Auckland District Health Board

Learning Needs Analysis for culturally competency training programmes for the primary and secondary health and disability workforce

April, 2009

Dr Annette Mortensen
Project Manager
Northern DHB Support Agency

1. Executive Summary

Summary

Why do we need cultural competence training for the ADHB primary and secondary health and disability workforce?

- The need to develop cultural competence is underpinned by legislative requirements. Section 118(i) of the Health Practitioners Competency Assurance Act (HPCAA) requires that health practitioners observe standards of cultural competence as set by their professional authority.
- Central Auckland has the most ethnically diverse population of any region in New Zealand.
- By 2016 Asian peoples with comprise 34 % of the Auckland District Health Board population
- Central Auckland ethnodemographic trends highlight the importance of providing culturally responsive primary and secondary health and disability services for the populations served.
- The indications are that the patterns of poor health that are occurring in low socio-economic groups in New Zealand, in particular Pacific groups, including diabetes, obesity and cardiovascular disease, poor mental health, and oral health, and high smoking rates are being replicated in some ethnic groups settled in Auckland (ARPHS, Harbour PHO & WDHB AHSS, 2007; Gala, 2008, Solomon, 1999; 1997; 1995; 1993).

What training do ADHB primary and secondary health and disability services want?

- Refugee and migrant communities in local, regional and national consultation processes, health and disability research, health service evaluations, and health needs analyses give a strong indication that clients from culturally and linguistically diverse backgrounds are commonly not receiving culturally appropriate care in health and disability services.
- Cultural competency training is part of the programme of work for the *Auckland Regional Settlement Strategy Refugee and Migrant Health Action Plan. The Auckland Regional Settlement Strategy Health Workstream Steering Group* recommended the introduction or expansion of culturally competency training for the primary and secondary health and disability workforce in Auckland DHB.
- It is proposed that ADHB Learning and Development Units enhance and expand the culturally competence/diversity programmes that are currently available to the workforce to include cultural competencies for working with Asian and other new migrant groups and refugee groups.
- It is proposed that ADHB Learning and Development Units extend all cultural competency training programmes to the ADHB funded primary health workforce.
- Cultural competency programmes need to be part of the practitioner's Performance Management and MECA (Career and salary Progression (CASP) process); and professional development programme

- The delivery of cultural competence training needs to be modular including core competencies and training tailored to meet the needs of practitioners, clinical services and the populations served (see Appendix 2)

How do ADHB primary and secondary health and disability service providers want cultural competency training to be provided?

- The ADHB primary and secondary health and disability workforce need flexible learning options including: workshops, seminars, simulated learning sessions; e-learning via MOODLE; self-evaluation tools; CD ROMs; case study discussions; video materials; and hard copy resources.
- Practitioners want a modular approach including core competencies and advanced training options 'tailored' for practice and clinical settings
- Sustainable and effective cross–cultural practice requires ongoing cross-cultural supervision, peer review, and case management processes for practitioners that are appropriate to the clinical setting and the populations being served.
- Cross- cultural competency training programmes should become a sustainable component of the ADHB Learning and Development Unit framework for cultural competency workforce development for the primary and secondary health and disability sectors.

How will cultural competency training make a sustainable difference to practice?

- The transcultural and inter cultural mental health training programmes, and the transcultural service delivered by ADHB Community Mental Health Services provide a demonstration model for sustainable cultural competency development and practice in other ADHB health and disability services
- Through organisational and professional development processes that build cross-cultural competency into clinical practice, supervision and mentoring processes

How will we know if cultural competency training has made a difference?

- Cultural competency training needs to be evaluated, and the outcomes for clients from culturally diverse backgrounds assessed
- The end goal is achieving good health outcomes for clients

2. Introduction

Since the early 1990s, the ethnic demography of the Auckland region has changed significantly (Department of Labour, 2006; Department of Labour and Auckland Sustainable Cities Programme, 2007; Statistics New Zealand (SNZ), 2006). Auckland is the gateway to New Zealand for many migrants and refugees, and where the greatest proportion chooses to settle. The region has settled over 200 diverse ethnic groups (SNZ, 2006). Over half of the population in the region has come from other countries (SNZ, 2006). Of the 50,700 New Zealand adult non-English speakers, over 65 percent live in Auckland. Almost three-quarters of the people, who come to New Zealand from the Pacific Islands, and two-thirds of those who come to New Zealand from Asia, live in Auckland.

Central Auckland has the most ethnically diverse population of any region in New Zealand (SNZ, 2006). The ethnic composition of the ADHB population is projected to change over time with growth expected in the proportion of Asian peoples in the population (ADHB, 2009). A number of regional and national health studies and consultation processes including the health needs assessments conducted by Auckland and other DHBs have highlighted the need for more culturally responsive

health and disability services, and for a culturally competent workforce to meet the needs of the increasing ethnic diversity in District Health Board health populations (Asian Public Health Project Team. 2003; Auckland District Health Board, 2001; 2002; 2006a;2006b)

The Health Practitioners Competency Assurance Act (HPCA Act) includes a requirement for registration bodies to develop standards of cultural competence and to ensure that practitioners meet those standards. Increasingly, groups such as the New Zealand Medical Council (NZMA), Royal College of General Practitioners, Public Health Physicians, Nursing Council of New Zealand (NCNZ), and the Aotearoa New Zealand Association of Social Workers (ANZASW) have an interest in developing the cultural competence frameworks for the culturally and linguistically diverse (CALD) groups in New Zealand. The issues of relevance for the development of CALD cultural competencies in health and disability sectors include:

- the recognition of culture as a determinant of health status;
- the continuing poor health status of Māori, Pacific and ethnic minority groups;
- health inequalities between the dominant cultural group and Māori or other minorities;
- the inclusion of the Treaty of Waitangi and/or principles of the Treaty in legislative, regulatory and contractual requirements of health practice; and
- recognition of the need for a culturally competent health and disability workforce to address both issues of equity and health disparities.

The Auckland District Health Board (ADHB) (2008) *District Annual Plan* for 2008 to 2009 identifies healthier communities and environments; and equity in health status between populations as key results to be achieved. Reducing health inequalities is one specific outcome for the Auckland District Health Board with a particular focus on improvements for ethnic groups, and low socio-economic groups with poor health outcomes. To support this action the Ministry of Health Migrant Health Budget 2008, contracted through the Northern DHB Support Agency, has awarded the Auckland District Health Board funding to provide cross- cultural competency training to the ADHB funded primary and secondary health and disability workforce. The area of Cross- cultural competence focuses on the skills, behaviours and attitudes required to work with the culturally, linguistically and religiously diverse groups served in the ADHB region.

Benefits of cultural competence in healthcare

A healthcare organisation that is 'culturally competent' is able to provide culturally responsive services, and to benefit from the diversity in the workforce. The development of cultural competence has been identified as an effective access and equity strategy, as well as a quality improvement process that is linked to improved client outcomes (Betancourt et al 2003; Brach & Fraser 2002; DHFS & AIHW 1998).

Specifically, the benefits of delivering culturally competent healthcare include:

- Improved access and equity for all groups in the population
- Improved consumer 'health literacy' and reduced delays in seeking healthcare and treatment
- Improved communication and understanding of meanings between clients and service providers, resulting in:

    - better compliance with recommended treatment

- clearer expectations
- reduced medication errors and adverse events
- improved attendance at 'follow-up' appointments
- reduced preventable hospitalisation rates
- improved client satisfaction
- Improved client safety and quality assurance
- Improved 'public image' of health and disability services
- Better use of resources.
- Better health outcomes for clients and for culturally diverse populations

Conversely, it follows that there are substantial risks that are likely to incur costs if healthcare provision is culturally incompetent.

2.1 Defining Cultural Competence

The concept of 'cultural competence' was developed in health care to better meet the needs of increasingly culturally diverse populations, and in response to the growing evidence of disparities in the health of ethnic minority groups (Betancourt et al., 2003; Brach & Fraser, 2002). In New Zealand, interpreting what is meant by cultural competence is complicated by the fact that the Health Practitioner's Competence Assurance Act does not give a clear definition of the term. Professional registration bodies for the health and disability workforce in New Zealand have each defined cultural competence in different ways. Some examples of the definitions that are being used are shown in this section including those of the Medical Council of New Zealand (MCNZ), Nursing Council of New Zealand (NCNZ), and the Aotearoa New Zealand Association of Social Workers (ANZASW).

2.1.1 The Medical Council of New Zealand

The Medical Council of New Zealand published the following *Statement on Cultural Competence* in August 2006.

Purpose of this statement

1. This statement outlines the attitudes, knowledge and skills expected of doctors in their dealings with all patients

1. The Council has developed a complementary *Statement on best practices when providing care to Mäori patients and their whänau* which deals with the standard expected of doctors when dealing with Mäori patients. A resource booklet entitled Best health outcomes for Mäori: Practice implications has also been developed which addresses the disparity between mainstream and Mäori health outcomes, discusses cultural concepts and provides advice for doctors. These resources should be read in conjunction with this statement. The Council also aims to develop additional resources to help doctors when treating patients from other cultural groups

Introduction

2. Medical doctors in New Zealand work with a population that is culturally diverse. This is reflected by the many ethnic groups within our population, and also in other groupings that patients may identify with, such as disability culture, gay culture or a particular religious group. The medical workforce itself includes many international medical graduates and a variety of ethnic groups. Cross cultural doctor-patient interactions are therefore common, and doctors need to be competent in dealing with patients whose cultures differ from their own

3. Patients' cultures affect the ways they understand health and illness, how they access health care services, and how they respond to health care interventions.

The purpose of cultural competence is to improve the quality of health care services and outcomes for patients

4. Benefits of appreciating and understanding cultural issues in the doctor-patient relationship include:
    - Developing a trusting relationship
    - Gaining increased information from patients
    - Improving communication with patients
    - Helping negotiate differences
    - Increasing compliance with treatment and ensuring better patient outcomes
    - Increased patient satisfaction

5. Cultural appreciation or understanding also has the potential to improve the efficiency and cost-effectiveness of health care delivery

Statutory responsibilities

6. In addition to setting standards of clinical competence, the Medical Council has a responsibility under section 118(i) of the Health Practitioners Competence Assurance Act 2003 to ensure the cultural competence of doctors

7. The Code of Health and Disability Services Consumers' Rights (the Code) also imposes a statutory duty upon doctors. The Code states:

Right 1 – Right to be treated with respect
(1) Every consumer has the right to be treated with respect.
(2) Every consumer has the right to have his or her privacy respected.
(3) Every consumer has the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, social and ethnic groups, including the needs, values and beliefs of Mäori

Right 2 – Right to freedom from discrimination, coercion, harassment and exploitation
Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation

Right 3 – Right to dignity and independence
Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual

Definition of cultural competence

8. The Council has adopted the following definition of cultural competence:

"Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:

- That New Zealand has a culturally diverse population
- That a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship
- That a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding."

9. Cultural mores identified by the Council are not restricted to ethnicity, but also include (and are not limited to) those related to gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status or perceived economic worth

10. The Council emphasises that doctors need to be able to recognise and respect differing cultural perspectives of patients, for the purpose of effective clinical functioning in order to improve health outcomes for patients

Cultural competence standards

11. To work successfully with patients of different cultural backgrounds, a doctor needs to demonstrate the appropriate attitudes, awareness, knowledge and skills:

12. Attitudes

- A willingness to understand your own cultural values and the influence these have on your interactions with patients
- A commitment to the ongoing development of your own cultural awareness and practices and those of your colleagues and staff
- A preparedness not to impose your own values on patients
- A willingness to appropriately challenge the cultural bias of individual colleagues or systemic bias within health care services where this will have a negative impact on patients

13. Awareness and knowledge
- An awareness of the limitations of your knowledge and openness to ongoing learning and development in partnership with patients
- An awareness that general cultural information may not apply to specific patients and that individual patients should not be thought of as stereotypes
- An awareness that cultural factors influence health and illness, including disease prevalence and response to treatment
- A respect for your patients and an understanding of their cultural beliefs, values and practices
- An understanding that patients' cultural beliefs, values and practices influence their perceptions of health, illness and disease; their health care practices; their interactions with medical professionals and the health care system; and treatment preferences
- An understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings
- An awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the clinical situation

14. Skills
- The ability to establish a rapport with patients of other cultures.
- The ability to elicit a patient's cultural issues which might impact on the doctor-patient relationship
- The ability to recognise when your actions might not be acceptable or might be offensive to patients
- The ability to use cultural information when making a diagnosis

- The ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan
- The ability to include the patient's family in their health care when appropriate
- The ability to work cooperatively with others in a patient's culture (both professionals and other community resource people) where this is desired by the patient and does not conflict with other clinical or ethical requirements
- The ability to communicate effectively cross culturally and:

    - Recognise that the verbal and nonverbal communication styles of patients may differ from your own and adapt as required.
    - Work effectively with interpreters when required
    - Seek assistance when necessary to better understand the patient's cultural needs

2.1.2 The Royal New Zealand College of General Practitioners

The Royal New Zealand College of General Practitioners (2007) in *Cultural competence: Advice for GPs to create and maintain culturally competent general practices in New Zealand* use the Medical Council of New Zealand's (2006) broad definition of cultural competence which is:

'an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. A culturally competent doctor will acknowledge:

- That New Zealand has a culturally diverse population.
- That a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor. patient relationship.
- That a positive patient outcome is achieved when a doctor and patient have mutual respect and Understanding.'

2.1.3 Auckland Region Allied/Public Health/Technical MECA

Cultural Responsiveness
This practice domain advances the competencies for practitioners regarding cultural competence for pacific cultures or for people from other cultures that you interact with in your clinical/professional practice. Cultural responsiveness requires and awareness of cultural diversity and the ability to function effectively and respectfully when working with people from different cultural backgrounds. It also requires awareness of the practitioner's own identity and values, as well as an understanding of how these relate to practice. Cultural mores are not restricted to ethnicity but also include (but are not limited to) those related to gender, spiritual beliefs, sexual orientation, abilities, lifestyle, beliefs, age, social status, or received economic worth. The development of objectives based on the themes identified below relies on maintaining key relationships to ensure oversight, direction, leadership and guidance from the appropriate people within local organisations and the community.

Theme	***Example of Activities***
Demonstrates alignment of clinical/professional practice and appropriateness with policies related to other cultural population groups represented in your DHB	- Develops and maintains relationships with groups representing and identified culture - Demonstrates a working relationship with relevant community resources - Demonstrates an understanding and analysis of current issues in specific client groups - Links DHB Strategic plan with clinical practice in key target areas

Develops and in-depth understanding of and identified cultural group within your DHB	- Researches into an identified culture, its wider environmental context, leadership structure and its interplay with clinical practice - Researches DHB vision and values and that culture's population groups principles of health, linking this to own role and responsibilities - Researches disparities in the DHB population and links this to own service
Leads and supports an aspect of cultural responsiveness within own service area	- Demonstrates leadership and role modelling in both clinical and professional practice and service delivery - Challenges culturally inappropriate practices and supports staff to make changes - Is actively involved in developing cultural policies within own service - Develops needs assessment of cultural requirements for staff - Cultural knowledge and appropriateness is applied to clinical and professional practice - Demonstrates and understanding of own issues regarding cultural intervention - Demonstrates a working relationship with relevant community groups - Develops understanding and analysis of current issues in specific client groups - Leads the DHB Strategic Plan with clinical practice in key target areas

2.1.4 Nursing Council of New Zealand

Guidelines for Cultural Safety, the Treaty of Waitangi, and Maori Health in Nursing and Midwifery Education and Practice **(NCNZ, 2002)**

The cultural safety concept in the 2002 guidelines 'incorporate[s] a broad definition that 'in addition to ethnicity' includes, 'groups that are as diverse as social, religious and gender groups' (NZNC, 2002, p.4). The Nursing Council of New Zealand (2002, p.7) defines cultural safety as:

> *The effective nursing or midwifery practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.*
>
> *The nurse or midwife delivering the nursing or midwifery service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture*

> *has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.*

In 2007, *Competencies for Registered Nurses* were introduced including the requirement to practice "in a manner that the client determines as being culturally safe" (NCNZ, 2007, p. 9).

Cultural Safety Competencies for Registered Nurses

The Nursing Council of New Zealand, (2002) *Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing and midwifery education and practice* serve as the basis for the indicators of competence related to the practice of cultural safety for all ethnic groups in New Zealand. The 2007 *Competencies for registered nurses* provide the indicators that nurses are expected to demonstrate when practising "in a manner that the client determines as being culturally safe" (NZNC, 2007, p. 9). The competencies include the nurse's ability to (NZNC, 2007, p. 9):

- apply the principles of cultural safety to nursing practice;
- recognise the impact of the culture of nursing on client care and endeavour to protect the client's wellbeing within this culture;
- practise in a way that respects each client's identity and right to hold personal beliefs, values and goals;
- assist the client to gain appropriate support and representation from those who understand the client's culture, needs and preferences;
- consult with members of cultural and other groups as requested and approved by the client;
- reflect on his/her own practice and values that impact on nursing care in relation to the client's ethnicity, culture and beliefs;
- avoid imposing prejudice on others and provide advocacy when prejudice is apparent

2.1.5 The Aotearoa New Zealand Association of Social Workers (ANZASW)

The cultural competencies required by registered social workers are described in the

- The Auckland Region Allied/Public Health/Technical MECA and;
- The ANZASW Standards of Practice

The ANZASW Standards of Practice

The ANZASW is the professional body which provides the structure for accountability of social workers to their profession. The ANZASW sets ten practice standards for the assessment of practitioner competency. The following standards of practice pertain to cultural competence:

Standard 3
The social worker establishes an appropriate and purposeful working relationship with clients, taking into account individual differences and the cultural and social context of the client's situation.
This standard is met when the social worker;

- Uses cultural and gender appropriate verbal and non-verbal communication
- Is able to work with a variety of individuals and groups and when the social worker demonstrates a knowledge of:
- The concepts of culture, class, race, ethnicity, spirituality, sex, age and disability and understands the impact of racism, poverty and sexism at a personal and institutional level

Standard 7
The social worker has knowledge about social work methods, social policies, social services, resources and opportunities and acts to ensure access for clients.
This standard is met when the social worker demonstrates a knowledge of:

I. Social work practice with Pakeha, Maori and Pacific Islands peoples and other ethnic groups, including the following aspects:
   a. Communication processes
   b. Planned, purposeful social work processes
   c. Groups processes
   d. Change strategies
   e. Preventative strategies
   f. Social planning, social action
   g. Community work and community development
   h. Power and authority issues
   i. Privacy and confidentiality
   j. Empowerment strategies

II. Social services, including the following aspects:
   a. The role of government
   b. The role of non-governmental organisations (NGOs)
   c. The role of volunteers
   d. Teamwork and multidisciplinary processes
   e. Organisation and management practice
   f. Research principles and practice

III. Social policies including the following aspects:
   a. Policy issues for people who may be disadvantaged on the grounds of race, gender, economic status, disability, sexual orientation and age
   b. Contemporary social policy directions
   c. Strategies for influencing policy
   d. Strategies for the promotion of informed participation

IV. Resources and opportunities including the following aspects:
   a. The identification of needs including gaps in existing services
   b. The expansion and promotion of a range of choices and opportunities
   c. The use of networks to support clients, colleagues and communities in meeting social needs
   d. The availability of funding sources and procedures for obtaining funds
   e. The significance of culturally appropriate resources and personnel

Standard 7
The social worker supervisor has knowledge about social work and supervision methods, social policies, social services, resources and opportunities and acts to ensure access for clients.

