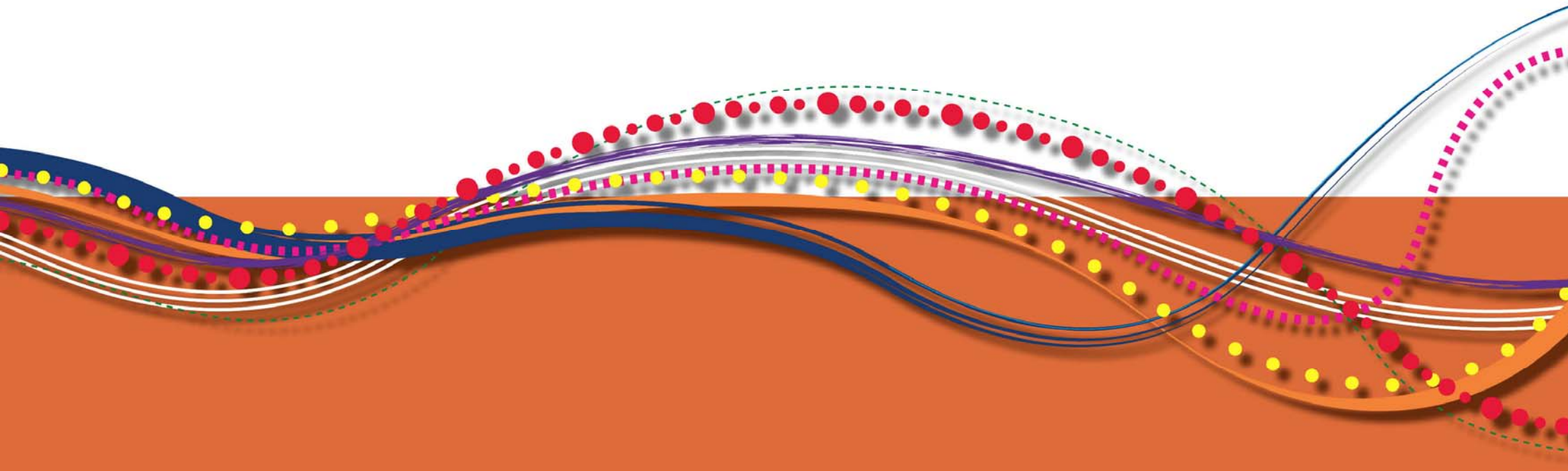
Queensland Health

Five Cross Cultural Capabilities

for clinical staff



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communication
self reflection
context
collaboration
cultural understanding

Five cross-cultural capabilities: for clinical staff

Self-reflection

You should be able to:

- consider what your own culture is and how you feel about different cultural beliefs and values
- demonstrate a sound understanding of 'culture'
- conduct a cultural self-assessment to identify your own culture, and position your cultural beliefs against that of the health system
- conduct an assessment of the organisational and professional cultures to which you belong
- identify and address personal and organisational biases.

Cultural understanding

You should be able to:

- gain a better understanding of 'culture', and potential cultural differences
- recognise power relations that are produced in the health system, and exhibit sensitivity to the impact of power differentials on culturally and diverse consumers
- conduct a cultural assessment to determine and accommodate different needs
- elicit different explanatory models and respond appropriately
- understand different consumer behaviours may be influenced by culture
- employ self-reflection to explore differences and similarities across cultures.

Context

You should be able to:

- consider a range of social factors that may impact on consumer behaviour
- understand the impact of migration and exile on individuals
- consider the interplay of other individual factors such as gender, sexuality, age and socioeconomic contexts on identity
- understand that individuals may not identify with their own culture, and many individuals within Australia consider themselves 'bi-cultural'
- appreciate that individuals may have more than one identity and identity is subject to change
- avoid cultural determinism and identify individual needs.

Communication

You should be able to:

- be sensitive and responsive to varying cultural norms in relation to verbal and non-verbal communication
- communicate effectively across cultures
- be sensitive to, and overcome, potential barriers to effective cross cultural communication
- deliver information in culturally appropriate and targeted ways
- avoid making assumptions or judgements about individuals based on their communication style.

Collaboration

You should be able to:

- gain trust and build relationships with individuals across cultures
- work towards consensus with individuals and families from diverse backgrounds
- understand the importance of, and able to involve culturally and linguistically diverse (CALD) clients in, decision-making processes
- conduct community consultation and engagement
- work across disciplines to provide appropriate care
- skilled at facilitating linkages including development of referral pathways
- skilled at establishing formal and informal collaborative networks
- value and facilitate the exchange of information across disciplinary boundaries.

