



Government of **Western Australia**  
Department of **Health**

# **Multicultural Health Diversity Café 7: ‘Improving health equity through CaLD data collection and use’**

## **Executive Summary and Key Points**

**30 November 2017**

Cultural Diversity Unit  
Chronic Disease Prevention Directorate  
Public and Aboriginal Health Division

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## Executive Summary

**‘Improving health equity through CaLD data collection and use’** was the theme of the seventh Multicultural Health Diversity Café Diversity Café 7, which was held at the Bendat Parent and Community Centre on 30 November 2017 from 9 am to 1 pm. Diversity Café 7 brought together 80 staff from within the WA health system, government agencies, not-for-profit organisations and a number of consumers.

A robust population health monitoring and surveillance system that includes data on culturally and linguistically diverse backgrounds (CaLD) populations is an important element of a culturally competent service. Such data is critical to understanding the characteristics and needs of CaLD consumers and communities, and identifying and addressing inequities in health care.

**In this Café, six speakers from various disciplines and organisations** shared their work and knowledge of data collection and use as it related to consumers from CaLD backgrounds. The speakers were:

- Dr Sallie Forrest, Public Health Medicine Registrar, DoH
- Dr Susan Lee, Training Coordinator, Women’s Family and Health Services
- Myles Burleigh, Director, Migration Statistics, Australian Bureau of Statistics (ABS)
- Helen Maddocks, Manager, Strategy and Planning, OMI
- Dr Aesen Thambiran, Director, Humanitarian Entrant Health Service
- Elizabeth Lang, Health Consumer.

**The speakers’ presentations were followed by buzzing sessions** in which tables of participants engaged in conversations guided by questions related to the preceding presentations. The main points from each table’s buzzing sessions were recorded on Post-it® notes and displayed on the Summary Wall.

**The Diversity Café series** seeks to replicate a convivial café environment in which delegates meet to learn from each other, be challenged, share, discuss, listen, ask and showcase current work with consumers and carers from CaLD backgrounds.

**Diversity Café 7** was organised by the Department of Health (DoH) Cultural Diversity Unit (CDU) in collaboration with the Office of Multicultural Interests (OMI) of the Department of Local Government, Sport and Cultural Industries and the Equal Opportunity Commission (EOC).

**The Café was facilitated by** Ruth Lopez, DoH and Diana MacTiernan, EOC.

*The Multicultural Health Diversity Café series offers other learning opportunities for service providers on their ongoing journey to cultural competency, specifically around providing equitable access to safe and high quality health programs and services for people from CaLD backgrounds.*

# Session 1

## Presentation 1:

### Review of Cultural and Linguistic diversity data collection practices in the WA health system, Dr Sallie Forrest

Dr Sallie Forrest presented on the preliminary findings from a *Review of Cultural and Linguistic diversity data collection practices in the WA health system*, a project she undertook from Sept 2016 to October 2017. The aim of this project was to assess current data collection practices in relation to the health of CaLD populations in Western Australia and to make recommendations for improvement. For the purpose of this project CaLD populations ‘included groups and individuals who differ according to religion, race, language or ethnicity, except those whose ancestry is Anglo Saxon, Anglo Celtic, Aboriginal or Torres Strait Islander.’

Sallie set the context for her research outlining WA’s cultural diversity and Australia’s long history as a migrant nation and changes in population demographics over time. She also discussed how different cultural backgrounds and beliefs, and migration experiences, can influence health behaviours (relating to diet, exercise, drinking alcohol and smoking); health care access and beliefs (restricted by new and unfamiliar systems, transport costs, need for interpreters, stigma around mental health, doctors being the authority, low health literacy among CaLD populations) and health outcomes (mortality often better but poor morbidity in relation to particular outcomes or groups, namely, maternal/perinatal health, some cancers or refugees).

Sallie stressed the importance of data collection that captured and addressed health disparities and servicing issues, and the need to properly consider what is to be measured and how.

The scope of Sallie’s research was limited to WA health system health outcomes and access issues, and did not encompass health behaviours (or risk factors). The main focus of her research was on actual variables measured rather than the processes of data collection and collation, analysis techniques and implementation.

Sallie’s review suggested need for:

- Development of a WA health system ‘minimum core set’ for Patient Administration Systems (PAS) and core datasets that included country of birth, need for interpreter, preferred language and Indigenous status, and piloting of ‘Main language other than English spoken at home’ as filter question to ‘Need for interpreter’ then ‘Preferred language’.  
Other optional variables to add based on program needs: year of arrival, country of birth of parents and year of arrival of parents, ancestry, religious affiliation, proficiency in spoken English.
- Work with jurisdictions to develop an Australian CaLD health standard set.
- Quality improvement measures – mandatory, standards, software, audits, feeder and auto populating processes.
- Increased data linkage capability.
- Establishment of a working group to progress the review recommendations.

## Presentation 2:

### CaLD data collection and use: the Women's Health and Family Services' experience, Dr Susan Lee

Dr Susan Lee presented on the Women's Health and Family Services (WHFS) experience of CaLD data collection and use and two important questions that guide the services approach to research and any kind of data collection. 'Why are you collecting this information? What are you doing with the data?'

She highlighted the need to be clear about what is going to be done with the data and made the following observations: 'If no one is going to look at the data, why are you collecting it? You are wasting your employees' and your service users' time. You need to have a plan for who is going to look at the data and allocate time and resources to do so.'

She also talked about planning for what would be done if a problem is identified in the course of collecting data. At WHFS, for example, a first step is to monitor and identify early issues as they arise and discuss with management. 'Is it just a bump in the statistics? Is there a need to change something?'

Gender and age were important data variables that WHFS collected: gender as it relates to determinants of health like employment, education and literacy, and age as it relates to accessibility and appropriateness of services for different groups like older, younger or LGBTQI people.

