Waitemata District Health Board

Best Care for Everyone

Best Practice Principles:
CALD Cultural Competency Standards and Framework

Date: November 2014

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Contents

1. OVERVIEW

1.1 Purpose

The purpose of this document is to:

1. Provide Information about CALD population demographics and characteristics, increasing workforce diversity, service barriers and why the need for cultural competence
2. Recommend Best Practice approaches to guide clinical leaders, management, funders, planners, health workforce working in DHB Provider Arm, the Primary Health and NGO sectors about:
   - what is required to achieve the Best Practice Principles for CALD Cultural Competency Standards
   - what is required to achieve cultural competencies for working with CALD service users and what cultural competency training and resources are available to support the workforce
   - what are the competencies and training required for the workforce working in a multicultural health environment

CALD in this document refers to migrant and refugee populations from Asian, Middle Eastern, Latin American, and African (MELAA) backgrounds.

1.2 Scope

This document would be useful for Waitemata District Health Board (WDHB) clinical leaders, managers, funders, planners, as well as the health and disability workforce working with culturally and linguistically diverse (CALD) migrant service users/consumers/patients/clients and their families /carers from Asian, Middle Eastern, and African backgrounds.

Out of Scope: Maori /Tikanga Training and Recommended Best Practice and Cultural Competencies Best Practice and Cultural Competencies are not discussed in this document.

2. Definitions

Term	Definition
Asian	Asian refers to people originating from Asia countries including countries in West Asia (Afghanistan and Nepal) South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong, Japan), and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Cambodia). This definition is commonly used within the health sector and is the basis of the Statistics New Zealand Asian ethnicity categories.
CALD	CALD refers to culturally and linguistically diverse
CALD populations	CALD populations in this document refer to culturally and linguistically diverse populations from Asian, Middle Eastern, Latin American and African backgrounds.
MELAA	MELAA in this document refers to Middle Eastern, Latin American and African groups
Migrants	Migrants (also known as immigrants) refer to people who were born overseas who settle in New Zealand.
Refugees	The term 'refugee' refers to people from a refugee background. Refugees arrive in New Zealand under one of three categories which are as:

	▪ Quota refugees ▪ Family reunification members ▪ Asylum seekers
Consumers Service Users Patients Clients	The terms “Consumers”, “Service Users” and “Clients” and “Patients” used in this document refer to the same group of people who are receiving services from the health and disability sectors (DHB provider services, primary health services and non-government organisations)
Carers Familiies Family memb ers	The terms “Family members”, “Families” and “Carers” used in this document refers to the group of people who provide unpaid or paid care, that is they are looking after • people who are receiving services from the health and disability services provided by DHB provider services, primary health and NGO sectors Or • people who are recovering at home after receiving services from the health and disability services provided by DHB provider services, primary health and NGO sectors

NB: Please refer to the glossary for other abbreviated terms.

3. Demographic Overview

The following are the demographic details and population characteristics of the CALD populations from Asian, Middle Eastern and African backgrounds.

3.1 Asian population profile and characteristics

The term 'Asian' is used in New Zealand to describe culturally diverse communities origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the west to Japan in the east.[4] This definition of 'Asian' excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia. The ethnicity protocols subdivide the level 1 group 'Asian' into five level 2 categories: 'Other Asian', 'Chinese', 'Indian', South East Asian' and 'Asian NFD'.

3.1.1 Migration Trends and Demographic Changes

Auckland's Asian ethnic population has seen significant growth since the 2006 census. In 2013, 23.1 % of people living in the Auckland region identified with one or more Asian ethnic groups compared with 18.9 % in 2006 (SNZ, 2014a). Between 2006 and 2013, in the Auckland Region the Asian population grew by 71,064 (31.2%) (SNZ, 2014a). The fastest growth for the Asian were in the 75 plus age bracket. However, the biggest growth in numbers for each was in the 25 to 44 year age bracket (Walker, 2014). Among the 517,182 Aucklanders born overseas, the most common birthplace reported in the 2013 Census was Asia (SNZ, 2014a). The Auckland region accounts for two-thirds of New Zealand's Asian and Pacific ethnic group populations, and half of its Middle Eastern, Latin American, and African ethnic groups (Gomez, King & Jackson, 2014).

Migration Trends

Permanent Migrants to New Zealand

In 2012/13, 38,961 people were approved a resident visa. The largest source countries of permanent migrants to New Zealand were China (15 %) and the United Kingdom and India (13 % cent). India was the largest source country of skilled migrants (19 %). The growth in skilled migrants from India is mainly due to an increase in Indian international students transitioning to residence (MBIE, 2014).

China is the largest source country of family-sponsored migrants

The Capped and Uncapped Family Streams enable New Zealand citizens and permanent residents to sponsor close family members for residence. In 2012/13, 11,291 people were approved for residence through the Uncapped Family Stream and 4,401 people were approved through the Capped Family Stream. These two streams comprised 40 % of all residence approvals. China was the largest source country of residence approvals in both the Uncapped (42 %) and Capped (17 %) Family Streams (MBIE, 2014).

International/Humanitarian Stream - Quota Refugees

The largest source countries of quota refugees in 2012/13 were Burma (28 %), Bhutan (18 %) and Iraq (17 %) (MBIE, 2014).

Source countries for International students

In 2012/13, China remained the largest source country of international students (27 %) followed by India (13 %) and South Korea (8 %). International students have become an important source of skilled migrants for New Zealand and other countries. Over the last decade, 22 % of international students gained permanent residence in New Zealand within five years of being issued their first

student visa. In 2012/13, 42 % of skilled principal migrants were former international students (MBIE, 2014).

Of the metro Auckland DHBs, Auckland DHB had the highest proportion of the Asian population (26%). Asian peoples were 17% of the WDHB population. CMDHB, Asian groups were 21% of the population.

For the Asian population the most represented level 2 ethnicities were Chinese and Indian, each accounted for over a third of Asian ethnicity responses. Thirteen percent of the Asian population spoke no English. The top three languages spoken by the Asian population other than English were Hindi, Mandarin and Cantonese. Twenty-one percent of the Asian population in the Auckland Region were born in New Zealand. The younger age brackets for Asian groups had a much higher proportion born in New Zealand.

The growing Asian population is reflected in increasing religious diversity in New Zealand (SNZ, 2014b; 2014c). The number of people affiliating with the Sikh religion more than doubled since 2006. In the 2013 Census, there were large increases in people affiliated with Hindu (40%) and Muslim (28%) faiths SNZ, 2014c).

3.1.2 Asian population characteristics

- Asian groups are not homogenous in nature
- They are very diverse in terms of cultural beliefs, customs, religious practices, education, acculturation level and social structures, although they do share certain collective cultural values and orientation
- Asian sub groups within Asian Chinese and Asian Indian communities are heterogeneous in nature.
- In New Zealand, Chinese migrants mainly come from China, Hong Kong, Taiwan, Malaysia, Singapore, and Vietnam. Indian migrants mainly come from India, South East Asian countries and Fiji.
- Asians in New Zealand may be local-born or first, 1.5, second, third, and fourth generation migrants.
- There is no typical Asian traditional family system.
- There are different customs and religious beliefs in Asian countries that influence death and funeral practices; end of life care issues and serious illness; and family violence
- Culture and religion play a significant role in how disability and mental health are perceived, how the issues are dealt with, and their health seeking patterns, thus it is important to explore cultural barriers and how these barriers influence help-seeking behaviors.
- Culture and religious practices influence how people view abuse, whether they seek help, how they communicate their experience and from whom they are likely to seek assistance.
- Asian countries have vastly different health systems to New Zealand. There are no Primary Health Organisations (PHOs) and Asian migrants have no concept of general practice (or PHO) enrolments. Asian migrants are not familiar with the health system in New Zeeland, the services available, the different roles of health providers.
- There are a large number of non-English speaking Asians in the ADHB, WDHB and CMDHB districts
- Chinese peoples in New Zealand speak a variety of languages and dialects eg. Mandarin, Cantonese, Hokkien, Foochow, Hakka, Teochew, Shanghainese, Taiwanese. Indian peoples speak a variety of languages/dialects. Korean peoples speak Korean and some Koreans from China speak Mandarin.
- Mandarin, Cantonese and Korean speaking patients are the top three interpreting service users in Waitemata DHB.