Cross-cultural capability one: self-reflection: understanding 'self'

Self-reflection can simply be thought of as self-awareness and it requires that you identify both your strengths and areas for growth, particularly in relation to working across cultures. This is the first **step** in achieving cultural capability and should be practiced across each of the cultural capabilities outlined in the strategy.

Before you can begin to have insight into diverse communities, individuals and groups, you need to understand and know your own culture and identity, whether this is your personal ethnic, spiritual or cultural heritage or your professional or organisational affiliations. Evidence has shown that our attitudes, whether we are conscious of them or not, have a direct and significant impact on the people around us[1]. Critical self-reflection involves being aware of your own culture and value systems to avoid biases or making assumptions about cultures or groups that are seemingly different from your own. Through self-reflection, health care providers are able to acknowledge their own cultural beliefs and values, including their beliefs about health, which will allow them to make adjustments, where appropriate, to work competently and sensitively across cultures.

> "Only a self-aware physician can completely understand his/her reactions to or expectations of a patient, judge the extent to which personally held biases might influence the situation and attempt to manage that bias[2]," (p. 535)

Self-reflective practice avoids the common pitfall of ascribing 'difference' on to a cultural 'other'. **Ethnocentrism** is a term used to describe the imposition of your own cultural values and beliefs onto another individual culture. It occurs when a way of doing things, outside your own personal worldview, is deemed invalid and inferior, and your culture is seen as the standard or the norm. **Stereotyping** occurs when different cultural groups are reduced to a set of core characteristics and seen as a 'type' devoid of a range of unique personal characteristics. It is important to remember that stereotypes can be positive or negative and stereotypes are, in themselves, neither true nor false. Indeed some individuals do fit stereotypes. Steve Irwin, for example, in many characteristics conformed to stereotypes of Australian identity. Stereotypes, on the whole, overlook the complexity of individuals, and the individuality within groups.

Self-reflective practitioners are able to think about the 'strangeness' of their own cultural norms and practices before labelling a culture or way of doing things different from their own as strange or radically different. In doing so, they avoid **exoticism –** the tendency to view different cultures as inherently mysterious and incompatible with their own. Exoticism also often involves romanticising different cultures or seeing a different culture as inherently benign or simplistic.

In practice, the consequences of self-reflection would allow individuals to avoid making conclusions about difference and value judgements about behaviours or actions. Self-reflection allows staff to reflect on their own cultural background and preferences and to also illuminate shared practices across cultures. It also allows individuals to query their own assumptions and bridge divides or barriers between cultural groups.

- Self-reflection is a competency specification of the Australian Government's Cultural Competency in Health: A Guideline for Policy, Partnerships and Participation [3]. It is also the first competency employed by a number of health services, including New South Wales Health Department (South-East Illawara Area Health Services and Eastern Sydney Multicultural Unit). It is included in training modules delivered by the Victorian Centre for Ethnicity and Health and Judith Miralles and Consultants, and in many international cultural competency modules such as Health Canada and the United States. The Victorian Department of Human Services' Aboriginal and Torres Strait Islander Cultural Competence Framework also include self-reflection as a critical first step in developing cross-cultural skills.

Self-reflection has long been central to nursing practice but has also been established as a starting point for cross-cultural work more generally, across disciplines.

- Self-reflection is the starting point for cultural capability. It is an established foundation of many disciplines and considered best practice in the field of cross-cultural work.
- Self-reflection should be integrated into all cultural competency training.
- Self-reflection starts by providing tools for developing a sophisticated framework for thinking about intercultural communication and engagement. It may then be practiced situationally, or as the need arises.
- Self-reflection increases individual cultural awareness knowledge and skills.

Examples of self-reflective practice in other training materials and in a health context

How to reflect on your own culture:

Think about a time when you were with a group of people from another country, or even another part of Australia. What were the similarities and differences in culture?

What would you describe as your culture? How would you rank the following in order of importance: ethnicity, family, work, the future, diet and religion? Do you believe that your clients have the same priorities?

Consider the list of areas where cultural variations in beliefs and values frequently occur. Can you immediately determine your preferences? What about the preferences of a friend or current client? Would the choices you make in your role as a **XX** be different from those for yourself or someone you care about?

Do you believe it is appropriate to discuss health issues with a client's family and friends? Why? What about discussing health issues such as menstruation, pregnancy and sexually transmitted disease with members of the opposite sex?

What does your body language say about you? How might a client from another culture interpret your posture, eye contact and the tone of your voice? Could your body language be communicating something different from your words?

