested working closely with ethno-specific organisations and consumers to ensure the messages conveyed were culturally appropriate.

> *We have to adapt the way we approach things differently for different groups and that requires a much better knowledge and that goes back to the communities, not just us.*

The use of support groups in diabetes education for CALD communities generated considerable discussion. Participants with experience in operating support groups reported that this strategy could be useful, but that problems could arise with it.

The theory is fine but it could get out of hand... suddenly someone decides they're the 'expert' because they're the chairman of the local support group...They might have the best intentions but it can be quite counterproductive because of their power in the group.

Also need to prevent support groups becoming social groups.

Participants felt that support groups should be part of an ongoing program that was well structured and had quality control mechanisms set in place to eliminate problems of support groups becoming too autonomous.

We see support groups as part of an umbrella arrangement that talks about the structure... with reporting, evaluation and quality control mechanisms... It doesn't need to be obvious, but it needs to be there.

One participant reported plans by her organisation to set up support groups in the future based upon a framework that has been used effectively with ongoing cancer support groups. The framework included financial incentives to operate in a manner stipulated by the organisation and open communication between the organisation and support group. The participant suggested applying the same structure to diabetes support groups for people from a CALD background.

The supports are there and the structure for that support group is the same as for the one in (any other area).

The need for appropriate resourcing of ongoing support groups was also recognised by one participant.

…last year we built up all these groups, then suddenly this year, all these (support group facilitators)…have been replaced by untrained people.

A number of participants described the benefits of developing partnerships with ethno-specific organisations to enhance education service provision. Some participants provided examples of how the expertise of a cultural organisation could be utilised to provide a culturally appropriate service to CALD communities.

One bicultural health worker reported how a guest speaker visually demonstrated the effects of olive oil in the blood stream during a talk to a group of elderly Italian people.

Because that person consulted with us he was able to present the information in such as a way that people were very responsive.

Attaching yourself (health organisation) *to the cultural organisation is a much better idea because you can fine tune your resources and you don't waste so much.*

The same participant commented that resources and communities could be accessed more easily for education purposes by working in partnership with ethno-specific organisations because they were perceived as credible sources of information.

When Italian people come to us (ethno-specific organisation), *they feel at ease...They* (the clients) *may ask 'I've heard of this course. What do you think?*

Participants reported that working with ethno-specific organisations could also promote community ownership of programs.

> *Cultural programs arranged through cultural centres, with them bringing in their own skills... It's not imposed upon them. It's part of what the community is asking for and we are providing the service. So they own it.*

Furthermore, participants reported that the established networks that ethno-specific organisations and Multicultural Access Unit have with community based ethnic media could be accessed to promote the CALD community's awareness of diabetes services and information.

Participants stated that there was a need to formalise partnerships with ethno-specific organisations at all levels of operation, from policy to practice, rather than relying on informal networking to achieve partnerships.

> *If the person moves on, links are lost.*

> *Partnerships need to be structural and sustainable.*

One participant reported that building partnerships more broadly between public and private sectors could overcome barriers to accessing local facilities for programs. The benefits of a partnership were perceived as reciprocal to all parties.

> *We need to educate even people at the swimming pool and try to get them to understand...they'll be benefiting in the long run.*

6.5 Integration and co-ordination of services

6.5.1 Referral processes

General practitioners

Some of the GPs interviewed reported that, although they referred clients to other services, many clients did not take up those referrals because they could not see their relevance.

They identified a number of problems with allied health and hospital services which they felt contributed to failure of clients to take referrals. Some interviewees reported that clients did not want to use the services because access to interpreters and bicultural allied health professionals was very limited. Several believed that dietitians did not provide culturally appropriate information about food.

Community-based service providers

Participants in the focus group for community-based service providers and bicultural health workers identified three main difficulties in providing an integrated service:

- Lack of flexibility within the health system
- Perceived unwillingness of GPs to advise clients of all services available and refer between services
- Not knowing other allied health service providers they could refer clients to.

> *Health systems, too, you know how they are now re-structured and they all have their different units…you are not allowed to service outside your 'box'* (ie. unit).

We are right into...customer focus but what we are really talking about is customer responsibility... If you ask for the service you will get it and often a Rolls Royce service. But if you don't, there isn't the pro-activity on the part of the health services...

Podiatrists, we get asked very often where to refer someone and we have no idea where to send someone who is actually going to be competent in treating a diabetic client.

…more contacts for myself so that I can network with different service providers to be able to help my clients just a little bit more…

I think some doctors should know we (allied health professionals) exist.

…educating general practitioners that we are not there to steal their clients, just that we are there basically, in the long run, to save money…

Several participants expressed a need for more opportunities to network with other service providers as a means of increasing their awareness of available services and the relevance of the services other than their own discipline.

I (optometrist) *would like to see more regular seminars where we can get together as a team and educate each other, provide each other with information so when I need to refer my diabetic clients I know where.*

6.6 Issues for service usage

6.6.1 Knowledge of causes and complications of diabetes

Italian consumers

Some participants in the Italian focus groups said they did not know the cause of diabetes. Others cited a variety of causes, including ageing, heredity, grief, depression and stressful life events, such as war and migration, pregnancy, another illness, being overweight, and diet.

I would not know the causes because I got diabetes without even knowing about it.

I got it because of the trauma of losing my husband.

I think it's the food.

Sugar, too many sweets and those things, if you eat too much of them, you're more at risk.

Participants were asked how they would describe diabetes and most had difficulty answering this question. Most of those who attempted to describe it did so with reference to its impact on their lifestyle rather than its physiological nature.

I don't even know what it is. It's very difficult to understand what it is really.

It's the most horrible thing in the world. It makes you really feel you don't have the freedom to do what you please.

A disease that doesn't make sense but it makes you try and find some sense in the way it works.

You must eat regularly. Small amounts but regularly.

Diabetes is something which changes your whole life around.

One participant described diabetes as a condition in which the pancreas does not function properly to produce enough insulin.

Participants cited a number of complications resulting from diabetes which they had either experienced themselves or learnt about from relatives, friends or acquaintances. These included:

- Leg amputation
- Foot problems
- Haemorrhage in the eye
- Loss of sight
- Dizziness caused by sight problems
- Damage to the pancreas
- Kidney problems
- Nerve damage or dysfunction and loss of sensation.

I know one lady who does not see at all because she had really high diabetes. She would eat everything and then lost her sight completely.

…most important maybe are the problems with the feet, sight, a lot of dizziness…and you risk falling…

Nerves maybe, I sometimes have no 'sensation'.

Several participants cited problems associated with low blood sugar levels.

I fell because of my blood pressure and my sugar levels had fallen very low.

I know when my sugar levels have gone down because I don't feel well.

Working, I perspire, and it (blood sugar level) *goes too low and this is when you have to be careful, when it goes too low, your legs start to go…*

Vietnamese consumers

Some participants in the focus groups for Vietnamese consumers stated that they did not know the cause of diabetes, some stated that not even doctors knew the cause, and others cited various causes, including:

- Lack of exercise
- Eating freely
- Sugar in the blood
- Ageing
- Inheritance
- Failure of the immune system or kidneys.

I do not know the reason.

Even my doctor says that there is no single reason and that he does not know the true reason for my diabetes.

We are often overweight, and do not exercise. These factors can lead to diabetes.

I think it's because of age, lack of exercise and eating freely.

I think it's probably because my mother had it.

The kidneys cannot produce enough insulin so the excess sugar stays in the blood.

Participants cited a number of complications of diabetes which they had either experienced themselves or learnt about from relatives, friends or acquaintances. These included:

- Heart problems
- Leg amputation
- Kidney failure
- Blurred or damaged eyesight
- Damage to the lungs.

He just ate whatever he liked because he thought his diabetes had been cured. As a result, it had led to heart problems.

I know one lady, her leg had to be amputated.

I saw people in the hospital who need blood filtration due to kidney failure.

My eyesight has become blurred.

6.6.2 Knowledge and skills for self-management of diabetes

Italian consumers

Participants in the focus groups for Italian consumers reported a range of management strategies including eating appropriately, being physically active, monitoring their blood sugar levels and taking medications.

Much of the discussion focused on the need to avoid certain foods, particularly sweet foods, to manage their diabetes. Some participants found this difficult to do and reported that the more they tried to cut down the more they wanted to eat. Others reported that they did not avoid certain foods altogether but ate only small amounts of them. Some foods were mentioned by a number of participants as being particularly hard to forgo, especially certain fruits such as grapes and figs.

…you can't eat too much or too many rich things, I always have that on my mind and I have to control myself, but the more I think about it the more I want to eat.

I had lost seven or eight kilos. But then my mouth - that's something else.

If I see a biscuit I am tempted. I can't change that.

I like fruit very much but I can't eat it because it contains a lot of sugar.

I am careful with my foods, but I don't give up everything, always a little.

Some participants reported doing regular physical activity while others said it was difficult to be physically active for various reasons including health problems, lack of enjoyment, fears for their safety or family responsibilities. Some reported that they used housework, gardening or bocce (Italian bowls) for physical activity.

I go swimming twice a week which is very good for me.

I should walk but I have arthritis in my knees.

'I don't go (walking). *I don't like to go walking by myself.'*

I don't go walking because my husband is very ill and I have to be there for him.

Some participants reported that they relied entirely on their doctor to monitor their blood sugar levels while others self-monitored their blood sugar between visits to their doctor. Several stated that they were aware of the relationship between their blood sugar levels and risk behaviours. Some expressed distress at having to perform self-monitoring.

We have a blood test (every six months) *but we also check our own sugar levels. We have a machine and we do our own checks at home.*

When I eat things, like fruit especially, it (blood sugar level) *goes high.*

I've noticed something though that when my sugar is at 8, I work in the garden, it goes to 4 and 3.5.

…nervous especially when I don't see the blood coming out and so sometimes months and months go by and I don't measure it.

Because with the sticks, it is very fastidious, you have to take blood and you have to put water and I am not able to do this. My son does this.

A number of participants said that they used medications to control their diabetes, although most acknowledged the importance of self managing the risk factors for complications as well as taking medications. Most participants reported that they were able to remember to take their medications or had developed strategies to help them remember.

I take tablets. I watch what I eat. I walk nearly every day for about 40 minutes.