This standard is met when the social worker supervisor demonstrates knowledge of:

Social work and supervision practice with Tangata Whenua and Tauiwi, including Pacifika peoples and other ethnic groups, including the following aspects:

a. Communication processes
b. Planned, purposeful social work processes
c. Groups processes
d. Change strategies
e. Preventative strategies
f. Social planning, social action
g. Community work and community development
h. Power and authority issues
i. Privacy and confidentiality
j. Empowerment strategies

3. Context

Refugees, Asian and other migrant groups under utilise health and disability services; show disparities in health status; and have inequitable access to services compared to other health populations (Auckland Regional Public Health Service (ARPHS), Harbour PHO & Waitemata District Health Board's (WDHB) Asian Health Support Services (AHSS), 2007; Rasanathan, Ameratunga & Tse, 2006; Scragg & Maitra, 2005). Commonly, cultural barriers are cited as a reason for not using health and disability services (Department of Labour & Auckland Sustainable Cities Programme, 2007), and the low utilisation of primary health services, in particular, is noted in a number of studies (Gala, 2008; Ngai, Latimer & Cheung, 2001).

Multiple New Zealand studies of refugee and migrant health nationally (Asian Public Health Project Team, 2003; Denholm & Birukila, 2001; Denholm & Jama, 1998; Ho, Au, Bedford & Cooper, 2003; Jackson, 2006; Ministry of Health, 2001); regionally (Aye, 2002; Ho, Guerin, Cooper & Guerin, 2003; Lawrence, 2007; Mortensen, 2008; North & Lovell, 2002); and locally (Lawrence & Kearns, 2005); and the health needs assessments conducted by Auckland District Health Board and the Northern District Health Board Support Agency (NDSA) (ADHB, 2001; 2006a; 2006b; NDSA, 2006) have identified health professionals' lack of cultural knowledge and skills as a major barrier to accessible, safe and equitable health services for the ethnically diverse groups served. As well, New Zealand research with health care providers indicates that nurses and other health professionals are ill prepared to provide for the care of culturally diverse groups (Lawrence & Kearns, 2005; Mortensen, 2008; North & Lovell, 2002).

The Asian Health Chart Book (Ministry of Health, 2006) reveals major differences in health outcomes for South Asian groups. South Asian groups have high rates of obesity, type 2 diabetes and cardiovascular disease (Gala, 2008). In New Zealand, the prevalence of diabetes and coronary heart disease is highest among Indian men when compared with European, Maori and Pacific groups (Gala, 2008). The disparities between South Asian and other populations are increasing

as the mortality rates for CVD are falling faster in non-South Asian population health groups (Gala, 2008). There are major differences in health service use between recent migrants and established communities, similar for Chinese, Indian and 'Other' Asian ethnic groups, that is, for almost all health indicators, recent or first-generation migrants do better than long-standing migrants or the New Zealand born. This is believed to largely reflect a healthy migrant effect and over time as acculturation impacts, healthy migrants become less healthy (Gala, 2008).

A number of studies of refugee and migrant health care in New Zealand indicate that the health workforce is under prepared to meet the needs of the diverse ethnic populations served (Denholm, 2004; Lawrence, 2007; North & Lovell, 2002; Mortensen, 2008). North and Lovell's (2002) survey of the impact of immigrant patients on primary health care services in Auckland and Wellington showed that health practitioners believed that clients from ethnically diverse backgrounds expressed their concerns, symptoms, and pain differently from other patients. Health practitioners reported that understanding the presentation of symptoms is central to diagnosing, and providing adequate treatment. Two-thirds of the respondents in the survey were nurses, less than half had received any training related to the care of clients from refugee, Asian and other migrant backgrounds, and most expressed the need for cross-cultural education (North & Lovell, 2002).

The skills of cross-cultural communication including the use of interpreters are essential to client safety (Gray, 2007; Wearn et al., 2007). Practitioners who can use interpreters effectively, and communicate cross-culturally are more likely to receive accurate information; to ensure that the client understands the result of tests and screening; and to provide the client with information and instructions on medications, treatments and follow up. Communicating effectively with the client depends on the practitioner's ability to gain rapport. The ability to adapt to different verbal and nonverbal communication styles where the culture of the practitioner is different to that of client is an important skill to avoid misunderstanding and actions that may be unacceptable to the client and their family. The ability to use cultural assessment tools, and to use the information gained aids good client outcomes. Working with the client's cultural beliefs, values, and practices and applying this knowledge in planning care is more likely to lead to client satisfaction with the services offered.

4. Aims and Objectives

The purpose of the delivery of cultural competency programmes to the Auckland District Health Board primary and secondary health and disability workforce is the delivery of services that are responsive, accessible, and culturally appropriate for the culturally, linguistically and religiously diverse groups served in the region. The programmes will make a significant contribution to ensuring that ADHB health and disability services provide culturally competent care for their ethnically diverse populations.

The aims of the learning needs analysis are to:

1. To provide a stocktake of the cultural competency training available to the ADHB health and disability workforce, and on the evaluation outcomes of programmes where available
2. To assess unmet cultural competency training needs for a broad sample of ADHB health and disability services (including by professional group, specialty area, and primary and community health sectors) with health workers from ethnically diverse backgrounds as key stakeholders.
3. To assess health and disability workforce preferences for cultural competency learning modalities, information retrieval systems, and booking systems
4. To review the literature on best practice for cultural competency training for the health and disability workforce
5. To identify the critical features of culturally competent organisations
6. To investigate measures both organisational and professional of the impact of the cultural competency training on client outcomes and workforce practices.

The objectives for cultural competency training are that:

- The accessibility, acceptability and quality of ADHB primary and secondary health and disability services for clients from CALD backgrounds will be improved through the provision of culturally competent care
- Health outcomes for clients from CALD backgrounds will be improved through the provision of culturally competent care because:
- Health and disability workers will have a better knowledge of client's cultures and how:
  - they affect the ways that clients and their families understand health and illness
  - how they access health care services and;
  - how they respond to health care interventions

5. Population Demography

Asian peoples are overall the second largest population groups in the ADHB region, representing 18.7 per cent of Central Auckland's total (SNZ, 2006). Asian peoples are the fastest growing groups in the Auckland region, and in Auckland City will increase by 100,000 (from 77,000 in 2001 to 177,000 in 2016), in Manukau City by 52,000 (from 46,000 to 98,000), in North Shore City by 37,000 (from 26,000 to 63,000), and in Waitakere City by 27,000 (from 20,000 to 47,000) (SNZ, 2006).

Additionally, the Auckland District Health Board (2002) records refugee populations of approximately 40,000 people. Approximately 1,500 refugees settle in New Zealand every year, 65 per cent of whom will reside in Auckland (New Zealand Immigration Service (NZIS), 2004). The refugee groups settled in the last decade include peoples from Iran, Iraq, Afghanistan, Sri Lanka, Bosnia, Kosovo, Somalia, Eritrea, Ethiopia, Sudan, Vietnam, Cambodia, Laos, Burma, Bhutan, Burundi, Rwanda, the Democratic Republic of Congo, Brazzaville, Sierra Leone, Zimbabwe, Palestine, Algeria and Columbia. There are significant disparities in the health of refugee groups and other New Zealand populations (Ministry of Health, 2001).

Cultural, Religious and Linguistic Diversity in Central Auckland

In the Census 2006, almost one in five people in Central Auckland identified with an Asian ethnic group, the highest proportion of all regions in New Zealand. Asian populations are made up of diverse ethnic sub-groups. The seven largest Asian ethnic groups in Census 2006 are Chinese (147,570), Indian (104,583), Korean (30,792), Filipino (16,938), Japanese (11,910), Sri Lankan (8,310) and Cambodian (6,918). Other Asian ethnic groups include Thai, Filipino, Japanese, Sri Lankan, Laotian, Cambodian, Vietnamese, Burmese, Bhutanese, Nepalese, Tibetan and Indonesian groups (Asian Public Health Project Team, 2003).

The number of people born in India who were living in New Zealand more than doubled between 2001 and 2006. The number of people born in the Republic of Korea and Fiji also increased significantly. Between 2001 and 2006, the numbers of people in New Zealand able to have a conversation about everyday things in Hindi almost doubled, from 22,749 to 44,589. The number of people able to speak Mandarin increased from 26,514 to 41,391, the number of people able to speak Korean increased from 15,873 to 26,967.

Acknowledging religious diversity is an integral part of providing culturally competent care. The Census 2006 data records Muslim peoples in the Auckland region to number 40,000, along with increases in groups of Buddhist, Hindu and other faiths.

Auckland District Health Board Ethnic Populations Present and Future

Central Auckland has the most ethnically diverse population of any region in New Zealand. The ethnic composition of the ADHB population is projected to change over time with growth expected in the proportion of Asian peoples in the population, and a reduction in European peoples (ADHB, 2009) (see Table 1)

Table 1: Projected Ethnic Composition of Auckland City by 2016 (ADHB, 2009)

Ethnic Groups	Percentage of Auckland City Populations
European	51%
Asian Peoples	34%
Maori	8%
Pacific Peoples	13%

Auckland District Health Board's population is made up of the following ethnic groups

Table 2: Ethnic Groups in Central Auckland (ADHB, 2009)

Ethnic Groups	Percentage of Auckland City Populations
European	65.7%
Maori	8.4%
Pacific Peoples	13.7%
Asian Peoples	18.7%
Other nations	1.6%

The languages most commonly spoken in Central Auckland are shown in Table 3

Table 3: Common Languages Spoken (ADHB, 2009)

Languages spoken	Number in Population
English	320,295
Samoan	14,226
Yue	9,993
Maori	8,799
Northern Chinese	8,469
Tongan	8,217
French	8,178
Hindi	7,941

Table 4: List of languages provided by the ADHB (ADHB, 2009)

Albanian	**Algerian**	**Amharic (Ethiopian Dialect)**	**Arabic**
Assyrian	**Azurbijan**	**Bahasa Indonesia**	**Bahasa Malaysia**
Bengali (Indian Dialect)	**Bosnian**	**Bulgarian**	**Burmese**
Burundi	**Cambodian**	**Cantonese**	**Chaldean (Iraqi dialect)**
Chin (Burmese dialect)	**Chiuchow (Chinese dialect)**	**Cook Island**	**Croatian**
Czechoslovakian	**Dari (Afghani language)**	**Dinka (Sudanese dialect)**	**Dutch**
Eritrean	**Ethiopian**	**Farsi (Iranian language)**	**Fijian Hindi**
French	**Fujian (Chinese dialect)**	**German**	**Greek**
Gujerati (Indian dialect)	**Ha-Ka (Chinese dialect)**	**Hindi**	**Hokkien (Chinese dialect)**
Italian	**Japanese**	**Karen (Burmese dialect)**	**Kinyarwanda (Rwanda)**
Kiribas (Kiribati)	**Kirundi (Burundi dialect)**	**Korean**	**kurdish**
Lao	**Latin**	**Latin American**	**Macedonian**
Mandarin	**Marathi (Indian dialect)**	**Moroccan**	**Niuean**
Pampango (Philipino dialect)	**Philipino (Tagalog)**	**Polish**	**Portuguese**

Punjabi	**Pushtu (Afghani language**	**Russian**	**Samoan**
Serbian	**Serbocroatian**	**Shanghinese**	**Singalese (Sri Lankan)**
Slovakian	**Somali**	**Spanish**	**Sudanese**
Swahili	**Swiss-German**	**Tahitian**	**Taiwanese**
Tamil (Sri Lankan)	**Thai**	**Tigrinya (North Ethiopian dialect)**	**Tokelauan**
Tongan	**Tunisian**	**Turkish**	**Ukrainian**
Urdu (Pakistani)	**Vietnamese**	**Yugoslav**	**Rohingya (Burmese dialect)**

Table 5 represents the numbers of requests for interpreters in non-English speaking groups resident in the Central Auckland region from 2003 to 2006.

Table 5: ADHB Job Statistics by Languages over 4 Financial Years

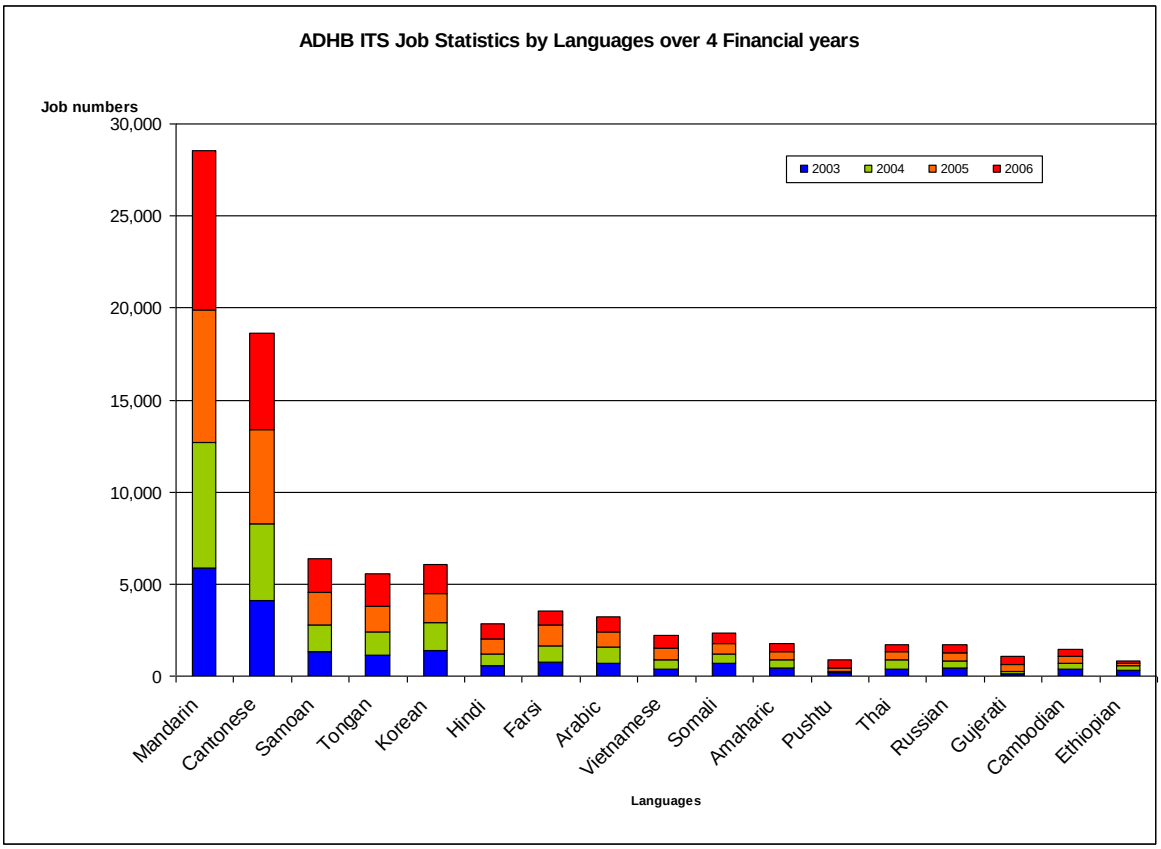


Table 6 shows the percentage of South Asian groups residing in the ADHB region. To give an indication of the diversity within ethnic groups, South Asian groups in Central Auckland include peoples from the Indian subcontinent, that is: India, Pakistan, Sri Lanka, Bangladesh, Nepal, Bhutan, Maldives, South African and Fiji Indians. There is significant diversity in language, culture and religion within and between South Asian groups. The range of languages spoken include: Hindi, Gujarati, Urdu, Fiji Hindi, Bengali, Tamil, Telegu, Nepalese, Bhutanese, Oriya, Sindhi, Kashmiri, Sinhala, Konkani, Marathi, Pashto, Kannada and Farsi.