3.2 Middle Eastern, Latin American, African population profile and characteristics

Prior to 2005, individual ethnicities that were recognised as African, Middle Eastern or Latin American were classified under the 'Other' ethnicity group (at Level one). In 2005, in response to the growing number of people identifying as Middle Eastern, Latin American or African, SNZ created a new Level 1 ethnicity group known as 'MELAA'. This acronym refers to Middle Eastern, Latin American or African ethnicities.

3.2.1 Demographic Changes

The Middle Eastern, Latin American and African (MELAA) ethnicity grouping consists of extremely diverse cultural, linguistic and religious groups. In the 2013 census, 2 % of the Auckland region's population are recorded as MELAA, representing an increase of 34 % between 2006 and 2013 Censuses (Gomez, King & Jackson, 2014) This group is one of the fastest growing population groups and has unique health needs.

The fastest growth for the MELAA populations were in the 75 plus age bracket. However, the biggest growth in numbers for each was in the 25 to 44 year age bracket (Walker, 2014). The MELAA population grew by 6,006 (34.0%) (Walker, 2014). The Auckland region accounts for two-thirds of New Zealand's Asian and Pacific ethnic group populations, and half of its Middle Eastern, Latin American, and African ethnic groups (Gomez, King & Jackson, 2014).

Of the metro Auckland DHBs, Auckland DHB had the highest proportion of the MELAA population (2%). MELAA peoples were 2% of the WDHB population, in CMDHB MELAA makes up 1% of the population.

For the MELAA population about half was Middle Eastern and a quarter each for African and Latin American ethnic groups.

Eight percent of the MELAA population spoke no English. The top three languages spoken by the MELAA population other than English were Arabic, Spanish, and Persian.

The younger age brackets for MELAA groups had a much higher proportion born in New Zealand. Twenty-one percent of the MELAA population in the Auckland Region were born in New Zealand (Walker, 2014).

3.2.1.1 Middle Eastern People - demography and socioeconomic determinants

Middle Eastern people are the largest of the MELAA groups in Auckland. Since 1994, refugees from Iran and Iraq have formed the largest population of New Zealand's refugee intake and overall they make up the largest Middle Eastern population in Auckland. Fifty percent identify as Muslims and 30% as Christians. Middle Eastern people have (Perumal, 2011):

- a young population, with a large proportion of children
- the largest proportion of people who have lived longer in New Zealand compared with other MELAA groups
- the greatest proportion of people who are not conversant in English (11%); 50% spoke Arabic
- a greater proportion of people living in high deprivation areas and are more likely to live in crowded houses, compared with Europeans
- a higher unemployment rate, a higher percentage of people on a benefit and a lower mean income, despite having similar qualifications to Europeans.

3.2.1.2 African people - demography and socioeconomic determinants

African people are the second largest MELAA group in Auckland. Similar to Middle Eastern people, many came to New Zealand as refugees from the late 1980s (predominantly from the Horn of Africa). By the early 2000s, the majority came as migrants from South Africa and Zimbabwe. As these two ethnicities are

classified as 'European' in New Zealand, Ethiopians and Somalis are the largest identifiable African groups in Auckland. Most Africans identify as Christians (65%). African people:

- are a relatively young population compared with Europeans
- have the greatest proportion of people living in the most deprived areas within the MELAA group and the greatest disparity in deprivation distribution compared with Europeans
- may live in more crowded circumstances compared with all other ethnicities; they have the largest proportion of people with ≥ 6 residents per household and the lowest proportion of people living in houses with ≥4 bedrooms
- have the highest proportion of one parent households of all compared ethnicities
- have similar school qualifications to Europeans but a higher unemployment rate, lower mean annual income and a higher proportion of people on the unemployment benefit.

3.2.1.3 Latin American people - demography

Latin American people make up the smallest proportion of the MELAA group. Chilean refugees arrived in the 1970s but by the 2000s, voluntary migrants from Brazil made up the largest Latin American population, most coming as students and working holiday visitors. Latin Americans had the highest PHO enrolment growth compared with other MELAA ethnicities from 2006 to 2010.The majority are Christians (70%) and are mainly Catholic. Latin American people have:

- a more mobile and younger population (consisting mainly of 20-34 year olds) than Europeans
- the largest proportion of people with post school qualifications of all compared ethnicities but had a higher unemployment rate and a lower mean income than Europeans.

3.2.2 Perumal's (2011) health needs analysis of MELAA populations in the Auckland regions showed that health service providers (HSP) had:

- Key concerns around MELAA populations social issues such as isolation and poverty and the impact on health and mental health of Middle Eastern and African communities.
- Key cultural differences noted in these communities included the importance of faith and family engagement in health/mental health, the differences in gender roles and the varying perceptions of illness and disability.
- The main barriers to health care provision was language and communication difficulties, health illiteracy, cost of health care, the lack of cultural understanding by Health Service Providers and the lack of trust and fear of Western health care models.
- Enhancers to healthcare include having HSPs that understand their backgrounds, the appropriate use of interpreters, having targeted services, engaging with religious leaders and communities and providing well coordinated services.
- Prioritised improving access to mental health services by ensuring that secondary mental health services offered culturally appropriate and timely services
- Understood the stigma and shame attached to mental health issues and the need for mental health destigmatisation and community awareness programmes in communities and faith communities

4. Workforce Diversity

4.1 Asian and Migrant Workforce

Within the Health and Community Services sector, forty nine percent (49%) of Asians were employed as Professionals compared to thirty seven percent (37%) of the total population, reflecting the highly qualified and skilled nature of the Asian workforce in New Zealand. The Asian workforce is youthful. Half of the Asian working-age population were aged between 15-34 years compared to a third in this age group in the total population. The Asian workforce is highly qualified and is more likely to have tertiary qualifications especially in the younger age groups. There is a growing demand for doctors in New Zealand and migrant doctors from South Asia are of increasing importance in filling this gap. Similarly, the reliance on migrant nurses from Southeast Asia has also grown (Department of Labour, 2010)

With an ageing population there will be a growing demand for paid caregivers. The proportion of older people aged 65 years and over in New Zealand is projected to double over the next 30 years. As the incidence of disability increases with age, so does the need for care. This means that there will be a demand for migrant workforce to fill such paid caregiver position. The projections show that the number of paid caregivers needs to treble over the next three decades in order to meet the likely future demand for paid care (Department of Labour 2009).

As the proportion of New Zealand-born Asians increases, health employers need to be pro-active in recruiting and training more bi-lingual Asian workforce especially when providing services, assessment, screening, diagnosis that relies significantly on affective understanding and verbal communication such as psychiatrist and psychological services.

4.2 Increasing Cultural Diversity of Health & Disability Workforce

The health and disability workforce in the Auckland region is becoming increasing ethnically diverse reflecting trends in immigration and the changing demography of the Auckland region. The Asian health workforce is young, largely overseas born and many are from non-English speaking backgrounds. The Asian workforce is a critical part of the Auckland region's health workforce (Department of Labour, 2010). There are also challenges faced by the Asian workforce as described in Section 10.

As the Auckland region population ages, the demand for health services will grow and future providers of health services are likely to be different to the main groups of service users (Badkar, Callister & Didham, 2008). These trends highlight the need to prepare the workforce to be culturally competent to manage cross-cultural interactions between employers and employees, as well as between patients and health service providers to provide culturally appropriate and safe services.

Similar to other developed countries, New Zealand's population is ageing. The Asian workforce, with over half aged under 35 years, is an important source of young workers. In the future they will be as large as the Māori workforce, forming an important source of skilled labour and adding diversity to our workplaces. (Department of Labour, 2011).

5. Service barriers

Current experience and research conducted in New Zealand shows that Asian, and MELAA migrants and refugees are encountering difficulties in accessing New Zealand health services. In addition to the many wider systemic barriers, it has been found that language and cultural issues are the two most widely experienced barriers to service utilisation, adversely affecting equitable access to appropriate and quality care (Ho, Au, Bedford, & Cooper, 2002; Mehta, 2012; Ngai, Latimer, & Cheung, 2001; Walker, Wu, Soothi-O-Soth & Parr, 1998).

Asian and MELAA migrant populations are unfamiliar with New Zealand health and disability systems and many experience access barriers due to low English proficiency levels and a lack of knowledge of what services are available. Many migrants have difficulty understanding the roles and functions of different agencies and health professional roles within the NGO, primary, secondary care and social service sectors.