Susan also discussed the *Ethnicity Data Collection Tool* that was developed by Dr Anne Aly and Gavin Currie in 2011 for the Integrated Services Initiative Capacity Building Project for Women and Children (<https://whfs.org.au/professional-resources/>) and how this has been integrated into the WHFS's e-Client Record Management System. The tool is used to develop an annual snapshot of usage of therapeutic services and in surveys with service users. The WHFS has also adapted the tool taking out a question on religion, as they found that it did not inform service delivery as much as they initially thought it might. The question/s on visa category are used sometimes where relevant, likewise, for country of birth or ethnicity.

Susan shared the WHFS still has difficulties identifying, understanding and capturing ethnicity and cultural identity data due to different interpretations of people. She ended her presentation by quoting writer Taiye Selasi who speaks on behalf of 'multi-local' people (those who feel at home in the town where they grew up, the city they live now and maybe another place or two).

'How can I come from a country?' Taiye asks, 'How can a human being come from a concept?'  
[https://www.ted.com/talks/taiye\\_selasi\\_don\\_t\\_ask\\_where\\_i\\_m\\_from\\_ask\\_where\\_i\\_m\\_a\\_local](https://www.ted.com/talks/taiye_selasi_don_t_ask_where_i_m_from_ask_where_i_m_a_local).

## Buzzing Session 1: main points of discussion

**What is your own experience in data collection and use in your own programs and services? Consider how CaLD data inform your policies, programs and services.**

### Purpose of data collection

- Guides the organisation to create programs and services according to needs.
- Used to identify gaps in service delivery among hard to reach groups and to inform new projects.
- Informs patient centred care/service provision, for example, to identify the need for and organise an interpreter.
- Usually used for reporting and funding purposes, including reporting to Boards of Management, funders and researchers.
- Determines language proficiency for particular health needs, for example, diagnosis and complicated treatment.
- Getting accurate information to determine appropriate interpreter.
- Data collection is very important for a multicultural service organisation – helps in reporting and funding submissions.
- Enables provision of services that consumers are comfortable with and/or matching consumer preferences. For example, women prefer to discuss health issues with a female service provider.
- Data is collected to customise services for consumers and to inform services.
- Data is used for clinic planning (future financial requirements and service provision); base for interpreter contracts/training and regional assessments pertaining to understanding metro and regional spread and what services are required.
- Some issues raised were:
  - Sometimes, there is a mismatch between a purchaser and a provider understandings and requirements of data collection. Not all data collected may be useful to service providers, but may be required by funders.
  - Not maximising the use of data collected.

### Consumer focus

- Need for flexible, individualised service for clients.
- It is important for consumers/clients to complete their own information, where possible.

### Training and support for Service Providers

- Highlight importance of cultural sensitivity for service providers and interpreters.
- Conduct ongoing education and training, not just one-off sessions.
- Develop standard scripts in plain English to enable consistency.
- Emphasise requirements for staff to maintain confidentiality.
- Staff need to understand why they are collecting the information, for example, training for Ward Clerks to understand why data collection is important and how it is used.

### Data variables collected

- Settlement grants collect name of program, country of birth, year of arrival and language spoken at home.

### What needs to be considered/ Recommendations

- Need to revisit purpose of collecting CaLD data often to ensure fit for purpose.
- Contracted services should have CaLD data requirement built in.
- Translating material for all minority languages, not just those with higher numbers to ensure equitable access.
- Data collection and amalgamation often involves different groups in silos, so communication needs to be better maintained.
- Consider how the availability and quality of data impacts on quality of work outcomes.
- Data collection needs to be relevant and easy to access for end user.
- Small sample size for CaLD groups makes it difficult to analyse or use data.
- Data is contextual and individual.
- One may not know why they are collecting data to start with until one is asked to review available data.
- There is a need to train staff to record data.
- We need to identify target groups.
- Data collection and processing require allocation of resources.
- People from CaLD backgrounds come from many countries, however, ABS does not provide information about smaller groups as their information is generalised. For example, Africa has 54 countries which have similar but also different cultural practices.
- Questions asked must be in everyday language.
- Data collection can interfere with client engagement/relationship (where data collection is onerous, repetitious, etc.)
- Issues with dissemination of data to external stakeholders.
- On the ground, staff do not necessarily understand differences in terminology (interpreter vs translator).

## Session 2

### Presentation 3:

#### Measuring cultural diversity in Australia, Myles Burleigh, Australian Bureau of Statistics

Myles Burleigh opened his presentation with the observation that Australia administers a progressive migration program compared to countries like New Zealand, Canada, United States and the United Kingdom, noting Australia has a higher proportion of overseas-born people (with Western Australia having the highest percentage of overseas born people of all Australian states).

Myles provided an historic overview of approaches to measuring of cultural diversity beginning with the Australian Census, which he conceded had not captured diversity well. An ABS paper *The Measurement of Ethnicity in the Australian Census of Population and Housing* (1984) included main data requirements for a direct ethnicity questionnaire, namely ability to identify small ethnic groups and be cross-classified with other Census data items; available at small geographic areas; and self-perceived group affiliation approach. Data gaps, however, were identified. He noted that surrogate measures (such as country of birth of person and parents, etc.) by their nature do not directly measure a person's ethnicity and can obscure and mask the ethnic compositions of some groups limiting their utility for planning and other purposes.

In 1986, an ancestry variable was piloted but was dropped after a Census review found that the annual census did not code or group this variable. In 2001, this variable reappeared. The utility of English proficiency as a variable was also reviewed because of the implications of findings for future demands of aged care services.

In 1999, the ABS published the *Standards for Statistics on Cultural and Language Diversity*. The Standards provided a consistent method for measuring cultural and language diversity in all statistical and administrative collections; allowed data from different sources and different time periods to be compared and integrated in a meaningful way; enabled international comparisons improving the quality, relevance and accuracy of data produced; reduced development and operational costs for agencies collecting data on cultural and language diversity by providing a ready-made and reliable method for use in all service provision settings.

The Standards recommend four core variables namely country of birth of person, main language other than English spoken at home, proficiency in spoken English and Indigenous status. Additional variables are ancestry, country of birth of father and mother, first language spoken, languages spoken at home, main language spoken at home, religious affiliation and year of arrival in Australia.