Table 6: Percentage of South Asian population in ADHB, usually resident, total response (SNZ, 2006)

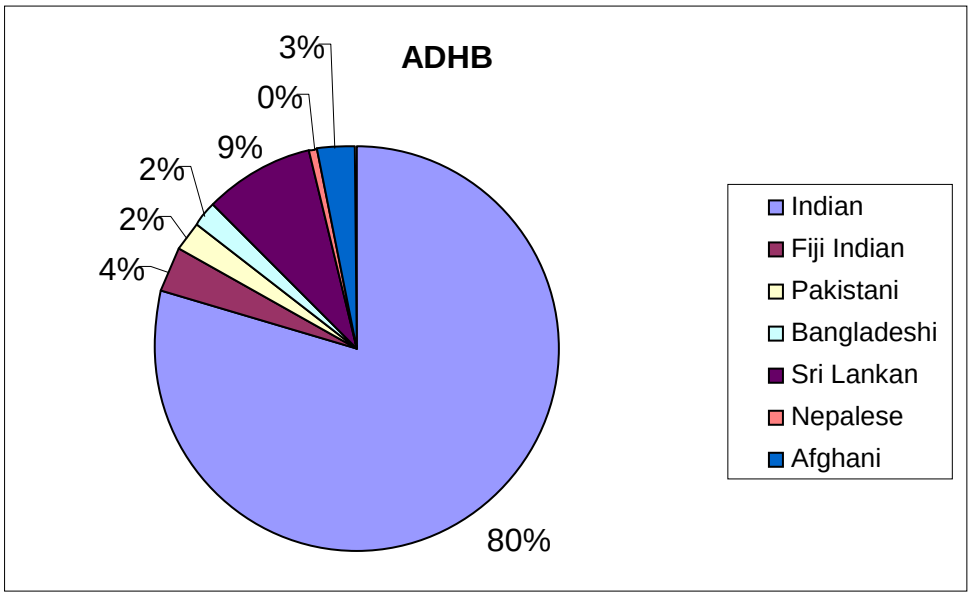


Table 7 shows the number of South Asian peoples and groups in Central Auckland by comparison with other DHBs in Auckland, and in New Zealand.

Table 7 South Asian Population Distribution

Ethnicity	ADHB	CMDHB	WDHB	Waikato	Capital and Coast	Canterbury	Rest of NZ	All NZ
Indian	28,605	27,708	14,160	5,031	7,104	3,135	13,221	98,967
Fiji Indian	1,296	2028	855	285	324	171	657	5,616
Pakistani	861	336	324	78	84	126	243	2,049
Bangladeshi	675	129	186	66	66	72	294	1,488
Sri Lankan	3,252	939	870	333	1134	441	1341	8,313
Nepalese	156	60	123	30	24	84	177	654
Afghani	1,104	258	480	90	57	519	33	2,538
South Asians	**35,949**	31,458	16,998	5,913	8,793	4,548	15,966	119,625

Religious Diversity

Increasing religious diversity was noted in the 2006 Census. The number of people indicating an affiliation with the Sikh religion increased from 5,196 to 9,507 (up 83.0 percent) between 2001 and 2006, while people affiliated with either Hinduism (up from 39,798 to 64,392) or Islam (up from 23,631 to 36,072) also increased by more than 50 percent (61.8 percent and 52.6 percent, respectively). Almost 8 in 10 people (78.8 percent) affiliated with the Hindu religion were born overseas, particularly in Southern Asia and the Pacific Islands. A similar proportion of people affiliating with Islam (77.0 percent) were born overseas, mainly in Southern Asia, but also in the Middle East. The majority of people born overseas affiliating with Buddhism (37,590 people) were born in Asia (34,422 people). Of the people born overseas affiliating with Hindu and Muslim religions, almost half (49.8 percent and 48.0 percent, respectively) had arrived in New Zealand less than five years ago. More than one-third (36.1 percent) of overseas-born Buddhists arrived in New Zealand less than five years ago.

6. Current State and Gap Analysis

6.1 Stocktake of Cultural Competency Training available to the ADHB Health and Disability Workforce

6.1.1 Provided by ADHB provider

Mental Health - Migrants and Refugees - Transcultural Issues in Mental Health

The cultural competence programmes provided for the Auckland District Health Board health workforce are focused on secondary mental health services and include the following:

This day training programme is run twice a year for ADHB secondary mental health services. There are no pre-requisites and no eligibility criteria for attendance at this course

Course Goals

To provide participants with the knowledge and skills to work with culturally diverse communities from refugee and migrant backgrounds.

Learning Objectives

- To differentiate between the groups, refugees, asylum seekers and migrants and to assess their needs accordingly
- To have the skills to recognise PTSD/Depression
- To have the skills to ask about torture experiences
- To recognise the stressors involved in re-settlement for refugees and migrants
- To be able to access resources related to the care of refugees and migrants and to refer to appropriate services
- To be able to appreciate the differences in cultural values while working with clients who come from another ethnic group
- To develop strategies and skills in working with Chinese families
- To be able to articulate the concept of “acculturation” and to apply this model while working with migrants and refugees
- To use professional health interpreters that are appropriate to the ethnic group, language and gender of the client

Mental Health - Intercultural Workshop-Developing Cross-Cultural Rapport

This day training programme is run twice a year for ADHB secondary mental health services. There are no pre-requisites and no eligibility criteria for attendance at this course

Course Goals

- To improve mental health professionals’ knowledge of cultural competencies
- To enhance mental health professionals’ cross cultural clinical skills

Learning Objectives

- To provide training for mental health clinicians that supports them in achieving

- rapport with their multicultural clients
- To provide training that effectively communicates the key concepts and Important factual knowledge required for these competencies
- To provide training that assists participants to build their skills and confidence In applying these cultural competencies

The programme is designed to:

- To assist practitioners to gain confidence and competency in internationally agreed core cultural competencies
- To reinforce learning through access to course materials, references and resources with the objective of deepening practitioner understandings of the social and personal values of clients
- To enable the practitioner to distinguish between description and interpretations of client behaviour
- To assist participants to connect observable client behaviour to underlying core values and core beliefs
- To assist participants to recognise that how we behave is motivated by values, beliefs, "cultural sense" and that these are often outside our conscious awareness
- To assist participants to apply what is learned by solving relevant "cases"/critical incidents

6.1.2 Provided by Regional Provider

NDSA (2007) *Cross-Cultural Resource for interpreters and health practitioners working together in mental health Part 1*. Auckland: NDSA

NDSA (2007). *Cross-Cultural Resource for Interpreters and Health practitioners working together in mental health Part 2.* Auckland: NDSA

The CD Rom is a cross-cultural training support resource developed specifically for Interpreters and health practitioners working together in mental health but is applicable to general health settings. The CD Rom contains scenarios, questions and answers, with information including:

- An introduction to the need for specialised training for Interpreters working in mental health settings and for the need for mental health practitioners and interpreters to work effectively together
- The roles of the interpreter: Expected competencies; Code of Ethics for Interpreters
- Common errors made during interpreting sessions
- Mental health terminology
- Cross-cultural issues (interpreters and practitioners): how beliefs and practices about health affect presentations of illness
- Pre and post-briefing, structuring of the interpreting session.
- Factors that affect the working relationship between the interpreter, the practitioner and the client
- The meta-skills involved in mental health interventions
- Role plays and exercises including: demonstrations from trainers with questions for practitioners; questions for practitioners to research, reflective-learning opportunities for practitioners

- An information resource section including: research; journal articles; support services; contacts for supervision and professional development opportunities

University of Auckland: Centre for Asian Health Research and Evaluation Asian Mental Health
http://www.fmhs.auckland.ac.nz/soph/centres/cahre/amh/index.html

Free on-line training modules for mental health practitioners which use case scenarios. The modules are:

1. Self Reflection
2. Asian Philosophy
3. Clinical Issues

CAHRE has also produced an interactive CD teaching package on "Asian mental health: Training and development for real skills". This provides entry level of training on Asian mental health to health and social services students nationwide (commissioned by Te Pou, The National Centre of Mental Health Research, Information and Workforce Development).

Waitemata DHB & Refugees as Survivors NZ Trust (2007). Cross–Cultural Resource: For health practitioners working with culturally and linguistically diverse (CALD) clients. Auckland: Waitemata DHB & Refugees as Survivors NZ Trust (see Appendix 7)

Cross-Cultural Interest Group for Mental Health Workers

Live seminar via web site from work or home computers on www.presentationcentral.co.nz. For information contact Valu Fineanganofo Ph [09] 638-0414 or Email: ValuF@adhb.govt.nz

In 2002, Dr Sai Wong set up the Cross-Cultural Interest Group to raise awareness and to enhance understanding and skills in cross-cultural clinical work, providing a free forum for sharing and discussion. The Cross-Cultural Interest Group meets monthly. Speakers present on their practices and experiences in the context of working with diverse cultural groups. Topics have included ethics in cross cultural practice, perceptions of mental illness from diverse Asian cultural perspectives, ethnic variations in the response to, and side effects of psychotropic medication, herbal-drug interactions and the use of Indian traditional medicine. From 2008 videoconferencing has allowed practitioners in other locations in New Zealand to participate in the meetings

6.2 Linkages

There are linkages between the proposed cultural competency training programmes for CALD populations and the cultural competency training being offered to meet bicultural and Pacific Best practice competency requirements:

There will be a links to:

- The development by ADHB Planning and Funding of a cultural competency policy for the ADHB health and disability workforce
- The ADHB Bicultural competency programmes which include:
    1. Tikanga: Recommended best practice e-learning

2. Treaty of Waitangi in Practice (Te Korito) (8 sessions per year are provided)
3. Tikanga in Practice (6 sessions per year are provided)

The Treaty of Waitangi in practice training is a mandatory requirement and must be completed within a year based on need and accreditation of prior learning. The training modality is face to face. The goal is to provide participants with the knowledge and skills necessary to understand the role of Te Tiriti o Waitangi in ADHB policy and practice. The learning objectives are that participants are able to:

- Explain and demonstrate a common understanding of the Treaty of Waitangi: it's historical context and principles
- Identify the articles of the Treaty of Waitangi, and describe key principles;
- Recognise the effects on Maori communities and Maori health status from historical policies
- Identify Crown responsibilities for Maori health
- Describe ADHB Maori health responsibilities and key policy documents
- Describe ways in which they can implement health services consistent with the Treaty of Waitangi

To complete the course participants must complete the Tikanga in Practice e-learning modules and the Tikanga in Practice module. When the participant has completed the three courses and the post course assessment for Tikanga in Practice, they are able to access a Te Korito certificate online.
A Treaty–on-line e-learning tool is in development and will be available to all staff in 2009:

- An ADHB Pacific cultural competency programme is under development:
- The availability free of charge of ADHB e-learning and on-line library via MOODLE to ADHB funded PHOS and NGOs

There are linkages to:

- The Primary Health Interpreting Pilots. The 'working with interpreters' training which is being provided by the ADHB Interpreting Service to ADHB funded primary health services is part of the Primary Health Interpreting Pilots[1]
- Regional cross cultural mental health training programmes including:

    - WDHB and Refugees as Survivors mental health practitioners cross-cultural training programme available on-line http://www.caldresources.org.nz/info/courses.php#moduletop
    - WDHB and Refugees as Survivors general health practitioners cross-cultural training programme available on-line http://www.caldresources.org.nz/main/index.php

    - NDSA (2007) *Cross-Cultural Resource for interpreters and health practitioners working together in mental health Part 1*. (see section 7.1)
    - NDSA (2007). *Cross-Cultural Resource for Interpreters and Health practitioners working together in mental health Part 2.* (see section 7.1.2)

[1] The ADHB Interpreting Service has been funded to provide interpreters to ADHB funded PHOs from August 2008. Training for the primary health workforce is being rolled out to the general practices participating in the three year pilot which is a project of the *Auckland Regional Settlement Strategy Health Workstream.*

- Waitemata DHB and Refugees as Survivors NZ Trust (2007). *Cross–Cultural Resource: For mental health practitioners working with culturally and linguistically diverse (CALD) clients* (see Appendix 7)

Cultural competency training, and professional development, and MECA career and salary progression processes (CASP) should be linked (see section 2):

- For example, the Aotearoa New Zealand Association of Social Workers (ANZASW) is the professional body which provides the structure for accountability of social workers to their profession. ANZASW sets 10 Practice Standards for the assessment of practitioner competency. A number of the standards of practice pertain to cultural competence (see Appendix 2.1.5)

Organisational accreditation processes and cultural competency training for the ADHB primary and secondary health and disability workforce should be linked:

- For example, PHOs are being encouraged to introduce Cornerstone (see Appendix 3) which is an accreditation package developed by the Royal College of General Practitioners specifically for General Practice. The accreditation process includes indicators for culturally competent organisations and workforce[2]

6.3 Organisational Constraints

- An organisational mandate for the provision of cultural competence for the CALD populations will be instrumental in ensuring that cross-cultural training is available for all staff in all ADHB health and disability service
- Project Management and Coordination
  There is limited capacity in the ADHB Learning and Development Service to manage and implement cultural competency programmes for CALD populations. Recruiting a project manager to coordinate the implementation of an agreed cultural competency plan for the ADHB health and disability workforce is uncertain with the directive to District Health Boards not to increase FTE in administrative roles
- Service managers have highlighted the need for flexible learning options and in some cases the preference for on-line learning modules because when staff are released for day training, "backfilling" staff rosters is problematic. However, when interactive training is offered day long training is preferable to half day training in regard to filling rosters
- On-line booking and e-learning opportunities via MOODLE and Healthpoint need to be available to primary health providers[3]
- Staff in general practices prefer evening and/or weekend training sessions in addition to the availability of on-line learning and resources

[2] The Royal New Zealand College of General Practitioners (2007). *Cultural Competence: Advice for GPs to create and maintain culturally competent general practices in New Zealand* is available on line at: http://www.rnzcgp.org.nz/assets/Documents/qualityprac/culturalcompetence.pdf

[3] ADHB has offered ADHB e-learning and library resources via MOODLE free of charge to any ADHB funded primary health provider. The portal can be customized to meet agency needs. Primary health response to the offer has been poor.

7. Literature Review

Summary

Cultural competence operates concurrently on a number of different organisational levels.

- At the systems, organisational or programme level, a coordinated and comprehensive plan needs to be in place to support the efforts of individuals. Such a plan includes strategies to address policymaking, infrastructure building, workforce development, programme administration and evaluation, and service delivery.

Four Dimensions of Cultural Competence

These are: systemic, organisational, professional and individual. The dimensions are interrelated so that cultural competence at an individual or professional level is underpinned by systemic and organisational commitment and capacity. Applying the four domains of cultural competency to health care organisations means:

- placing CALD background communities at the centre of organisational approaches to promoting healthier living and environments;
- ensuring that the health system can capture, enumerate and measure diversity, and consider diversity in programming, planning and resource allocations;
- acknowledging that cultural competency at management level affects the service culture of every organisation;
- recognising the need for a culturally competent evidence base in health promotion and health service delivery, supported by research into cultural competence issues and leading to culturally competent monitoring and evaluation;
- developing and implementing training and practice standards to ensure that information on people from CALD backgrounds is used as a context for interaction not as a tool to assume behaviours or attitudes; and
- recognising the policy imperative to increase both the quality and resourcing of professional development

Key features of Cultural Competence

Within Health Care Organizations

The ability of the health care organization to meet the needs of diverse groups of clients, as follows:

1. diverse workforce reflecting the populations served;
2. health care facilities convenient to communities;
3. language assistance available for clients with limited English proficiency;
4. ongoing staff training regarding delivery of culturally and linguistically appropriate services;
5. tracking quality of care across cultural, religious and ethnic subgroups;
6. including communities in priority setting, planning, delivery, and the coordination of care.

Within Interpersonal Communication

The ability of a provider to bridge cultural differences to build an effective relationship with a client, as follows:

1. explores and respects patient beliefs, values, meaning of illness, preferences and needs;
2. builds rapport and trust;
3. finds common ground;
4. is aware of own biases or assumptions;

5. maintains and is able to convey unconditional positive regard;
6. is knowledgeable about different cultures;
7. is aware of health disparities and discrimination affecting ethnic minority groups; effectively uses interpreter services when needed.

Taking cultural competency from theory to action (Wu & Martinez, 2006)

This paper provides principles and recommendations for implementing cultural competency in the field. The following six principles are key to a successful cultural competency effort:

1. Community representation and feedback at all stages of implementation;
2. Cultural competency integrated into all systems of the health care organization, particularly quality improvement efforts;
3. Ensuring that changes made are manageable, measurable, and sustainable;
4. Making the business case for implementation of cultural competency polices;
5. Commitment from leadership; and
6. Staff training on an ongoing basis.

Effectiveness of cultural competence training

- There is excellent evidence to suggest that cultural competence training increases the knowledge, skills and attitudes/behaviours of healthcare providers (Beach et al., 2004).

- There is good evidence that cultural competence training improves client satisfaction and poor evidence that it affects client adherence or health outcomes (Beach et al., 2004).

7.1 Organisational Cultural Competence

National Health and Medical Research Council (2005). Cultural competency in health: A guide for policy, partnerships and participation. Australian Government, National Health and Medical Research Council

A model for change

The National Health and Medical Research Council, Australia (2005) present a four-dimensional model for increasing cultural competency in the health sector. The dimensions are systemic, organisational, professional and individual — which interrelate so that cultural competence at an individual or professional level is underpinned by systemic and organisational commitment and capacity.

Integral to the model is the need for:

- capacity and conviction at systemic and organisational levels to direct, support and acknowledge culturally competent practice at an individual or professional level; and
- clear delineation of levels of responsibility and the interrelationship between these levels.

Systemic — effective policies and procedures, mechanisms for monitoring and sufficient resources are fundamental to fostering culturally competent behaviour and practice at other levels. Policies support the active involvement of culturally diverse communities in matters concerning their health and environment.

Organisational — the skills and resources required by client diversity are in place. A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels.

Professional — over-arching the other dimensions, at this level cultural competence is identified as an important component in education and professional development. It also results in specific professions developing cultural competence standards to guide the working lives of individuals.

Individual — knowledge, attitudes and behaviours defining culturally competent behaviour are maximised and made more effective by existing within a supportive health organisation and wider health system. Individual health professionals feel supported to work with diverse communities to develop relevant, appropriate and sustainable

Andrulis, D. Delbanco, T. Avakian, A. & Shaw-Taylor, Y (2007). *Conducting a cultural competence self–assessment.* Brooklyn, New York: Downstate Medical Centre

The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems

There are several reasons why a healthcare organization may wish to conduct an audit of its cultural competence. First, it may want to validate its understanding of the ethnic and cultural composition of its patient and employee populations. Further, it may seek to identify the unique attributes of a given cultural group to ensure access, appropriate treatment and effective communication between providers and patients. Additionally, the audit may reveal opportunities for the organization to make itself more attractive to diverse populations, thereby enhancing its marketing capabilities as well as strengthening its ties to community. Most important, the very act of conducting the self-assessment is a statement to the workforce, patients and community that the organization values diversity and desires to increase its cultural competence.