Asian and MELAA migrant populations are vulnerable. Research on service utilisation in New Zealand shows that Asian and MELAA populations are not accessing health services equitably with other populations and present late to services (Mehta, 2012; Perumal, 2011). The stigma associated with poor mental health is a significant factor in poor engagement with mental health services (Honey et al., 2014). There is a need for mental health and addiction services to assist Asian and MELAA service users and carers, (in particular non-English speaking service users) to navigate the network of services provided.

5.1 Language and Cultural Issues

There has been ample research into the language barriers which impact on initial access and communication between health providers and service users and the effect on health diagnosis and treatment. For non-English speakers, communicating without an interpreter impacts on the accuracy of assessments and on appropriate and timely care-planning; and subsequently on the quality of care received by the service user and their family..

Where practicable, the preferred approach is for health providers to provide a language-matched health professional for non-English speakingclients (Craig, 1999). Service users generally prefer speaking to a health professional who speaks their first language (Bowen, 2001; Holt, Crezee, & Rasalingam, 2001). However, given the great diversity of cultures, languages and dialects spoken by clients entering across Auckland region health services, more commonly language matched health professionals are not available.

Research suggests that the second best approach is to use skilled professional interpreters to address the communication barrier between clients and health providers (Bulwada, 2004). The use of qualified interpreters are mandated by DHB protocols and policies. Professional interpreters reduce the risk of misinterpretation, non-diagnosis or misdiagnosis of the client's illness. and may lead to treatment errors and/or non-compliance. Interpreters have been shown to reduce the number of Did Not Attends (Lim et al, 2012); to improve early intervention and compliance with medications and treatment plans. (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Hattar-Pollara & Meleis, 1995; Craig, 1999; Lin & Cheung, 1999; Kleinman, 2004; Tse, 2004).

In addition to language issues, culture can have a considerable impact on the service users' presentation of symptoms or problems, the way service users experience depression, service users' help seeking patterns, as well as client-practitioner communication and relationship, and professional practice (Craig, 1999; Kleinman, 2004).

6. Why the need for cultural competence?

A healthcare organisation that is 'culturally competent' is able to provide culturally responsive services and is able to benefit from diversity in the workforce. Cultural competence in organisations improves access and equity, as well as improving the quality of care 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 service users 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; and better health outcomes for service users 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. Therefore understanding the concepts of cultural competence is important. The following section explores the concepts.

6.1 Cultural Competence Concepts

One definition of culturally competent care which has wider application across the primary and secondary health workforce is the one used by the Medical Council of New Zealand. The Medical Council uses the following definition in their 2006 *Statement on 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 [health practitioner's] culture and belief systems influence his or her interactions with patients and accepts this may impact on the [health practitioner's-client] relationship
> - That a positive [client] outcome is achieved when a [health practitioner's and client] have mutual respect and understanding

The importance of this definition is that it recognises that health care workers need to be able to recognise and to respect differing cultural perspectives for the purpose of effective clinical functioning, and in order to improve health outcomes for the client groups served.

The Nursing Council of New Zealand, 2005 emphasises that "Cultural Safety" is a further aspect of Cultural Competence that applies directly the recipients of health services and to the providers of the services. It refers to the service delivery and provides consumers of services with an opportunity, and power, to comment on practice and influence the quality of service toward successful outcomes for service users. It requires that the providers of services are competent to work with service users and that they understand and recognise the limitations of some health practices when applied within some cultural contexts. It ensures the respect, enhancement and empowerment of the cultural identity and wellbeing of individual

service users, families and groups from diverse cultures. Unsafe clinical practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

Cultural Competence is also defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross–cultural situations (Cross et al., 1989; Isaacs & Benjamin, 1991). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Davis, 1997). Being culturally competent means having the capacity to function effectively in other cultural contexts.

In New Zealand, the Health Practitioner's Competence Assurance Act does not give a clear definition of the term. Professional registration bodies (Medical Council of New Zealand, Nursing Council of New Zealand and others) have each defined cultural competence in different ways.

There are five essential elements that contribute to a system's ability to become more culturally competent. The system should (1) value diversity, (2) have the capacity for cultural self–assessment, (3) be conscious of the "dynamics" inherent when cultures interact, (4) institutionalize cultural knowledge, and (5) develop adaptations to service delivery reflecting an understanding of diversity between and within cultures. Further, these five elements must be manifested in every level of the service delivery system. They should be reflected in attitudes, structures, policies, and services.

Cultural competence is a developmental process that occurs along a continuum. There are six possibilities, starting from one end and building toward the other: 1) cultural destructiveness, 2) cultural incapacity, 3) cultural blindness, 4) cultural pre–competence, 5) cultural competency, and 6) cultural proficiency. It has been suggested that, at best, most human service agencies providing services to children and families fall between cultural incapacity and cultural blindness on the continuum (Cross et al., 1989). It is very important for agencies to assess where they fall along the continuum. Such an assessment can be useful for further development.

Eisenbruch et al's (2001) model describes the four different organisational levels in which cultural competence should be evident, that is, at the system, organisation, profession and individual levels. Lewin et al's (2002) model describes the critical areas in which cultural competence should be evident (Domains), the particular areas that should be examined for evidence in cultural competence (Focus Areas) and the specific evidence that should be monitored and assessed (Indicators).

The domains include organisational values, governance, planning, monitoring, evaluation (quality), communication, workforce/staff development, organisational infrastructure and services/interventions.

7. Best Practice Principles: CALD Cultural Competency Standards

The following CALD cultural competency standards will assist the health and disability organisation to:

- meet requirements of Cultural Competence, Cultural Safety and Quality standards
- facilitate practitioner compliance with accreditation standards for cultural competency required by the Health Practitioners Competence Assurance Act (HPCAA), 2003
- meet relevant legislative requirements and government policies including the Health and Disability Act, 1994 and Code of Rights, 1999 and the HPCAA, 2003
- achieve CALD cultural responsiveness in service delivery
- achieve CALD cultural competency in workforce/staff development
- achieve CALD cultural competency in funding, planning, contracting and monitoring
- achieve CALD cultural competency in organisational commitment

7.1 Standard 1: Service Planning and Evaluation

The service's planning processes recognise the relevance of cultural and language barriers in service planning, implementation and evaluation.

7.1.1 Principle

Cultural and linguistic diversity must be acknowledged and reflected in all stages of service planning, implementation and evaluation.

7.1.2 Performance Measures

The service has:

7.1.2.1 a Strategic Plan, or equivalent, clearly stating its commitment to addressing the identified needs of people from CALD backgrounds

7.1.2.2 a policy for ensuring delivery of culturally appropriate services to all CALD groups in the service region

7.1.2.3 incorporated a statement about cultural diversity considerations in its recruitment policy / documentation / processes for all positions at the service.

7.2 Standard 2: Community Engagement and Consultation

The service or organisation collaborates with government and broader community stakeholders working with people from CALD backgrounds

7.2.1 Principle

To promote a coordinated approach to providing services, inter-sectoral links must be established with ethnic community organisations, non-government sectors and government agencies relevant to the Asian/MELAA communities they serve.

7.2.2 Performance Measures

The service has:

7.2.2.1 a representative on the WDHB Asian Health Governance Group with responsibility for implementing the CALD best practice standards across the service.

7.2.2.2 liaised, consulted and fostered links with relevant multicultural or ethno-specific agencies, organisations or community-relevant resources in the course of client or case management. Linkages and consultations may be with, but are not limited to:

- Asian health support service and/or other relevant services
- migrant resource centres
- places of worship
- ethnic community organisations
- CALD consumer and carer advisory groups

7.2.2.3 Representation of CALD communities on its internal committees across all levels of service development and delivery

7.2.2.4 Representation, where possible, on various CALD community associations in its service region

7.2.2.5 Disseminated information in English and in key CALD languages based on the profile of the CALD communities within its service region, via one or more modalities, including print, audio-visual or community information sessions and forums on:

- illness prevention
- suicide prevention
- recovery
- health service promotion
- health service information
- stigma reduction
- benefits and rights of service users and their carers to different cultural groups at community venues, including but not limited to:
    - community centres
    - places of worship
    - schools
    - ethnic community organisations
    - refugee services and services for survivors of torture and trauma
    - CALD Consumer Advisory Groups (CAGs)
    - children's, youth and women's centres
    - other meeting places deemed important for the specified communities

7.2.2.6 Ensured that its staff and/or clinicians delivering a health service program are aware and respectful of:

- existing alternative or complementary health and/or health service providers (e.g., traditional 'folk healers')
- key individuals in the specified community who may be consulted on religious and spiritual beliefs influencing assessment, treatment and management.