Myles talked about the three elements of a standard: a standard question, a standard classification and a standard index for coding of responses.

He ended his presentation with an overview of the diversity of Australia as shown in the findings of the last ABS Census.



## Presentation 4:

### Guide to cultural and linguistic data collection for the public sector, Helen Maddocks OMI

‘Statistics ... aid the decision making process by enabling us to establish numerical benchmarks and monitor and evaluate the progress of our policy or program. This is essential in ensuring that policies are meeting initial aims and identifying any areas which require improvements.’

*A guide for using statistics for evidence based policy, ABS*

Helen Maddox talked about the value of cultural and linguistic data collection and use in identifying the diversity of clients, assessing the impact of policies and programs on different groups, reviewing the extent to which services are responding effectively to the needs of different groups and in informing the development of legislation, policy, budgets, action plans, reports and research proposals.

Using the example of the *First Interim State Public Health Plan for Western Australia: draft for consultation*, Helen highlighted how statistics form the basis of evidence-based policy and help to frame such documents. The draft plan included a range of statistics that highlighted health issues relating to the general population and Aboriginal people, noting how this was also reflected in the images used throughout the document. Helen suggested a correlation between the lack of data on other population cohorts and the selection of images in the document, and queried whether it provided all the data needed to tell a complete story?

Helen referred participants to the *Guide to cultural and linguistic data collection for the public sector* produced by the Office of Multicultural Interests (OMI) and the cultural and linguistic indicators that are presented in detail in the Guide. These are based on the ABS recommended ‘core indicators’ namely country of birth, main language other than English spoken at home, proficiency in spoken English and Indigenous status.

The guide suggests how to address issues around privacy and confidentiality and the factors that may hinder collection of the data and provides some guide questions that can be asked when gathering the data.

Helen encouraged the collection of the core data set and consistent data collection to allow for comparisons to be made across agencies and programs, and customising data variables for the service being provided, suggesting the development of a set of standards for the health system.

The Guide is available on the Office of Multicultural Interests website <https://www.omi.wa.gov.au/Resources/Publications/Pages/ViewPublication.aspx?DocID=61>

## Buzzing Session 2: main points of discussion

**What data do you see are most critical to your work? What issues/barriers have you encountered when sourcing CaLD data? Where are the gaps for you?**

### Data most critical to work

- Language and English proficiency (verbal and written proficiency might vary)
- Country of birth (although not sufficient to indicate cultural identity)
- Ethnicity
- Languages spoken
- Visa category
- Interpreter requirements
- Location of settlement by geographical area
- Groups which are accessing services and which ones are not, particularly for screening services
- Minimum core set

### Issues

- How to make equity a measurable outcome, so minority groups get counted and serviced.
- Need to identify refugee vs skilled migrants.
- More information about minority groups in order to provide appropriate cultural care.
- How the data collected is being used.

### Gaps

- The interpretation of ethnicity.
- Limited time to collect data from clients and limited space on forms to record information.
- Lack of available data relating to specific measures. For example, country of birth not ideal or representative.
- Lack of available data and impetus to collect data for monitoring purposes.
- Clients fear about why data is being collected.
- Confidentiality.
- Relevance of question to client. Need to inform clients of reason for collecting data.
- Lack of additional resources to implement this.
- Lack of information and education around cultural practices and needs by service providers and stifling of creativity and innovation within DOH.
- Clear reasons why services collect data.
- Understanding our customers.
- Choosing variables carefully.
- Data is needed to understand patients' cultural needs.
- Not all fields are being filled resulting in incomplete data.
- Staff not understanding or not having appropriate attitude to collecting data.
- No standard or consistent data collection.
- No detail and analysis.

- ABS website has lots of data. Its availability, however, is limited or we do not know how to use/access it to maximise its full potential.
- Lack of consistency of data.
- Not enough or not specific enough detail in data collected.
- Data not easily accessible.
- Lack of resources (time and cost).
- Need for a centrally located data set.
- NGOs do not have resources to access scholarly articles.
- Need an overarching CaLD framework for WA health that would include data collection and use.
- CaLD data not available for specific area of work
- Importance of communicating respectfully.
- Due to mental illness stigma, consumers may not want to answer questions. Also could be due to the format and way the questions are asked. Consumers are often suspicious.
- Data collection is seen as an administrative burden on clinical staff (even when they understand need and purpose).
- Sharing data collected with other service providers. This could be facilitated by written consent.
- Lack of awareness and application of the WA health system language services policy.
- Keeping up-to-date data especially with transient population.
- Ethnicity, language spoken is not collected in most clinical forms.

## Session 3

### Presentation 5:

#### CaLD data collection in practice, Dr Aesen Thambiran

Dr Aesen Thambiran introduced his presentation by tracing the beginnings of the Humanitarian Entrant Health Service (HEHS) from the Migrant Health Unit where free and voluntary post-arrival screening for all refugees settling in WA has been provided for over 30 years. Now based at the Anita Clayton Centre, HEHS provides excellent referral pathways and assesses 80-90% of humanitarian entrant arrivals.

The process starts with a nursing assessment comprising medical, social, and obstetric and immunisation history, screening bloods and CXR, treatment, immunisation and a management plan. A review with a medical officer is offered two weeks later which then includes K10 (Kessler Psychological Distress Scale) and oral examination. Clients are seen as family groups and an on-site professional interpreter is always engaged.

Aesen discussed some of the issues faced by staff when collecting information or data from clients: it is not seen as important; assumptions that clients who are able to respond in English will fully understand the conversation; staff feeling uncomfortable or reluctant to ask clients where they were born or their preferred language.

To address these issues, he has implemented a number of strategies at HEHS to ensure data collection is done. These include clear guidance on referral pathways and documentation; establishment of systems to better capture the client information required (and that are shown to make daily work easier for staff, enhance patient care, facilitate patient handover/ referral and transfer of useful cultural information and extraction of data for audit/reporting). These strategies have led to staff becoming more comfortable and confident in their interactions with clients and ability to ask for information.