The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems, developed by Andrulis, Delbanco, Avakian & Shaw-Taylor (2007), is an approach to assessing organizational cultural competence. The protocol builds upon the Georgetown University, Child Development Center's Continuum of Cultural Competency.

The cultural competence protocol is a tool that can be used by health care providers, including hospitals and clinics, to conduct organizational assessments of their cultural competence. It is particularly useful for services involving culturally and ethnically diverse populations. The protocol’s questions are organized according to four cornerstones of cultural competence:

- a health care organization's relationship with its community;
- the administration and management's relationship with staff;
- inter-staff relationships at all levels;
- the patient/enrolee-provider encounter.

The protocol allows organizations to score responses and then place themselves on a five point spectrum of cultural competence, ranging from inaction to a fully realized "learning" organization.

The protocol has many uses. For example, it can serve as a formal organization-wide review tool or as a department- or clinic-specific assessment instrument. While the protocol is intended to be administered as a self-assessment, it is possible to use it in conjunction with an external organization. In addition, the protocol's format requires actively engaging a broad spectrum of health care staff and encourages the use of focus groups with patients. In all, the protocol can provide a health care organization an opportunity to assess what it does well in providing care to diverse populations, where its gaps lie, and how it could create an agenda for improving its services.

The Lewin Group (2002). *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile.* USA: The Health Resources and Services Administration, U.S. Department of Health and Human Services.

"How do we know cultural competence when we see it?"

This project aimed to contribute to the methodology and state-of-the-art of cultural competence assessment. The product – *An Organizational Cultural Competence Assessment Profile* serves as a future building block that advances the conceptualization and practical understanding of how to assess cultural competence at the organizational level.

The specific objectives of this project were to:

1. develop an analytic framework for assessing cultural competence in health care delivery organizations;
2. identify specific indicators that can be used in connection with this framework; and
3. assess the utility, feasibility and practical application of the framework and its indicators.

About the Organizational Cultural Competence Assessment Profile

- The Assessment Profile is an analytic or organizing framework and set of specific indicators to be used as a tool for examining, demonstrating, and documenting cultural competence in organizations involved in the *direct delivery* of health care and services.
- The Profile addresses whether an organization has or exhibits the particular features that should be evident or manifest in a culturally competent organization across the spectrum of critical areas or domains of organizational functioning.
- Use of the Profile is most appropriate for a health care delivery organization's *internal* assessment of cultural competence. At a general level, the Profile can help organizations frame and organize their perspectives and activities related to the assessment of cultural competence. More specifically, the Profile can be used in routine performance monitoring, regular quality review and improvement activities, assessment of voluntary compliance with cultural competence standards or guidelines, and periodic evaluative studies.

Knowing Cultural Competence when we see it: Components of the Profile

The Assessment Profile has three major components:

1. *domains* of cultural competence;
2. *focus areas* within domains; and
3. *indicators* relating to focus areas, by type of indicator.

A: Domains and Focus Areas: Where to Look for Evidence of Cultural Competence

The Profile's seven domains are described below.

1. *Organizational Values:* An organization's perspective and attitudes with respect to the worth and importance of cultural competence and its commitment to provide culturally competent care.
2. *Governance:* The goal-setting, policy-making, and other oversight vehicles an organization uses to help ensure the delivery of culturally competent care.
3. *Planning and Monitoring/Evaluation:* The mechanisms and processes used for: a) long and short-term policy, programmatic, and operational cultural competence planning that is informed by external and internal consumers; and b) the systems and activities needed to proactively track and assess an organization's level of cultural competence.
4. *Communication:* The exchange of information between the organization/providers and the clients/population, and internally among staff, in ways that promote cultural competence.
5. *Staff Development:* An organization's efforts to ensure staff and other service providers have the requisite attitudes, knowledge and skills for delivering culturally competent services.
6. *Organizational Infrastructure:* The organizational resources required to deliver or facilitate delivery of culturally competent services.
7. *Services/Interventions*: An organization's delivery or facilitation of clinical, public health, and health related services in a culturally competent manner.

B. Indicators by Type: Specific Evidence to be Used in Assessing Cultural Competence

Indicators in the Profile were classified into four types:

1. structure indicators,
2. process indicators,
3. output indicators, and
4. intermediate outcome indicators.

Structure indicators are used to assess an organization's capability to support cultural competence through adequate and appropriate settings, instrumentalities, and infrastructure, including staffing, facilities and equipment, financial resources, information systems, governance and administrative structures, and other features related to the organizational context in which services are provided.

Process indicators are used to assess the content and quality of activities, procedures, methods, and interventions in the practice of culturally competent care and in support of such care.
Output indicators are used to assess immediate results of culturally competent policies, procedures, and services that can lead to achieving positive outcomes.

Intermediate outcome indicators are used to assess the contribution of cultural competence to the achievement of *intermediate* objectives relating to the provision of care, the response to care, and the results of care.

A. Key Observations

Assessment is Not an Isolated Event

- The assessment of cultural competence should not be considered an isolated event, but rather a continuous process that is emphasized and integrated in an organization's overall assessment activities.
- Cultural competence assessment, like other significant management activities, should be clearly identifiable and targeted to garner the leadership and resources required, while being an integral part of an organization's regular performance and quality assessment activities.

Importance of Assessing Institutionalization

- It is important to assess the "institutionalization" of cultural competence in an organization, i.e., the extent to which cultural competence is an integral part of the organization's service, management and business functions.

Validation of the Components of the Profile

- The perspectives and activities of the health care sites visited for this project give credence to the Profile's seven evidence-based domains as appropriate performance areas for assessing cultural competence.
- The sites emphasized the importance of assessing the domain of Organizational Values as the necessary precursor to culturally competent performance. In particular, dedicated leadership for championing and implementing cultural competence and cultural competence-related data collection and analysis were noted as two critical indicators of an organization's commitment to cultural competence.

Wilson-Stronks, A., Lee, K.K., Cordero, C.L., Kopp, A.L., Galvez, E. (2008). *One Size Does Not Fit All: Meeting The Health Care Needs of Diverse Populations.* Oakbrook Terrace, IL: The Joint Commission

Hospitals, Language, and Culture: A Snapshot of the Nation (HLC) is a cross-sectional qualitative study, funded by The California Endowment, designed to explore how 60 hospitals across the country provide health care to culturally and linguistically diverse patient populations. Their latest report, One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations provides a framework for hospitals to develop and employ practices for meeting diverse patient needs.

There is no "one size fits all" solution, and the road map to cultural competence is unique for each organization. However, based on data gathered from the HLC study, this report recommends that organizations:

- Identify the needs of the patient population being served and assess how well these needs are being met through current systems
- Bring people across the organization together to explore cultural and language issues by sharing experiences, evaluating current practices, discussing barriers, and identifying gaps
- Make assessment, monitoring, and evaluation of cultural and language needs and services a continuous process
- Implement a range of practices spanning all four themes in a systemic manner aligned with patient needs and organizational resources

Framework Overview

The thematic framework presented in this report was derived from current practices that hospitals are employing to provide care and services to diverse patients.

1. Building a Foundation
   Policies and procedures that systemically support efforts to meet the needs of diverse patients can help elevate the priority of these issues within the organization, drive efforts, and draw staff support
2. Collecting and Using Data to Improve Services
   Data collection and use allows the effectiveness and utilization of cultural and language services to be monitored, measured, and evaluated, which can be useful for planning and designing services
3. Accommodating the Needs of Specific Populations
   Developing practices that address the challenges of certain populations contributes to providing safe, quality care and decreasing health disparities
4. Establishing Internal and External Collaborations
   Collaborations can provide hospitals with additional opportunities for developing cultural and language programs and services when resources are limited or help them engage the community to share information and resources

Wu, E. & Martinez, M. (2006). Taking cultural competency from theory to action. USA: California Pan-Ethnic Health Network. Retrieved 28 May, 2009 from www.cmwf.org

This paper provides principles and recommendations for implementing cultural competency in the field. The following six principles underpin organizational cultural competency efforts:

1. Community representation and feedback at all stages of implementation;
2. Cultural competency integrated into all systems of the health care organization, particularly quality improvement efforts;
3. Ensuring that changes made are manageable, measurable, and sustainable;
4. Making the business case for implementation of cultural competency polices;
5. Commitment from leadership; and
6. Staff training on an ongoing basis.

7.2 Cross-Cultural Training

Beach, M.C., Cooper, L.A., Robinson, K.A., Price, E.G., Gary, T.L., Jenckes, M.W., Gozu, A., Smarth, C., Palacio, A., Feuerstein, C.J., Bass, E.B. & Powe, N.R. (2004). *Strategies for Improving Minority Healthcare Quality. Evidence Report/Technology Assessment No. 90.* (Prepared by the Johns Hopkins University Evidence-based Practice Center, Baltimore, MD.) AHRQ Publication No. 04-E008-02. Rockville, MD: Agency for Healthcare Research and Quality.

- The purpose of this report is to systematically review the evidence to determine the effectiveness of interventions designed to improve the quality of healthcare and/or to reduce disparities for ethnic minorities. It focuses on evaluations of interventions aimed at healthcare providers or organizations, as recent work suggests these factors contribute substantially to the inequities.
- We examined broadly any type of strategy aimed at improving the quality of care in an ethnic minority population of patients, and then looked more specifically at strategies designed to improve the cultural competence of healthcare providers or organizations.

Methods

The study question was what strategies have been shown to improve the cultural competence of healthcare providers or organizations?

- Researchers performed electronic searches of MEDLINE, the Cochrane Collaboration's CENTRAL Register of Controlled Trials, EMBASE, and the following three specialty databases: the specialized register of Effective Practice and Organization of Care Cochrane Review Group (EPOC), the Research and Development Resource Base in Continuing Medical Education (RDRB/CME), and the Cumulative Index of Nursing and Allied Health Literature (CINAHL).

Results

- Sixty four articles addressed the specific question of strategies to improve cultural competence.

Findings

Effectiveness of cultural competence training

Overview of Reviewed Studies

- Of the 64 articles that qualified for our review, only two described randomized controlled trials, eight studies were concurrent controlled trials, and four had an external (nonconcurrent) control group. Most studies were designed without a comparison group; these had either a post intervention evaluation only (n=25), a pre- and a post intervention evaluation (n=20), or a qualitative evaluation (n=5). Most of the interventions targeted nurses (n=32) or physicians (n=19).
- The content of the curricular interventions varied. Using a previously developed framework to categorize cultural competence curricular content, 30 we found that most interventions focused on specific cultural content (n=45), general concepts of culture (n=43), language (n=15), and patient-provider interaction (n=13). Most interventions used more than one training method, and no two studies used exactly the same methods. The most common training methods were group discussion (n=29) and lectures (n=29). Most studies used more than one method for evaluation; the most common method was provider self assessment forms (used in 33 studies). Only four articles attempted to measure patient outcomes. Most included some measure of provider outcome; attitude (n=44), knowledge (n=30), or skills/behaviours (n=22).

Results of Reviewed Studies

- The study focused on the 34 studies with the strongest study design (studies that either had a comparison group and/or did a pre- and post intervention evaluation).
- *Knowledge.* Of the 19 studies that evaluated the effect of cultural competence training on the knowledge of healthcare providers, 17 demonstrated a positive effect, one study showed no effect, and one study demonstrated a partial/mixed effect. Eleven of these studies tested the provider's knowledge about general cultural concepts, seven evaluated culture-specific knowledge, and one did not provide details to allow determination of content. There was no obvious pattern regarding which type of knowledge was enhanced by cultural competence training. Overall, there is excellent evidence to suggest that cultural competence training increases the knowledge of healthcare providers.
- *Attitudes.* Of the 25 studies that evaluated the effect of cultural competence training on the attitudes of healthcare providers, 21 demonstrated a positive effect, one showed no effect, and three showed a partial/mixed effect. The

most common attitude outcome measured was cultural self-efficacy (measured in three studies), but other types of attitudes were greater understanding of the impact of socio-cultural issues on the patient-physician relationship, more positive attitudes toward community health issues, and an increased interest in learning about patient and family backgrounds. Overall, there is good evidence to suggest that cultural competence training favourably affects the attitudes of healthcare providers.

- *Skills.* Of the 14 studies that evaluated the effect of cultural competence training on the skills of healthcare providers, all demonstrated a positive effect. For example, in one study, participants were given 16 one-hour sessions in which they practiced communication skills with the community volunteers. They were subsequently shown to be significantly more competent in interviewing a non-English-speaking person as rated by a masked psychologist who viewed videotapes of interviews. Other types of skills/behaviours improvements were an increase in nurses' involvement in community-based cancer education programs, an increase in self-reported social interactions with peers of different races/ethnicities, and an improved ability of participants to conduct a behavioural analysis and treatment plan. Overall, there is good evidence to suggest that cultural competence training favourably affects the skills/behaviours of healthcare providers.
- *Patient outcomes.* Only three articles evaluated patient outcomes: one targeted physicians, one targeted mental health counsellors, and one targeted a mixed group of providers. All three reported favourable patient satisfaction measures, and one demonstrated improved adherence to follow-up among patients assigned to the intervention group providers.
- In terms of the methods used to bring about such improvements in patient satisfaction and (in one case) adherence, one study trained four mental health counsellors about the attitudes that low-income, African-American women bring to counselling (4 hours total), another trained nine physicians to speak Spanish (20 hours total), and a third implemented a state-mandated, 3-day training program focused on team training, recipient recovery principles, clinical issues, and cultural competence for all staff who have contact with recipients of inpatient mental healthcare. Overall, there is good evidence that cultural competence training improves patient satisfaction and poor evidence that it affects patient adherence or health outcomes.

Research on Cultural Competence

- Curricular objectives need to be measurable and linked to outcomes that can be measured objectively. There is a dire need for standardized, reliable, and valid instruments to measure aspects of cultural competence. Studies should also measure the effect of the curricular interventions on healthcare process and patient outcomes. For the results to be meaningful studies need to have a pre- and post-intervention evaluation and/or a comparison group; there is certainly a need for more randomized controlled trials in this area.
- Researchers should comprehensively describe the curricular interventions, such that they can be replicated in different settings. Studies also ought to include more comprehensive information about resources needed and the cost of cultural competence training. Knowledge on this topic is evolving rapidly, and updated evidence assessments will be needed in the near future.

Stewart, S. (2006a). Cultural competence in health care. Sydney, Australia: Diversity Health Institute.

Key features/elements of effective training

Much is still contested in the field of cultural competence learning and teaching. However, despite the absence of a solid evidence base in relation to what training approaches are most effective, there is emerging from the literature a picture of what might constitute 'good practice'.

- Trainers – the training must be delivered by trainers who demonstrate a level of cultural competence. In addition to a good knowledge of diversity issues, a number of other criteria have been proposed for selecting suitable trainers. These include demonstrating important personal attributes such as self-awareness and psychological adaptability, empathy and responsiveness, freedom from ethnocentricity and an ability to act as an agent of change. In addition, the literature frequently notes such important trainer characteristics as commitment to the principles of adult education, good process competence, familiarity with the routines and procedures of the health facility in which the participants work (vital for credibility) and strong facilitation skills to manage diverse opinions and sometimes emotionally volatile situations. Some commentators note that a mixed ethnicity and mixed gender training team has benefits, but also potential drawbacks.
- Content – A broad, inclusive understanding of 'culture' as complex, dynamic and fluid is necessary to underpin the content. Such an understanding encompasses the range of dimensions of human diversity and look beyond narrow definitions of 'culture' that relate only to birthplace, language and ethnicity. Connected to this idea is that cultural competence is not about knowing everything there is to know about this or that particular cultural / linguistic group. Indeed the pursuit of such an unrealistic goal invariably leads to stereotyping.

The three interrelated learning domains of awareness, knowledge and skills are frequently proposed as the basis for an appropriate framework for cultural competence training.

- Awareness – The starting point for effective cultural competence training must be self-examination, rather than a focus on 'the other', as this can only perpetuate an 'us and them' way of thinking which is precisely what is to be avoided. This includes encouraging participants to become aware of their own internalised beliefs and biases (including those deriving from their organisational and professional culture) and how these might impact on interactions with client/patients.
- Knowledge – In terms of equipping learners with the necessary knowledge base, trainers need to contextualise their training to clinical settings and the policy and legislative frameworks that are relevant to the learners.
- Skills – skills development in the areas of cross-cultural communication, including, but not limited to, knowing when and how to work with professional interpreters, conflict resolution, negotiation of explanatory models and critical thinking are typically cited in the literature as integral to effective cultural competence training.
- Format/Techniques – Consistent with adult education theory, good cultural competence training will involve a range of techniques to accommodate the diversity of adult learning styles, acknowledge prior learning experiences, and be tailored to meet the specific needs of the participants. The approach taken and the balance of activities addressing each of the learning domains (affective, cognitive, psychomotor) will obviously vary depending on a number of factors, including the time available. However, evidence suggests that

practical and experiential activities yield the best results when facilitated skilfully.

7.2.1 Clinical Care and Medical Education

Betancourt, J.R., Weissman, J.S., Kim, M.K. Park, E.R. & Maina, A.W. (2007). Resident physicians' preparedness to provide cross-cultural care: Implications for clinical care and medical education policy. USA: Health Workforce Information Centre.

- In a national study of resident physicians in their final year of training, few residents reported feeling unprepared in a general sense to care for patients from diverse cultural backgrounds. Yet far more felt unprepared to care for patients with specific cultural characteristics, including those who hold health beliefs and/or religious values that can affect the acceptance of western models of health care. This gap in perceived levels of preparedness indicates shortcomings in graduate medical education that need to be addressed.
- Recommended reforms include integration of cross-cultural training into curricula (both during and after medical school) in accordance with standard principles, the appropriate training of faculty (to ensure useful instruction, as well as mentors and role models), and the mandatory and formal evaluation of residents' cross-cultural communication skills.