As an individual, how do you value personal independence, family, freedom, meaningful work, spirituality, etc? How does this have an impact on your relationships with clients? Continually reflecting on your reactions to your and your clients' cultures will assist you in providing culturally capable care[4].

Questions to develop self-reflective practice

What client behaviours or practices make me feel uncomfortable?

How do I respond when I am frustrated?

What are my biases and prejudices?

What keeps me from understanding or putting myself in others shoes?

Do I believe other beliefs are valid?

When I judge others, what am I feeling?

Do I reflect on my status and how this might affect communication and interaction with others?

How do I feel when others make judgements or statements about me on the basis of my race, culture, ethnicity, gender or sexuality?

Summary of why understanding self is a capability

The first step to recognising and having capacity to respond to the needs of others is to be aware of your own needs and biases and how you may perceive others as a result. Providing the best health care to all people means understanding biases and using self-reflection as a way to deepen your understanding of culture to avoid making assumptions or stereotypes about cultures other than your own. In addition, reflecting on one's own identity, status, position and belonging in the organisational culture will allow a standard of professional and ethical conduct that supports and values diversity in the workplace.

Knowledge	Skill	Behaviour
1. It may be challenging to identify and recognise your own culture, your values, norms, biases, and belief systems. 2. Know that your culture may have an impact on the way you work with consumers from backgrounds different from your own. 3. It is important to recognise the institutional power your role within the health system grants you. The power differential between health provider and consumer may often be exaggerated in relation to CALD consumers who are more likely to feel disempowered, reluctant to voice complaints about the health system and feel powerless to express dissatisfaction. Anglo-Celtic Australians, in general, value egalitarianism and may feel more empowered and entitled to speak as an equal to their doctor, ask direct questions, and assert their needs. 4. There are both similarities and differences across cultures.	Can identify own cultural background, maintain self-awareness and address biases. Can identify how your own cultural values and biases may impact on your work. Can map and compare your culture against Queensland Health organisational culture, practices and processes. Can explain Queensland Health systems and organisational processes and practices to consumers who may be unfamiliar with these. Can identify the authority or power within your role within the organisation in relation to the consumer and can reduce power differences. Can empower CALD consumers by providing them with information and resources and ensuring their rights and responsibilities are understood. Can elicit feedback and involve CALD clients in decision-making. Can identify universal norms or shared values across cultures. Can identify when differences result in feelings of discomfort or frustration and are able to get to the bottom of the problem.	Exhibits cultural sensitivity including sensitivity about the operation of power. Responds to instances where the impact of policy decisions on culturally and linguistically diverse consumers have not been considered. Addresses frustrations by seeking to better understand underlying reasons and/or solutions to alleviate frustrations or dispel misunderstanding. Is sensitive to power imbalances, is ethical with the power and trust held, and works to reduce power differences, wherever possible and appropriate. Avoids ‘us and them’ thinking and challenges it in the workplace.

Cross-cultural capability two: cultural understanding

Self-reflection is about identifying your own cultural values and belief systems, understanding that you do have a culture, and recognising your own culture may influence the way you work. Self-reflective practice helps you bridge differences by identifying commonalities and the power relationship, including the power to label a different cultural practice as 'strange' or incompatible with your own, or the dominant culture. This cultural capability is about building individual capacity to consider the impact of differences in views, health beliefs and values and how these might play out across Queensland Health both in terms of service delivery and in terms of workforce functioning.

It is impossible to know everything about the many different community groups and clients that you work with in the health care setting. All cultures have unspoken rules. A lack of understanding of these subtle and unspoken rules leads to offence and inadvertently breaking these conventions. Behaviours can be incorrectly interpreted as rudeness and lead to misunderstanding.

Attribution is the process whereby we make assumptions about the motivation behind people's behaviours based on what would make sense in our own culture. Attribution includes the assumptions we make about why a person is behaving the way they do, i.e. what motivates the visible behaviour that we are observing, based on what would make sense in our own culture. An attribution may be positive or negative; an attribution may be correct or incorrect[5].

It is impossible to know all the different rules that might exist across different cultural groups. However, it is possible to approach your work with the understanding that different and complex cultural conventions exist, and to seek out these conventions in order to both improve understanding, to adapt to whatever cultural codes you encounter, and to avoid incorrectly attributing negative characteristics onto a particular group or person.

The purpose of this strategy is not to outline specific details of each CALD consumer or community group that might be encountered. Cultural competency infers a set of capabilities: the knowledge, skills and behaviour required to work across cultures. As medical anthropologist Arthur Kleinman explains, the problem is that the term 'cultural competency' suggests that culture can be "reduced to a technical skill for which clinicians can develop expertise.[6]" (p.1673) However, it is not that simple given the complexity and varying contexts in which culture exists. In fact, it is important to have humility or modesty about how much can be meaningfully and immediately understood about cultures different than your own [7].