Given a large proportion of the WA population comes from overseas; caring for migrants and refugees is core business for all health services. A routine part of the registration process in any facility should be asking about country of birth and preferred language. How can we provide person-centred care if we do not know where our clients come from? How can we provide safe care if our clients do not understand what we are saying to them? Accurate CaLD data collection helps us provide high quality care.

Aesen described how HEHS staff identify a client's preferred language on clinical software and onsite interpreters are booked for clinic appointments; the appointment letters sent in the clients' language; recording of interpreter engagement and name of interpreter; and inclusion of preferred language and country of birth in all outgoing letters such as GP referral letters and summaries. He then showed samples of the forms and letters HEHS staff use.

Some of the benefits of data collection, based on the HEHS experience, are improved efficiencies in contacting and communicating with patients, better clinical outcomes, improved consumer satisfaction and treatment completion, reporting on interpreter use and costing and research and audit.

## Presentation 6:

### Issues and concerns around providing personal information, Elizabeth Lang

Elizabeth Lang's presentation was informed by her personal experiences as a young person, woman, mother and relative, human services worker and interpreter working in health settings.

Elizabeth referred to ABS Census data that highlighted the diversity of the Australian population, and the importance therefore of CaLD consumer engagement with our health system. The 2016 Census showed over half of Australia's population are overseas-born (49%) or have at least one parent born overseas, and that there are 300 separately identified languages spoken in Australia and that Australians identified with over 300 ancestries (ABS 2016 Census data).

She talked about the worries for CaLD health consumers when asked to provide personal information: 'What are the repercussions of providing ethnicity data? Why are you targeting me? What impact/shadow is this going to have on my community?' She also talked about the need for care in framing of messages and awareness of assumptions and how these can skew data. For example, booking an interpreter based on consumers' accents or appearance even when they can fully speak and understand English can result in skewed data.

Challenges faced by CaLD health consumers, according to Elizabeth, include lack of health literacy among CaLD groups; difficulty navigating the health system, particularly by newly arrived migrants, refugees and asylum seekers; issues of trust; anecdotal accounts from family/community of negative experiences; perceptions of health services and messages as either irrelevant or not accepting of them; challenges with using interpreters; lack of understanding of patients' cultural contexts e.g. role of family in decision making; difficulty gathering CaLD specific data; lack of adequate funding for interpreters in health settings – time restrictions; underutilisation of mental health services (hospital and community based) - cultural understandings/perceptions around mental illness differ (NMHCCF, 2014); gender dynamics and norms – female and male health staff.

Elizabeth recommended: increasing CaLD engagement through involvement of CaLD community members in development, implementation and review of policies, programs and services (OMI, 2014); sector development – comprehensive cross cultural competency training for health workers and other health staff; CaLD consumer data – need to incorporate innovative approaches for engagement (Principe, 2015).

### **Buzzing Session 3: main points of discussion**

**How can service provider staff be supported to collect private, personal and sensitive information?**

**How can service providers assure consumer of privacy, confidentiality and the purpose of collecting data to encourage them to give personal information voluntarily?**

#### Support for staff

- Build a work culture that makes it everyone's business to collect data.
- Gather support from higher/top management.
- Use accurate data to inform policies and programs.
- Employ cultural diversity workers in hospitals similar to Aboriginal Health Workers.
- Use data to full capacity within services (usually just used for reporting for funding purposes).
- Develop and implement internal policies around privacy and confidentiality and access to data.

#### Training and education on cultural competency, data collection and recording

- All health staff, including receptionists and management, should have mandatory cultural competency training to understand, feel more comfortable asking questions, how to ask questions and the reasons for asking questions.
- There is a need for training and education around communication, empathy and importance of collecting data and recording.
- More mandatory practices and training for primary, tertiary and allied administration staff.
- Share individual experiences/case studies to help service providers increase awareness of issues faced by CaLD groups.
- Mentor colleagues.
- Hold staff training around identifying when an interpreter is needed and encourage staff to engage interpreters, when required.
- Provide more options for education. For example, use fact sheets.
- Provide feedback to staff who collect data so they can see what data is being used for.

#### Raising consumer health literacy

- Raise health literacy in communities so that when questions are asked, people have the context and understand the relevance/importance of data collection for them individually and for their communities.
- Conduct community sessions that explain what is being done, reasons for doing so and involve community members in the design of processes, policies and programs.
- Conduct focus groups to get guidance on framing questions and conveying information.
- Take time to communicate National Standards of Privacy and Confidentiality and establish trust and support.

### Tools and resources

- Provide an easy to use and accessible tool.
- Provide information about various cultural norms.
- Develop creative ways to identify people.
- Use technology so clients can enter their personal details in an electronic digital system.
- Collect anecdotal cases such as case studies to help inform improvement in processes and approaches.

### Additional Tips

- Ask patients what is appropriate.
- Around confidentiality, ask consumer where they would prefer to provide information.
- Request permission to ask questions, practice being client-directed and enquire what consumer's preferences are.
- Provide an example of how the information will be used and write this in large fonts on forms.
- Assure people their names will not be included.
- Make the process easy for staff. For example, investigate the software used by the Humanitarian Entrant Health Service.
- Ask why there is hesitance to provide information and address these concerns.
- Enable staff more time to effectively use interpreters and have discussion with consumer.
- Collect sensitive information in private space and not in busy waiting room.
- Communicate with patient either verbally or in written form.
- Differentiate migrants and humanitarian entrants at SA2 level.
- Allocate longer appointment times to enable building trust and relationships.

# The speakers

## **Dr Sallie Forrest**

Dr Sallie Forrest is in her final year of a 3-year specialty training program to become a public health physician. She currently works for the Public and Aboriginal Health Division within the Western Australian Department of Health. She has a background in medicine and public health and has worked as a doctor in hospitals in WA and Scotland, and in General Practice, the NGO sector and more recently in the Humanitarian Entrant Health Service and the Metropolitan Communicable Disease Control Program in WA.