Manderson, L. & Allotey, P. (2003). Cultural politics and clinical competence in Australian health services. *Anthroplogy & Medicine, 10* (1), 71-85

- Medical competence is demonstrated in multiple ways in clinical settings, and includes technical competence, both in terms of diagnosis and management, and cultural competence, as demonstrated in communication between providers and clients. In cross-cultural contexts, such communication is complicated by interpersonal communication and the social and cultural context. To illustrate this, Manderson & Allotey (2003) present four case studies that illustrate the themes from interviews with immigrant women and refugees from Middle Eastern and Sahel African backgrounds, conducted as part of a study of their reproductive health.
- In their analysis, they highlight the limitations of conventional models of communication. Manderson & Allotey (2003) illustrate the need for health providers to appreciate the possible barriers of education, ethnicity, religion and gender that can impede communication, and the need to be mindful of broader structural, institutional and inter-cultural factors that affect the quality of the clinical encounter.

Conclusions

- Health professionals tend to ask minority patients fewer questions and provide less information to them than to English-speaking patients. A further reason for the continued inability to address cross cultural communication is the operationalisation of the concept of cultural diversity. Strategies for cultural competence, defined as a demonstrated awareness and integration of health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy, have had limited success because of difficulties in the integration of the three areas.

- As Manderson & Allotey (2003) demonstrate in the case studies, ideas of professional competence are culturally informed. While clinicians and other

health providers may interpret competence in terms of scientific evidence, skills and outcome, patients see competence as linked to their own sense of positive well-being, with respect to process (the subjective feeling of being cared for) and outcome (such as not dying). This has implications in terms of training and the ability of providers to diagnose, treat, get results and explain satisfactorily to the patient what is happening. Conversely, the inability to demonstrate clinical competence in terms of diagnostic capacity and therapeutic outcomes is interpreted by women from Sahel Africa and Middle Eastern background as examples of medical mismanagement, often wilful.

- Communication in clinical encounters (as elsewhere) is not a matter of linguistic capacity (of the patient) or, in its absence, the appropriate use of interpreters. We suggest that communication, and hence patient participation in decision making, depends on the health provider also recognising the limitations to communication and appreciating how various factors operate to affect the quality of the clinical encounter. Acknowledging the importance of the diversity and the varying needs of different community groups and sections of the population is one method of enhancing communication in health-service provision to culturally diverse populations but Manderson & Allotey (2003) have argued, recipe approaches fail to take account of individual differences in background and in expectations of patient–provider relationships, clinical consultations and competence. One step towards addressing difficulties in clinical encounters, and, importantly, in the management and care of people who seek medical advice, is through appreciating that cultural, historic, economic and other factors contribute to misunderstandings of information and assessments of skill and competence.

Hruschka, D.J. & Hadley, C. (2008). A glossary of culture in epidemiology.
***J Epidemiol Community Health, 62*, 947-951**

- Focusing exclusively on ‘‘culture’’, and not examining alternative hypotheses, may mask the causal role of other social factors such as deprivation and institutional racism. When defining culture in terms of socially learned norms, values and behaviours, it is possible to investigate empirically its influence on health. A necessity in such studies is unpacking how culture in a particular setting might be responsible for the health outcomes of interest. This mirrors the need to identify the causal pathways underlying ‘‘neighbourhood effects’’ or any other aggregate-level context effects. A particularly successful strategy has been an iterative approach that includes in-depth ethnography to identify potential cultural pathways and large scale population studies that test alternative hypotheses for population differences (ie structural factors, beliefs, racism, education).
- Once we understand how beliefs, values, norms and behaviours affect health, it is important to understand how to reinforce or counteract their action. Cultural values and behaviours may be quite persistent, and there are numerous cases of cultural or behaviour interventions that either have no effect or have unintended negative consequences. Nonetheless, there are notable successes, including the decline in smoking among US adults, increased seatbelt use, correct use of rehydration salts and increased contraceptive use. Recent interventions indicate that capitalising on general cultural processes of transmission, as well as understandings of local cultural systems, can improve these success rates. Further, theoretical and methodological research on how beliefs, values, norms and practices change and persist in populations should help improve our understanding of why some interventions succeed while others fail.

7.2 .2 Primary Health

Padayachee, J. (2005). Cultural competence of health professionals: Is Asian health being considered? New Zealand: Medical Council of New Zealand

- The aim of this study was to determine whether the primary health services delivered by general practitioners are responsive, accessible, and culturally appropriate for the Asian population groups served. Interviews were conducted with twelve randomly selected general practitioners practicing in the Auckland region. The research question asked whether general practitioners are culturally competent in the delivery of health care to their Asian patients. The results of the study showed that:
  - Language was sited as the most significant barrier
  - Practitioners had a minimal understanding of the Asian beliefs that affect health care
  - All practitioners stated that they were open to complementary medicine
  - The practitioners understood that differences in gender roles existed among Asian groups
  - The influence of acculturation was recognised
  - There was an understanding that the family had an important role in Asian people's lives, but few attempts were made to involve the family in health care
  - There was limited understanding of the needs of and risk factors for Asian patients
  - Little was done to ensure treatment plans had a cultural perspective
  - Most general practitioners thought that training in Asian health was needed.

7.2.3 Mental Health

Bhui, K., Warfa, N., Endonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7,* 15.

Cultural competency is now a core requirement for mental health professionals working with culturally diverse patient groups. Cultural competency training may improve the quality of mental health care for ethnic groups. In this study a systematic review was conducted that included evaluated models of professional education or service delivery. The results show that of 109 potential papers, only 9 included an evaluation of the model to improve the cultural competency practice and service delivery. All 9 studies were located in North America. Cultural competency included modification of clinical practice and organizational performance. Few studies published their teaching and learning methods. Only three studies used quantitative outcomes. One of these showed a change in attitudes and skills of staff following training. The cultural consultation model showed evidence of significant satisfaction by clinicians using the service. No studies investigated service user experiences and outcomes. The conclusions drawn were that there is limited evidence on the effectiveness of cultural competency training and service delivery. Further work is required to evaluate improvement in service users' experiences and outcomes.

7.2.4 Measuring Individual Cultural Competence

Stewart, S. (2006a). Cultural competence in health care. Sydney, Australia: Diversity Health Institute.

Various tools/instruments to assess competence at the individual level

One approach to assessment has been the development of a number of tools or instruments for individual practitioners/clinicians to assess their own cultural competence. For this to be most effective, scrupulous honesty on the part of the individual is called for. The results of such self-assessments are intended to encourage self-reflection and to give the individual some 'baseline data' about their own cultural competence. Embedded in such tools is the notion that there are a number of personal characteristics or attributes that a culturally competent individual demonstrates and which, presumably those who are not yet competent can develop. Other possible ways of measuring individual cultural competence include clinical case file audits and the incorporation of cultural competence into staff orientation and performance management processes. However, in the absence of agreed practice standards, the value of such assessment tools is questionable.

In addition to individual checklists, there are a number of models (mainly developed in the USA) that provide useful practical frameworks for implementing and assessing cultural competence at both the individual and the organisational level. Most of these are based on a developmental continuum approach.

7.3 The Role of Staff from Ethnic Backgrounds

Bhui, K., Warfa, N., Endonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7,* 15.

Bhui et al's (2007) systematic review of evaluated models of the effectiveness of cultural competency training in health services shows that cultural competence must be embedded at the organisational level. The literature revealed several domains of organizational cultural competency including attention to organizational values, training and communication. Culturally competent organisations actively design and implement services that are developed according to the needs of their service users. This involves working with others in the community, for example traditional healers, religious and spiritual leaders, families, individuals and community groups.

Matthews, C., Klinken Whelan, A., Johnson, M. & Noble, C. (2008). A piece of the puzzle — the role of ethnic health staff in hospitals. *Australian Health Review 32* (2), 236-245

The role of ethnic health staff in hospitals has not been clearly articulated for managers and practitioners. This paper describes findings from a study based on ethnic and allied health staff interviews and observations of ethnic health staff interactions. Care was provided to language concordant patients directly and by assisting practitioners to work within the patient's cultural paradigms and family schema. The scope of practice involved: engaging patients in a therapeutic relationship, patient assessment, linking assessment with care options, facilitating communication between patients and practitioners, education, smoothing hospital experiences, referral and interpreting. Ethnic health staff displayed a range of specialised skills that managers need to harness within multidisciplinary teams to reach patients from diverse backgrounds

Manderson, L. & Allotey, P. (2003). Cultural politics and clinical competence in Australian health services. *Anthroplogy & Medicine, 10* (1), 71-85

Medical competence is demonstrated in multiple ways in clinical settings, and includes technical competence, both in terms of diagnosis and management, and cultural competence, as demonstrated in communication between providers and clients. In cross-cultural contexts, such communication is complicated by interpersonal communication and the social and cultural context. To illustrate this, we present four case studies that illustrate the themes from interviews with immigrant women and refugees from Middle Eastern and Sahel African backgrounds, conducted as part of a study of their reproductive health. In our analysis, we highlight the limitations of conventional models of communication. We illustrate the need for health providers to appreciate the possible barriers of education, ethnicity, religion and gender that can impede communication, and the need to be mindful of broader structural, institutional and inter-cultural factors that affect the quality of the clinical encounter.

8. Summary of Key Findings

Service Provider or Practitioner Group	Preferred Modalities	Comments
Mental Health Services	▪ Interactive ▪ CD Rom ▪ E-learning ▪ Individual and group cultural supervision and mentoring ▪ Cross-cultural interest group ▪ Link Cultural Competency Training to MECA (Career and salary Progression (CASP) process)	▪ Introduce a modular model to reduce repetition ▪ Train clinicians/trainers in intercultural training model ▪ Training on 'Working with Interpreters' highlighted ▪ Tailor training for service settings e.g. Eating Disorders, In-patient services ▪ It is increasingly difficult for mental health staff to be released for day long training. Alternatives need to be offered, for example, 2 hour onsite slots run over a month.
Community Child Health and Disability Services	▪ Interactive ▪ E-learning ▪ Individual and group cultural supervision and mentoring ▪ Link Cultural Competency Training to MECA (Career and salary Progression (CASP) process)	▪ Generic core competencies should include general cultural Information, for example, working with Asian families, working with Muslim families, working with refugee families ▪ Training on 'Working with Interpreters' highlighted ▪ Training tailored to specific practitioner roles and clinical settings needs to be provided, for example, rehabilitation services require specific training regarding the management of strokes when the client is an older Indian woman including
A+ Links	▪ Interactive ▪ E-learning ▪ Individual and group cultural supervision and mentoring	▪ Generic core competencies should include general cultural Information, for example, working with Asian families, working with Muslim families, working with refugee families ▪ Training on 'Working with Interpreters' highlighted

		▪ Training tailored to specific practitioner roles and clinical settings needs to be provided, for example, rehabilitation services require specific training regarding the management of strokes when the client is an older Indian woman including:
Nursing/ Women's and Children's Health	▪ Interactive ▪ Simulated learning (using actors) ▪ E-learning ▪	▪ E-learning first preference ▪ Day long programmes preferable to 2 hour blocks
Social Workers	▪ Interactive ▪ E-learning (including video sequences) ▪ Use of cultural expertise in social work teams ▪ Individual and group cultural supervision and mentoring	▪ Preference for interactive learning
Primary Health/ General Practitioners	▪ Interactive ▪ E-learning ▪ Mental health- individual and group cultural supervision	▪ Link to Cornerstone accreditation ▪ E-learning via MOODLE (free access to all ADHB on-line training and library resources

8.1 Mental Health Services

Key Issues

Multiple cross cultural training options and modalities are available to the secondary mental health workforce. There are a mix of providers including: ADHB Community Mental Health Services; the Te Pou CALD cross-cultural training programme provided by Refugees as Survivors and Waitemata DHB, Asian Health Support Service; the NDSA funded Mental Health Interpreter Training for interpreters and practitioners; the University of Auckland, Centre for Asian Health and Evaluation Research (CAHRE) Asian Mental Health CD (in development); and a non-funded cross-cultural interest group. Cross cultural mental health training options include:

1. A bi-annual one-day course: 'Migrants and Refugees - Transcultural Issues in Mental Health'
2. A bi-annual one-day course: Mental Health - Intercultural Workshop: Developing cross-cultural rapport
3. Regional Mental Health Interpreter and mental health practitioner training
4. A cross-cultural interest group for all mental health staff provided monthly in the evenings
5. A CD is being developed through the School of Population Health, Centre for Asian Health Research and Evaluation which is for mental health practitioners who are working with Asian clients.

Key Issues

- There is considerable repetition and overlap in the training offered to the ADHB secondary mental health workforce. Better outcomes would be

achieved from the training if there was a more systematic approach to training including the introduction of prerequisite modules. The model shown in Appendix 2 was proposed as a means of integrating the strands of cross-cultural training that are available to the ADHB mental health workforce. The model proposes core training as a pre-requisite to specialised case management training which would be tailored to specific clinical settings such as Eating Disorders, community mental health settings, maternal mental health and in-patient settings.

- As a pre-requisite the transcultural issues session provides a good base for further learning and could be reframed as an introductory module
- The Mental Health–Intercultural model has the advantage of providing training related to a wide range of specific cultural groupings and provides a good introduction to working with culturally diverse groups. The shortcomings are that:
    - The training is expensive (US $100 US per 5 participants). The training is purchased by culture (e.g. the purchaser is billed for each culture requested)
    - The model is designed for business competence and needs to be tailored to mental health and other health services competency requirements. The feedback from participants is that the most valued part of the training is the session in which the mental health clinician/trainer applies the model to case work.
    - It would be more cost effective to fund ADHB mental health clinicians/trainers (and potentially clinicians in other settings) to train as trainers in the use of the *Cultural Detective* model[4]

- The mix of cultural competency training available to the ADHB mental health workforce has increased cultural awareness among practitioners. However, clients from CALD backgrounds are still as a general rule are referred on to the cross-cultural 'expert' practitioners. Many practitioners still lack the skill and confidence to manage the cultural aspects of care themselves in spite of the increased awareness of the impact of culture on the treatment, management and recovery of the client.
- ADHB community mental health services provide a transcultural mental health team (TCMHT). The trans-cultural team provides clinical services to clients with significant cultural issues that impact on their ability to access mental health services and act as a consultation resource to clinical staff within the Community Mental Health Centre (CMHC) teams. The Trans-cultural clinical team positions are located in each of the four CMHC's (see Appendix 4). It is important as well that cross cultural skills are developed across the whole team and that the 'expert' cross-cultural roles within the TCMHT are used to greatest advantage as trainers, consultants and supervisors.

- To become culturally competent in practise it is important that the theoretical knowledge gained through training is integrated into specific practices and policies and applied to the clinical setting in which the practitioner works. This requires:
    - Ongoing supervision of cross-cultural practice (in primary and secondary settings)

[4] Inter-cultural training is based on the use of the *Cultural Detective* training model (see http://www.culturaldetective.com/)

        - Training tailored to specific clinical settings and specific to the skill set for the clinical issues being addressed, for example the management of eating disorders, acute care and maternal mental health
        - Supervision for the whole team is the most efficient way to disseminate and maximise the benefits of training
        - Ongoing cultural competency supervision is required in order to build and maintain the capacity of the mental health workforce to provide culturally competent interventions (Including for those from matched cultural backgrounds)
        - On-line learning and cross-cultural resources are valuable (although on-line learning alone not preferred by mental health practitioners)

- It is increasingly difficult for mental health staff to be released for day long training. Alternatives need to be offered, for example, 2 hour onsite slots run over a month. This issue was highlighted in particular for staff working in acute in-patient facilities
- Leadership from management and support for the provision of cross-cultural competency training and supervision is essential to the sustainability of culturally competent practice in clinical settings
- Cross-cultural training has been delivered to ADHB secondary mental health staff since 2003. The outcomes of having a TCMHT and of the training available is:
    - The earlier referral of cases requiring cultural support,
    - Requesting and taking advice from expert cultural practitioners,
    - Mental health interpreters and clinicians working better together,
    - The quality of mental health interpreting has improved,
    - Clinicians are more sensitive in terms of the cultural needs of clients

- The Mental Health Interpreter Training has been highly effective in improving the quality of interpreting provided and clinician utilisation of interpreting services. The training enables interpreters and mental health practitioners to work more effectively together and with the client. The training package provides skills training in cultural competencies for clinicians. The ADHB Asian Mental Health Coordinator made the observation that the Mental Health Interpreter Training had made the biggest difference in terms of clinical outcomes for mental health clients. The model of training would have utility applied to general health settings. The training has led to significant improvements in the collaborative working relationship between the clinician and the interpreter

- The cross-cultural interest group provided monthly free of charge by Dr Sai Wong to any mental health staff who wish to attend. The numbers attending the programme are high and are growing. Many interpreters attend the training sessions. The seminars are available live to those wishing to participate on-line. Broadcasted media presentations are available to mental health practitioners from around New Zealand. Topics have included:
    - The use of Chinese herbal medications
    - The toxicity of Chinese herbal medications
    - Indian mental health practices
    - Japanese mental health practices

- Cultural competencies need to be specific to the culture of the client.