I control myself really, if I need to take an extra tablet, otherwise I watch my diet.

I need to take my medication before food, so I know that when I eat I have to take my medication first.

Many participants reported that making lifestyle changes had little impact upon their health condition.

I don't know how to control it any more. Whatever you say, I don't eat this, I don't eat that and it's the same thing.

Participants reported that they obtained information on managing their diabetes from their doctors, dietitians, DAWA, community health services, hospitals and from other literature they read. Some participants reported difficulties in obtaining the information they needed or reading the information in English.

I went to a dietitian specially for diabetes…because there's always something new to learn.

The one I went to I like it a lot because it helped me a lot. There were many explanations, lots of information on what to do, so now I know what to do about my health, having been to that (name of community health centre) clinic.

I have learnt a lot from reading books. I have spent a lot of money but I at least have learnt something useful.

I don't know what fruit I can eat.

It would be a very good idea for the government to give something in the way of education, especially to those who speak only Italian.

Participants identified a variety of reasons why some people would not manage their diabetes appropriately, including:

- Not being able to believe that one has diabetes
- Behaving as though one does not have it in order to avoid believing that one has it
- Believing that it is not necessary to manage diabetes because death is inevitable
- Lack of motivation or skills to perform the necessary self-management tasks.

I did know someone but he is dead now. He never said he had diabetes, he said he went dancing one evening and his shoes hurt him…and from his shoes he got an infection, from this infection they cut his leg off…

…when they told me that I had diabetes… because my mother-in-law died of diabetes, I cried and cried, and in three weeks I lost two stones…Then slowly I started to resign myself to it…

The lack of will to do it.

Participants in the Italian focus groups expressed various feelings about managing their diabetes including:

- Sadness at the need to make lifestyle changes, in particular at having to avoid foods that they enjoyed
- Fear at the changes in their blood sugar levels
- Powerlessness to make the necessary changes to diet and exercise behaviours
- Lack of energy as a result of changes to their lifestyle, particularly to eating patterns.

I was a little, how do you say, depressed at first.

You feel sad and a little down all the time when you can't really eat everything you'd like to eat.

After lunch one day I got very scared because my blood sugar levels had reached 16.

…everything has changed. I also feel weak all the time.

Participants reported both positive and negative effects of family support, with some saying that family members helped them to avoid harmful foods, while others reported their family sometimes encouraged them to eat foods they should avoid.

...our children agree with everything we do, so for us it does makes a difference because they want to watch themselves too.

They're always on my back and tell me not to eat certain things, especially my wife.

They (family) *say don't eat this, don't drink that. My daughter especially says look after yourself, look after yourself.*

At times they (family) *say, oh go on, eat some of this it is not that bad for you.*

One participant felt quite discouraged, saying that friends frequently did not understand his condition and need to adhere to a controlled diet.

When I'm with friends, they might say one more glass won't do anything!...They think you don't want to drink it or aren't sociable!

Another participant reported that friends were very supportive and responsive to her needs especially in emergency situations.

...once I was at a friend's place, and while I was there my sugar dropped so low so I had to ask for a glass of Coca Cola, he said 'immediately!' because he knew why.

Vietnamese consumers

Participants in the Vietnamese focus groups reported a range of methods of controlling diabetes, predominantly avoiding certain foods, particularly sweet foods, high fat foods, tropical fruits and seafood and engaging in physical activity.

I can still take sweet things and rich foods, but I must take them in moderation.

By exercising and reducing my intake of sweet things.

Before I did not play tennis and now I do I noticed that my diabetes condition has improved even though I do not take medicine.

I normally walk about 10 km each day. I am over 80 years old now.

Other methods of managing diabetes reported by participants included:

- Using medications
- Self-monitoring of blood sugar levels
- Regular visits to a doctor, hospital clinic, or nurse
- Support group participation.

> *I have to take two tablets twice a day.*
>
> *I inject medicine twice daily.*
>
> *My nurse asked me to buy a machine which I did.*
>
> *I participate in* (name of support group facilitator's) *group, see doctors and a diabetes educator.*

Common self-management problems reported by participants were related mainly to:

- Remembering to take medications
- Following an appropriate diet
- Exercising regularly.

> *Sometimes I forget* (to take medication), *but because I am used to it now. Three years now so I have got used to it.*
>
> *Whenever I go overseas to Vietnam I usually don't follow my diet there. It is a bit difficult to do so overseas. Especially when we go out.*
>
> *Because I work in a factory where the hours are long I often just go home to eat and sleep so I don't have time to exercise or go for a walk.*

Participants cited three main sources of information about diabetes. These included:

- Pamphlets
- Family members
- GPs.

> *I have been told by family members and by reading pamphlets that I should not eat sweet things and that I should exercise more.*
>
> *My doctor gave me pamphlets and other materials to read on diabetes so that I could keep watch of my condition.*
>
> *My doctor has given me guidance as to the types of food I can eat such as reducing my intake of sweet things.*

Some participants reported that they had difficulty accepting the lifestyle changes that their diabetes required whilst others reported feeling healthier as a result of making the changes.

> *I feel quite miserable. I really want to eat it.*
>
> *I feel very uncomfortable that I have to stick to a fixed diet and am not free to do what I want.*

I feel normal, I feel healthier.

Yes. It was a bit difficult, but I was able to overcome it.

Varying opinions were expressed on the importance of support from family and friends. Some participants felt it was helpful in reminding them to keep to their diet while others felt that they managed without support. Several participants stated their families did not understand their problem, with one participant stating that his family believed he was healthy because he did not look unwell.

For me, family and friends support have helped me tremendously to overcome the sufferings. I feel it would be harder without their support.

My family often remind me to diet properly and to visit the doctor.

No, I look after myself.

They see me look healthy and normal so they don't visit me.

A number of participants reported that apathy and the belief in the inevitability of death prevented the proper management of the disease by some members of the Vietnamese community.

There is one person who is quite old. He said that well we are all going to die in the end so just eat all you like while you can.

...there are people who are afraid that if they own up to their disease their children will find it difficult to find a family of their own.

Vietnamese participants were asked whether some other members of their community might believe that diabetes was caused by supernatural forces. They rejected this notion.

No-one that I know believes that is the cause of diabetes. It depends on what we eat.

Community-based service providers

Participants in the focus group for community-based service providers expressed the view that, for some of their clients, the development of skills for self-management was affected by their perception that their diabetes may resolve spontaneously or that the treatments available in Australia were not effective.

…because some of my clients are elderly people and again they don't want to accept the fact that they have diabetes forever and again they expect to have a miracle, a cure from Vietnam.

We are applying Western medicine and Western answers to medical problems as we perceive them.

Participants suggested a number of ways in which service providers could help consumers to improve their self-management skills, including:

- Accepting cultural differences
- Addressing cultural myths where appropriate
- Promoting self-efficacy for management of diabetes.

> *The best thing you can do is meld your arguments and that culture and try to get an outcomes that the client sees as appropriate… I don't see changing someone's culture to meet my expectations of their health outcomes is what I'm there for.*
>
> *Realising that it is a big step for an Italian woman to give up her oil.*

General practitioners

Most of the GPs interviewed felt that clients generally had little awareness of the seriousness of diabetes and its complications. Some interviewees reported that their clients found it difficult to accept their condition, did not understand the need for lifestyle changes and treatment, or believed that the lifestyle changes and treatment would not prevent them from dying.

Most interviewees felt that making the necessary lifestyle changes was difficult for many of their clients. They believed that many clients preferred their traditional eating patterns, such as eating large quantities of fruits in season and consuming significant amounts of wine with meals, and were reluctant or unable to increase the amount of physical activity they undertook. Some had experienced starvation and therefore thought that all food was good for them.

Opinions on the willingness of clients to take up advice varied, with some interviewees reporting that clients were unwilling to accept the advice given or pretended not to understand it. Others felt that most clients were very amenable to following advice given on the management of their diabetes. Several interviewees commented that an older Vietnamese person who does what he or she has been told may lose the respect of the younger members of their family. Some interviewees believed that clients regarded educational information as boring and not applicable to them as individuals.

Interviewees perceived that many of their clients could not see the value of, or had difficulty with the tasks required for self-management of diabetes. These difficulties included:

- Not being able to conduct blood glucose self-monitoring
- Not wanting to change lifetime dietary habits
- Not being able to self-administer insulin
- Having a needle phobia
- Relying on adult children to collect supplies and equipment from DAWA and thus not receiving instruction in using equipment
- Forgetting to take medications or not persisting with medications
- Reluctance to exercise
- Having co-morbidities which reduced the ability for self-management
- Having low self-efficacy regarding self-care
- Preferring, in the case of Vietnamese clients, to use herbal remedies rather than those prescribed by GPs.

Some interviewees reported that most clients did not feel it was necessary to access podiatrists and ophthalmologists for early detection of complications, particularly for those who could see and whose feet did not hurt.

6.6.3 Support and education for self-management

Services required when first diagnosed

Italian consumers

Participants in the Italian focus group reported that the services they would like to have had when they were first diagnosed with diabetes included:

- A thorough explanation of their disease and how to manage it, rather than just information on diet
- Written materials in Italian
- An Italian support group
- Advice from health professionals with an understanding of Italian culture
- Information on new research on diabetes.

Vietnamese consumers

Participants in the Vietnamese focus groups reported that the services they would have liked when they were first diagnosed with diabetes included:

- Written information
- Dietary information and advice
- Support groups.

Resources and dissemination of information

Italian consumers

Participants cited a variety of information resources that they thought were appropriate for Italian people with diabetes, including:

- Videos
- Regular seminars and presentations
- Written materials in Italian
- Posters
- GPs.

Several participants commented that written materials were difficult for some people to use because of problems with their eyesight. Some reported however that when materials were provided in English a family member would often translate them.

Participants suggested places where information could be disseminated included:

- Italian radio
- 'Il Globo' - Italian newspaper
- Other local and community newspapers
- Italian clubs
- Churches
- GP surgeries
- Hospital clinics
- Bicultural health workers who could inform different groups of available services.