## **Dr Susan Lee**

Dr Susan Lee is the Training Coordinator at the Women's Health and Family Service. She has worked for the past 27 years in health promotion with vulnerable groups of women including migrant and refugee women, Aboriginal women, women who have mental health and/ or alcohol and other drug issues and women who have experienced family and domestic violence. She has also worked extensively with service providers to build their capacity to work more effectively with these groups. Dr Lee's current professional interests include gender and health issues and how to make oral health services more accessible to vulnerable groups of people.

## **Myles Burleigh**

Myles Burleigh is the Director of Migration Statistics at the Australian Bureau of Statistics. This unit is responsible for statistics on overseas arrivals and departures, migration, and characteristics of migrants once they have settled in Australia. Myles has previously headed the Education and Training, Health and Disability, and Data Integration statistics units within the ABS and worked on both the 2006 and 2011 Censuses of Population and Housing.

A graduate of the Australian National University, Myles has also undertaken post-graduate qualifications at ANU and the University of Canberra in both Communications and Social Research.

## **Helen Maddocks**

Helen Maddocks is Manager, Strategy and Planning at the Office of Multicultural Interests (OMI), Department of Local Government, Sport and Cultural Industries.

Helen's career path has had a strong focus on equity and diversity, with experience working with a range of equity groups in relation to employment and training and at the Office of Equal Employment Opportunity. Her career has seen her working with inspirational people in these areas as well as in Aboriginal Affairs and Disability Services and multicultural affairs.

Helen puts her public service longevity down to a career blessed by diversity, challenge and meeting and working with wonderful people both within and outside government.



## **Dr Aesen Thambiran**

Dr Aesen Thambiran is the Director for the Humanitarian Entrant Health Service, which provides post-arrival health screening for people from refugee backgrounds settling in WA. He has worked in refugee health for over a decade and has experience in working with clients from sub-Saharan Africa, the Middle East, West Asia and South East Asia. He engages professional interpreters and transcultural communication techniques on a daily basis. He is the immediate past Chair of the Royal Australian College of GP Special Interest Group in Refugee Health and was on the editorial panel for the Australian Society for Infectious Disease publication *Recommendations for Comprehensive Post-Arrival Health Assessment for people from Refugee-like backgrounds* (2016 edition).

## **Elizabeth Lang**

Elizabeth Lang is a passionate human rights advocate and has presented on a number of platforms, nationally and internationally including at the UNHCR NGO consultations Switzerland in June 2016. Originally from South Sudan, she sought refuge in Australia with her family in 1998.

She is the founder of Diversity Focus, providing diversity consulting and training in the context of domestic and family violence. She is currently doing her PhD at Curtin University exploring the nature of domestic and family violence in immigrant and refugee communities and developing a framework to enable more effective assessments and interventions for people from collectivist cultural backgrounds. Elizabeth is also a Sessional Academic at Curtin and has taught a range of multidisciplinary units since 2015.

## Café convenors

The Multicultural Diversity Café was convened by:

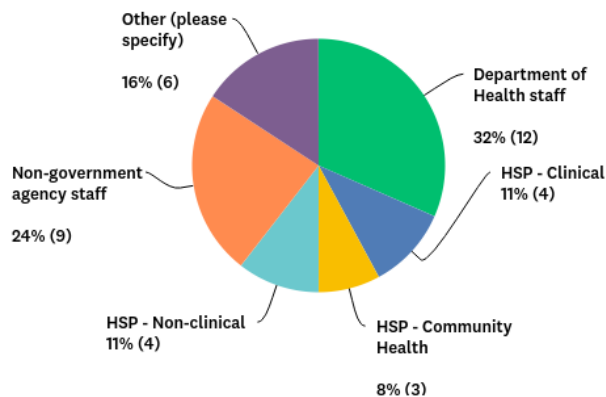
- Ruth Lopez  
Senior Policy Officer, Cultural Diversity Unit  
Chronic Disease Prevention Directorate  
Public and Aboriginal Health,  
Department of Health
- Kelli Monaghan  
Policy Officer, Cultural Diversity Unit  
Chronic Disease Prevention Directorate  
Public and Aboriginal Health,  
Department of Health
- Helen Maddocks  
Manager, Strategy and Planning  
Office of Multicultural Interests  
Department of Local Government, Sport and Cultural Industries
- Diana MacTiernan  
Manager  
Equal Opportunity Commission

## Evaluation results

A Survey Monkey questionnaire was sent to participants following the Diversity Café. Responses were received from 38 participants comprising 48% of the total attendees.

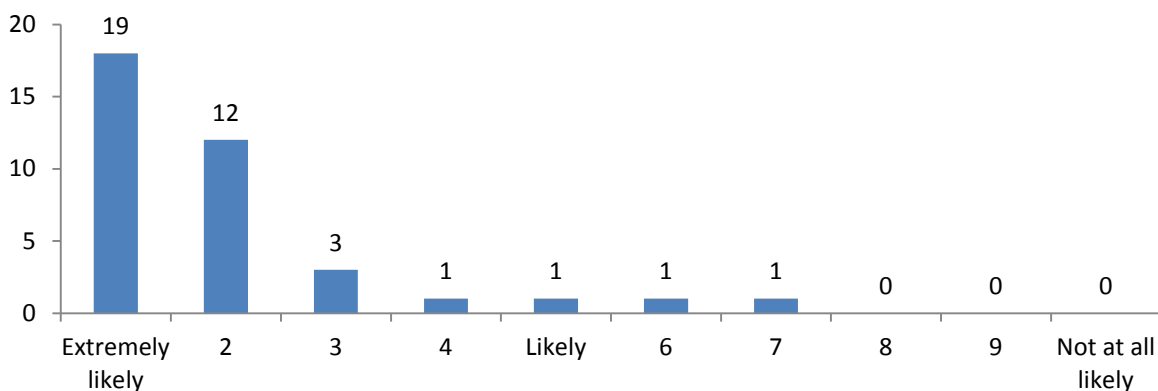
### Q1: What best describes your profession?