Having the capability to reflect critically on culture and appreciate that culture is complex will prevent damaging stereotypes that have occurred in the past, when individuals have had a false sense of cultural competency. American studies have found that ethno-specific cultural awareness has led to a widely-held stereotype that all Latin-American patients 'over-express' pain, which resulted in under-prescribing pain relief and a

reduction of pain management care for Latino patients. Other studies suggest that a reluctance to ask for help in managing pain have led to under-prescribing patterns of particular ethnic groups.

The lesson is that different communities may have different expectations of the health system and different norms of behaviour as a patient, with some groups typically and often for historic reasons behaving more stoically, while other groups openly and graphically detail their illness and discomfort.

"The theme that has emerged from much of the research is that racial and ethnic minorities are at risk for problematic access to pain care, poor pain assessment, and often receive inferior treatment for their pain complaints for all types of pain and across all kinds of treatment settings. As a result, the quality of pain treatment is becoming an important topic in the national debate about health and healthcare disparities.[8]" (p. 1)

A report, Are You Talking To Me? Negotiating the Challenges of Cultural Diversity in Children's Health Care found "evidence to suggest that hospital staff erroneously assumed that some 'ethnic' families were inclined to over-use or mis-use hospital facilities.[9]" (p. 11). In addition, the perception that CALD families used the paediatric hospital as a 'first port of call' in comparison to Anglo-Australian families was found to be both quantitative and qualitatively inaccurate. In fact, Chalmers and Rosso-Buckton (2008) found the opposite was true, indicating that there is potential underutilisation and inaccessibility of services for CALD consumers. It is feasible that such erroneous perceptions and attitudes about CALD consumers may well have had an impact on the services they received.

Therefore, it is important to understand that cultural differences do exist and, wherever possible, the aim should be to work within a cultural framework to respond appropriately and sensitively to CALD consumers within a mainstream system and with a Western biomedical model.

Below are some common cultural differences that may need to be considered in clinical interventions. Bear in mind that many individuals, regardless of their background, may identify with cultural values other than their own.

- Collectivism vs. individualism: Australian culture and society is predominantly individualistic and the individual is the most important 'unit' of society. In practice, this means that individual success, rights and freedoms prevail over collective or communitarian principles. Individualism is fundamental to many of Australia's key institutions. Other cultures are collectivist. This means that collective needs and goals are prioritised over individual needs and goals.
- Power distance can vary across cultures. Some cultures are seemingly more rigidly hierarchical while others, like Australia, are seen to be more egalitarian. Some cultures may afford greater respect to elders than others. The practice of providing care for elders in nursing homes may be diametrically opposed to the reverence and regard elders are afforded in some cultures.
- Gender relations may vary across cultures. In Australia, formal constitutional and legal rights for women have been advanced for more than a hundred years and these are just beginning to be formalised in some nations and communities. White, middle-class women in particular,

have had greater opportunities and access to rights across work and family life. Aboriginal and Torres Strait Islander women (and men) were only granted the right to vote in Queensland in 1965.

- Alternative health beliefs, customs and treatments exist in all cultures. Cultural epidemiology and medical anthropology help explain different cultural health beliefs and the cultural determinants of health. Understanding of different culturally-based models, explanations, beliefs and treatments leads to better services and outcomes since it allows the mainstream practitioner to build trust and gain insight into how to best communicate and prescribe treatments. It also ensures that customs and rituals (for example around mourning and palliative care, birth etc) and healing practices can, wherever practicable, be respected and observed.

The purpose of this cultural capability is to outline some broad cultural differences and how these might play out, and how they should be considered, in health service delivery. Culturally-sensitive approaches and responses are required to improve services to diverse consumers and it is everyone's responsibility to improve the accessibility and responsiveness of services that the Queensland Government delivers to a diverse group of people.

Summary of why cultural understanding is a capability

Lack of understanding of, and respect for, cultural differences result in inequalities in health care (e.g. underutilisation of services, underutilisation of preventative health care, poor adherence to treatment plan as a result of lack of translated information etc.). Understanding the existence of cultural differences is necessary for clinical staff to respond to these potential differences.