Vietnamese consumers

A variety of forms of information were considered appropriate for Vietnamese people, including:

- Flyers
- Pamphlets
- Videos
- Articles in local newspaper
- Vietnamese radio

Participants commented that information is often passed around by word of mouth. Other dissemination avenues included:

- Vietnamese doctor clinics
- Pharmacies and other shops
- The Vietnamese Community Centre
- Vietnamese catholic community networks
- Vietnamese temples.

Use of support groups

Italian consumers

A support group for Italian people with diabetes has been in operation since March 1998 and most of the support group members who participated in the focus group had belonged to it since its inception. Several of these participants stated that attending the group had helped them to understand their diabetes and learn more about managing it. Knowing that support was available had helped other participants to feel more confident about coping with their condition.

> *The talks that they give help us.*
>
> *…it's good to listen to things like that* (talk from nurse educator on effects of low blood sugar level*) so you know what's happening. The more you listen to them the more you learn.*
>
> *When you have something like this* (diabetes) *and you're afraid of many things, you may also have horrible thoughts. You think 'I might die from this' but hearing more information and a word of comfort makes you feel like there is some help out there and you gain more confidence in yourself.*

Several support group members reported that they valued the opportunity to share information with other diabetes sufferers in an informal setting.

> *I like it because you can listen to a lot of things and you can relax too. I also like talking about things with other people.*
>
> *It's very nice and it also gets you out of the house. And you meet different people too.*

Some participants from the support group expressed dissatisfaction at the fact that the facilitator and guest speakers were English-speaking. They reported that this made it difficult to obtain the information they wanted in the time available to the group.

> *…at the meetings they speak to us in English first then someone repeats it in Italian, and it's more complicated.*
>
> *It's confusing and it becomes very long and our time runs out very quickly.*

We are all Italian here so it would make sense to have someone conduct the meetings only in Italian instead of repeating everything twice.

Participating Italian consumers were asked about the value of support groups and how they thought these should be run. Most felt it would be beneficial to have a support group for Italian people with diabetes in the inner city area of Perth.

I think that meetings would be helpful especially for those that don't understand English at all.

Participants felt that it was important to have information provided directly in Italian if more support groups were established.

…it's much better in Italian otherwise it all ends up in confusion and many things are missed.

They suggested that costs be kept to a minimum, that government financial assistance be provided and that the venue be local, such as:

- North Perth Migrant Centre
- Italo-Australian Welfare and Culture Centre Inc.
- Anywhere in North Perth.

Participants in the Italian focus group agreed with the following suggestions for establishing other support groups:

- Support groups be conducted in the preferred language through use of bicultural health workers
- Costs be kept to a minimum
- Support groups be scheduled on weekdays during the day
- Membership be open to interested family members and there be no limitations on numbers.

Participants emphasised the importance of having someone with experience, such as a hospital staff member, to organise support groups and a bicultural health worker to facilitate them if more support groups were established.

(Support group members) *would definitely not be capable of doing something like this.*

There would be a need for a person who speaks both languages, to speak to these people and organise meetings.

Participants agreed with various suggestions on how the support group could be improved, including:

- Healthy meal demonstrations
- Supermarket visits guided by an expert
- More check-ups (e.g. blood sugar levels, blood pressure checks)
- Bicultural health workers to present the information in Italian.

Participants identified language problems and forgetting to attend as the two main barriers to attendance at a support group. They stated that the latter problem could be overcome by circulating a meeting schedule ahead of time.

Vietnamese consumers

Participating Vietnamese consumers who were members of the Vietnamese support group cited a number of benefits they had experienced from the support group.

> *This group informed me about medication.*
>
> *I know more clearly and in details. My health is much better. I tend to forget but now I can control the sugar level in my body much better.*
>
> *I am very pleased with the group. I remain like this* (healthy) *after so many years because I learn from the group.*

Vietnamese participants did not report problems related to having information interpreted for them during the meetings but did emphasise the importance of having a bicultural health worker to facilitate support groups if more were developed.

> *I am most pleased with the information given by* (name of health worker) *and translated by* (name of bicultural health worker).
>
> *We need a professional health worker and an interpreter because we don't understand English.*
>
> *We would need the* (bicultural health worker) *to be there to guide us, and I think if the worker couldn't make it the meeting should be cancelled.*

Participants in the focus group for community members with diabetes agreed with the facilitator that it would be helpful to have a support group.

> *… good to have that group so that you could teach each other.*
>
> *Yes. We really need one like that.*

Participating consumers identified a number of functions for support groups. These included:

- Sharing experiences and information
- Teaching and supporting each other
- Education including advice on diet and purchasing of food
- Establishment of a walking group.

> *Yes. We need a support group because in that group the clients can support each other, the health worker can show us how important it is to manage our diabetes and we could do some exercise together by going to the park or for a walk.*

Participants suggested the following criteria for establishing support groups:

- Located at the Vietnamese Community Centre
- Minimal cost, not more than five dollars per session

- Financial assistance provided
- A bicultural facilitator, either health worker or doctor
- 8 - 10 members
- A varied and informative program.

Some participants felt that the group should be specific to Vietnamese people while others felt that it should be open to other cultural and language groups.

Self-management education programs

Italian consumers

Participants felt that public education activities would be very beneficial for Italian people with diabetes and their families.

> *There should be meetings, like this one today.*
>
> *Going out to speak to more people because many people don't know.*
>
> *People who give talks, meeting or groups.*

Most were interested in attending a series of education sessions when this was proposed to them. Various formats were suggested for the education sessions, including live demonstrations and lectures. Participants suggested a variety of activities that they would like included in the sessions such as dancing (eg. 'Tarantella'), cooking demonstrations and healthy recipes. Some participants stated that it would be beneficial to attend the education series before joining a support group.

Some said they would be willing to have an interpreter for the course if necessary.

> *It would be important to have some professionals come and talk to the group. If they can't speak in Italian, then speak in English. There is always someone to explain.*

Although a number of participants expressed concerns about transport for the sessions, the group was able to generate a number of solutions to this problem including the use of a taxi service available to seniors through the City of Stirling and arrangements between participants to provide lifts for one another. Participants suggested Lockridge, Leederville, Morley and Bassendean as suitable locations for the program. Some participants also expressed concerns about the ability of potential participants to pay for the education sessions and the need for government assistance with the cost.

Vietnamese consumers

Most participants were interested in attending a series of education sessions when the idea was proposed to them. They thought that most people would be willing to attend an education program run for 2-3 hours per week over a four week period. Participants considered a bicultural health worker the most appropriate person to provide support and education

Participants suggested a variety of topics they would like included in an education program focusing mainly on the problems encountered in managing diabetes and how to overcome those problems.

Some participants said they would be willing to contribute to the cost of the sessions while others felt that they could not pay. Transport was a concern for some participants but they felt that this

problem could be overcome by either having transport provided or holding the program at a location close to a bus route. The Vietnamese Community Centre was suggested as an appropriate location.

6.6.4 Knowledge of existing services

Italian consumers

Although participants in the Italian consumer focus groups were aware of various services other than those provided by GPs (e.g. dietitians, podiatrists) many reported that they did not use them, or used them infrequently. More participants had used a podiatrist than a dietitian.

> *No, just the doctor, that's it.*
>
> *Q. Who has ever been to see a community health nurse, or a health professional who is based at one of these community health centres, or used another service like Silver Chain ?*
> *A. No, none of these.*
>
> *I just go to my doctor, but he said that diabetes affects your feet as well.*
>
> *He* (doctor) *told me about the eye specialist, the foot specialist and I didn't ask him about anything else.*
>
> *I used to go before* (to a podiatrist) *but not because I had bad feet thank God, just to check them and to cut my nails and tell me they're OK and I don't need anything.*
>
> *I used to go before* (to a dietitian) *because I wanted to know how I could heal myself, I didn't want to accept being diabetic.*

Participants gave various reasons for not using some of the services available. These included:

- Lack of knowledge of the services available
- Lack of time
- Location of service
- Lack of motivation
- A perception that clients are not welcome at some services.

> *We don't really know about these* things (other services available).
>
> *I don't go to any of these places because I am not well informed.*
>
> *I don't really know* (what services other Italians use). *If they get a letter to say 'let's go and see what this is about' no, they just let it go.*
>
> *They do treat us somewhat bad.*
>
> *They* (other services) *don't want you because they say you can go to your doctor.*

Vietnamese consumers

Participants in the Vietnamese consumer focus groups reported they had a limited knowledge of services other than those of GPs and relied mostly on their GP for information and support.

We don't know of such services.

Q. What about a dietitian?
A. No, we just control our diet ourselves according to the doctor's advice.

Most people only see the family doctor.

Most participants seemed to have only limited awareness of DAWA (*Is that where we buy our needles?*). One participant reported that using hospital services was more difficult than attending the support group because she needed an interpreter at the hospital.

6.6.5 Language and cultural differences

Italian consumers

Some participants in the focus groups for Italian consumers described problems they had experienced in using services related to language and cultural differences. Most of these occurred when using the services of a GP or hospital.

We have an Italian doctor so we don't need an interpreter for him.

We push ourselves and try to make ourselves understood.

No, never had an interpreter (provided by the speaker's GP).

I felt very uneasy, you know, the nurses all speak English and I suffered because they couldn't understand me and I couldn't explain myself.

A few participants reported that some service providers have skills in languages other than English that they sometimes do not use.

The problem with these young people, nurses and others who won't speak Italian, is that their parents have only taught them a dialect and they are embarrassed to speak dialect…

…but sometimes when I'm there and can't speak and there's someone there who is Italian and refuses to speak to you in Italian, I get really angry.

Vietnamese consumers

Most participants in the focus groups for Vietnamese consumers expressed satisfaction with the interpreter services, or reported using strategies other than an interpreter to overcome the language barrier.

My daughter is the interpreter, but sometimes there are interpreters for me if I require them.

For (name of support group facilitator) *group I don't need an interpreter, whereas I need an interpreter when I attended the specialist or hospitals.*

Community-based service providers

Some participants in the focus group for community-based service providers felt that not all Italian and Vietnamese people have a sufficient understanding of the systems of service provision to access services effectively.

I have become very aware that a lot of what we do is based on our knowledge of the Medicare system, the government system, the transport system… working on the presumption that they know how all these systems work …and …I find out that they don't.

Several participants regarded the lack of interpreter services for ongoing care and follow-up as a barrier to the use of services, particularly for problems relating to self-management.