- 32% of respondents were Department of Health staff
- Health Service Provider (HSP) staff were:
  - 11% Clinical
  - 11% Non-clinical
  - 8% Community Health
- 24% were Non-Government agency staff
- 16% did not specify their profession



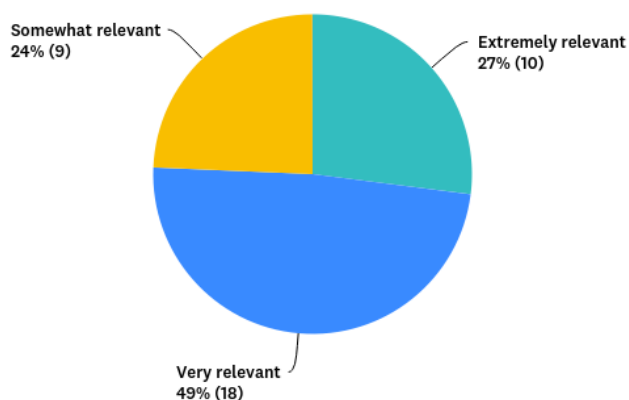
### Q2: How likely is it that you would recommend the Diversity Cafe series to a colleague?

Most of the respondents were extremely likely to recommend the Diversity Café series to a colleague.



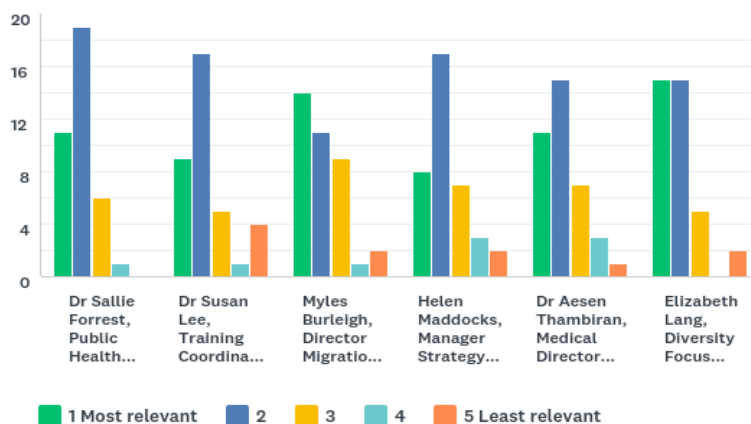
### Q3: How relevant was the Café topic to your work?

- 27% of respondents said the topic was extremely relevant
- 49% replied 'very relevant'
- 24% replied 'somewhat relevant'.



### Q4: Were the Café presentations helpful to your work?

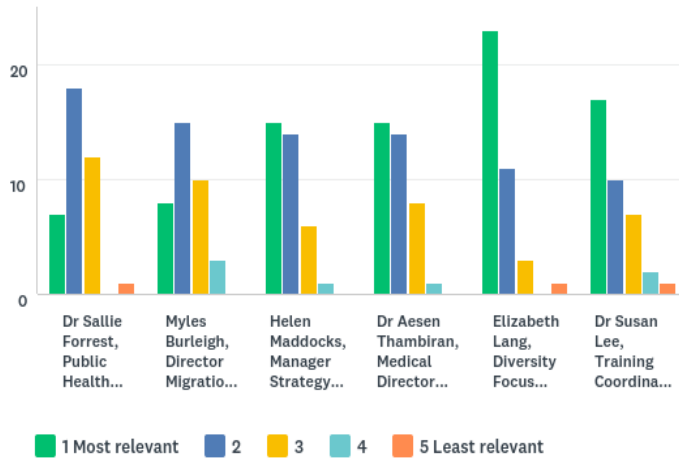
Respondents rated the presentations using a 1 to 5 scale, with five being the least relevant. Most of the respondents rated the presentations as most or very relevant.



### Q5: How engaging were the speakers? Please rate using 1 to 5, with 5 being the least relevant.

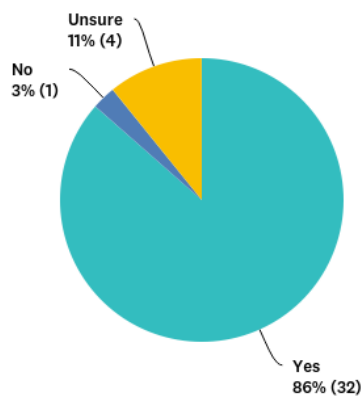
All the speakers rated highly.

One respondent commented that it was great to hear a consumer perspective.



**Q6: Did the Café format work for you? (Presentations followed by buzzing sessions and identifying three priority issues)**

Eighty-six percent of the respondents said the Café format worked well for them.



Shorter Little Presentations Ideas Breaks

Some comments received were:

*'I like the brainstorming and sharing of ideas. Good to meet new people and establish networks.'*

*'Since our table had people from various disciplines, we had a bit of a hard time relating to what each one was saying. I learned from the many conversations, but didn't get the opportunity to go in depth with how it applied to my setting. At some point in the day, it would be helpful to discuss with others in similar positions. At the same time, it was great to hear and reflect on others' perspectives.'*

**Q7: What were the key learnings about 'Improving health equity through CaLD data collection and use' that you took away from the Café experience?**

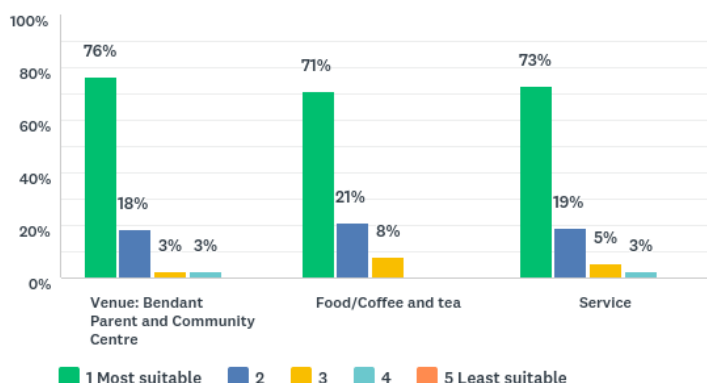
# Questions Cohort Importance Care Services Relevant Health Backgrounds CaLD Data Collection Providing ABS