Knowledge	Skill	Behaviour
1. Different cultural norms, health beliefs, practices and behaviours exist.	Can identify potential different cultural norms and practices that exist.	Treats each person as an individual that has their own cultural beliefs, norms and values which may need to be understood to support best health outcomes and productive workplaces. Exhibits modesty about cultural knowledge of other groups and recognises the limits of personal and professional knowledge.
2. Gaining cultural understanding may require community consultation and gaining trust of diverse and emerging communities.	Is skilled at community consultation and developing links with community to develop a richer understanding and develop needs-based policies to determine and plan health services. Can access a range of information sources to develop a knowledge base about existing community groups and new and emerging communities. Can keep self and colleagues informed and accesses information for the staff and community.	Is consultative and works with the community to gain a richer understanding of culture and to involve communities in the development of services. Values diversity; maintains respect for difference and shows respect by adhering to specific cultural protocols and frameworks.
3. Structural barriers, biases, and challenges exist within the mainstream health system that impact on CALD consumer's access, experience and health outcomes.	Is skilled at performing cultural analyses to identify and respond to barriers and biases in the system.	Is sensitive to biases and barriers in the system that impact on CALD people. Does not treat culture or multicultural issues as supplementary but integrates into all aspects of work.
4. There are a number of culturally and spiritually-based and alternative health beliefs that CALD patients may use to explain and supplement their treatment and care. Understanding and working with these alternative and culturally specific health beliefs improves health outcomes for CALD clients.	Can develop clinical governance policies, frameworks and guidelines to support the elicitation of culturally-specific explanatory models and the embedding of cultural understanding in patient-centred care models. Individual care plans are able to accommodate or incorporate alternative or traditional models of care, whenever possible.	Embeds cultural understanding into all practices and is open to different health beliefs.

Knowledge	Skill	Behaviour
5. Cultural differences may also determine a range of needs (for example, diet and spirituality) that need to be planned for in the development of services.	Able to assess the potential impact of culturally blind policies and embed cultural awareness and specificity so that a range of cultural preferences may be offered or made available. Amends standards of care and policies that are culturally insensitive. Can integrate CALD needs into all aspects of policy, service and human resource development planning.	Demonstrates openness to different belief systems including alternative health beliefs.
6. Australian health care and system is based on a Western individualist model. Policies tend to be based on the Western nuclear model of family.	Can develop family-centred models of care and policies to accommodate collectivist cultures and extended family structures and responsibilities.	Recognises that Western individual models of family and health may not address the needs of culturally and linguistically diverse people.
7. Same-sex clinical services are often preferable for many women. Different cultural gender norms may also determine the need for same-sex services for some CALD women.	Able to determine gender cultural norms and provide gender-specific services.	Is sensitive to different gender norms and able to provide services and information according to varying genders.
8. Cultural norms about how to behave as a patient/consumer exist. Behaviours interpreted as rude, demanding or challenging may, in fact, signal that different cultural rules are operating.	Can look beyond own cultural norms about appropriate behaviour and identify if different cultural conventions are operating.	Avoids making assumptions and seeks to improve cross-cultural understanding by considering different possible motivations.
9. Your role within the health system grants you a level of institutional power that may be pronounced in relation to CALD consumers. 10. Anglo-Celtic Australians value egalitarianism and may feel more empowered and entitled to speak as an equal to their manager or superior, ask direct questions, and assert their needs and rights.	Can identify the authority or power of your role within the organisation in relation to others and can reduce power differences.	Does not abuse power and recognises that power is related to race and culture.

Knowledge	Skill	Behaviour
11. New recruits may feel disempowered or lack knowledge of the organisational culture and professional norms. These barriers may be pronounced for employees coming from a different country or different health system.	Can empower newly arrived overseas-trained colleagues through adequate orientation and resources, ensuring their rights and responsibilities are understood.	

Cross-cultural capability three: context

It is important to be able to put understandings of culture in context, and to understand the situation of an individual client or population group. Definitions of culture therefore need to consider the "complex combination of socio-historical factors and personal experiences that frame individual notions of 'cultural identity' and 'belonging'.[10]" (p. 16) Far too often, culture is poorly conceptualised and applied in health, resulting in dangerous immodesty and damaging stereotypes.

- Culture is not static or homogenous: it is dynamic and can change over time and place, just as individuals change over time and place – that is, according to context.
- Cultures are complex and dynamic and there can be a high degree of difference, and even discord, within a particular culture despite the existence of a set of dominant norms, values and beliefs. There is greater within group difference than between group difference.
- Culture does not always or solely determine or explain behaviour. Cultural determinism is the belief that culture alone determines or predicts behaviour. The kind of thinking that says "it's because of his culture that he behaves this way …" In considering the range of factors that influence behaviour, it is important to understand that culture is not always the most important. For example, the reason a CALD patient is not 'compliant' with a treatment plan may not be because of cultural differences; rather, it may be that socioeconomic constraints and other social, emotional and financial factors are at play.