They come in, they see me six times, they get it all beautifully translated, but after that they are out there on their own.

…more comfortable ringing (the bicultural health worker) *up …it's a two minute thing to sort out…whereas they may well ignore that problem or panic for the two weeks it takes them to get an appointment with me through an interpreter.*

General practitioners

Participating GPs felt that allied health professionals and general practitioners needed cultural training, although some felt that general practitioners would not attend because they were a very conservative group who would be unlikely to change. The inner city area had a number of older GPs in single practices who may not have the time or motivation to move to new service delivery models.

Some interviewees felt that service providers for CALD groups should be required to speak the language of their clients. Some participants expressed the need for bicultural dietitians and programs delivered by bicultural facilitators. Others considered a more accessible system for interpreter services important.

6.6.6 Transport to services

Italian and Vietnamese consumers

Most participants in the consumer focus groups reported that lack of transport made it difficult to access services although many reported that they relied on family or their own resources to overcome these problems.

I don't have anyone (to transport me) *and it's a bit too far away.*

I always have to go with my children.

One participant reported that they rarely went to DAWA because there was no bus route to it.

Community-based service providers

Participants in the focus group for community-based service providers reported that transport was a problem, particular when using centrally located services. Concern was expressed over the changes to booking regular transport by one of the local government authorities. It was reported that regular bookings could no longer be made but that the clients must arrange transport separately for every occasion on which they needed it. This created significant problems for those with poor English skills and discouraged them from using the transport thus preventing them from attending the weekly physical activity classes. Another problem which was mentioned was that the pool at which the hydrotherapy classes were held was too cold for most participants.

Another participant described a local government authority which provided two mobile bus routes in the area, picking up people at different locations on a daily basis. The same participant suggested applying this concept to other local government authorities by educating counsellors of the transport issues affecting their CALD residents.

> *…can we collaborate to do something, help these people in terms of transport and getting them from one place to another.*

6.6.7 Preference for services provided by general practitioners

General practitioners

Participating GPs reported that although they provided clients with referrals to other services their clients often did not take up those referrals. They gave various reasons for this including:

- Loyalty to the referring doctor
- Preference for a service provider who speaks their first language and understands their culture
- Not being aware of the relevance of other services
- The cost of services provided by other service providers
- Problems associated with transport, particularly for elderly patients, such as having to rely on family members or negotiate the public transport system with poor English skills.

Several of the GPs interviewed felt that systems for communication, referral and coordination between general practitioners and allied health professionals needed to be improved. Some reported that building partnerships with other organisations and service providers was important.

Participating GPs made a number of suggestions for improving clients' use of other services, including:

- Improving education materials and education programs to increase awareness of the seriousness of complications, the need for lifestyle changes and the nature of the changes that needed to be made
- Providing education sessions in clients' first languages
- Providing community-based ethno-specific support groups
- Home visits by trained ethno-specific health workers
- Recognising the role of GPs as case managers and adequately remunerating them for this role
- Providing bicultural sessional allied health professionals and bicultural nurses to work in conjunction with GPs for education and counselling.

Participating GPs who suggested the use of bicultural nurses felt that GPs and nurses should work together because clients knew their GPs and would therefore be more likely to attend the sessions than if the GPs were not involved. They also felt that the transport problems experienced by many clients could be overcome by offering the service locally.

Italian consumers

Although participants in the Italian consumer focus groups reported that they relied mostly on their GP for services, some reported low satisfaction with the services of those GPs. Dissatisfaction was caused by failure to provide clients with adequate information about services and diabetes in general, and failure to refer clients to other services.

They're (GP) *all too busy, you can't ask them too many things. When I ask him something he says one thing at a time, we'll deal with that other question next time. It's not like I go to him everyday.*

My doctor is Italian, but he has never given me any information on what I should do or what is available. He checks me, he listens to what I have to say and that's it.

…he gave me all these books and sent me home to read them. Later on I found out myself that there was this diabetes association.

Vietnamese consumers

Participants in the Vietnamese consumer focus groups reported that the family doctor was the service provider they used most often. Overall, participants reported being satisfied with the service they received from their GP. They expressed a preference for services delivered by Vietnamese doctors, and in some cases, by female doctors. One participant preferred a specialist to a GP and another stated that they preferred a hospital clinic because they received more advice and equipment.

I would be more satisfied to see a Vietnamese doctor because it is easy for me to communicate with him.

I feel uncomfortable to see a male doctor but I am sick so I have to see a doctor.

The hospital gives more tests than the family doctor. It can give me more advice on the medicines that I can take.

Some participants reported feeling uneasy requesting a referral to other services from their regular GP.

We usually rely on our family doctors to recommend us to a specialist. But sometimes we are afraid of asking our family doctors for a recommendation because we are afraid he might feel bad. And he might wonder why are we going to someone else? Don't we trust him ?

Community-based service providers

Some participants in the focus groups for community-based service providers stated that clients tended to rely on GPs for their care and not to recognise the need for allied health care for diabetes.

A sort of perception that the doctor will fix everything and they are sort of a passenger in the whole thing.

The general practitioner is their first point of contact and they see them basically as God…so really it's up to them (GPs) *to sort of push them onto allied health practitioners.*

6.6.8 Satisfaction with services other than those of general practitioners

Italian consumers

Some participants in the Italian consumer focus groups expressed a high degree of satisfaction with various services.

…and that's (community health centre) *where we learnt so much. It was very nice.*

Three years ago at (district hospital) *I did a course and it helped me very much.*

Other participants described a range of problems they had encountered with non-doctor services. These included:

- Time delays between identification of a problem and referral
- Time delays in identification of potential problems.
- The perception of long waiting times at hospital and medical clinics
- Lack of time for consultations
- Language barriers and lack of access to interpreters
- Location of service
- Transport problems.

They don't give you much of their time. About 10 minutes and then they send you away.

They don't tell you straight away (about available services). *They only tell you when the problems start.*

My feet feel itchy though and I just can't wait all this time. Until the specialist has the results he can't do anything.

Vietnamese consumers

Some participants in the Vietnamese focus groups described a range of problems they had encountered with services other than those of GPs. These included:

- Length of waiting time at hospitals
- Cost of specialist services
- Lack of government assistance with medications and monitoring equipment
- No perceived benefit from accessing service.

I had to wait at least an hour and my daughter also had to take a day off to drive me there.

I was a member but now I quit membership there. It was because I felt like I gained no benefit from it. I joined so I can buy medicine and testing needles. Since I found out that I can buy them at any pharmacy, I quit the membership.

6.7 Integration and co-ordination of services

Italian consumers

One participant in the Italian focus group expressed the need for a coordinated service provided in one location.

There should be somewhere to go, every so often…where you can have your feet checked, your eyes checked, everything related to your diabetes.

General practitioners

Some interviewees suggested that all services for diabetes and shared care be based around a partnership between GPs and the community. One GP suggested a pilot project to demonstrate

the role of GPs as case coordinators. This would provide benchmarks for the HDWA and support the case for more Federal funding for divisions of GP for additional services. Outreach screening provided in the community, close to GP practices, by specialists and allied health professionals was also suggested as a means of improving services.

Community-based service providers

Several participating allied health professionals expressed a need for a service which could provide all the allied health services clients needed in one location. The preferred location was a community health centre.

> *…one stop shops in community health centres with the range of services available e.g. podiatry, dietetics, exercise…*

Allied health professionals expressed a need for more opportunities to learn about the services provided by other disciplines and how these related to the overall care of people with diabetes. Participants discussed the benefits of integrating their services, including the dissemination of verbal and written information, and examples of where this type of intrasectoral collaboration had, or was already occurring.

> *…pharmacists should be able to help a lot because we see so many* (people).

> *…there is no reason why it can't be done at the local level for all those sort of health professionals, like pharmacists and optometrists, who feel marginalised but are very much a part of the person with diabetes.*

> *I would like to see the pharmacists put in contact with the local diabetes educators, like in* (health service area)*…they* (pharmacists) *can say* (to their clients) *there's a diabetes team, here's the telephone number, here's the name…so that the pharmacists and the educators are working as a sort of local team.*

Royal Perth Hospital

Participants in the focus group for service providers from the RPH expressed a need for a system by which clients could be followed up to ensure that they can use the equipment and access ongoing supplies. The National Diabetes Supply Scheme registration and order forms are not printed in languages other than English. In many cases family members have to be relied on to collect supplies from DAWA and other agencies.

DISCUSSION

7.1 Prevalence

This review of data on the demography and health status of the Western Australian CALD population indicates that the prevalence of diabetes is higher in the CALD population than in the Australian-born non-Aboriginal population (McCarty, et al., 1996; Prometheus, 1998).

Examination of data on the Italian and Vietnamese communities revealed that the burden of diabetes falls heavily on the Italian community because its population is older and, in its older population, the age-standardised rate of hospital separation for diabetes is higher than in the Australian-born, non-Aboriginal population. At present diabetes is less of a burden to the Vietnamese community, because its population is younger, and its overall age-standardised rate

of hospital separations is similar to that of the Australian-born non-Aboriginal population. However, the rate is much higher among Vietnamese people in the 75-79 year age group than in Australian-born non-Aboriginal people in the same age group. Thus, the burden of diabetes for the Vietnamese community is likely to increase as the Vietnamese population increases in both number and age.

7.2 Service provision and usage

This study revealed that very few diabetes services are provided specifically for the Italian or Vietnamese communities in inner city Perth. Apart from GP services, most of the services used by the Italian and Vietnamese consumers were provided by mainstream service providers using mainstream interventions and mainstream education resources. Bicultural health workers for Vietnamese people are employed in some health services in Western Australia. There is only one bicultural health worker in the inner city area of Perth. The exact number of bicultural GPs was hard to establish but is estimated to be four Italian-speaking and four Vietnamese-speaking GPs. The quantitative data collected on participants of the focus groups suggest that community members are prepared to travel out of their local area in order to see a general practitioner with whom they can communicate in their first language. Most GPs in the study spoke either Italian or Vietnamese and had the same cultural background as their clients. Several allied health professionals in the study - an optometrist, a podiatrist and two pharmacists were bicultural. One support group is provided specifically for Italian people and one for Vietnamese people, although both of these were slightly outside the inner city area of Perth. The Italian support group uses an interpreter and the Vietnamese group is facilitated by a bicultural health worker.