7.3 Standard 3: Evaluation, Research and Service Delivery Development

The service engages in evaluation, research and development of culturally appropriate service delivery for people from CALD backgrounds.

7.3.1 Principle

Strategies to enhance service delivery for people from culturally and linguistically diverse backgrounds must be evidence-based.

7.3.2. Performance Measures

The service has:

7.3.2.1 an organisational culture which promotes research and development relevant to cultural and language appropriate health service in consultation with relevant stakeholders, including CALD carers, consumers and their families

7.3.2.2 linked with external agencies that have had wide research experience with CALD communities

7.3.2.3 protocols for collecting patient or client demographic data that are useful and relevant to the demographic profile of CALD communities in the given catchment or service area

7.3.2.4 generated, through a mapping and needs exercise, or other appropriate information gathering or research, a profile of the CALD communities within its service region, which includes information, such as:

- population size of each community
- demographic and religious characteristics
- socio-economic status
- language requirements
- relevant community organisations
- how best to access the specified communities
- cultural sensitivities

7.3.2.5 conducted research or projects in collaboration, or independently, to measure the needs of the CALD population in its region. Examples of projects could be:

- looking at the referral patterns or pathways typically taken by CALD consumers who access health services in the service catchment area
- determining what kind of programs the CALD communities would like to attend that may be congruent with their explanatory model of psychosocial remediation
- looking at the proportion of people from CALD backgrounds accessing service.

7.4 Standard 4: Equitable Access

The service ensures equitable access for people from culturally and linguistically diverse backgrounds, and their carers and families.

7.4.1 Principle

The rights of people from CALD backgrounds**,** and their carers and families, as set out in the *Code of Family Rights* and *The Code of Health and Disability Services Consumers' Rights (1996) and* other legislated rights, must be ensured when delivering health services.

7.4.2 Performance Measures

The service:

7.4.2.1 has informed people from CALD backgrounds and their carers of their rights and responsibilities, using the client's preferred language and modality, where necessary, when accessing and using the service

7.4.2.2 has promoted awareness of its programs by disseminating information in English and in appropriate languages, via one or more modalities including print, audio-visual or community information sessions and forums, to different cultural groups in places including, but not limited to:

- local doctors
- hospitals
- community centres
- places of worship
- schools
- libraries
- other meeting places deemed important for the specified communities
- chemists
- family courts
- ethnic radio and TV
- the service website, if available

7.4.2.3 has developed policies and procedures to facilitate the accommodation of specific culture-based needs of its CALD consumers, their carers and families, such as:

- childcare needs
- family roles and obligations
- dietary needs
- religious needs

7.4.2.4 has processes in place to access accredited interpreters who have been trained in health interpreting to address communication barrier, when required

7.4.2.5 has employed appropriately qualified and culturally competent bi-lingual cultural support staff to work with clinicians to provide engagement and communication with service users and carers, elicit socio-cultural information, bridge cultural misunderstanding, , improve service users' and families' knowledge of the health system, services, roles, the Western concept of working in collaboration, independent decision-making, choices, recovery, empowerment and information about the illness etc

7.4.2.6 has formally qualified and culturally competent health clinicians who are competent to work with interpreters to provide culturally appropriate assessment, diagnoses or treatment if there is no language matching clinicians or cultural staff.

The following are specifically for services providing assessment, screening, diagnosis that relies significantly on affective understanding and verbal communication such as psychiatrist and psychological services:

7.4.2.7 has employed formally qualified and culturally competent bi-lingual clinicians (psychiatrists and psychologists) whose language matches with the client's first language, where possible, to conduct assessment, diagnoses or treatment (at least to meet the needs of the large non-English speaking Asian groups eg Mandarin, Cantonese and Korean)

7.4.2.8 or, has a formal process to access a pool of formally qualified and culturally competent bi-lingual clinicians to match to the client's first language, where possible,

- to provide direct clinical interventions: one off interviews to help clarify diagnosis
- to provide indirect consultations (consultation without seeing the service users): eg. for treatment planning

7.4.2.9 has a formal process to access a pool of formally qualified and culturally competent bi-lingual psychologists to provide direct therapeutic interventions

7.4.2.10 has employed appropriately qualified and culturally competent bi-lingual cultural support staff to work with clinicians to provide engagement and communication with service users and carers, elicit socio-cultural information, bridge cultural misunderstanding, psycho-education, general counselling, improve service users' and families' knowledge of the health system, services, roles, the Western concept of working in collaboration, independent decision-making, choices, recovery, empowerment, etc

7.5 Standard 5: Workforce/Staff Development

The service makes available and encourages:

- staff to undertake accredited CALD cultural competency training to achieve the level of CALD cultural competencies required to work confidently with CALD service users and carers
- staff to achieve the level of competency required to work effectively with non-English speaking CALD service users and carers when working with interpreters
- staff to use culturally appropriate assessment and planning tools
- staff to access language matching bi-lingual clinical cultural clinicians or cultural staff, when language barriers make it difficult to engage and elicit information and likely to hinder the assessment, diagnosis, or treatment process
- staff to access skilled interpreters when language is a barrier and there are no language matching bi-lingual clinical cultural clinicians or cultural staff
- staff to access translated information / resources for service useres and carers
- staff to access ongoing supervision for cultural practice and peer review of case management
- staff to access literacy and numeracy courses if these impact on staff to staff or staff to patient interactions
- staff to access training to improve culturally diverse team relationships
- managers to access training to understand how to manage culturally diverse teams

7.5.1 Principle

CALD cultural awareness, sensitivities, knowledge and skills must be incorporated in the development of all health services or programmes.

7.5.2 Performance Measures

The service has:

7.5.2.1 ensured that all staff undertake the essential and highly recommended CALD cultural competency training courses within the first 12 months of employment at the health service and ongoing annual professional development thereafter.

7.5.2.2 ensured that policy documents specify that assessment instruments or inventories administered on CALD service users are culturally appropriate, and where feasible, are culturally validated

7.5.2.3 conducted development and implementation of more culturally appropriate assessment, review and treatment plans

7.5.2.4 incorporated cultural competency into staff orientation and performance review requirements.

7.5.2.5 ensured that all staff know where language and interpreting policy /guidelines are and know how to assess, access and work with accredited interpreters, when required

7.5.2.6 ensured that all staff knows how to access formally qualified and bi-lingual clinical cultural clinicians or bi-lingual cultural staff, when required

7.5.2.7 ensured that all staff know what are the best practice principles for cultural responsive service delivery

7.5.2.8 ensured that all staff are assess for literacy and numeracy skills and can access training to improve these if it impacts on staff to staff and staff to patient interactions

7.5.2.9 ensured that all staff know the competencies required and how to access training to improve culturally diverse team relationships

7.5.2.10 ensured managers have access to training on how to manage culturally diverse teams

7.6 Standard 6: Consumer Participation

The service ensures CALD consumer and carer participation in service planning, implementation and evaluation.

7.6.1 Principle

CALD service users and carers are involved in the planning, implementation and evaluation of the health service.

7.6.2 Performance Measures

The service has:

7.6.2.1 consulted with CALD service users and carers in the planning, implementation and evaluation of policies and programs for the service, so that issues of cultural diversity are incorporated

7.6.2.2 engaged suitably trained CALD service users and carers to deliver services where appropriate (e.g., a peer support service)

7.6.2.3 taken satisfaction surveys of CALD service users, translated or interpreted, in preferred languages to:

- inform continuous improvement
- determine cultural appropriateness of various programs delivered by the service
- determine cultural competence of staff.

7.7 Standard 7: Planning, Funding, Contracting, Monitoring

The service or organisation has a commitment to be culturally responsive to the CALD communities in the areas of funding, planning, contracting and monitoring.

7.7.1 Principle

The funding and planning arm of the organisation/service are culturally responsive to the CALD communities and embed the Best Practice Principles – CALD Cultural Competency Standards into all their funding, planning, contracting and monitoring activities.