8.2 Community Child Health and Disability Services (CCH&Ds) and A+ Links

Key Issues

- **Link Cultural Competency Training to MECA (Career and salary Progression (CASP) process)**
    1. It is important to link cultural competency training learning objectives to CASP requirements/HPCAA cultural competency requirements as identified by each professional group and service performance appraisal processes
    2. All staff develop goals with team leaders which may include cultural competencies, for example,
        - understanding the religious requirements of Muslim families and demonstrating in practice how this is respected (e.g. provision of halal food for in-patients)
        - demonstrating that resources have been accessed for increasing the practitioner's knowledge of the ethnic communities served
        - applying theoretical learning to practice as demonstrated through case review/critique processes
    3. For professional leaders the main criteria for evaluating practitioner learning is "has the knowledge/skill been applied successfully to practice"

- **Cultural Competency Training needs to be grounded in cultural safety, generic core competencies, and be tailored to specific settings, practitioner roles and practice and clinical populations**

1. Understanding cultural safety is the baseline for culturally competent practice Cultural competence is the next step which is about effective practice to achieve good health and disability outcomes for the client from the services being offered
2. Generic core competencies should include general cultural Information, for example, working with Asian families, working with Muslim families, working with refugee families,
3. Training tailored to specific practitioner roles and clinical settings needs to be provided, for example, rehabilitation services require specific training regarding the management of strokes when the client is an older Indian woman including:
    - Understanding South Asian perceptions of disability, rehabilitation, independence, and the role of older person
    - How to engage families when perceptions of health and illness; and care and support are opposed to western concepts, for example, the practitioner to be effective must engage with the whole family and not just the client referred
4. Practitioner's need the skills to explain New Zealand health and disability services to clients who are new to New Zealand, and from non-western backgrounds to ensure, for example,
    - Clients' understanding and acceptance of the role of allied health staff (Occupational therapists, dietetics, Physiotherapists)
    - The ability to match the approach taken, to the culture of the client and their family

        - That cross-cultural encounters between clients and practitioners are not misunderstood, for example, gaining parental permission to undress the child for examination; opening the curtains in home to let in daylight; explaining non-violent parenting skills
5. Practitioners need culturally appropriate assessment skills
6. Practitioners need cross-cultural cultural supervision to deliver effective sustainable culturally competent practice

- Clients of CCH&D and A+ Links who are from diverse backgrounds are commonly significantly high needs families
- Competent interpreters were highly valued by practitioners. Interpreters provided an important source of cultural information which was essential during assessment processes, for example, the interpreter is able to advise the practitioner about how some questions/issues/interventions could be perceived and to provide guidance on how questions could be phrased so that there would be more likelihood that the therapeutic intervention would be acceptable
- It is important that all staff in the health and disability team become culturally competent and that staff from culturally diverse backgrounds are not always expected to case manage clients from the same or similar ethnic groups to their own.
- Allied health staff from culturally diverse backgrounds can access "cultural supervision" -the purpose of the supervision is to guide newcomers through the challenges of working in the New Zealand health system
- It is important that practitioners have clear pathways for cultural advice (e.g.- access to Kai Atawhai for Maori clients is highly valued)
- Additionally, knowing where to go to access information about services for refugee, migrant and Asian groups would be valuable for staff (The Lifeline booklet of services which is not now available was well-used)
- CCH&D and A+ Links have a level of staff turn over and therefore cultural competency training needs to be sustainable and repeated
- The flexible learning approaches offered for bicultural training provide a good model for cultural competency training for CALD groups including:
    - The availability of on-line learning via MOODLE
    - Self-evaluation modules
    - Workshops, interactive training
- CCH&D staff need skills training focused on gaining best outcomes from the clinical encounter including:
    - The effective use of interpreters
    - Negotiating gender/power issues in families (i.e. when the mother is the main carer but treatment/interventions/communication is through the male head of the house
    - Working appropriately with Muslim families
    - Maintaining professional boundaries without causing offence (i.e. it is customary to offer food, gifts etc to guests in some cultural contexts; health workers need to maintain the role of the professional rather than the family friend)
    - Understanding the client's cultural conceptions/interpretations of health and illness including the expected roles of the sick person, the disabled person, the older person, and the family members of the above
    - Understanding the client's cultural norms, beliefs and customs; and as well, recognising individual variations and the impact of

acculturation on client responses to health and disability services
- How to communicate with families concepts such as “Disability support services”; “reaching the child’s potential”; and ‘rehabilitation’
- How to gain family agreement to professional support and the therapeutic interventions provided by physiotherapists, Occupational therapists, Speech therapists and other allied health practitioners when these therapies are unknown to families
- Assessing and intervening in the case of Family Violence and child protection issues

Proposed training components

The following learning components, competencies and modalities for the delivery of training were proposed:

(1-4 via e-learning)

1. Understanding the clients journey (the refugee/migrant experience)
2. Understanding cultural background (norms, beliefs, customs)
3. Understanding cultural concepts of sickness, health and disability (including cultural prohibitions and taboos e.g. around toileting) and impact on the acceptance (or not) of DHB services, care and interventions
4. The ability to explore individual perceptions and acculturation
5. Providing culturally appropriate care and empowering clients to use services and entitlements fully in New Zealand
6. Tailored programmes for service settings e.g. CCH&D provides a half day seminar on ‘Child protection Issues and working with refugee and migrant families’ (This course is always booked out)

Resources (Hard copy and on-line)

1. Refugee Health Handbook
2. Ready access for staff for an up-to-date list of the services available for refugees, Asian and ethnic groups, ethnic group organisations and Information about ethnic groups in New Zealand would be of value
3. Information about refugee support services in New Zealand

8.3 Nursing Development Unit

- Flexible approaches to learning need to be offered including face to face and on-line learning via MOODLE. The advantage of e-learning is that the learner can go back to the training resources easily. Mastery self–learning options give the learner feedback on the knowledge gained
- Cultural competency learning needs to be organised in progressive stages (the Tikanga best practice model which requires the learner to complete pre-requisite training modules before proceeding to the next stage is a good example)
- To test the learners knowledge of concepts and facts simulated training is used in which the learner is asked to apply theoretical concepts to situation/actors may be used for this exercise
- There is a need for cultural competency training to be applied to specific clinical settings
- The preferred learning modality for offering training to the nursing workforce is a modular e-learning programme via MOODLE.
- Where face to face training is offered day-long training sessions are preferred, however, rostering nursing staff to cover for those on training days is increasing problematic and in particular during the winter months
- For the primary health nursing workforce access to ADHB MOODLE is being offered to ADHB funded primary health services. This would include any on-line

training opportunities available to the ADHB community and secondary services [5]. MOODLE is free of charge to PHO users and can be customised to meet their needs

8.4 Women's Health and Children's Emergency Department

Cross–cultural issues in the management of clients from diverse cultural and religious backgrounds include:

- Requests by Somali and other Muslim clients for female practitioners which cannot always be met
- The management of Female Genital Mutilation (FGM) in Somali women
- The care of women from refugee backgrounds (Grief and loss, depression, PTSD and Rape Trauma issues)

8.5 ADHB Social Work Team

The Cultural competencies required by registered social workers are described in the
- Auckland Region Allied/Public Health/Technical MECA (see section 2.1.3)
- ANZASW Standards of Practice (see section 2.1.5)

Key Issues
- The ADHB social work service actively recruits a culturally diverse workforce to match and meet the needs of the populations served
- In the team informal processes of cultural supervision, cultural information sharing, peer supervision and mentoring are used to inform practice when the client is from a cultural background which is different to that of the social work practitioner
- To provide sustainable and meaningful cultural competency training and ongoing supervision for the ADHB SW team, building on the existing cultural skill and expertise base is preferred to a "one-size fits all" training package which may not be applicable to the clinical training requirements/practice of social work. This would require arrangements whereby the currently informal roles of the social workers providing cultural supervision are recognised formally
- In the above respect the ADHB Transcultural Mental Health model of cultural consults and supervision (Appendix 4) is of interest and may be applicable to the ADHB social work team and practice
- Linking cultural competency training to the competencies required of social workers in the Auckland Region Allied/Public Health/Technical MECA and the ANZASW Standards of Practice (see section 2.1.5) is essential
- The ANZASW Standards of Practice (Appendix 2) also outline culturally competent practice for social work supervisors (see section 2.1.5)
- A train–the –trainers model in which SW could become trained in the intercultural or other appropriate cross-cultural models of working effectively with culturally diverse clients and groups would be of value. There is interest in developing a role/roles in the team that could encompass cross-cultural training for the SW team
- Developing cross-cultural training resources appropriate to the needs of ADHB CALD populations and applied to social work practice would be a valuable asset
- Nursing staff in ADHB services have given feedback that social work practice in terms of cultural and religious sensitivity, awareness of cross-cultural gender issues, and conducting culturally appropriate family meetings has been valuable in enabling client/family engagement

[5] ADHB MOODLE is hosted externally. The "Sandpit" system means other services can join externally. Through the MOODLE club learners can access the ADHB Library.

- A resource has been developed by ADHB social workers titled *Effective Family Meetings* (this includes work with Maori, Pacific and Pakeha families but could be inclusive of culturally diverse families).
- Flexible learning options including e-learning options would be used by the social work team. However, the importance of interactive training programmes was emphasised.
- Social work practitioners highlighted the need for training in the following areas:
    - Working with Muslim families
    - Family violence interventions in families from culturally diverse backgrounds
    - Cultural constructions in client responses in regard to tissue and bone issues
    - Refugee groups and responding to multiple trauma (both as part of the refugee experience and once settled in New Zealand)

8.6 Primary Health Services

- Cornerstone is an accreditation package developed by the Royal College of General Practitioners specifically for General Practice (see Appendix 3). Cornerstone accreditation for Primary Health Organisations is recommended by the Ministry of Health. The accreditation process includes assessing the cultural competence of the organisation and of the general practitioner[6] . Currently, bicultural competency training is the only training available to ADHB PHOs.
- The primary health workforce needs to be able to access to ADHB L&D training website for information about the training available, to book training on line, receive updates on new training programmes, and to participate in the e-learning opportunities available. The availability on-line of a "culture folder" containing a list of all the cultural competency training available and on line resources and training modules would be of value including Tikanga best practice modules. Access through Health point is the preferred option for primary health practitioners.
- Face to face training needs to be delivered to all staff, in 2 hour blocks at out of hours times, that is, evenings and weekends. Continuing Medical Education/Continuing Nursing Education accreditation is an incentive to attend cultural competency training

8.6.1 General Practitioners

- The populations presenting to general practices in central Auckland represent considerable ethnic diversity
- A web-based learning tool which is available in the general practice is the preferred option for general practitioner cultural competency training delivery. The e-learning tool should include:

    - Cultural information on the populations served
    - Information about refugee specific issues
    - Information about managing diverse cultural issues, for example, gender and religious issues

[6] The Royal New Zealand College of General Practitioners (2007). *Cultural competence: Advice for GPs to create and maintain culturally competent general practices in New Zealand.* New Zealand: Royal New Zealand College of General Practitioners. Retrieved 20 June, 2009, from http://www.rnzcgp.org.nz/assets/Documents/qualityprac/culturalcompetence.pdf

- Healthpoint could potentially be used as a web based cultural competency learning site with links to web sites that contain cultural information. Editorial rights to the webpage would need to be available to a web manager in order to update the site. Primary Health Organisations funded by ADHB could link to the website. These options would be available to practice nurses as well.
- Other e-learning options include Pro-tube –these are 10-15 minute video clips which can be viewed in practice on a range of clinical topics and could be used additionally to provide cultural information.

9. Conclusions

9.1 Organisational Leadership

A commitment to operationalise cultural competence must be evident in the leadership of an organisation and embedded in key performance indicators (Andrulis, 2007; Beach, Saha & Cooper, 2006; Stewart, 2006a; Wu & Martinez, 2006). Without 'diversity champions' at the most senior levels, efforts at the individual level are unlikely to create or sustain substantial systemic change (Andrulis, 2007; Stewart, 2006a).

9.2 Combination of strategies at different levels

Organisational and Systemic Levels

The process of becoming culturally competent in healthcare requires multi-level strategies and involves both 'top-down' and 'bottom-up' change management strategies. At the organisational and systemic levels, this occurs in relation to the development of policy and guidelines, implementation frameworks and guidelines and workforce development plans. It may require re-examination of mission statements, protocols and procedures, data collection, administrative practices, staff recruitment and retention, staff orientation and professional development opportunities, interpreting and translating processes, research tools, community partnerships, health promotion activities, complaints mechanisms, client satisfaction surveys, capacity building and participatory action research involving consumer consultants (Betancourt et al 2003).

Valuing workforce diversity and fostering culturally inclusive workplaces are fundamental to organisational cultural competence strategies. Reciprocal learning between health service providers and culturally and linguistically diverse consumers is also integral to fostering a culturally competent health system (Stewart, 2006a)

Individual/Clinical Level

The process of individual cultural competence development may be facilitated by organisational education and training initiatives. However, in addition to cultural competency training other opportunities for individual and professional group learning include working with the cultural expertise available in the workforce and using cultural supervisors and mentors. Another option in relation to cultural competence training is integrating diversity issues into 'mainstream' courses for health workers, at the undergraduate (pre-service) level as well as in the context of continuing professional development.

Appendix 1

Statistics New Zealand Level 2: Asian Categories

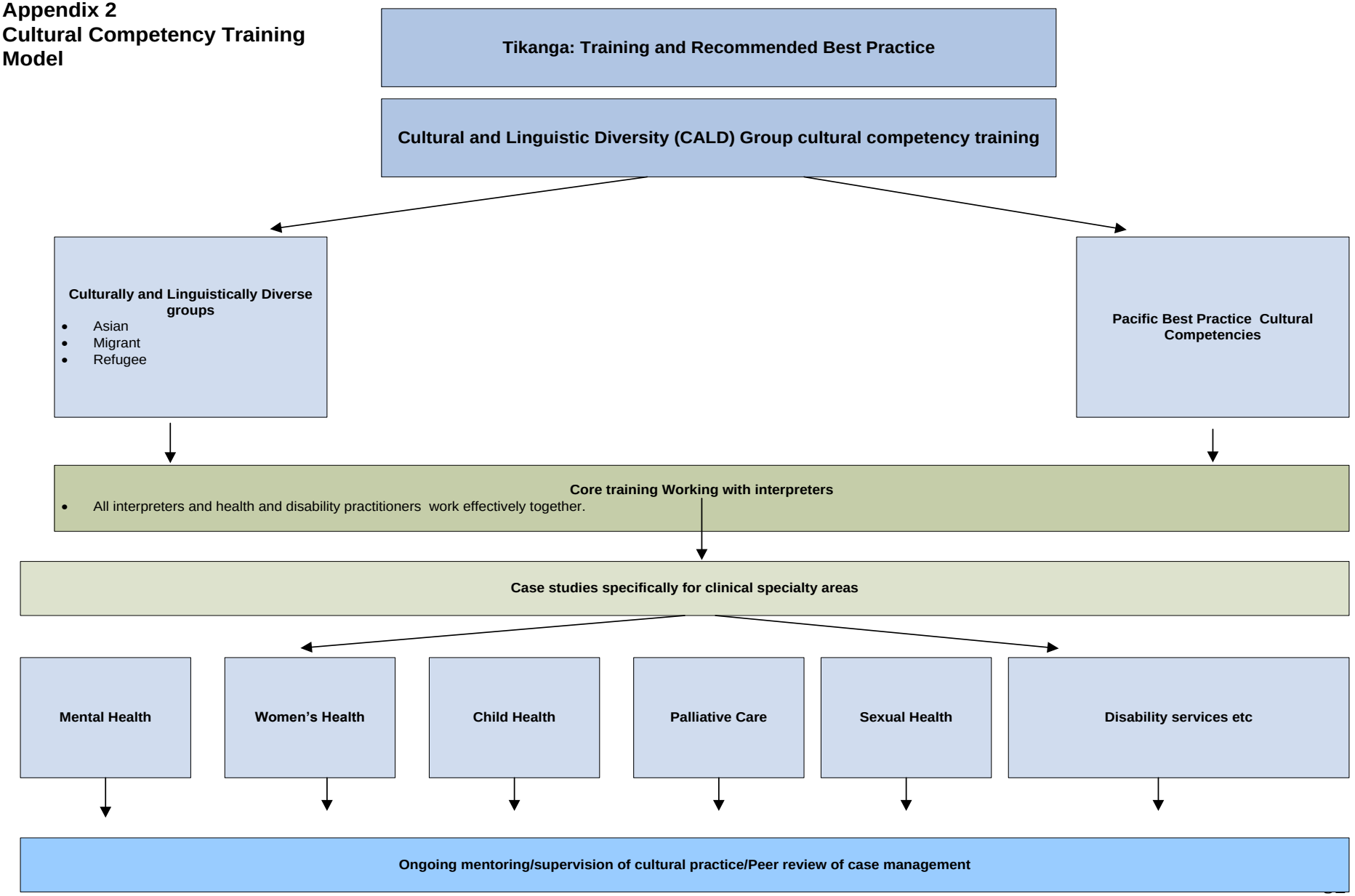
Table 1: Statistics New Zealand Level 2: Asian Categories

Chinese	Indian	Other Asian

Chinese NFD Hong Kong Chinese Cambodian Chinese Malaysian Chinese Singaporean Chinese Vietnamese Chinese Taiwanese Chinese NEC	Indian NFD Bengali Fijian Indian Gujarati Tamil Punjabi Sikh Anglo Indian Indian NEC	Asian NFD Southeast Asian NFD Filipino Cambodian Vietnamese Burmese Indonesian Laotian Malay Thai Southeast Asian NEC Japanese Korean Afghani Bangladeshi Nepalese Pakistani Tibetan Eurasian Asian NEC

Notes: NEC=not elsewhere classified; NFD=not further defined

Appendix 2
Cultural Competency Training Model



Appendix 3

The CORNERSTONE General Practice Accreditation Process

http://www.rnzcgp.org.nz/cornerstone/

CORNERSTONE is a combined quality improvement and quality assurance process which uses a set of measurements collated in the publication *Aiming for Excellence.* The CORNERSTONE General Practice Accreditation process requires general practices to review themselves against a set of indicators established by a multidisciplinary group and now regarded as the standard for New Zealand general practice. The indicators are grouped under five headings:

1. Factors affecting patients
2. Physical factors affecting the practice
3. Clinical practice systems
4. Practice and patient information management
5. Quality improvement and professional development

There are 49 indicators in this latest *Aiming for Excellence.* Each indicator describes a measurable element of practice performance for which there is evidence that it can be used to assess the quality, and change in the quality, of care provided.

Participation in the programme enables practices to validate the quality of the patient care they provide against a recognised standard.

Each indicator has been designed to consider patients first. Key considerations are:

- Is the practice safe, accessible, effective, efficient, responsive and sensitive to cultural groups?
- Is the practice team actively committed to improving the quality of service provided?