Giglia (op cit.) and Lego (op cit.), in recent reviews conducted in Perth, also reported a lack of culturally specific services for various CALD communities including the Italian and Vietnamese communities. Colagiuri (1998) reported there is growing recognition that some groups may experience certain barriers in obtaining access to mainstream services and that targeted assistance through appropriate planning, delivery and coordination of services is required. People from a CALD background are clearly identified in the Western Australian Diabetes Strategy (HDWA, 1999) as one of these groups.

7.3 The impact of language and cultural differences

Community-based and RPH service providers found that the cultural gap between themselves and their CALD clients made it difficult to give information and advice that clients could understand. The GPs in the study had less difficulty with this, perhaps because most were of similar cultural background to their clients. All three groups of services providers felt that the cultural backgrounds of their clients made it difficult to provide interventions with which their clients could easily comply, and to ensure that clients were followed up regularly. According to Goldflam and Lymon (1998, p13), *understanding cultural attitudes is particularly important if service providers are going to reach, and involve, the Vietnamese and Italian communities through appropriate activities*.

7.4 Use of interpreters

Some service providers used interpreters to help overcome the language differences whilst others either spoke the language themselves or relied on family or other staff to interpret. Consumers and service providers found that using interpreters slowed the delivery of services and reduced confidence in the quality of those services. For some consumers hearing the information in both languages caused confusion. Other recent studies have found a lack of interpreters available to CALD clients, low use of interpreters and a preference for GPs who spoke the client's language (Arkles; Gagliardi; and Giglia; op cit.).

7.5 Perceptions of health and illness

Service providers in this study reported that alternative beliefs about the aetiology and management of diabetes were common amongst the Vietnamese people with diabetes. However, Vietnamese consumers used Western concepts of health, illness and risk factors to describe the causes and management of diabetes. They gave very little information on non-western explanations for the disease and alternative strategies (e.g. herbal remedies) used to manage it.

The Vietnamese consumers may have felt that, because the needs assessment was being conducted by a mainstream organisation, they should give western-style explanations of diabetes. Yelland and Gifford (1995) reported this problem, known as *courtesy bias,* in focus group data collected from participants from South East Asian groups. Their study and this one used a Vietnamese focus group facilitator. This should have helped to reduce courtesy bias, so there could be another explanation which should be explored. In this study the Vietnamese facilitator did not probe for information after asking the initial question on non-western beliefs. This may have been because she felt uncomfortable probing for alternative explanations and strategies for managing diabetes.

Nguyen (1999) found that Vietnamese clients generally distrusted Western medicine and preferred alternative remedies and recommended that more research be undertaken into the effectiveness of alternative remedies. Arkles (1997), in discussing her findings from a review of problems affecting access to services in many CALD communities, offered the following insights into perceptions of health in other cultures. She stated that:

- Concepts of health and illness vary across cultures
- Individuals from other cultures may not understand the purpose of a service if it is not one that was offered in their country of origin
- Some cultures believe it is not possible or appropriate to attempt to halt the course of one's disease
- Some cultures place the responsibility for managing a person's illness with the health care provider rather than the individual.

While the beliefs of different cultures are all equally valid, non-western beliefs will impact differently on compliance with western-style management of diabetes and should therefore be understood by service providers. When services are being provided for people from CALD backgrounds, the potential for differences in belief systems needs to be made explicit and strategies to overcome them actively sought by service providers. The findings from this study suggest that more effective methods of obtaining such sensitive information be developed and used to increase understanding of consumers' attitudes and behaviours.

7.6 Overcoming the effect of language and cultural differences

7.6.1 Partnerships between service provider organisations and ethno-specific organisations

A number of participants in this study stated that partnerships between diabetes care service providers and ethno-specific organisations would promote access to services. The Federation of Ethnic Communities' Councils of Australia Inc (Arkles, 1997) recommended a similar strategy in 1997 and the WA Diabetes Strategy includes a strategy for *the development of partnerships with local communities for localised planning of culturally appropriate services that address special needs groups* (p 45).

Such partnerships will enable service providers to deliver diabetes services to CALD communities with the guidance of people who fully understand the cultural context in which the disease sits. This is in sharp contrast to the experience of many of the consumers in our study who found, even when they were able to overcome practical problems such as transport and language differences, that the services they accessed did not fit with their beliefs and values.

The ethno-specific organisations which participated in this study have made a significant contribution to it and are keen to participate in local level planning and implementation of initiatives arising from it. Their support will be invaluable in improving the appropriateness of future services.

7.6.2 Increasing the supply of culturally appropriate health staff

Service providers from all three groups in our study felt that either more bicultural health professionals or bicultural health workers were needed. A register of bicultural allied health staff available to work with people of their own culture on a sessional basis would help to meet this need. A simple training and accreditation process would ensure that they have adequate language skills and cultural knowledge to provide appropriate services. A financial incentive may further encourage allied health professionals to pursue accreditation and offer their services. These suggestions are consistent with Arkles (op cit., iv) who recommended the pool of bicultural health workers be increased by *locating (bicultural) staff in areas accessed by high numbers of non-English speaking consumers or be placed in services which service large numbers of 'at risk' communities.*

Training in diabetes education for bicultural health workers would also help to meet this need and is in keeping with the WA Diabetes Strategy that *local health services and primary care providers provide opportunities for appropriate credentialling for diabetes-related positions* (p46). Allied health professionals in the study acknowledged the valuable role of bicultural health workers in providing clients with simple but timely information or support. Training health workers as diabetes educators would help to overcome the concerns expressed by specialist providers at RPH about the quality of services provided by bicultural health workers.

The WA Diabetes Strategy proposes *that specialist teams receive cultural awareness training* (p 47). All three groups of service providers in this study were sceptical of the benefits of cultural awareness training for service providers, some because of the time involved, and others because they doubted it could help them understand the needs of individual clients. The cross-cultural education available through the Multicultural Access Unit could address these concerns because it is provided to health professionals on a one-to-one basis in relation to specific situations and clients. It does not assume that one set of guidelines can be applied equally to all members of one cultural group. Health professionals should have access to this training in their workplace and should be regularly reminded that it is available.

Consumers did not state directly that they wanted more of their services delivered by bicultural health professionals and health workers. However they did state that they were satisfied with services received from professionals who spoke their language of origin or were of a similar cultural background. The consumers who attended the Vietnamese support group strongly advocated that future support groups be run by a bicultural facilitator. Overall, therefore, it seems that they would be in favour of increasing the pool of bicultural health professionals.

7.7 Improving education for self-management

7.7.1 Consumer readiness for self-management education

A number of studies have found that people with diabetes from CALD communities have difficulty with self-management practices and are therefore at increased risk of complications (Arkles; Gagliardi; and Nguyen, op cit.). Some service providers in this study felt that consumers did not understand the seriousness of diabetes and were therefore not motivated to adopt and maintain good self-management practices.

Although most consumers in this study could not give an accurate description of the cause of diabetes, many could name at least one complication and knew that poor self-management practices can result in complications. A number of consumers gave good descriptions of their own self-management practices and some described how those practices affected their state of health. Thus, consumers may be more motivated and ready to take up education for self-management than service providers assume. Problems with compliance, described by some service providers, may be due at least as much to the cultural inappropriateness of the advice given by mainstream service providers as it is to consumers' lack of understanding of the disease.

Other studies have found that mainstream interventions have proved unsuccessful when applied to CALD groups and that practitioners have concluded from this that CALD groups are non-compliant rather than considering that the interventions may be inappropriate (Brown and Hanis, 1995). This has resulted in CALD clients being prescribed insulin more frequently than English speaking patients with diabetes (Arkles, op cit.; Brown and Hanis, 1995). If service providers can work in partnership with ethno-specific organisations it should be possible to develop more culturally-relevant education programs which consumers can access.

7.7.2 Using support groups as an education tool

A number of studies (eg. Gilden, et al, 1992; Lowe and Bowen, 1997; and Simmons, 1992) have found that support strategies such as information provision, education programs and support groups promote proper management of risk factors, prevent future admissions and improve glycaemic control. Despite their general understanding of the need for self-management some consumers were not able to achieve the necessary lifestyle changes, and many had experienced depression and sadness due to the changes they had to make. However, the support group members in this study commented that the group had helped them to develop and maintain self-management skills. Moreover, they valued the opportunities it provided for social interaction and sharing of experiences. This was particularly true for members of the Vietnamese group which was facilitated by a Vietnamese bicultural health worker. Thus support groups can help consumers acquire and maintain good self-management practices within their own cultural context.

Those consumers who did not attend a support group stated that they would do so if they were more widely available. They were also receptive to the idea of a series of education sessions, with some consumers suggesting that a series of education sessions was an important prelude to joining a support group. They stressed the need for bicultural facilitators, information in their first language and organisational assistance in running the groups. They were also clear that issues such as cost, location and transport would need to be addressed. Ethno-specific community organisations were a commonly cited venue for disseminating written education materials and are thus likely to be an appropriate venue for the education programs and support groups. Hahn and Gordon's (1998) study found that African American people with diabetes wanted a non-medical setting, transport and child care to be provided and health messages that were framed positively.

Some community-based service providers were concerned that it would be difficult to provide a good quality service through a community-run support group. This problem could be overcome by ensuring that funding for groups is dependent on meeting certain operational standards. The groups could be designed around models used by other organisations in Western Australia.

7.7.3 Improving resources and materials for self-management education

Many problems with written education materials on diabetes for CALD communities have been reported in the literature (Arkles; Nguyen,op cit., and Wallace, 1996). Much of the discussion by participants in this study, particularly the service providers, focused on the problems associated with written educational materials. There were concerns not only at the paucity of language-specific written materials and the lack of funds to produce any more, but that available materials may be out-of-date, inaccurate or not culturally appropriate. Most service providers were not able to assess the materials themselves because they could not read the language in which they were written. Service providers advocated for a central agency to take responsibility for the development, review and distribution of written materials, although they had varying opinions on which organisation should be responsible for this task.