To understand the situation of a client or population group the following contexts should be considered:

- A person or community group's context includes, but is not limited to the following: employment, housing, income, dependents, access to transport and childcare, health status (social determinants of health); and the context of country of origin and the migration process. The social context may be a more critical factor in accessing health services.
- There are a range of specific issues for refugees and humanitarian entrants that must be considered. In addition to complex and interrelated health issues, refugees (many now from sub-Saharan Africa, Middle-East and South-east Asia) have little experience with the Australian health care system.
- From the moment a person from a CALD background arrives and settles in Australia, he or she is already in a different context and will undergo transformation from his or her cultural identity. The local Australian community also undergoes shifts in its identity (e.g. from Anglo-Celtic dominant to multicultural). This process is often referred to transculturation which is the dynamic and reciprocal exchange between cultures that results in the formation of something new.
- Young people who are born to migrants often experience ambivalence and confusion about their cultural identity and sense of belonging. The desire to fit into the dominant Australian culture often overrides their sense of loyalty or belonging to their own cultural heritage. This can result in intergenerational conflict and stress.

Acculturation

- Acculturation is the term given to describe the process of adopting the cultural traits or social patterns of another group.
- Understanding where an individual consumer sits on this acculturation continuum can help predict their familiarity, and effective use of mainstream services.

Knowledge	Skill	Behaviour
1. Know that cultural considerations must be informed by context. 2. Individual factors such as gender, socioeconomic status, sexuality and social factors may be more important than considerations of cultural background. Individuals will therefore vary in terms of their cultural belonging and identity. There is greater within group difference than differences between groups. 3. Culture can change according to context. Historical factors can also contribute to new cultural norms and formations. 4. Migration is a major life change and likely stressor. Individuals vary in their capacity to gain cultural and linguistic capital. Country of origin, level of education, age, gender, existing community network and personal attributes all play a part. 5. Individuals may vary greatly in terms of their identification with their cultural background. Children of migrants, in particular, may experience stress and confusion relating to the pressure of 'fitting in' with Australian mainstream culture while maintaining their own cultural heritage. Being 'bi-cultural' brings with it a range of potential intergenerational and intercultural stresses particularly if young people distance themselves from their community or deny their cultural heritage. 6. Refugees and humanitarian entrants may have endured social dislocation, severe trauma, famine, war and/or injuries. Post-traumatic stress disorder and other issues may not emerge in initial screening processes but complex health problems may emerge or worsen.	Able to consider contextual factors alongside cultural considerations in undertaking assessments, developing care plans and providing services. Can elicit contextual information about the client/client group that may impact on health care and consider in health care planning and delivery. Can access relevant and most up-to-date information about the client group. Can assess, prioritise and respond to greatest individual need or most critical factor in delivering individualised patient-centred care. Able to take into consideration migration or asylum seeking status and processes in all assessments. Able to facilitate links with communities and access other services when needed. Skilled in establishing continuity of care plans with clients/ client groups (particularly refugees).	Avoids cultural determinism and stereotyping. Never assumes that a belief or particular practice common to a particular culture is adopted by all its members. Exhibits awareness of, and responsiveness to, social, emotional and cultural factors.

Cross-cultural capability four: communication

Communication capability in a cross-cultural setting refers to the capacity to overcome cultural and linguistic barriers to achieve shared understanding and convey information. It also requires the capacity to adapt communication styles, and take cues from people to achieve mutual understanding.

American studies have found that ethnic minorities receive less information about their health conditions and treatment from doctors than non-ethnic white Americans, as a result of a number of entrenched attitudes and factors including a lack of cross-cultural communication capability[11]. In addition, studies have also found that CALD patients have a preference for a service provider from the same cultural or linguistic background, feeling it will result in better understanding, communication and service [12].

Studies have also found that communication is a significant workplace issue. Communication is implicated in adverse events and documented in sentinel reporting literature as a major contributing factor [12-16]. Between-group conflict and poor integration across organisations compounds poor communication and is further implicated in adverse events, quality and safety[17]. Occupational health and safety may also be compromised by poor communication and exacerbated by cross-cultural communication barriers.

Communication, particularly among diverse groups, is a critical factor in developing collegial relations in the work team. "Research highlights a significant association between racial diversity and difficulties with communication and conflict resolution in teams.[18]" (p. 31)
Without adequate diversity management strategies and cross-cultural communication training in place, health organisations stand to miss out on the benefits of a diverse workforce. This is particularly relevant for Queensland Health which relies on a highly skilled, overseas-trained and recruited workforce. One of the greatest barriers to integration of overseas-trained professionals, despite having English as a first or second language, is the Australian vernacular. Sarcasm, irony, and subversiveness are well appreciated Australian communication and humour styles that do not always translate well across cultures.