- Great ideas about potential data collectables.
- Historical and technical awareness of ABS collection of data.
- The expertise, resources and agencies available to assist with queries as the need arises in our work.
- There is not a 'one size fits all' for CaLD data collection, context is key to applying the most suitable method and collecting only what is needed. Training, education and support for those collecting CaLD data is also key to maximising data quality as well as ensuring consumers are well informed and comfortable with the process and how their data will be used.
- Constraints in the public health system that prevent us from providing the level of care required by CaLD patients.
- The topic commanded far greater attention than I thought it would. I thought there would only be a handful of people there.
- The areas that needed to work more for initial settlers.
- Always remember that you need to know what you are going to use the data for and only collect if it will be seen by someone.
- Core questions to gather.
- The biggest thing for me is that we shouldn't collect data for the sake of it, but should be using the data to improve our service provision.
- Don't assume all cultural groups have the same needs and beliefs about health.
- We have a long way to go! We need to promote better data collection across all areas to enable us to provide best evidence based service to this cohort. More collaboration and sharing between agencies and departments is vital.
- Looking from someone else's view.
- Translating personal values, professional attitudes, perception of care into practice.
- Many data collectors don't know what to do with the data they have. Users are not aware of what data is available already.
- I valued learning the standard 4 questions and the additional questions to choose from the ABS. I like being able to align my questions with a National and State framework. Overall, we need to drive and help people from all backgrounds feel empowered to have a voice and feel included. I will make sure to have a more inclusive lens.
- Migrants from NMES overtaking migrants from English speaking backgrounds.
- CaLD data collection is vital to health services.

- My organisation collects CaLD data quite well. Less medical/legal text is appropriate and peer review of texts and translations is beneficial. Diverse staff in health & community services is a massive help.
- The importance of having standardised ways to measure either across the sector or more clearly defined by funding bodies
- The importance of getting buy-in and feedback from staff to introduce measurements.
- Introducing some feedback mechanism for clients
- Refer to the OMI guidelines; acknowledge that data for CaLD is limited; advocate for improved data collection for CaLD populations
- More confidence in the ABS data and access to more detailed data regarding humanitarian and migrant individuals
- That data collection via Health will remain a 'numbers game' with vulnerable populations remaining in that state as low numbers are not catered to, thus, not providing real equity in the health sector.
- The importance and purpose of data collection.
- A lot of data is collected but not used. Some data out there is outdated. Collecting data should be directly relevant to the consumer and should be explained why it is being collected.
- The need for relevant data to effective policy and program development.
- The need to use data collected for planning purposes not just for reporting.
- The importance of a good data collection system.
- The difficulty in interpreting data in a small organisation with limited budget and skills of employees
- Country of Origin does not represent ethnicity.
- Data is only as good as the people who collect it.
- We need to come up with collection processes that limit bias/racism etc.

**Q8: Was the venue, food/coffee, tea, and service suitable for the Diversity Café # 7? Please rate using 1 to 5, with 5 being the least suitable.**

Respondents agreed the venue, catering and service were 'most suitable'.



**Q9: Do you have any additional comments or suggestions?**

Hear Opportunity **Presenters** Morning  
Event Venue Forward

Respondents said the Café was very organised, interesting and informative. Some expressed their thanks and appreciation to CDU for another event with great topics and very accessible presenters who were happy to share their information. Some of the responses are quoted below:

*'The Diversity Cafes are my favourite networking and professional development events. The topics are usually very relevant and applicable to my work. I always find presenters have been carefully selected and have much to teach me.'*

*'I appreciated the opportunity to discuss issues with colleagues as well as hear from the presenters. I made several useful contacts I will follow up for my current project work.'*

*'It would be good to have the feedback and suggestions to be taken in a digital format so that it can be used for future implantation in services and provide feedback as an evidence base for other stakeholders in the health industry.'*

**Q10: Do you have any suggestions for future Diversity Cafe topics?**

- Overcoming practical issues with data collection.
- More on language use, question wording and decision making in what to collect with examples of how others use this data.
- How to differentiate services to provide for non-English speaking Australians without discriminating.
- Explore opportunities for ethnographic research and other qualitative research in CALD communities.
- Stigma and discrimination, domestic violence, mental health.
- Effective and equitable health care provision to vulnerable populations, what does this look like?
- What services are accessible to clients living in the community who are on Bridging Visas and are Medicare ineligible?
- Accommodating for diversity within the prenatal program in WA.



# Appendix A: Diversity Café Program



Government of **Western Australia**  
Department of **Health**

## Multicultural Health Diversity Café 7:

‘Improving health equity through CaLD data collection and use’

9.00 am – 1 pm

Thursday 30 November 2017

Bendat Parent and Community Centre, 36 Dodd St, Wembley

## Program

<b>8.30 am</b>	Registration	
<b>9.00 am</b>	Introduction to Diversity Café 7	<b>Ruth Lopez</b> , Senior Policy Officer - Cultural Diversity, Chronic Disease Prevention, Public and Aboriginal Health Division, Department of Health (DOH)
<b>9.10 am</b>	Acknowledgement of country	
<b>9.15 am</b>	<b>Session 1:</b>  Speaker 1: Research findings, learnings and recommendations around data collection and use  <b>Q &amp; A</b>	<b>Dr Sallie Forrest</b> , Public Health Medicine Registrar, Department of Health
<b>9.45 am</b>	Speaker 2: CaLD data collection and use: the Women’s Health and Family Services’ experience  <b>Q &amp; A</b>	<b>Dr Susan Lee</b> , Training Coordinator, Women’s Health and Family Services
<b>10.10 am</b>	<b>Buzz session 1:</b> What is your own experience in data collection and use in your own programs and services? Consider how CaLD data inform your policies,	