Service providers agreed that written education materials needed to be kept simple. GPs wanted videos and pictorial information to overcome language and literacy problems. Italian and Vietnamese consumers wanted videos and ethnic radio as well as written materials. Given that some consumers have problems with literacy in their first language due to limited schooling or poor eyesight, and thus cannot read written materials even when they are available, ethnic radio would be an important medium for education.

A recent study of the health education needs of CALD women in Eastern Perth found that the women preferred ethnic radio to other educational media (Gillam, Bayly and O'Neil, 1998). O'Neil (1998) found that ethnic radio was very effective in disseminating women's health information to CALD communities. The medium is cheap to use and when information changes, listeners can quickly and easily be advised, whereas updating written materials is slow and costly. O'Neil's program included a voice answering machine for listeners to leave a message if they wanted information on a particular topic after the radio presentation. The radio presenter would then telephone with the requested information. If more diabetes-trained bicultural health workers were available, a similar system could be used for people with diabetes. Italian and Vietnamese radio stations assisted greatly with recruitment of consumers for the present study and may be supportive of future diabetes education programs which use ethnic radio.

7.8 Improving integration and coordination of services

Improved consumer education programs will enable consumers to be full partners in the management of their diabetes. However, even as full partners, consumers themselves cannot take responsibility for obtaining all the services required to minimise their risk of complications. Whilst individual service providers can refer clients to other services which complement or augment their own, these findings suggest that they do not have the broad overview needed to ensure that consumers receive a comprehensive service any more than the consumers themselves. The responsibility for ensuring that services articulate easily with one another, that protocols are in place for referral and that good relationships exist between the many different service organisations that have a role to play must rest with those who provide overall service planning. The achievement of an integrated service is one of the main aims of the WA Diabetes Strategy (p. 11).

Participants in this study identified four main barriers to either providing an integrated service in the case of service providers, or accessing a full range of services in the case of consumers. These were:

- Referral from GPs to allied health professionals and related services
- Referral between allied health professionals
- Problems with transport and the location to services
- The cost of services.

7.8.1 Improving the referral process

Referral from GPs to allied health services was a concern for service providers and consumers alike, although each group had a slightly different perspective on the issue. GPs felt that, in many cases their efforts to refer patients on to other services were compromised by the patient's:

- Failure to realise the importance of other services
- Need for a linguistically and culturally appropriate service
- Problems with transport
- Problems with the cost of services.

Vietnamese GPs in a study conducted in Melbourne gave similar reasons for their patients' reluctance to use other services (Nguyen, op cit.).

Consumers in this study reported that they were more likely to use their general practitioner than any other service provider. Studies of diabetes services conducted in other parts of Australia and with other CALD communities have also reported that people with diabetes from CALD communities prefer their GP to other service providers (Arkles; Nguyen; and Perth, South-Eastern Division of General Practice; op cit.).

Although most consumers in the study were satisfied with GP services, some felt that they either did not refer them to other services, or referred them only after complications had begun to emerge. The failure of general practitioners to refer patients to other services was cited by Gagliardi (op cit.) as a cause of dissatisfaction with general practitioner services. In some cases, consumers in this study were reluctant to request a referral from their GP even when they felt they needed it, for fear of offending the practitioner. Arkles (op cit.) and Nguyen (op cit.) both found that CALD clients hold general practitioners in high regard and this attitude may contribute to their reluctance to ask them for referrals to other services.

In contrast to the views of GPs and consumers, community-based allied health professionals felt that general practitioners did not refer clients to them because they did not understand how their services helped to reduce the risk of complications.

RPH mostly refer clients to services within the hospital and back to their general practitioners, but seldom refer CALD patients to other education services within the community. This is due largely to the perception that clients will not have access to an interpreter when using other services.

Overall GPs, consumers and allied health professionals had different perspectives on referral of clients. The differences seem to reflect a lack of communication between the groups. The three groups of service providers need opportunities to share their views and understand each other's perspective on the provision of services so that ultimately they can reach a consensus on how and

when referrals should occur. The WA Diabetes Strategy (p45) proposes *systematic and thorough communication protocols between GPs and allied health professionals.*

Allied health professionals in this study felt that they needed more opportunities to learn about the services provided by other disciplines and how these related to the overall care of people with diabetes. They wanted opportunities to network with allied health professionals and bicultural health workers. This would enable them to refer clients more effectively between disciplines and thus increase the integration of services. Workshops and network meetings attended by representatives from all allied health professional groups and bicultural health workers would assist to develop the necessary networks.

7.8.2 Transport

One very practical difficulty, acknowledged by consumers and service providers alike, was lack of transport to services. GPs cited this as a reason why clients used their service in preference to other services. Community-based service providers acknowledged that consumers may not have adequate language skills or the tacit system knowledge required to use public transport. Many consumers relied on family members, who were not always available to take them to appointments.

Although the health sector does not have direct responsibility for transport, lack of transport impacts directly on the use of services and therefore warrants attention. Mobile clinics (Arkles, op cit.) are one method of overcoming this problem. Another is to have council transport booking services operated by interpreters for a certain period each day, or for booking services to use a system of recorded messages in languages other than English to assist people from CALD communities to book council transport (O'Neil, op cit.).

Community-based service providers reported that a lack of knowledge of various systems, including public transport and health care, affected access to and use of services by CALD communities. One way to overcome this problem is to provide information to newly arrived migrants which maps out available services and how to access them. This concept has been trialed by the Northern Suburbs Migrant Resource Centre in collaboration with the EPPCHU and Fremantle Migrant Resource Centre through the development of the *Cultural Mapping Kit* (Northern Suburbs Migrant Resource Centre, 1998) which covers a wide range of topics. The kit has been distributed to religious groups, Community Settlement Scheme workers and Adult Migrant Education Service workers who have contact with new migrants.

Strategies such as the *Cultural Mapping Kit* are in keeping with the National NESB Women's Strategy (op cit.) which advocates interventions which address social and economic conditions conducive to health, such as access to key social resources (e.g. child-care, transport). The Strategy rejects traditional style health promotion-based programs which emphasise individual lifestyle practices in isolation from other major factors which determine health behaviours and health outcomes.

7.8.3 Location services in accessible places

Another method of reducing transport problems would be to re-locate the services to centres easily accessible to people with diabetes from CALD communities. Locations should be determined in consultation with the relevant ethno-specific community organisations. Consumers recommended their cultural clubs and religious houses as good places from which to disseminate education materials. Rather than housing services permanently in any one location, mobile clinics could visit appropriate venues on rotation to provide education and assessment.

Community-based service providers in the study recommended community health centres as a location that would be sufficiently local to overcome transport problems. GPs recommended that bicultural allied health professional and bicultural nurses provide services on a sessional basis either at their surgeries or close by. Service providers and consumers all agreed that providing a range of services in one place at one time would make services more accessible.

Lack of transport impacts directly on uptake of services needed to reduce the risk of complications. If services are provided in places that consumers can easily reach and are familiar with, access and use of services should improve.

7.8.4 Cost of services

Access to services is mediated by social and economic factors (Alcorso and Schofield, op cit.). Consumers and service providers in this study all commented that the cost of services, particularly those provided by allied health professionals, was a factor in consumers' reluctance to use them. Thus it is imperative that the cost of services be within the reach of consumers and that they understand the true value of those services in relation to preventing complications.

CONCLUSION

It is generally recognised that people from CALD communities have difficulties accessing and using mainstream diabetes services. These difficulties impact upon the overall management of their condition and place them at greater risk of diabetes-related complications such as loss of sight, amputation of lower limbs and renal failure. These complications have significant social costs for people with diabetes and their families. They are also a huge burden on the health care system, a burden which will grow as the CALD population in Western Australia ages and increases in size.

In 1998 the LAC of the ICIDCP in Perth Western Australia identified the lack of services appropriate to the needs of CALD communities as a barrier to providing a comprehensive, integrated care service for residents of the inner city area of Perth. In the following year the EPPCHU, which is responsible for implementing the ICIDCP, conducted an assessment of the diabetes service needs of the Italian and Vietnamese communities in consultation with the LAC. The assessment focused on the Italian and Vietnamese communities because they are the largest CALD groups in the inner city population, but it was anticipated that the findings would be relevant to other CALD communities and that where they were not relevant, further investigation could be conducted in the future.

Both qualitative and quantitative techniques were used to conduct the needs assessment. A literature review and service audit were conducted. Data were collected from service providers and consumers. Service providers were represented by GPs from the Perth Division of General Practice; community-based service providers who were predominantly allied health professionals but also included a bicultural Vietnamese health worker and a social worker from one of the ethno-specific organisations; and health professionals from RPH. Consumers were represented by Italian and Vietnamese people with diabetes, some of whom were community members living in the inner city area and some of whom were members of either the Italian or Vietnamese support groups, and lived in the northern suburbs of Perth. The ethno-specific community organisations representing the Italian and Vietnamese consumers played a vital role in recruiting the members of the community for the needs assessment.

The needs assessment revealed that very few culturally specific diabetes services are available to Italian and Vietnamese people with diabetes in the inner city area of Perth. The two support

groups that cater to these groups are located slightly outside the inner city area. One Vietnamese bicultural health worker is provided by the community health service, but she meets the needs of her community in relation to all health problems, not just diabetes. RPH uses interpreters for all clients from CALD communities, and community-based service organisations have free access to interpreters if they are a charitable organisation. There are several bicultural allied health professionals, including two pharmacists, an optometrist and a podiatrist working in the private sector. Apart from these, all services for people with diabetes are provided by mainstream health professionals and are based on western concepts of health and illness.

The assessment identified a number of problems for service providers and consumers. These were related to the language and cultural differences between service providers and people with diabetes from CALD communities, education for self-management of diabetes, and integration and coordination of diabetes services. Participants in the needs assessment generated a wide range of suggestions as to how these problems could be overcome. These suggestions have been drawn together and considered in light of the recently released WADS (HDWA, op cit.). The recommendations developed from this study have been designed to promote the implementation of that strategy.

RECOMMENDATIONS

Recommendation 1. Reduce the effect of language and cultural differences

Establish a working party to devise and implement strategies to increase the number of bicultural allied health professionals and bicultural health workers available in the inner city area and to ensure that workplace-based, situation and client-specific cultural awareness training is available for health professionals who want to use it.