7.7.2 Performance Measures

The organisation/service has:

7.7.2.1 a policy to update their Health Needs Assessment of the Asian and MELAA groups every five years

7.7.2.2 an inequality framework within the funding and planning team to incorporate the Best Practice Principles – CALD Cultural Competency Standards into all the funding and planning documents

7.7.2.3 an inequality framework for contracting team to incorporate the Best Practice Principles – CALD Cultural Competency Standards into all the contract documentation requiring health providers to be culturally responsive to the CALD communities

7.7.2.4 an inequality framework to incorporate the Best Practice Principles – CALD Cultural Competency Standards for monitoring health providers activity

7.8 Standard 8: Management Support

The service or organisation has proactive support from senior management for developing CALD cultural competence and cultural service responsiveness initiatives

7.8.1 Principle

A formal commitment to dedicating resources is essential to achieving cultural competency in the various domains such as organisational values, governance, planning, monitoring, quality, communication, workforce development, organisation structure, services/interventions

7.8.2. Performance Measures

The organisation/service has:

7.8.2.1 budgetary policies and practices that allocate resources and fiscal support to facilitate delivery of evidence-based programs for CALD communities and to assist the service in achieving cultural competency.

7.8.2.2 genuine and active support for FTEs who are designated the responsibility for monitoring the progress of the service in attaining cultural competency through the implementation of the Best Practice Principles – CALD Cultural Competency Standards

8. CALD Cultural Competencies for Working with Service Users

To work successfully with service users and carers from diverse cultural and linguistic backgrounds the health workforce needs to demonstrate appropriate attitudes, awareness, knowledge and skills including (Medical Council of New Zealand, 2006):

1. Attitudes
   a) A willingness to understand your own cultural values and the influence these have on your interactions with patients.
   b) A commitment to the ongoing development of your own cultural awareness and practices and those of your colleagues and staff.
   c) A preparedness not to impose your own values on patients.
   d) 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.

2. Awareness and knowledge
   a) An awareness of the limitations of your knowledge and openness to ongoing learning and development in partnership with patients.
   b) An awareness that general cultural information may not apply to specific patients and that individual patients should not be thought of as stereotypes.
   c) An awareness that cultural factors influence health and illness, including disease prevalence and response to treatment.
   d) A respect for your patients and an understanding of their cultural beliefs, values and practices.
   e) 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.
   f) An understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings.
   g) 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.

3. Skills
   a) The ability to establish a rapport with patients of other cultures.
   b) The ability to elicit a patient's cultural issues which might impact on the doctor-patient relationship.
   c) The ability to recognise when your actions might not be acceptable or might be offensive to patients.
   d) The ability to use cultural information when making a diagnosis.
   e) The ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan.
   f) The ability to include the patient's family in their health care when appropriate.
   g) 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.
   h) 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.

9. CALD Cultural Competency Training and Resources – Working with Service Users

9.1 CALD Training Programme - Working with Service Users

The CALD Cultural Competency Training Programme was developed by WDHB Asian Health Support Services as part of the Asian, Migrant and Refugee Health Action Plan, funded by the Northern Regional Alliance (NRA). The cultural competency training programmes are in addition to the bicultural and Pacific cultural competency programmes which are already in place in the Auckland region District Health Boards.

9.1.1 Rationale for the provision of CALD Cultural Competency Training:

- Ensure that culturally and linguistically diverse groups in the Auckland region have equitable access to appropriate health and disability services
- Ensure that culturally and linguistically diverse groups in the Auckland region have access to culturally appropriate health and disability services
- Ensure that health care is safe and effective for culturally and linguistically diverse groups served by Auckland region DHB/MoH funded primary and secondary health services (as per the list of organisations/providers specified by the NRA)
- Under section 118 of the Health Practitioners Competence Assurance Act 2003, registration authorities have a responsibility to set standards of cultural competence, review and maintain the competence of health practitioners, and set programmes to ensure ongoing competence.

9.1.2 Health Practitioners Competency Assurance Act (HPCA Act)

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, Public Health Physicians and the Nursing Council of New Zealand have an interest in developing the cultural competence frameworks related to the culturally and linguistically diverse (CALD) groups in New Zealand. The issues of relevance for the development of CALD cultural competencies in Auckland region DHBs includes:

- The recognition of culture as a determinant of health status;
- Poor health status in some ethnic groups;
- Health inequalities between Asian/MELAA groups and Māori, Pacific and European groups;
- The recognition of the need for a culturally competent health workforce for CALD populations to address both issues of equity and health disparities.

To be effective, members of the primary and secondary health sector need to practice in a way that is culturally competent and that meets the requirements of the HPCA Act.

The aim of the CALD cultural competency training programme is to:

- Increase the health workforce's level of confidence to work with CALD service users and carers
- Enhance the cross-cultural interactions in the long term
- Increase CALD patients' satisfaction with the services delivered
- Reduce miscommunication, misdiagnosis, non-compliance of treatment and follow up, and disengagement with service providers

9.1.3 CALD Cultural Competency Training Programme for Working with Service Users includes:
CALD 1: Culture and Cultural Competency (Pre-requisite)
CALD 2: Working with Migrant Patients
CALD 3: Working with Refugees Patients
CALD 4: Working with Interpreters
CALD 5: Working with Asian mental health clients
CALD 7: Working with Religious Diversity
CALD 8: Working with CALD families-Disability Awareness
CALD 9: Working in a Mental Health Context with CALD clients
NB: CALD 6 Working with refugee mental health clients been replaced by the new CALD 9 online and face to face course
For more information about the courses, go to www.caldresources.org.nz
The above courses are CME/CNE and MOPS accredited.
All the above courses are available in face to face and e-learning formats except for CALD 5 which is only offered in face to face format.

9.2 CALD Resources – Working with Service Users

The following is a range of supplementary resources available to CALD learners. These are not courses, they are supplementary resources to further increase cultural awareness, knowledge and skills as part of the cultural competency developmental process.

The resources provide additional cross-cultural communication tips and guidelines, research material to increase cultural specific knowledge about working with Asian and MELAA groups. Most of the resources include case studies/scenarios.

Some of these resources have pre-requisites before it can be accessed. See Table 3 for more information:
(S1) Toolkit for Staff Working in a CALD Health Environment
(S2) Cross Cultural Resource for Health Practitioners working with CALD clients
(S3) Refugee Health Care: A Handbook for Health Professional
(S4) Ayurvedic Medicine
(S5) Working with CALD Families – Disability Awareness
(S6) Working with Religious Diversity
(S7) Working with Asian mental health clients
(S8) Working with MELAA mental health clients
(S9) CALD Family Violence Resource for Health Practitioners working with Asian and MEA clients
(S10) CALD Older People Resource for Health Providers working with Asian and MEA clients
(S11) CALD Children and Women's Health Resource (will be made available in 2015-2016)

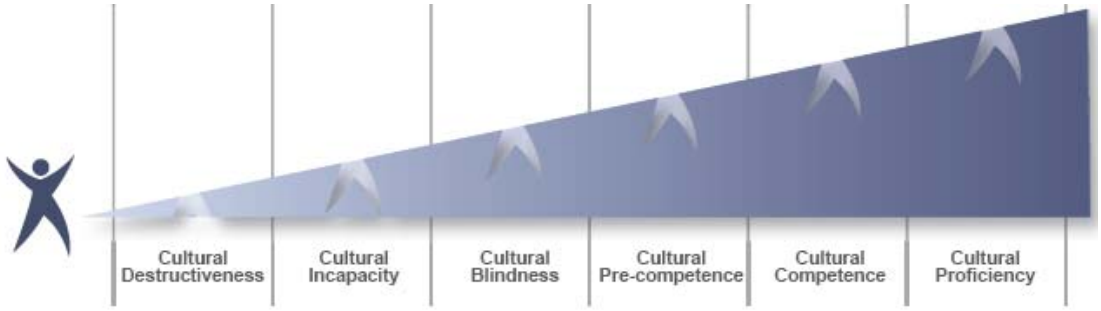
NB: There are also other cultural-specific courses, resources and workshops that are useful for enhancing cultural knowledge which may not be listed in this document.

9.3 Cultural Competency Framework - Working with CALD Service Users

Cultural competence is a developmental process. It requires the learner to ensure ongoing education of self and others, to research for additional knowledge and develop approaches based on cultural considerations, to seek ongoing mentoring, supervision of cultural practice in order to advance along the cultural competence.