Cultural competent communication in the cross-cultural context also entails 'linguistic competency' which is defined as "the capacity of an organisation and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences, including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organisational and provider capacity to respond effectively to the health literacy needs of populations served. The organisation must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

This may include, but is not limited to, the use of:

- bi-lingual/bicultural or multilingual/multicultural staff
- cross-cultural communication approaches
- sign language interpreter services
- multilingual telecommunication systems
- videoconferencing and telehealth technologies
- print materials in easy to read, low literacy, picture and symbol formats
- materials in alternative formats (e.g. audiotape, Braille, enlarged print)
- varied approaches to share information with individuals who experience cognitive disabilities
- materials developed and tested for specific cultural, ethnic and linguistic groups
- translation services including those of:
  - legally binding documents (e.g. consent forms, confidentiality and patient rights statements, release of information, applications)
  - signage
  - health education materials
  - public awareness materials and campaigns [19].

Knowledge	Skill	Behaviour
1. Know that different cultural norms and styles in verbal and non-verbal communication exist. (when to talk, eye contact, pacing and pausing, directness etc.)	Can take cues from the other (e.g. eye contact, formality) and adapts or reciprocates accordingly to achieve a positive communication experience.	Avoids assumptions and works to understand different cultural norms in communication. Does not attribute negative behaviours on to a person without considering further possible personal or cultural contexts. Treats all clients equally regardless of communication styles and English-language proficiency.
2. The need to be directly and fully informed about health condition is a Western cultural norm. In many cultures, it is not acceptable to directly inform patients about serious conditions or ask direct questions that might result in losing face, loss of hope, or shame. Family members may gradually deliver 'bad news', downplay the harsh realities, or choose to conceal some information.	Skilled at gauging the level and amount of direct information that a patient will tolerate and how this information will be conveyed by family members or carers. Skilled at working with families and carers to deliver information that is necessary such as informed consent and diagnoses and determining ways in which it can be sensitively delivered (See also cultural capability five: collaboration).	Does not impose own cultural norms of communication on to others (i.e. doesn't demand eye contact).
3. Translating medical discourse into culturally appropriate and palatable terms can often improve health outcomes.	Skilled at employing cultural understanding to adapt communication style to suit the audience and deliver messages in a culturally appropriate manner.	Exhibits sensitivity to different cultural taboos around health.
4. Communication issues are found to be amongst the most common contributing factor in adverse events, patient satisfaction and outcomes[20-22]. Language barriers are associated with adverse outcomes [23].	Manages risk relating to language barriers and understands that a professional interpreter allows quality of care and ethical standard of care.	
5. Interpreter services must be obtained for low-English proficiency speakers. Children and other family members should not be used as interpreters[24]. Other factors in relation to dialect, class and gender may undermine the effectiveness of the interpreter services.	Skilled at assessing when an interpreter is required by asking open-ended questions and asking clients to repeat, in their own words, the information that has just been given. Has training in working with interpreters and understands the interpreter's role. Is able to request an interpreter. Skilled at working with interpreters, building	Integrates interpreter services as an essential aspect of equitable quality care.

Knowledge	Skill	Behaviour
	in time for pre-interview/briefing and identifying any barriers in relation to dialect, class, gender or other factors that may impede the quality of the service or accuracy of information provided.	
6. Verbal skills do not always equate to high-level of English proficiency or having adequate literacy or numeracy to comprehend complex written documents or lengthy discussions. Translated information may be required.	Skilled at assessing literacy and resourcing translated materials.	Avoids making value judgements about non-English speaking people or speakers with low-English proficiency. Ensures the same standard of information and care is given to patients with low-English proficiency.
7. Cross-cultural communication may require more time; building in more time for communication with patients in initial consults is likely to improve outcomes, compliance and understanding, and avoid re-admission or additional consults [25].	Capacity in giving clear information and skilled at summarising and clarifying information.	Provides tailored care and takes the necessary time to ensure understanding.
8. Research shows that native English-speaking Australians tend to assume that speakers with 'foreign' or 'thick' accents are inferior, uneducated, stupid or even childlike. Culturally and linguistically diverse staffs face discrimination because of the perception that they are not able to meet professional standards in oral and verbal communication.	Skilled at communicating with speakers whose first language is different.	Values bi or multi-lingualism and does not prohibit conversation between people in languages other than English. Does not discriminate against persons whose first language is not English. Provides necessary support to colleagues whose first language is other than English.