The working party should consist of representatives from organisations in the inner city area, including:

- Ethno-specific community organisations
- Consumer groups
- Perth Division of General Practice
- Diabetes-specific organisations
- Community-based health service organisations
- Professionals organisations representing relevant allied health professions
- RPH.

Specifically the working party should examine the feasibility and estimate the cost of:

1.1 Providing incentives for bicultural allied health professionals to:

- Obtain accreditation as language-specific service providers for clients from similar cultural background to their own
- Register as sessional service providers for clients from similar cultural background to their own
- Provide services to clients from similar cultural backgrounds at appropriate locations chosen on the basis of the recommendations of the working party on integration of services (see *Recommendation 3*).

1.2. Increasing the pool of bicultural health workers by:

- Training bicultural health workers as diabetes educators to Australian Diabetes Educators' Association and credentialling standards through the National Training Accreditation Council
- Providing information to GPs, allied health professionals and specialist service providers on the role of bicultural workers in diabetes care for patients and clients from CALD communities and how they can be accessed.

1.3. Policy change by health service organisations, where necessary, so that health professionals can receive situation and client-specific cultural awareness training if they request it

Recommendation 2. Improve education programs and materials

Establish a working party to identify strategies to increase the availability and improve the quality of education programs and materials for people with diabetes in CALD communities.

The working party should consist of:

- Ethno-specific community organisations
- Consumer groups

- Perth Division of General Practice
- Diabetes-specific organisations
- Community-based health service organisations
- Professionals organisations for relevant allied health professionals
- RPH.

The working party should examine the feasibility and estimate the cost of:

2.1. Further developing diabetes education programs for CALD communities in inner city Perth and implementing these in partnership with designated ethno-specific organisations

Options the working party should consider when determining who will deliver the program include:

- Bicultural allied health professionals with a similar cultural background to the participants
- Bicultural health workers trained as diabetes educators
- Diabetes educators with cultural awareness training and support available.

Options for media to deliver the programs should include face-to-face education sessions, ethnic radio programs, audio materials and audio-visual materials.

The range of programs to be considered should include:

- A series of education sessions on causes, complications and self-management of diabetes for **newly diagnosed** people with diabetes
- A series of education sessions for people **with long-term diabetes** who wish to update their self-management skills
- One-off sessions provided in response to requests from partner organisations or consumer groups.

2.2. The establishment of ethno-specific diabetes support groups for people from CALD communities.

In particular the working party should consider:

- Formalising of partnerships, roles and responsibilities between diabetes-specific and relevant ethno-specific community organisation for the purpose of establishing support groups
- Quality assurance mechanisms for support groups
- Provision of facilitators with appropriate cultural background and training for the role of support group leader.

2.3. Establishing a system and agreed lines of responsibility for producing and disseminating educational materials, including written and audio-visual materials

In particular the working party should consider:

- Designation of responsibility, and allocation of funding, for identifying, reviewing and disseminating educational materials in language other than English at the local level

- Designation of responsibility, and allocation of funding, for maintaining a catalogue and collection of available educational materials and disseminating information on resources to service providers
- Designation of responsibility for funding and preparation of new materials where materials already developed either locally, nationally, or in other states, are not considered by the reviewing organisations to be appropriate to local needs.

Recommendation 3. Increase the integration and co-ordination of services

Establish a working party to develop strategies to promote referral of patients and clients between general practitioners, allied health professionals and other bicultural health workers, and examine the feasibility and cost of those strategies.

The working party should consist of representatives of:

- Perth Division of General Practice
- Organisations that provide allied health services to inner city Perth
- RPH
- Local government authorities
- Consumer organisations.

In particular the working party should consider:

- Adopting the strategies developed by the working party on reducing language and cultural differences (see *Recommendation 1*)
- Identifying the causes of differences in perceptions of referral rationales and practices between general practitioners, allied health professionals and consumers
- Developing a scheme that promotes consumers' requests for referrals from their general practitioners to allied health professionals and bicultural health workers and supports them in taking up those referrals
- Examining the value of, and sources of funding for, designated bicultural health workers who can act as the link between services and facilitate consumer access
- Examining the options, responsibility and sources of funding for case management
- Examining the options for reducing problems associated with transport to services
- Examining the options for co-location of services using a variety of strategies centred around the provision of localised services in places that are familiar and comfortable for people with diabetes from CALD communities (see *Recommendation 1*).

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APPENDIX ONE

LOCAL ADVISORY COMMITTEE MEMBER ORGANISATIONS

LOCAL ADVISORY COMMITTEE MEMBER ORGANISATIONS

- Derbarl Yerrigan Health Service
- Diabetes Australia of Western Australia Inc.
- Eastern Perth Public and Community Health Unit (Royal Perth Hospital)
- Italo-Australian Welfare & Cultural Centre Inc.
- Mercy Hospital
- Multicultural Access Unit (Health Department of Western Australia)
- Perth Division of General Practice
- Royal Perth Hospital
- Silver Chain Nursing Association
- Swan Health Service
- WA Optometrist Association

APPENDIX TWO

ORGANISATIONS INCLUDED IN THE DATA COLLECTION PROCESS

ORGANISATIONS INCLUDED IN THE DATA COLLECTION PROCESS

General Practitioners

- Bayswater Medical Centre
- Central City Medical Centre
- Dr. Chin
- Dr. Pham
- Ishar Multicultural Health Centre for Women's Health

Community based service providers

- Community Physiotherapy (Royal Perth Hospital) *
- Crystal Vision Optometrist
- Diabetes Australia of Western Australia Inc. *
- Eastern Perth Public and Community Health Unit
- Italo-Australian Welfare & Cultural Centre Inc. *
- Main Street Pharmacy
- Mirrabooka Community Health
- Multicultural Access Unit (Health Department of Western Australia) *
- North Metropolitan Health Service *
- Perth Division of General Practice
- North Perth Community Health Centre (Swan Health Service)
- Trinh's Pharmacy

(denotes the community based organisations who participated in the second session of the focus group)*

Royal Perth Hospital

Podiatry Clinic
Diabetes and Endocrinology Unit

APPENDIX THREE

RECRUITMENT MATERIALS

Radio announcement (announced 29/01/99)

(translated into Vietnamese)

REMINDER NOTICE 1:

Did you know that Vietnamese people four times more likely to develop diabetes than other Australians and that 11% of pregnant Vietnamese women develop diabetes. People from non-English speaking backgrounds, including Vietnamese people, experience difficulty in accessing diabetes services. This means that Vietnamese people often miss out on the ongoing community support they need to manage their diabetes well.

The Vietnamese Community Centre and the Health Department of Western Australia are working together to improve the situation for Vietnamese people but need your help. A choice of three community meetings have been organised next week for Vietnamese people with diabetes that live in the inner city area to find out how access to diabetes services can best be improved.

The first meeting will be held at the:

Vietnamese Buddhist Temple Chanh-Giac
45 Money Street, in Perth
Monday 1st February 1999

The second meeting is scheduled at the:

Catholic Church
in Chipila Street
West Minister
Wednesday 3rd February 1999

Lastly, the last meeting will be at the:

Vietnamese Community Centre
164 Lincoln Street
Highgate
Friday 5th February 1999

All meetings will be conducted in Vietnamese from 10am to 12pm lunch time. Lunch will be served and transport is available. These meetings are for people who have diabetes and live in the inner city area of Perth. Postcodes include 6000, 6003-6007, 6016 and 6050-6053.

Please register your interest before the meeting by contacting Hai Pham at the Vietnamese Community Centre on 9328 8914.
Your assistance will greatly benefit the Vietnamese community.

Radio announcement (announced 29/01/99)

(translated into Vietnamese)

REMINDER NOTICE 2:

A reminder to all Vietnamese people with diabetes and who live in the inner city area of Perth that a choice of three community meetings have been organised to find out how access to diabetes services can be improved for the Vietnamese community.

The community meetings are scheduled to commence next Monday February 1st from 10 to 12pm lunch time at different venues.

To participate you must have diabetes and live in the inner city area of Perth. This includes the cities of Perth and Vincent and the following suburbs: East Perth, West Perth, Leederville, Northbridge, North Perth, Glendalough, Mt Hawthorn, Coolbinia, Menora, Mt Lawley, Bedford, Inglewood, Meltham, Bayswater, Maylands and Highgate.

Each meeting will be conducted in Vietnamese.

Please register your interest to attend by contacting Hai Pham from the Vietnamese Community Centre on 9328 8914.

Remember your help is important and will greatly benefit the Vietnamese community.

APPENDIX FOUR

ORGANISATIONS WHICH ASSISTED WITH RECRUITMENT OF CONSUMER FOCUS GROUPS

ORGANISATIONS WHICH ASSISTED WITH RECRUITMENT AND ORGANISATION OF CONSUMER FOCUS GROUPS

- Bayswater Senior Citizens Centre
- Campania Association of Western Australia
- City of Bayswater
- Community Physiotherapy (Royal Perth Hospital)
- Diabetes Australia of Western Australia Inc.
- Italo-Australian Welfare and Cultural Centre Inc.
- North Metropolitan Health Service
- North Perth Community Health Centre (Swan Health Service)
- Perth Division of General Practice
- Royal Perth Hospital
- Silver Chain Nursing Association
- The Vietnamese Buddhist Association of Western Australia
- Town of Vincent
- Vietnamese Catholic Community
- The Vietnamese Community in Western Australia

Individual general practitioners also assisted with the dissemination of information about the project.