Research tells us that most service providers fall between cultural incapacity and cultural blindness on the following continuum (Cross et al., 1989). It is very important for service providers to assess where they fall along the continuum. Such an assessment can be useful for further development.

Cultural Competence Continuum



Cultural destructiveness - genocide or ethnocide; exclusion laws; cultural / racial oppression; forced assimilation.

Cultural incapacity - Disproportionate allocation of resources to certain groups; lowered expectations; discriminatory practices, unchallenged stereotypical beliefs.

Cultural blindness - Discomfort in noting difference; beliefs / actions that assume world is fair and achievement is based on merit; we treat everyone the same: this approach ignores cultural strengths. The belief that methods used by the dominant culture are universally applicable can lead to implicit or explicit exclusion of ethnic minority communities.

Cultural pre-competence - Delegate diversity work to others, e.g. cultural programs asked to be lead by those of that background; quick fix, packaged short-term programs; a false sense of accomplishment; inconsistent policies and practices; practitioners are sensitive to minority issues but these are not an organisational priority.

Cultural competence – Advocacy: on-going education of self and others; support, modeling, and risk-taking behaviors; a vision that reflects multi-culturalism, values diversity and views it as an asset: evidence of continuing attempts to accommodate cultural change; careful attention to the dynamics of difference, realising that equal access is not equal treatment.

Cultural proficiency - Interdependence; personal change and transformation; alliance for groups other than one's own; adding to knowledge-base by conducting research; developing new therapeutic approaches based on cultural considerations; follow-through social responsibility to fight social discrimination and advocate for social diversity.

The following pages contain the following diagram and tables:

- **Diagram 1: Cultural Competency Framework for Working with CALD Service Users**
  This framework is an overview of what is required for the health and disability workforce (working in mental health, addictions, forensics, disability, physical and general health services (DHB provider arm, NGO and primary health) to develop cultural capability

- **Table 1: Cultural Competency Training Framework for Working with CALD Service Users**
  This is a guide for managers and staff showing what are the cultural training and resources available for the health and disability workforce (working in mental health, addictions, forensics, disability, physical and general health services in the DHB provider arm, NGO and primary health sector) to develop cultural capability.

- **Table 2: CALD Cultural Competency Training Courses for Working with CALD Service Users**
  This table provides details about the courses listed under Table 1 (cross referenced). It outlines the competency level of practice, pre-requisites, who should do the courses, the course outline and the alignment with the core cultural competencies for learners described under Section 8.

- **Table 3: CALD Resources for Working with CALD Service Users**
  This table provides details about the supplementary resources listed under Table 1 (cross referenced). It outlines the pre-requisites, who should be viewing the resources, content and how to access the resources

Diagram 1: Cultural Competency Framework for Working with CALD Service Users

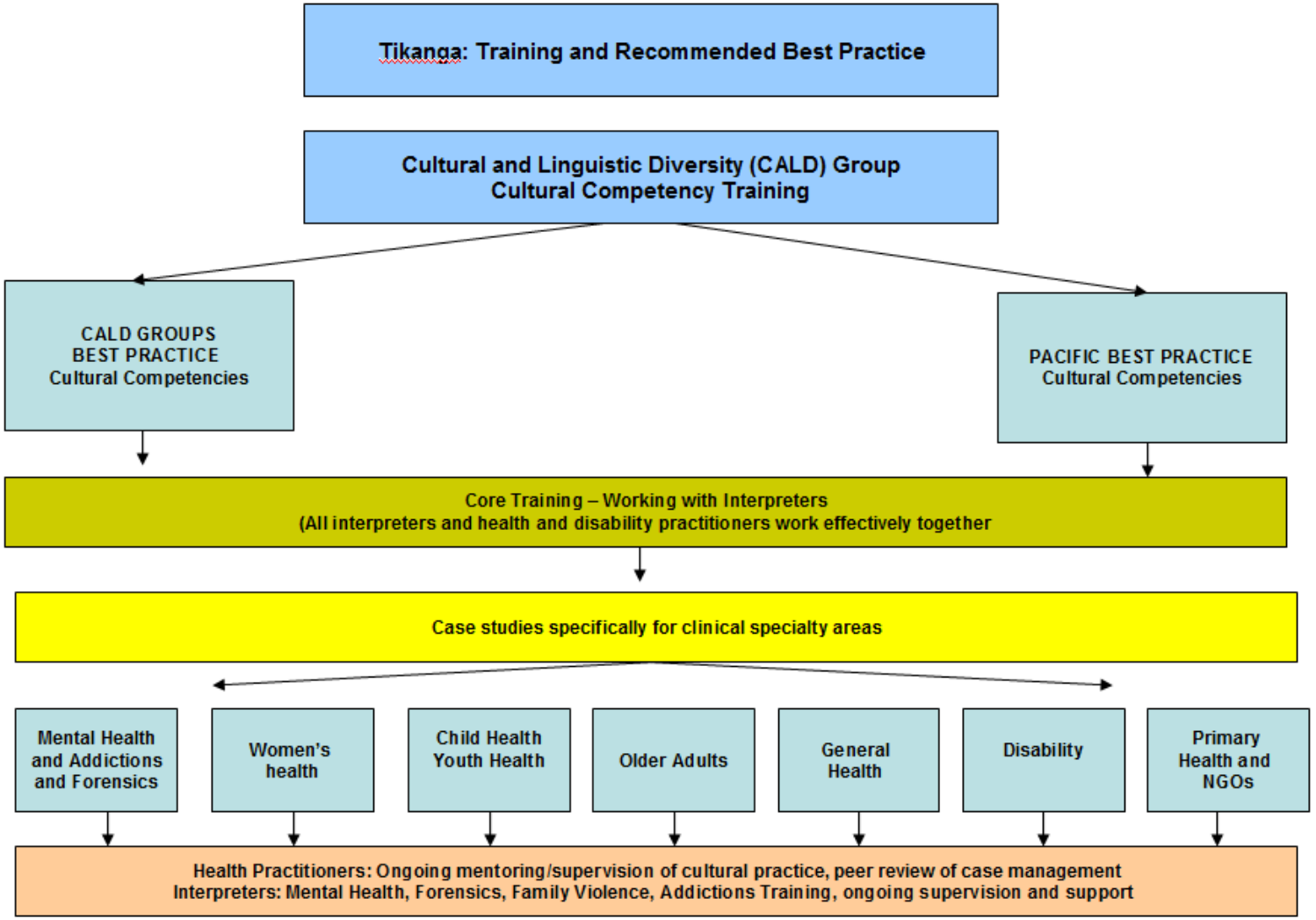


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Table 1: Cultural Competency Training Framework for Working with CALD Service Users

M = Mandatory (or Highly Essential Course); HR = Highly Recommended Course; R = Recommended Course; Optional = useful knowledge but is not essential

For staff working with Maori, Pacific, CALD service users/clients and families	Mental Health & Addictions Forensics (DHB Provider Arm, NGO)			Physical Health and Disability (DHB Provider Arm, NGO, Primary Health)				
Cultural Courses **Additional Online Supplementary Resources** **Ongoing supervision/peer review**	**Adults**	**Child Youth Family**	**MHS Older People**	**Disability**	**Older People**	**Child and Women's Health**	**Physical Health Services**	**Primary Health**
Cultural Courses								
(1) Maori Tikanga/Treaty - foundation course (not discussed in this document)	M	M	M	M	M	M	M	M
(2) CALD 1 Culture & Cultural Competency - foundation course	M	M	M	M	M	M	M	M
(3) Working with Pacific clients (not discussed in this document)	R	R	R	R	R	R	R	R
(4) CALD 2 Working with Migrant (Asian) Patients	R	R	R	R	R	R	R	R
(5) CALD 3 Working with Refugee Patients	R	R	R	R	R	R	R	R
(6) CALD 4 Working with Interpreters	HR	HR	HR	HR	HR	HR	HR	HR
(7) CALD 7 Working with Religious Diversity	R	R	R	R	R	R	R	R
(8) CALD 8 Working with CALD Families – Disability Awareness	R	R	R	HR	R	R	R	R
(9) CALD 9 Working in a Mental Health Context with CALD Clients	HR	HR	HR	Optional	Optional	Optional	Optional	R
(10) CALD 5 Working with Asian Mental Health Clients	HR	HR	HR	Optional	Optional	Optional	Optional	R
Additional online supplementary resources with case studies: (www.caldresources.org.nz) for ongoing CALD cultural competency development								
(S1) Toolkit for Staff Working in a CALD Health Environment	R	R	R	R	R	R	R	R
(S2) Cross Cultural Resource for Health Practitioners working with CALD Clients	R	R	R	R	R	R	R	R
(S3) Refugee Health Care: A Handbook for Health Professional	R	R	R	R	R	R	R	R
(S4) Ayurvedic Medicine	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional
(S5) Working with CALD Families – Disability Awareness	Optional	Optional	Optional	HR	Optional	Optional	Optional	Optional
(S6) Working with Religious Diversity	R	R	R	R	R	R	R	R
(S7) Working with Asian Mental Health Clients	R	R	R	Optional	Optional	Optional	Optional	R
(S8) Working with MELAA Mental Health Clients	R	R	R	Optional	Optional	Optional	Optional	R
(S9) CALD Family Violence Resource for Health Practitioners	R	R	R	R	R	R	R	R
(S10) CALD Older People Resource for Health Providers			R	Optional	R	Optional	R	R
(S11) CALD Children and Women's Health Resource (available in 2015-16)	Optional	R	Optional	Optional	Optional	R	R	R
Health Workforce: Ongoing mentoring/supervision of cultural practice, peer review of case management								
Interpreter Workforce: Ongoing mentoring/supervision /training and support								