	programs and services.	
<b>10.25 am</b>	<b>Move</b>	
<b>10.30 am</b>	<b>Session 2:</b>	
	Speaker 3: Standards for Cultural and Linguistic Diversity	<b>Myles Burleigh</b> , Director, Migration Statistics, Australian Bureau of Statistics
	<b>Q&amp;A</b>	
<b>10.55 am</b>	Speaker 4: Guide to cultural and linguistic data collection for the public sector	<b>Helen Maddocks</b> , Manager, Strategy and Planning, Office of Multicultural Interests
	<b>Q&amp;A</b>	
<b>11.20 am</b>	<b>Buzz session 2:</b> What data do you see are most critical to your work? What issues/barriers have you encountered when sourcing CaLD data? Where are the gaps for you?	
<b>11.35am</b>	<b>Move</b>	
<b>11.40 am</b>	<b>Session 3:</b>	<b>Dr Aesen Thambiran</b> , Medical Director, Humanitarian Entrant Health Service
	Speaker 5: Issues and concerns around collecting data	
	<b>Q&amp;A</b>	
<b>12.00 noon</b>	Speaker 6: Issues and concerns around providing personal information	Elizabeth Lang, health consumer
	<b>Q&amp;A</b>	
<b>12:20 pm</b>	<p>Buzzing session 3: How can service provider staff be supported to collect private, personal and sensitive information?</p> <p>How can service providers assure consumer of privacy, confidentiality and the purpose of collecting data to encourage them to give personal information voluntarily?</p>	
<b>12:35 pm</b>	Summary	Key ideas from the conversations
<b>1 pm</b>	Close	Thanks and Close

## Appendix B: List of Participants

Below are the Café participants who gave permission for their name and organisation to be listed in the Summary Report.

	Name		Agency or workplace
1	Ifrac	Abdullahi	Telethon Kids
2	Linda	Adam	WA Police
3	Rehab	Ahmed	Ishar Multicultural women's Health Centre
4	Kathy	Blitz-Cokis	Women's and Newborns Health Service
5	Tony	Bober	WA Aids Council
6	Nicki	Booth	Child and Adolescent Health Service
7	Marian	Brandreth	Princess Margaret Hospital
8	Sarah	Bright	Department of Health
9	Renai	Buchanan	Magenta
10	Myles	Burleigh	Australian Bureau of Statistics
11	Kelly	Cameron	Breastscreen WA
12	Lorena	Castelo	Volunteering WA
13	Marie	Chetty	WA Police
14	Beth	Chigwada	Hepatitis WA
15	Soo-Ming	Chung	Women's and Newborns Health Service
16	Krista	Coward	North Metropolitan Health Service
17	Karen	Crossley	Department of Health
18	Rosita	D'Adamo	Ethnic Disability Advocacy Centre
19	Ljiljana	Djordjevic	South Metropolitan TAFE
20	Jo	Fagan	Department of Health
21	Christina	Foo	Child and Adolescent Mental Health Service
22	Louise	Ford	Health Consumers Council
23	Sallie	Forrest	Department of Health
24	Zaneta	Georgievski	Australian Bureau of Statistics
25	Kim	Goodman	Department of Health

	Name		Agency or workplace
26	Kim	Greeve	WA Cancer and Palliative Care Network
27	Caroline	Gumede	
28	Mary	Gurgone	Fortis Consulting
29	Rebecca	Hall	City of Canning
30	Lesley	Harland	Sir Charles Gairdner Hospital
31	Iren	Hunyadi	Consumer
32	Breanna	Hutcheson	Child and Adolescent Community Health
33	Gabriella	Jerrat	Royal Perth Hospital
34	Carol	Kaplanian	Women's and Newborns Health Service
35	Laura	Kelly	Armadale Health Service
36	Natasha	Kusmuk	Department of Social Security
37	Tandi	Kuwana	Consumer
38	Elizabeth	Lang	Diversity Focus
39	Sue	Lee	Women's Health and Family Services
40	Vellar	Lim	Department of Communities
41	Karen	Lipio	Department of Health
42	Ruth	Lopez	Department of Health
43	Jennifer	Mace	Princess Margaret Hospital
44	Diana	MacTiernan	Equal Opportunity Commission
45	Helen	Maddocks	Office of Multicultural Interests
46	Dianne	Manfredi	Department of Communities
47	Suzanne	McEvoy	North Metro Health Service
48	Chital	Mehta	Department of Communities
49	Matt	Merema	Department of Health
50	Kelli	Monaghan	Department of Health
51	Eva	Mwakichako	City of Stirling
52	Emily	O'Connell	Department of Health
53	Rod	Ogilvie	Department of Health

	Name		Agency or workplace
54	Rachel	Pearce	Ishar Multicultural Women's Health Service
55	Stephen	Platt	Department of Health
56	Stacey-Mae	Prokopyszyn	Women's and Newborns Health Service
57	Kathy	Ride	Department of Health
58	Tony	Rush	King Edward Memorial Hospital
59	Jessica	Saayman	Child and Adolescent Community Health
60	Tessa	Scholefield	Child and Adolescent Mental Health Service
61	Holly	Scott	East Metro Health Service
62	Linda	Sewell	Department of Health
63	Krunali	Shah	Department of Health
64	Laura	Sifuna	Australian Red Cross
65	Anne	Slavin	Osborne Park Hospital
66	Priyanath	Snehaletha	Australian Red Cross
67	Denise	Sullivan	Department of Health
68	B-K	Tan	Armadale Health Service
69	Linda	Tarbotton	Communicare
70	Aesen	Thambiran	Humanitarian Entrant Health Service
72	Alexandra	Truelove	RUAH
72	Michael	Watkins	Department of Health
73	Nedra	Weerakoon	Office of Multicultural Interests
74	Tarun	Weeramanthri	Department of Health
75	Catrina	Wold	Injury Matters
76	Bernadette	Wright	Consultant
77	Majok	Wutchok	North Metro Health Service
78	Alex	Xiao	Department of Health
79	Grace	Yun	Department of Health

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