CORNERSTONE takes a whole practice approach to self assessment and gap analysis and the actions to identify and manage criteria that pose a risk to the practice and patients. CORNERSTONE assessors are peers who undertake a one day external assessment of the practice and systematically review the practice against the indicators, criteria and standards in *Aiming for Excellence*.

Health & Disability Auditing New Zealand (HDANZ) provide oversight of the CORNERSTONE General Practice Accreditation Programme and independent verification of the practice assessment reports. HDANZ is a Designated Audit Agency and accredited as an independent certifying body. They recommend practices to the College for final accreditation.

Appendix 4

ADHB Community Mental Health Centres: Transcultural Service

CMHC TRANS-CULTURAL SERVICE

SERVICE PRINCIPLES; MAY 04

- The ADHB/CMHC population includes people with refugee or migrant backgrounds from a wide range of countries and ethnicities. All clinical staff should possess the necessary skills to work effectively with clients who have cultural backgrounds other than their own. The trans-cultural team will provide clinical services to clients with significant cultural issues that impact on their ability to access mental health services and act as a consultation resource to clinical staff within the CMHC teams. Consultation will also be available to the ADHB Maternal Mental Health service.
- This service is for clients from a refugee or migrant background who have a mental illness AND significant trans-cultural issues that impact on their ability to access or participate in the clinical mental health service.
- Trans-cultural clinical team positions are located in each of the four CMHC's. These positions are employed by and accountable to the respective CMHC manager, within the context of the CMHC multi-disciplinary teams. In addition, a psychiatrist is located at St Lukes CMHC. The staff in designated trans-cultural positions will work together as a "virtual team", in order to share expertise with each other and across CMHC's.
- The trans-cultural team will not operate as an exclusive team and recognises that there are many clinical staff within the CMHC's who are willing and able to share their trans-cultural knowledge, either by consultation with other clinical staff or a one- off consultation with a client. This will be managed via the trans-cultural clinical team members in conjunction with CMHC managers on an "as needs and as able" basis.
- The trans-cultural team will develop collaborative relationships with relevant local health/social service providers and community support groups, e.g. RAS, RMS, On Tracc, in order to facilitate appropriate services for clients.

SERVICES PROVIDED BY THE TRANS-CULTURAL TEAM

- Clinical key worker service for a defined group of clients:
  - Those who have cultural issues related to mental illness / health
  - AND/OR those who experience barriers to accessing our service due to cultural understanding.
  - AND who agree to their key worker being the trans-cultural clinical team member.
  - The key worker caseload for each worker will be defined by the CMHC manager, taking into account whether the role is full time or part time, the demographic make up of the population and the amount of consultation time required of the trans-cultural team members.

- Consultation with other clinical staff. This may be:
  - via a fortnightly clinical consult group, for key workers from CMHC's or specialist services such as MMH. An outcome of this consultation may be a "one-off" clinical consultation with the trans-cultural psychiatrist and/or clinical team members.

  - 1:1 consultation with clinical staff from base CMHC, or within an MDT team review.
  - Phone consultation, e.g. with a MMH staff member.
- Psychiatric responsible clinician management for a defined group of complex clients. (Clients who have the trans-cultural Responsible Clinician will also have a trans-cultural Key worker). At the service commencement, this set of clients will be capped at a maximum of 30. Clients receiving this service will have their clinical records held on a CMHC wide HCC service titled Trans-cultural team. (All trans-cultural team clinical staff and all crisis nurses will have read/write access to this service.)

SERVICES NOT PROVIDED

- The service is not for clients who are Maori, Pacific or NZ born Pakeha.
- The trans-cultural team does not provide crisis services.
- Services are not provided to clients who live outside the ADHB geographic area.
- The trans-cultural team staff will not provide interpreter services. (Interpreters are accessed via the usual CMHC process.)
- Services are not provided to clients who do not meet the access criteria for a CMHC.

CRITERIA TO ACCESS THE TRANS-CULTURAL TEAM FOR CLINICAL SERVICES

- Client is resident in the ADHB area and aged 18 – 65 years.
- Client consents to participating in this service.
- Must be eligible for mental health service delivery from a CMHC and enters the service via the usual referral and assessment procedures.
- Has cultural issues related to mental illness/health and/or experiences barriers accessing a CMHC service due to cultural understanding, and/or for whom there are not adequate family or community supports.
- Factors which may indicate a client may benefit from clinical input from the trans-cultural team for a period of time include but are not limited to
  - The manner in which the client arrived in NZ (voluntary or involuntary)
  - History of trauma, in particular war, forced relocation from country of origin, torture.
  - Language barrier
  - Lack of cultural or family connection with others in Auckland

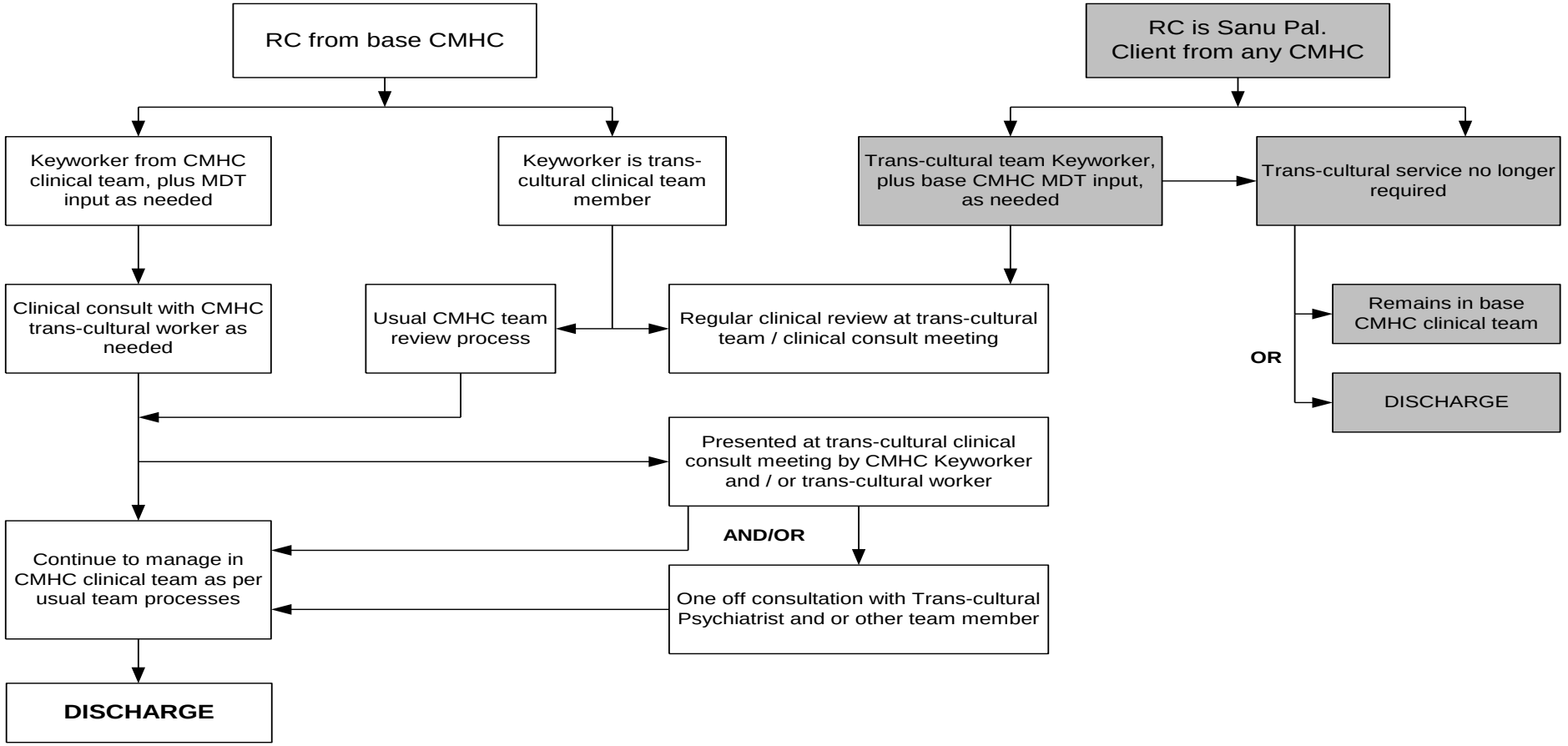
CRITERIA TO ACCESS THE TRANS-CULTURAL CONSULTATION SERVICE

- Current client of a CMHC or specialist community service, with a Keyworker & R.C
- Remains a client of the current CMHC clinical team, with consultation support from the trans-cultural service.

OTHER

- Crisis services will be provided by the CMHC in which the client is resident.
- All clinical records will be held on HCC.
- Consult group meetings will be held fortnightly at St Lukes CMHC. One–off consultations for specific clients, e.g. with the trans-cultural psychiatrist will be by appointment only and arranged via a trans-cultural clinical team member.
- Interpreters required for a trans-cultural team clinical consultation will be arranged and paid for by the referring CMHC.

CMHC TRANS-CULTURAL TEAM CLINICAL PROCESS



Appendix 5

Cultural Competency Resources

1. On-line Resources

CD Rom

- **NDSA (2007) *Cross-Cultural Resource for interpreters and health practitioners working together in mental health Part 1*. Auckland: NDSA**

- **NDSA (2007). *Cross-Cultural Resource for Interpreters and Health practitioners working together in mental health Part 2.* Auckland: NDSA**

This CD Rom is a cross-cultural training support resource developed specifically for Interpreters and health practitioners working together in mental health but is applicable to general health settings.

- The CD Rom contains scenarios, questions and answers, with information including:
- Introduction to the need for specialized training for Interpreters working in mental health, and for the need for MHP and Interpreters to work together
- Roles of the Interpreter; Expected competencies; Code of Ethics for Interpreters
- Some Common Errors made during interpreting
- Some mental health terminology
- Some Cross-Cultural Issues (Interpreters and practitioners) and how beliefs and practices about health affect presentations of illness
- Pre and post-briefing, structuring of session etc.
- Factors that affect the working relationship between Interpreter, practitioner and client
- Meta-skills involved in mental health interventions
- Role plays/exercises throughout. This could involve some demonstrations from trainers with questions for listeners, questions for listeners to find information on, reflections on own experiences etc.
- Information resource section, i.e. research, interesting articles, support services and contact nos., information on the proposal for a professional body for Interpreters, contacts for supervision facilities and professional development opportunities.

- **Waitemata DHB & Refugees as Survivors NZ Trust (2007).** *Cross–Cultural Resource: For health practitioners working with culturally and linguistically diverse (CALD) clients.* Auckland: Waitemata DHB & Refugees as Survivors NZ Trust
- **Cross-Cultural Interest Group for mental health workers**
  Live seminar via web site from work or home computers on www.presentationcentral.co.nz. For information contact Valu Fineanganofo Ph[09] 638-0414 or Email: ValuF@adhb.govt.nz

2. Websites

New Zealand

Auckland Regional Public Health Service Refugee Health Website
http://www.refugeehealth.govt.nz/

On the Auckland Regional Public Health Service, Refugee Health website you can access up-to- date information on refugees in New Zealand and internationally. The Refugee Health Service is part of the Auckland Regional Public Health Service (ARPHS). The service includes the greater Auckland region. Public Health plays a major role in supporting and strengthening healthy communities including refugees and new migrants.

The Refugee Health Service provides information, education, advocacy, communicable diseases control, health prevention and health promotion. The Refugee Health Service works in partnership with many health providers and communities to provide culturally appropriate and acceptable care.

Female Genital Mutilation (FGM) information
www.fgm.co.nz

Refugee Health Care: A Handbook for Health Professionals (Ministry of Health, 2001)
http://www.moh.govt.nz/moh.nsf/pagesmh/1292?Open
The Refugee Health Care Handbook has been developed for general practitioners and other health workers who care for refugee people. The book not only provides insights into the cultural and ethnic backgrounds of the main refugee groups in New Zealand but also provides guidance to health professionals on conducting culturally sensitive consultations and effective use of interpreters. In addition there is information and advice on physical and mental health issues common to refugee people, including conditions which may be unfamiliar to New Zealand practitioners.

Waitemata District Health Board: Asian Health Support Service
http://www.asianhealthservices.co.nz/

Asian Health Support Services (AHSS) is one of Waitemata District Health Board's (WDHB's) Clinical Support Services, established to support WDHB services to deliver culturally appropriate, accessible, consumer-orientated and effective services to Asian migrant and refugee communities. Asian is commonly referred to as people who come from Asia, including people coming from West Asia, e.g. Afghanistan, Nepal, South Asia, covering the Indian sub-continent, East Asia covering China, North and South Korea, Taiwan, Hong Kong, Japan, and South East Asia covering countries like Singapore, Malaysia, Philippines, Vietnam, Myanmar, Laos, and Kampuchea (Source: Statistics NZ 2003).

List of Asian Health Support Services offered include:

- Asian Cultural/Patient Support Service
- Asian Mental Health Cultural Support Coordination Service
- WATIS - Waitemata Auckland Translation & Interpreting Service
- Asian Cultural Perspective Workshops for Health Practitioners
- Asian Home Help Service
- iCare Health Information Line

Resources available include:

- Cross-Cultural Resources for practitioners working with culturally and linguistically diverse Clients
- Asian health publications www.asianhealthservices.co.nz
- Asian health population information www.asianhealthservices.co.nz

International

Canadian Cultural Profile Project
http://www.settlement.org/cp/

Citizenship and Immigration Canada provides Host Program funding to non profit organizations to recruit Canadian volunteer hosts and match them with new immigrants to Canada. The purpose of the match is to assist the newcomer to adapt quickly to life in Canada as well as provide the host with an appreciation of the challenges that the newcomer faces. Each cultural profile provides an overview of life and customs in the profiled country.

While the profile provides insight into some customs, it does not cover all facets of life, and the customs described may not apply in equal measure to all newomers from the profiled country. These cultural profiles were developed in association with the AMNI Centre at the Faculty of Social Work, University of Toronto.

Cultural Detective
http://www.culturaldetective.com/

Cultural Detective is a dynamic series of training tools that develop invaluable global business competence in individuals and organizations. The series results from collaboration among intercultural experts worldwide. Cultural Detective materials are designed, pre-packaged and ready for immediate individual or enterprise-wide use. Cultural Detective enables organizations and leaders to meet the high-performance demands of an increasingly global economy. The method can be adapted for health settings.

- Immediate Impact—Critical Incident/Business Case approach grounds learning for immediate application and results.
- Builds Competence—Approach encourages understanding similarities and differences as well as builds the skills and strategies for leveraging diversity and strengthening relationships.
- Highly Flexible—Values-based approach enhances cross-cultural effectiveness in any professional function (global team leader, procurement, sales, finance, ethics, etc.) or any industry (banking, telecom, education, healthcare, manufacturing, etc.).
- Theoretically Sound—Elegantly simple and practical design incorporates state-of-the-art intercultural thinking, avoids stereotyping and rote memorization of long lists of dos and don'ts.
- Versatile—Incorporate Cultural Detective into a team meeting, an existing management course, a coaching process, or use as the basis for longer-term learning.
- Engaging—Powerful metaphor, practical cases and multiple learning style approach engage participants in critical thinking and problem solving for accelerated learning.
- Systemic Competence—Develops shared vocabulary and mental models for transforming mindsets and using diversity as an organizational asset.
- Ongoing Benefits—Promotes real-time learning, ongoing candid dialogue, and continual process improvement. The many uses of the Cultural Detective Worksheet range from transforming conflict on teams, to planning strategy for new projects, to debriefing business trips or discussions.

Ethnomed
http://www.ethnomed.org/

The EthnoMed site contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle or the US, many of whom are refugees fleeing war-torn parts of the world.

Migrant Friendly Hospitals
http://www.mfh-eu.net/public/home.htm

The European project “Migrant-friendly hospitals” (MFH), sponsored by the European Commission, DG Health and Consumer Protection (SANCO) brought together hospitals from 12 member states of the European Union, a scientific institution as co-ordinator, experts, international organisations and networks. These partners agreed to put migrant-friendly, culturally competent health care and health promotion higher on the European health policy agenda and to support other hospitals by compiling practical knowledge and instruments. One

major strategy to test feasibility of becoming a migrant-friendly and culturally competent organisation was implementation and evaluation of three selected Subprojects in the diverse reality of European hospitals, with the local implementation financed out of hospital funds, but supported in a European benchmarking process.

National Center for Cultural Competence: Georgetown University Centre for Child and Human Development
http://www11.georgetown.edu/research/gucchd/nccc/index.html

The mission of the National Center for Cultural Competence is to increase the capacity of health care and mental health care programs to design, implement, and evaluate culturally and linguistically competent service delivery systems to address growing diversity, persistent disparities, and to promote health and mental health equity.

New South Wales (NSW) Multicultural Health Communication Service
http://www.mhcs.health.nsw.gov.au

NSW Multicultural Health Communication Service (Multicultural Communication) provides information and services to assist health professionals to communicate with non English speaking communities throughout New South Wales. There are over 450 publications on health in a wide range of languages and new publications are added regularly. Some multilingual resources produced by other services are also posted on this website and there are links to related websites. NSW MCHCS produces multilingual health resources, Guidelines, Protocols and Policies; undertakes research, communication and social marketing campaigns targeting people from cultural and linguistic, diverse backgrounds (CALD); provides advice to other agencies and workers undertaking research with CALD communities and; provides strategic advice to NSW Health, and handle enquiries from health staff about all aspects of multicultural communication.