NB: Some organisations may be able to set mandatory courses some may not and the recommendation for Mandatory could be changed to Highly Essential

Waitemata District Health Board
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Table 2: CALD Cultural Competency Training Courses for Working with CALD Service Users

The following table provides details about the courses listed under Table 1 (cross referenced). It outlines the competency level, pre-requisites, who should do the courses, the course outline and the alignment with the core cultural competencies learners described under Section 8.

The competency level of practice under column 2 can be broadly defined as:

- Level 1: Foundation – refers to the essential knowledge and skills for everyone working in mental health and addictions, forensics, physical health and disability (DHB Provider Arm, Primary Health and NGO sectors) to be able to engage and respond effectively to CALD service users and families
- Level 2: Capable – refers to the knowledge and skills required of the workforce to engage, to provide treatment, screening, diagnosis, and support CALD service users and families with a lesser degree of cultural complexity
- Level 3: Enhanced – refers to the knowledge and skills required of the workforce to engage, screen, assess, treat, support and work effectively with people with more complex cultural issues

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**
Ref (2) CALD 1 Culture and Cultural Competency	Level 1: Foundation (Base Knowledge) Mandatory or Highly Essential	Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	• Define culture. • Be aware of own cultural values. • Define four elements of cultural competency and identify ways in which these can be applied in practice. • Differentiate between observations, judgements and evaluations. • Demonstrate skills in cultural competence.	Attitudes • Understand one's own cultural values and the influence these have on the interactions with patients. • Understand the need for ongoing development of one's own cultural awareness and practices and those of colleagues and staff. • Be more aware of not imposing one's own values on patients. • Be more aware of the need 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. Awareness and knowledge • Gain an awareness of the limitations of one's own knowledge and be more open to ongoing learning and development in partnership with patients. • Gain an awareness that general cultural information may not apply to specific patients and that individual patients should not be thought of as stereotypes. Skills • Gain the ability to establish rapport with patients of other cultures.

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**
					• Gain the ability to elicit a patient's cultural issues which might impact on the health practitioner-patient relationship. • Gain the ability to recognise when one's own actions might not be acceptable or might be offensive to patients.
Ref (6) CALD 4 Working with Interpreters	Level 2: Capable Essential / Highly Recommended Pre-Requisite: CALD 1	All staff working with interpreters	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	• Become familiar with the interpreter's roles, responsibilities and code of ethics, as well as ethical dilemmas they may encounter. • Become aware of the challenges faced by health practitioners, interpreters and patients involved during interpreting sessions. • Become familiar with the rationale and principles of how to work effectively with interpreters by pre-briefing, structuring, and then de-briefing after your consultation.	Skills • Gain the ability to communicate effectively cross- culturally and work effectively with interpreters when required.
Ref (4) CALD 2 Working with Migrant (Asian) Patients	Level 2: Capable Recommended Pre-Requisite: CALD 1 (Highly Recommended to complete CALD 4)	All staff working with Asian migrant patients	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health	• Become aware of the challenges faced throughout the migrant journey. • Gain insight into the phases of settlement and acculturation process and its impact on family units. • Explore the explanatory models health and migrants' help-seeking behaviours.	CALD 2 will enhance awareness, knowledge and understanding when working with Asian migrant clients The courses will continue to remind participants about what they learn from CALD 1 in terms of attitudes and will: Awareness and knowledge • Gain awareness that cultural factors influence health and illness, including disease prevalence and response to treatment. • Understand how to respect different cultural beliefs, values and practices. • Understand that patients' cultural beliefs, values and practices

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**
			Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	• Know what to consider to accommodate health beliefs and faith-based practices. • Know what to consider when raising sensitive issues with migrant patients.	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. Skills • Have more confidence how to establish a rapport with patients of other cultures. • Gain the ability to elicit a patient's cultural issues which might impact on the health practitioner-patient relationship. • Gain the ability to recognise actions that might not be acceptable or might be offensive to patients. • Gain the ability to use cultural information when making a diagnosis.
Ref (5) CALD 3 Working with Refugee Patients	Level 2: Capable Recommended Pre-Requisite: CALD 1 (Highly recommend – to complet CALD 4)	All staff working with refugees patients	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	• Gain an understanding of pre and post-settlement challenges for refugees. • Gain knowledge of the psychological and physical challenges that refugees face. • Deal with sensitive issues with refugees. • Demonstrate the ability to use strengths of refugees in interventions. • Gain skills in working with refugee patients. •	CALD 3 will enhance awareness, knowledge and understanding when working with refugee clients The courses will continue to remind participants about what they learn from CALD 1 in terms of attitudes and will: Awareness and knowledge • Gain awareness that cultural factors influence health and illness, including disease prevalence and response to treatment. • Understand how to respect different cultural beliefs, values and practices. • Understand 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. Skills • Have more confidence how to establish a rapport with patients of other cultures. • Gain the ability to elicit a patient's cultural issues which might impact on the health practitioner-patient relationship.

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**
					• Gain the ability to recognise actions that might not be acceptable or might be offensive to patients. • Gain the ability to use cultural information when making a diagnosis.
Ref (9) CALD 9 Working in a Mental Health Context with CALD clients	Level 3: Enhanced Highly Recommended Pre-Requisite: CALD 1 (Highly recommend to complete CALD 4) and also recommended to complete CALD 2 and/or 3, and CALD 7	For practitioners providing assessment, screening, treatment, management plans, medication for Asian, MELAA (CALD clients) in a mental health context	Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People It is also useful for any clinicians working in non-mental health services who provide assessment, screening, treatment for Asian, MELAA clients in a mental health context	• Gain awareness of the challenges in multicultural assessment and diagnosis in mental health. • Become aware of how cultural values interact with Western psychological and psychiatric values. • Gain an overview of how different cultures express distress. • Gain skills in multicultural clinical assessment. • Develop skills in treating clients with different belief systems and practices in mental health.	CALD 9 will enhance understanding of CALD clients' beliefs and explanations around mental health, and of the impact these may have on the acceptance of treatment and interventions. It will also provide skills in multicultural clinical assessments. The course will continue to remind participants about what they learn from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge: • Understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings. • 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. Skills • Gain the ability to establish a rapport with patients of other cultures. • Gain the ability to elicit a patient's cultural issues which might impact on the health practitioner-patient relationship. • Gain the ability to recognise when actions might not be acceptable or might be offensive to patients. • Gain the ability to use cultural information when making a diagnosis. • Gain the ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan. • Gain the ability to include the patient's family in their health care when appropriate. • Gain the ability to work cooperatively with others in a patient's

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**

					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.
					• Gain 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.