APPENDIX FIVE

SURVEY FORM FOR COLLECTION OF DEMOGRAPHIC DATA ON CONSUMERS

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

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. HOW DID YOU FIND OUT ABOUT THE DIABETES PROJECT?
FLYER [ ]
COMMUNITY NEWSPAPER [ ]
RADIO [ ]
RELIGIOUS LEADER [ ]
FRIEND/RELATIVE [ ]
SOCIAL CLUB/GROUP [ ]
OTHER *(PLEASE SPECIFY)*[ ]

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

APPENDIX SIX

DATES AND TIMES OF CONSUMER FOCUS GROUPS

DATES AND TIMES OF CONSUMER FOCUS GROUPS

ITALIAN COMMUNITY CONSUMER GROUPS		
DATE	**TIME**	**LOCATION**
10TH March 1999	10am-12pm	Italo-Australian Welfare and Cultural Centre Inc. 209 Fitzgerald Street Perth WA 6000
11TH March 1999	10am-12pm	Italo-Australian Welfare and Cultural Centre Inc. 209 Fitzgerald Street Perth WA 6000
24th March 1999	10am - 12pm	Bayswater Senior Citizens Centre
13th April 1999	1.30pm - 3.30pm	Osborne Park General Practice (Support Group) (North Metropolitan Health Service

VIETNAMESE COMMUNITY CONSUMER GROUPS		
DATE	**TIME**	**LOCATION**
1st February 1999	10am-12pm	Vietnamese Buddhist Centre 45 Money Street Perth WA 6000
3rd February 1999	10am-12pm	Vietnamese Catholic Centre Chipila Street Westminster WA 6061
5th February 1999	10am-12pm	Vietnamese Community Centre 164 Lincoln Street Highgate WA 6003
30th March 1999	1pm-3pm	Mirrabooka Community Health Service (Support Group) 12/22 Chesterfield Rd Mirrabooka WA 6061

APPENDIX SEVEN

SCHEDULE FOR INTERVIEWS WITH CONSUMER FOCUS GROUPS

SCHEDULE FOR CONSUMER FOCUS GROUPS

1.0 I would like to start by asking you what do you do to look after your diabetes?

Probes:

- How did you learn to look after your diabetes?
- Have you had to make any lifestyle changes?
- How do you feel about the lifestyle changes you have needed to make?
- People with diabetes sometimes experience problems trying to manage their diabetes. What problems have you experienced trying to look after your diabetes?
- Can you comment on whether the support from family or friends makes a difference in how well you look after your diabetes?
- *Can you tell me what some of the medical problems of diabetes are?*
- *Some Vietnamese people might believe their diabetes was caused by spirits or other supernatural forces. Can you comment on how this may affect the way they manage their diabetes?* ***(asked of Vietnamese community only)***
- *In western medicine, it is thought that diabetes is caused by a number of factors. Can you tell me what you think caused your diabetes?*

2.0 There are a range of services available for people with diabetes. What services do you use to help you manage your diabetes?

Probes:

- What services do you think other people from your community use?
- How did you find out about these services?
- What were you told about services for people with diabetes when you were first diagnosed?

3.0 How satisfied are you with the service you receive?

Probes:

- *What aspects of the service you receive do you like?*
- *What aspects of the service you receive do you not like?*
- What problems do you or other (*use the term Vietnamese or Italian as appropriate*) people you know with diabetes have using these services?
- *Does the gender or ethnicity of a health practitioner make a difference?*
- Do you think feeling embarrassed or preferring to keep problems private stops some (*use the term Vietnamese or Italian as appropriate*) people with diabetes from seeking help?
- What have you or other (*use the term Vietnamese or Italian as appropriate*) people you know with diabetes done to deal with problems that you have identified using these services?
- How should these problems be overcome?

4.0 We have looked at those services you do use. Let us now turn to those services you know of but don't use? What services are they?

Probes:

- What has stopped you from using these services?
- *What could service providers do about this?*

5.0 Let us now explore some other services which may be offered to Vietnamese/Italian people with diabetes living in the inner city area.

Probes:

- Think back to when you were first diagnosed with diabetes, what would you have liked to happen at the time which could have made things easier for you?
- Who do you think is the most appropriate person to provide you with support and diabetes education?

There is a (*use the term Vietnamese or Italian as appropriate*) diabetes support group that has been operating in the northern suburbs for some time. The group meets monthly for two hours to talk about some of the issues affecting them.

- Would you like to see a similar type of group which is ongoing established in the inner city?
- Where should the meetings take place?
- How much would you be prepared to pay?
- Should these groups be culture-specific or open to other people from different backgrounds?
- What about if a bi-cultural worker was not available?

What are your views on attending an education program which ran for a specific time frame, for example, 1 two hour session a week over a four week period. The education program would offer general management advice, including dietary information and podiatry assessment.

- How much would you be prepared to pay?
- What topics would you like to see covered?
- Where should the meetings take place?
- What would stop you from attending?
- What time frame would suit you most?

It may be possible for us to develop some resources.

- Would these be useful for (*use the term Vietnamese or Italian as appropriate*) people?
- What type of resources do you think need to be developed?

6.0 How can information about services available to people with diabetes best be disseminated in the Vietnamese/Italian community?

Probes:

- *Can you identify appropriate venues where information resources could be made available for* (use the term Vietnamese or Italian as appropriate) *people?*

Additional questions asked of support group members only:

- *What did you expect when you first joined the support group?*
- *How satisfied are you with the support group?*
- *What aspects do you like about the support group?*
- *How has attending the support group helped you?*
- *What are some suggestions to improve the support group?*
- *What tips would you give people who wanted to start up a support group like this one?*
- *What do you think would stop people from attending a support group?*

APPENDIX EIGHT

SCHEDULE FOR INTERVIEWS WITH GENERAL PRACTITIONERS

SCHEDULE FOR INTERVIEWS WITH GENERAL PRACTITIONERS

Q1. Approximately how many (*use the term Vietnamese or Italian as appropriate*) patients with diabetes do you have on your current case load (or do you see per month)?

Q2. What other groups from CALD backgrounds with Type 2 diabetes do you have on your current case load? Please indicate how many you see per month from that group.

Q3. Research shows that general practitioners are often the primary source of information, support and service for people from a CALD background. What services do you provide to meet the specific needs of (*use the term Vietnamese or Italian as appropriate*) with Type 2 diabetes?

Q4. What are the difficulties for you in providing an effective service for (*use the term Vietnamese or Italian as appropriate*) patients with Type 2 diabetes?

Q5. What do you think are the difficulties experienced by (*use the term Vietnamese or Italian as appropriate*) people with Type 2 diabetes?

Q6. What are some strategies you use to overcome the difficulties identified?

Q7. What services do you use outside your surgery for patients with Type 2 diabetes from a CALD background?

Q8. How satisfied are you with the services that are provided by these agencies?

Q9. What would be helpful to support your management of patients from a CALD background with their diabetes care?

Q.10 Are there any other relevant issues you would like to discuss that have not been raised?

APPENDIX NINE

SCHEDULE FOR FOCUS GROUP AT RPH

SCHEDULE FOR FOCUS GROUP WITH RPH

Q1. Approximately how many Vietnamese and Italian patients with diabetes do you see per month?

Q2. What other groups from CALD backgrounds with Type 2 diabetes do you see per month?

Q3. What services does RPH provide to meet the specific needs of Italian and Vietnamese clients with diabetes?

Q4. What are the difficulties for RPH in providing an effective service for Italian and Vietnamese patients with diabetes?

Q5. How does your service deal with some of the difficulties that have been identified?

Q6. Where in your opinion are the gaps in services for people of a CALD with diabetes?

Q7. How can these gaps be overcome?

Q8. What do you perceive to be the barriers which prevent people from CALD backgrounds accessing diabetes services?

Probes:

- How can these barriers be overcome?

Q9. What can be done to support your management of CALD clients with their diabetes care?

Q10. Do you have any comments to add that have not been raised?

APPENDIX TEN

SCHEDULE FOR FOCUS GROUP WITH COMMUNITY BASED SERVICE PROVIDERS

SCHEDULE FOR FOCUS GROUP WITH COMMUNITY BASED SERVICE PROVIDERS

Q1. Let's begin by asking what services are provided to target the specific needs of Italian and Vietnamese patients with Type 2 diabetes?

Q2. What are the difficulties for you/your organisation in providing an effective service for Italian and Vietnamese patients with Type 2 diabetes?

Q3. How does your service deal with some of the difficulties identified?

Q4. Essential diabetes services are stated in the National Diabetes Strategy. Where in your opinion are the gaps in culturally appropriate programs and services for people of a CALD with diabetes?

Q5. How can these gaps be overcome?

Probe:

I would like to hear your views on the following interventions that are currently underway or being proposed:

The first example relates to the establishment of a culture-specific support group based on the northern suburbs model through the (*name of health centre*). The group meet monthly for two hours. The group is facilitated by a bi-cultural health worker who provides ongoing support and information.

- Is this the type of strategy that should be considered as a recommendation for the CALD project?
- What are the benefits to be gained from a support group for participants?
- What are the benefits to be gained from a support group for health professionals?
- Often the greatest issue is how to promote long term sustainability. What are your thoughts about how this could be achieved?

In Melbourne a diabetes management education program will be piloted for Vietnamese people with diabetes. The program involves two hour sessions offered over a four week period. After the four week period people are invited to attend a support group for ongoing information and support.

- In your opinion, can support groups and education programs be combined?
- Could a similar program be adapted as part of this project?
- Are these cost effective programs?
- Who needs to be involved?

Research has shown that GPs are often the primary source of information and support for people from a CALD. In our interviews with GPs, promoting the role of GPs as the appropriate case coordinator in pilot programs was raised.

The concept of having the mini-clinics which could operate from GP practices was raised by doctors. Based on preliminary discussions, mini-clinics could operate in a number of different formats:

- A bi-cultural person such as a receptionist, generalist health worker or interpreter could be trained and provided with culturally appropriate educational materials to offer education and information from GP practices. They would have access to a mentor for ongoing support and continuing education needs.

- Multidisciplinary bi-cultural diabetes education teams could be outreached to GP practices to conduct mini-clinics and education programs in the preferred languages in which comprehensive 45 minute diabetes assessments were provided to the patient. Ongoing support to these people could be facilitated through the development of support groups and the GP.
- What are your thoughts about mini-clinics?
- What are your thoughts on the education packages for bi-cultural educators

Q6. What can be done to support your management of CALD clients with their diabetes care?

Probe:
- How can some of these suggestions realistically be achieved?
- Who should be responsible for some of the suggestions proposed?

Q7. We have looked at the barriers from a service provider perspective. What are the barriers which prevent CALD groups access to a full range of diabetes services from a client's point of view?

Probe:
- Lack of awareness of diabetes services is a common theme raised by the communities and GPs in our research. This issue has emerged in the literature also. In your opinion, how can information about services available to people with diabetes best be disseminated in the Italian and Vietnamese and other CALD communities?

- Can you identify appropriate venues where information resources could be made available for Italian and Vietnamese people?

Q8. Is there anything else you would like to raise?