New South Wales (NSW) Refugee Health Service
http://ww.refugeehealth.org.au

State Government of Victoria, Australia, Department of Human Services: Multicultural Strategy

http://www.dhs.vic.gov.au/multicultural/html/cultdivguide.htm

The information provided within this website describes how the Department of Human Services is responding to the needs of Victoria's multicultural community. This website is coordinated by the Diversity Unit. The Diversity Unit provides advice and leadership in the development of policy, programs and services that recognise and respond to the diversity of the Victorian community. Multicultural policy is one of three portfolio areas of the Diversity Unit, Social Policy Branch. Current areas of work include:

- DHS Multicultural policy
- DHS Language services policy, funding and procurement
- Refugee health and wellbeing action plan
- Secretariat support to the Ministerial Advisory Council on Culture and Linguistic Diversity (MACCALD)
- Whole-of-Government reporting

Victorian Government Health Information: Culturally and Linguistically Diverse Patient issues
http://www.health.vic.gov.au/cald/hlth-service

Review of current cultural and linguistic diversity and cultural competence reporting requirements, minimum standards and benchmarks for Victorian health services

The Department of Human Services through the Statewide Quality Branch is currently reviewing the guidelines for Human Services Cultural Diversity Plans. The key objectives of this project are to:

1. Map and analyse current cultural diversity and cultural competence reporting requirements for Victorian health services from departmental and health service perspectives.
2. Map and analyse current national and international literature on cultural diversity and cultural competence reporting requirements, minimum standards and benchmarks for health services.
3. Develop a practical strategic framework for the development of appropriate standards for cultural diversity and cultural competence interventions for Victorian health services and make recommendations as to a set of minimum standards.

3. Books

Bell, D. (ed.) (2005). *New to New Zealand: A guide to ethnic groups in New Zealand (4th edition).* New Zealand: Reed Publishing (NZ) Ltd

This book is invaluable for anyone in contact with groups of people not indigenous to New Zealand but who have chosen to live here. For each country there are explanations about geography, history, religion, language and cultural etiquette. There is also a guide to basic greetings in the original languages (both written and spoken).

Denholm, I. (2004). *Female genital mutilation in New Zealand: Understanding and Responding: A guide for health and child protection professionals.* Auckland: Refugee Health Education Programme

Jackson, K. (2006). *Fates, Spirits and Curses.* Auckland, New Zealand: Refugees as Survivors

Ministry of Education (2008). *Defining diversity: A facilitation manual to use with New to New Zealand publication.* Auckland: Ministry of Education: National Migrant and Refugee Education Team

Ministry of Health, (2001c). *Refugee health care: A handbook for health professionals*. Wellington: Ministry of Health. Retrieved 24 March, 2001 from www.moh.govt.nz

Potocky-Tripodi, M. (2002). *Best practices for social work with refugees and migrants* (pp 183-253). New York: Columbia University Press.

Wepa, D. (Ed.).(2005). *Cultural safety in Aotearoa*. Malaysia: Pearson Education New Zealand

Appendix 6
Study Participants

Name	Position	Service
Kirsty Walsh Julie Arthur	Manager Project Manager	Women's Health and CED Women's Heath Medical Dept
Linda Haultain Cell 021983710 X23534 Tanya Suin WonKon Bong Andrew Lamb Matalau Loli	Manager	Social Work Adult and Paediatric teams (APH)
Georgina Miller	Allied Health Team Leader	A+ Links Home Health Allied Health
Patrick Au	Asian Mental Health Co-ordinator	Community Mental Health Services
Corinna Friebel	Pyschotherapist Transcultural mental health trainer	Community Mental Health Services Cornwall House
Jim Kreichbaum	General Practitioner Liaison	ADHB Planning and Funding service
Rachel Morris	Manager, Corporate and Provider Support	Tamaki Healthcare
Di Roud	Nurse Advisor	Professional Development Nursing Development Unit
Paul Baillie	Social Work Team Leader CCH&D	CCH&D social work team
Madeleine Sands	Team leader, ADHB Child Development Team	Community Child Health and Disability Service
Jane Goessi	Performance Coach	Learning & Development

Appendix 7

Waitemata DHB and Refugees as Survivors NZ Trust (2007). *Cross–Cultural Resource: For mental health practitioners working with culturally and linguistically diverse (CALD) clients*

To All Mental Health Practitioners

CROSS-CULTURAL ***TRAINING PROGRAMME***

FOR HEALTH PRACTITIONERS WORKING WITH CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) CLIENTS

RAS (Refugees as Survivors) and **WDHB** (Waitemata District Health Board) in association Te Pou have partnered to bring you CALD training.

With the growing Asian, migrant and refugee population across New Zealand, Mental Health Practitioners are having more and more cross-cultural interactions with migrant and refugee mental clients from different culture and language backgrounds.

Mental health consultation process involving the use of interpreters and when working with culturally and linguistic diverse (CALD) clients who have different concept of illness or presenting behaviours can be challenging for practitioners.

Achieving cultural competency to work with CALD clients is essential for the communication and diagnosis processes to improve the client-provider interaction and relationship.

The CALD training is a practical course designed to improve awareness, knowledge and skills how to work with and understand Asian, migrant and refugee clients from different cultural backgrounds and how to work with interpreters effectively to improve the communication process.

11. References

Andrulis, D. & Delbanco, T., Avakian, L. & Shaw-Taylor, Y. (2007). Conducting a cultural competence self-assessment. USA: Department of Health and Human Resources. Retrieved 20 May, 2009, from http://erc.msh.org/provider/andrulis.pdf

Asian Public Health Project Team (2003). *Asian Public Health Project Report*. Auckland: Asian Public Health Project Team

Auckland District Health Board (2001). *Health Needs Assessment 2001, Refugee Peoples Health* pp 230-238: Auckland: Auckland District Health Board

Auckland District Health Board (2002). *The strategic plan for Auckland District Health Board 2002-2007, Consultation document* pp 40-44. Auckland: Auckland District Health Board

Auckland District Health Board (2006a). *The Health of Migrants and Refugees: Auckland District Health Board Health Improvement Plan 2006-2010* pp 24-26. Auckland: Auckland District Health Board

Auckland District Health Board (2006b). *The Health of Asian People: Auckland District Health Board Health Improvement Plan 2006-2010 pp* 26-27. Retrieved 20 March, 2003, from http://www.adhb.govt.nz/downloads/publications/strategic_plan/060701-ADHB-HIP-2010.pdf

Auckland District Health Board (2008). *District Annual Plan 2008 to 2009*. Auckland: ADHB. Retrieved 2 June, 2009, from http://www.adhb.govt.nz/Publications/ADHB%20District%20Annual%20Plan.pdf

Auckland District Health Board (2009). *Domicile Population and Statistics.* Auckland: ADHB. Retrieved 6 June, 2009, from http://www.adhb.govt.nz/About/population_stats.htm

Auckland Regional Public Health Service, Harbour PHO and Waitemata DHB's Asian Health Support Services (2007). *Asian Smokefree Communities Pilot: A culture specific and appropriate approach that combines both smokefree promotion and smoking cessation in a family-oriented setting.* Auckland: Waitemata DHB Asian Health Support Services

Australian Research Alliance for Children & Youth (2008). *Achieving Outcomes for Children and Families from Culturally and Linguistically Diverse Backgrounds*. Western Australia: Australian Research Alliance for Children & Youth. Retrieved 20 May, 2009, from www.aracy.org.au

Aye, A.Z.N. (2002). *Identification of mental health needs and service gaps for small refugee groups in Auckland* Unpublished Masters thesis. Auckland: University of Auckland

Beach, M.C., Cooper, L.A., Robinson, K.A., Price, E.G., Gary, T.L, Jenckes, M. W. Gozu, A., Smarth, C., Palacio, A., Feuerstein, C.J., Bass, E.B. & Powe, N.R. (2004). *Strategies for improving minority healthcare quality.* Summary, Evidence Report/Technology Assessment: Number 90. AHRQ Publication Number 04-E008-1. USA, Rockville, MD: Agency for Healthcare Research and Quality. Retrieved 20 May, 2009, from http://www.ahrq.gov/clinic/epcsums/minqusum.htm

Beach, M.C., Saha, S. & Cooper, L.A. (2006). The role and relationships of cultural competence and patient centredness in health care quality

Bell, D. (ed.) (2005). *New to New Zealand: A guide to ethnic groups in New Zealand (4th edition).* New Zealand: Reed Publishing (NZ) Ltd

Betancourt, J.R., Green, A.R., Carillo, J.E. & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and healthcare. *Health Affairs*, *24* (2), 499-505

Betancourt, J.R., Green, A.R., Carillo, J.E. & Park, E. R. (2005). Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, *24* (2), 499-505

Betancourt, J.R., Weissman, J.S., Kim, M.K. Park, E.R. & Maina, A.W. (2007). Resident physicians' preparedness to provide cross-cultural care: Implications for clinical care and medical education policy. USA: Health Workforce Information Centre. Retrieved 20 May, 2009, from http://www.commonwealthfund.org/usr_doc/1026_Betancourt_resident_MDs_preparednes_provide_cross-cultural_care.pdf

Bhui, K., Warfa, N., Endonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7,* 15. Retrieved 20 May, 2009, from http://www.biomedcentral.com/1472-6963/7/15

Brach, C. & Fraser, I. (2002). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research & Review, 57* (suppl.1), 181-217

Denholm, I. (2004). *Female genital mutilation in New Zealand: Understanding and Responding: A guide for health and child protection professionals.* Auckland: Refugee Health Education Programme

Denholm, N. & Birukila, B. (2001). *Tuelimishane HIV/AIDS train the trainers manual.* Auckland: Refugee Health Education Programme

Denholm, N. & Jama, I. (1998). *Female genital mutilation in New Zealand: Understanding and Responding: Manual two, a guide for health professionals.* Auckland: Refugee Education Programme

Department of Human Services (2006). *Health service cultural diversity plans.* Victoria, Australia: Victorian Government. Retrieved 20 May, 2009, from http://www.health.vic.gov.au/cald/hlth-service

Department of Human Services (2006). *Cultural diversity guide.* Victoria, Australia: Victorian Government. Retrieved 20 May, 2009, from http://www.dhs.vic.gov.au/multicultural/downloads/cultural_diveristy_guide_2006.pdf

Department of Labour (2006). *Auckland Regional Settlement Strategy. Phase one opportunities for improving settlement outcomes.* Jointly led by Manukau City Council and the Department of Labour. Retrieved 24 March, 2007 from www.immigration.govt.nz/settlement

Department of Labour and Auckland Sustainable Cities Programme (2007). *Auckland Regional Settlement Strategy, Goal Four: Physical and Mental Health.* Retrieved 24 March, 2007 from www.immigration.govt.nz/settlement

DHBNZ (2008) Health workforce information: base data report (Snapshot at 30 September 2008). Wellington: DHBNZ. Retrieved 20 May, 2009, from http://www.dhbnz.org.nz/Site/Future_Workforce/HWIP/DHB_Base_Data_Reports.aspx

Diversity Health Institute (2006). *Cultural competence in healthcare*. Diversity Health Institute Position Paper. Sydney: Australia: Sydney West Area Health Service, Diversity Health Institute. Retrieved 8 February, 2008 from http://www.dhi.gov.au/wd...ltural%20competence.pdf

Ethnic Communities' Council of Victoria. (2006). *Cultural Competence: Guidelines and protocols.* Victoria, Australia: Statewide Resources Centre. Retrieved 20 May, 2009, from http://eccv.org.au/doc/CulturalCompetenceGuidelinesandProtocols.pdf

Gala, G. (2008). *Health Needs Assessment for Asian People in Counties Manukau.* South Auckland: Counties Manukau District Health Board. Retrieved 8 February, 2009 from http://www.cmdhb.org.nz/

Grant, J. (2002). Learning Needs Assessment: Assessing the need. *British Medical Journal, 324* (7330). Retrieved 28 May, 2009 from http://www.bmj.com/cgi/content/full/324/7330/0/g

Gray, B. (2007). English language difficulties at general practices in Auckland, New Zealand: a major limitation to good practice. *New Zealand Medical Journal, 120* (1264). Retrieved 28 February, 2009 from http://www.nzma.org.nz/journal/120-1264/2777/

Gray, M. & McPherson, K. (2004). Cultural Safety and professional practice in occupational therapy: A New Zealand perspective. *Australian Occupational Therapy Journal, 52* (1), 34 – 42

Guerin, B., Abdi, A. & Guerin, P. (2003). Experiences with the medical and health systems for Somali refugees living in Hamilton. *New Zealand Journal of Psychology, 32,* (1), 27-32

Ho, E., Au, S. Bedford, C. & Cooper, J. (2003). *Mental Health Issues for Asians in New Zealand: A Literature Review.* Prepared for Mental Health Commission. Migration Research Group, Department of Geography, University of Waikato

Ho, E.S. Guerin, P.B. Cooper, J. & Guerin, B. (2005). *The Public Health Needs of Waikato Migrants and Refugees.* Hamilton: University of Waikato

Hruschka, D.J. & Hadley, C. (2008). A glossary of culture in epidemiology. *J Epidemiol Community Health, 62*, 947-951

Jackson, K. (2006). *Fates, Spirits and Curses.* Auckland, New Zealand: Refugees as Survivors.

Lawrence, J. (2007). *Placing the lived experience(s) of TB in a refugee community in Auckland, New Zealand.* Unpublished PhD thesis. University of Auckland: Auckland

Lawrence, J. & Kearns, R. (2005). Exploring the 'fit' between people and providers: refugee health needs and health care services in Mt Roskill, Auckland, New Zealand. *Health and Social Care in the Community, 13* (5), 451–461

Manderson, L. & Allotey, P. (2003). Cultural politics and clinical competence in Australian health services. *Anthroplogy & Medicine, 10* (1), 71-85

Matthews, C., Klinken Whelan, A., Johnson, M. & Noble, C. (2008). A piece of the puzzle — the role of ethnic health staff in hospitals. *Australian Health Review 32* (2), 236-245

Medical Council of New Zealand (2006). *Statement on cultural competence.* Wellington: Medical Council of New Zealand

Ministry of Health (2001). *Refugee health care: A handbook for health professionals*. Wellington: Ministry of Health. Retrieved 24 March, 2001, from www.moh.govt.nz

Ministry of Health (2006). *Asian Health Chart Book 2006*. Intelligence Monitoring Report No 4. Wellington: Ministry of Health. Retrieved 24 March, 2007, from www.moh.govt.nz

Mortensen, A.C. (2008). Refugees as 'Others': Social and cultural citizenship rights for refugees in New Zealand health services. UK: VDM Verlag Dr Muller

National Health and Medical Research Council (2005). Cultural competency in health: A guide for policy, partnerships and participation. Australian Government, National Health and Medical Research Council. Retrieved 20 May, 2009, from http://www.nhmrc.gov.au/publications/synopses/_files/hp19.pdf

Ngai, M. M. Y., Latimer, S. & Cheung, V. Y. M. (2001). *Final report on healthcare needs of Asian people and health professionals in the North and West Auckland.* Auckland: Asian Health Support Service, Waitemata District Health Board

North, N. & Lovell, S. (2002). *Survey of Primary Health Care Services in Auckland and Wellington on the Impact of immigrant Patients.* Faculty of Medical and Health Sciences, The University of Auckland. Presentation at New Directions: New Settlers Conference, Wellington, 12-13 April, 2003

Northern District Health Board Support Agency (2006). *Improving mental health services responsiveness to Asian communities: Auckland Regional Asian Mental Health and Addictions Implementation Plan 2006 to 2010*. Prepared Northern Region Asian Mental Health & Addiction Advisory Group. Auckland: NDSA

Nursing Council of New Zealand (2007). *Competencies for registered nurses.* New Zealand: NZNC. Retrieved 14 February, 2009 from http://www.nursingcouncil.org.nz/RN%20Comps%20final.pdf

Potocky-Tripodi, M. (2002). *Best practices for social work with refugees and migrants*. New York: Columbia University Press.

Rasanathan, K., Ameratunga, S. & Tse, S. (2006). Asian health in New Zealand—progress and challenges. *The New Zealand Medical Journal, 119* (1244). Retrieved 11 February, 2009 from http://www.nzma.org.nz/journal/119-1244/2277/

Scragg, R. & Maitra, A. (2005). *Asian Health in Aotearoa: An analysis of the 2002/03 New Zealand Health Survey.* School of Population Health, University of Auckland. Auckland: The Asian Network Inc (TANI)

Solomon, N. (1993). *Migrant and refugee health and health services in the Auckland region.* A background paper commissioned by the Northern Regional Health Authority. Auckland, New Zealand: Hygeia Health Services Consultancy.

Solomon, N. (1995). *Ethnic minorities in the Northern Region: A health profile and a health services purchasing strategy.* Auckland: Hygeia Health Services Consultancy.

Solomon, N. (1997). *The cost of health services for refugees and asylum-seekers: A comprehensive report.* A report commissioned by North Health, a division of the Transitional Health Authority. Auckland, New Zealand: Hygeia Health Services Consultancy.

Solomon, N. (1999). *Refugees and asylum seekers in New Zealand: Directions for Public Health.* A report commissioned by the Public Health Operating Group of the Northern Regional Health Authority. Auckland, New Zealand: Hygeia Health Services Consultancy.

Statistics New Zealand (2006). *QuickStats about New Zealand's Population and Dwellings:* Wellington: Statistics New Zealand. Retrieved 15 March, 2007 from www.stats.govt.nz

Stewart, S. (2006a). Cultural competence in health care. Sydney, Australia: Diversity Health Institute.

Stewart, S. (2006b). Ringing in the changes for a culturally competent workforce. Australia:

Multicultural Mental Health, Australia. *Synergy, 3*, 8-12

The Lewin Group (2002). Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile. USA: The Health Resources and Services Administration, U.S. Department of Health and Human Services. Retrieved 20 May, 2009, from http://www.culturallycompetentmentalhealthnj.org/docs/2006-12-training/CC-LewinReport.pdf

Wearn, A., Goodyear-Smith, F., Everts, H. & Huggard, P (2007). Frequency and effects of non-English consultations in New Zealand general practice. *New Zealand Medical Journal, 120* (1264). Retrieved 28 February, 2009 from http://www.nzma.org.nz/journal/120-1264/2777/

Wepa, D. (2005). Culture and ethnicity: What is the question. In D. Wepa (Ed.), *Cultural safety in Aotearoa* (pp 30-38). Malaysia: Pearson Education New Zealand

Wu, E. & Martinez, M. (2006). Taking cultural competency from theory to action. USA: California Pan-Ethnic Health Network. Retrieved 28 May, 2009 from www.cmwf.org