Cross-cultural capability five: collaboration

The Joanna Briggs Institute's systematic review of cultural competency best practices identified collaboration as an index of individual and organisational cultural competency . Its systematic review found that organisations that promote collaboration and work collaboratively with each other will improve services for culturally diverse populations and contribute to a work environment that supports diversity. Collaboration between health care providers and other agencies was indicated to improve care to culturally diverse patient groups. An increase in collaboration between health care providers and culturally diverse groups and their communities could also improve services and workforce productivity and satisfaction[26].

- Collaborative practice can refer to the capacity to work across group barriers in the health system and draw on expertise across disciplines to improve patient outcomes.
- Culturally competent health care is in itself a collaborative and multidisciplinary model of patient-centred care that draws on the very best theoretical research and available models developed in the humanities and social sciences and applied to the 'hard' science discipline of medicine.
- Collaboration encompasses clinical skills when working with CALD consumers to arrive at a mutually-agreeable care plan that may entail incorporating culturally diverse health beliefs and healing practices, where necessary and possible.
- Collaboration also includes community engagement and partnership as an essential principle of cultural competency. In reviewing what experts see as a fundamental component of culturally competency, all indicated some form of community collaboration, whether this is expressed as partnerships with non-government organisations, community consultation as an essential element of sound policy development and service planning or development and support of community health workers and other cultural engagement models. Cultural capability is required to have the right knowledge, skills and behaviour to engage communities appropriately and effectively.
- Collaboration also infers productive and open exchange of information as well as compromise and respect for different perspectives.
- Collaborative individuals are skilled at building relationships, trust and developing networks. In diversity management literature, these are identified as 'soft skills' and are recognised as essential to the context of globalisation and to meeting the needs of CALD communities.

Greater participation by the patient in health care encounters has been found to improve patient satisfaction and improved adherence to treatment. As a result, there is a greater movement to view the patient as an expert in developing shared care. In fact, in one study, CALD patients' blood pressure lowered in health care encounters where the doctor spent more time giving appropriate information, clarifying issues, and negotiating a mutually-acceptable care plan.

- The quality of clinical communication is related to positive health outcomes.
- Reduction in blood pressure was significantly greater in patients who, during visits to the doctor, had been allowed to express their health concerns without interruptions.
- Concordance between physician and patient in identifying the nature and seriousness of the clinical problem is related to improving or resolving the problem.

- Explaining and understanding patient concerns, even when they cannot be resolved, results in a significant decrease in anxiety.
- Greater participation by the patient in the encounter improves satisfaction, compliance and the outcome of treatment (i.e. control of diabetes and hypertension).
- The level of psychological distress in patients with serious illness is less when they perceive they have received adequate information[27].

All of these clinical outcomes rely on effective cross-cultural communication strategies and being open to consensus-building, negotiation and collaboration in the doctor-patient relationship.

In addition, the establishment of collaborative networks have been found to be a powerful tool, particularly in bringing together a community of practitioners dedicated to improving Aboriginal and Torres Strait Islander health outcomes.

Knowledge	Skill	Behaviour
1. Collaborative care planning achieves better patient experience and outcomes.	Is able to allow patients to express their concerns without premature reassurance, interruption or closure. Is skilled at identifying and addressing patients concerns or views on the nature of the presenting problem and validating these perspectives.	Is open to exchanging information and to alternative possibilities.
2. CALD consumers may distrust mainstream services and the Western biomedical model. Studies have found that Vietnamese and Chinese patients in Australia often use alternative remedies but are wary of disclosing their practices with mainstream health providers for fear of ridicule or prohibition.	Is skilled at building trust and cross-cultural relationships. Is skilled at accommodating different cultural health beliefs and alternative therapies.	Is results-oriented and seeks solutions to problems. Seeks and shares information from, and between, a range of resources, starting with the consumer/patient.
3. Collaboration and effective consultation with community organisations and members is required to determine community concerns and develop appropriate goals and programs.	Is skilled at working with consumers, carers and/or family members to set goals and determine mutually-agreeable options and processes.	Consultative and open to exchange of information.
4. Bi-cultural workers, community liaison officers and other community health workers are important models of care that can provide links between service and community and improve health outcomes for CALD consumers.	Can work effectively with bi-cultural, liaison officers or community health workers.	
5. Particularly disadvantaged CALD patients may have a complex range of interdependent needs stemming from isolation, dislocation and lack of integration into existing social networks and services. All of these stressors may have an impact on their health and wellbeing.	Skilled at facilitating linkages across services and professionals including providing referral to other required services for CALD clients.	

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