Ref (10) CALD 5 Working with Asian Mental Health Clients	Level 3: Enhanced Highly Recommended Pre-Requisite: CALD 1 (Highly recommended to complete CALD 4 and 9) and also recommended to complete CALD 2 and/or 3, and CALD 7	For practitioners providing assessment, screening, treatment, management plans, medication for Asian clients in a mental health context	Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People It is also useful for any clinicians working in non-mental health services who provide assessment, screening, treatment for Asian, MELAA clients in a mental health context	• Understand the correlation between culture, religion and healing and how to apply this in a mental health setting. • Understand the various modalities for treatment and implications. • Increase awareness of different cultures and how to communicate with people of different cultures. • Understand the principles and gain skills of cultural assessment/management.	CALD 5 will enhance understanding of Asian clients' beliefs and explanations around mental health, and of the impact these may have on the acceptance of treatment and interventions. It will also provide skills in clinical assessments and management. The course will continue to remind participants about what they learn from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge: • Understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings. • 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. Skills • Gain the ability to establish a rapport with patients of other cultures. • Gain the ability to elicit a patient's cultural issues which might impact on the health practitioner-patient relationship. • Gain the ability to recognise when actions might not be acceptable or might be offensive to patients. • Gain the ability to use cultural information when making a

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**

					diagnosis.
					• Gain the ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan.
					• Gain the ability to include the patient's family in their health care when appropriate.
					• Gain 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.
					• Gain 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.

CALD 7 Working with Religious Diversity	Level 2: Capable Recommended Pre-Requisite: CALD 1 (Highly recommended to complete CALD 4) and also recommended to complete CALD 2 and/or 3	For practitioners providing assessment, screening, treatment, management plan, medications	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO)	• Gain an understanding of the rationale for developing religio-cultural competence in practice when working with CALD patients of different faiths and religious practices. • Be aware of, and gain knowledge about, selected religious beliefs and practices and the affect they have on health, behaviour and wellness. • Gain skills to enhance interventions and treatment compliance, and to develop greater rapport by understanding behaviours and expectations related to	CALD 7 will enhance understanding of and skills for religio-cultural competence. The course will continue to remind participants about what they learn from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge: • Understanding the different concept of religious practices and faiths • 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. Skills • Gain the ability to establish a rapport with patients of other cultures. • Gain the ability to elicit a patient's religio-cultural issues which might impact on the health practitioner-patient relationship.

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**

			- Adults
			- Child & Youth
			- Older People
				religious practices.
				
				• Know how to find and use resources related to religious needs and practices of CALD patients.
					• Gain the ability to recognise when actions might not be acceptable or might be offensive to patients.
					• Gain the ability to use religio-cultural information when making a diagnosis.
					• Gain the ability to work with the patient's religio-cultural beliefs, values and practices in developing a relevant management plan.
					• Gain the ability to include the patient's family in their health care when appropriate.
					• Gain 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.
					• Gain 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.

Ref (8) CALD 8 Working with CALD Families – Disability Awareness	Level 3: Enhanced Highly Recommended CALD 1 (Highly recommended to complete CALD 4) and also recommended to complete	For practitioners providing assessment, screening, treatment, management plan for disability clients	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions	• Gain an understanding of the rationale for culturally competent practice and disability awareness when working with CALD families. • Be more aware and have more knowledge of the cultural perspectives of the CALD population relating to disability and the impact it has on service providers. • Gain skills to work effectively and	CALD 8 will enhance understanding of cultural perspectives of the CALD population relating to disability and the impact it has on service providers and gain skills to work effectively with CALD children and adults and their families with impairments The course will continue to remind participants about what they learn from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge: • Understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings. • 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

CALD Cultural Competency Training Courses – Working with CALD Service Users					
Column 1 **Cross Referenced to Table 1** **Course Name:**	**Column 2** **Competency Level** **Pre-Requisite**	**Column 3** **Who**	**Column 4** **Sector**	**Column 5** **Course Outline** **Participants taking the course will be able to:**	**Column 6** **Aligned with Core Cultural Competencies** **Section 8**

	CALD 2 and/or 3 and CALD 7		Forensics (DHB Provider Arm, NGO)
			- Adults
			- Child & Youth
			- Older People
				broach sensitive issues with CALD children and adults with impairments and their families.
				
				• Know how to find and use resources to work with CALD children and adults with impairments and their families.
					clinical situation.
					Skills
					• Gain the ability to establish a rapport with patients of other cultures.
					• Gain the ability to elicit a patient's cultural issues which might impact on the health practitioner-patient relationship.
					• Gain the ability to recognise when actions might not be acceptable or might be offensive to patients.
					• Gain the ability to use cultural information when making a diagnosis.
					• Gain the ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan.
					• Gain the ability to include the patient's family in their health care when appropriate.
					• Gain 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.
					• Gain 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.

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Table 3: CALD Resources for Working with CALD Service Users

The following table provides details about the supplementary resources listed under Table 1 (cross referenced). It outlines the pre-requisites, who should be referring to the resources, content and how to access the resources for ongoing cultural competence development.

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
Ref (S1) Toolkit for Staff Working in a CALD Health Environment	No pre-requisite Recommend to have completed CALD 1 before viewing this	Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	This online toolkit is produced by WDHB and CMDHB Learning and Development team and is available in online format on the website www.caldresources.org.nz under CALD Resources-Cross Cultural Resources. It offers some guidance for staff and managers who work in primary and secondary care in a CALD health environment in New Zealand's WDHB. Section A of this toolkit is very useful for all staff to understand the cultural competence principles for working with patients, and colleagues in multicultural teams. It provides reflective questions and case examples to illustrate some of the principles in question.
Ref (S2) Cross Cultural Resource for Health Practitioners working with CALD clients	No pre-requisite Recommend to have completed at least CALD 1 before viewing this	Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment for CALD clients)	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions	This online toolkit is produced by WDHB Asian Health Support Services and Refugees-As-Survivors NZ This toolkit is available in two formats, that is, a Booklet format and an online format. The booklet can be purchased from the website www.caldresources.org.nz under CALD Resources - Cross Cultural Resources. The online format is available at no cost accessible via the website. The Booklet format is a very useful Desk-top guide which contains a summary of the online (e-Toolkit) version which includes • cross-cultural pre-interview checklist, interview questions, and guidelines for working with interpreters • Sections on 7 Asian cultures and 7 Middle Eastern cultures containing greetings, communication tips and guidelines for practitioners working with each of these cultures

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
			Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	The e-toolkit (online format) the comprehensive version of the above BOOKLET • It includes explanation, examples and background information on the points in the booklet. • It also includes additional issues, comparative tables, generalized sections on Asian, Eastern Mediterranean and African Cultures and video and audio clips of the greetings in each language. • It is not intended as a definitive guide on each culture, but contains information we considered useful to practitioners in a health setting who will work with CALD clients. • It is divided into four sections. The first contains general information about cultural competency, effective communication and working with interpreters. Section II contains generalised information about Asian cultures and then specific individual cultures which includes brief background information, greetings and communication tips, health beliefs and practices, family values, tips for practitioners working with culture-specific clients, health risks, women's and youth health, and spiritual practices. Section III contains information about Eastern Mediterranean and African cultures in the same format as Section II. Section IV contains additional resources.
Ref (S3) Refugee Health Care: A Handbook for Health Professional	No pre-requisite Recommend to have completed at least CALD 1 before viewing this	Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment for CALD clients)	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	This toolkit is produced by the Ministry of Health and available free for health practitioners. It can be ordered from the MOH website http://www.health.govt.nz/publication/refugee-health-care-handbook-health-professionals The handbook covers the following topics: • Refugees – Who they are and where they come from • Refugee Resettlement in New Zealand • The Consultation – Communicating Effectively with Refugee Clients • Physical Health Care • Mental Health Issues • Refugees with Special Health and Disability Needs • Contact List
Ref (S4)	CALD 1, 2	All staff	General Health:	This online toolkit is produced by WDHB Asian Health Support Services and Refugees as Survivors and is available via

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
Ayurvedic Medicine	courses	providing assessment, screening, management, treatment for CALD clients	(DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	www.caldresources.org.nz only for CALD learners who have a CALD user account. This resource is an informative video describing the ayurveda explanatory health model. An ayurveda practitioner explains the ayurveda model, beliefs and demonstrates an ayurvedic diagnosis and treatment procedures. The video is divided into different sections to provide easy access to relevant information.
Ref (S5) Working with CALD Families – Disability Awareness	CALD 1, 8 courses Also recommend to complete CALD 2, 3, 4, 7 and as the resource only provide a recap	All staff providing assessment, screening, management, treatment for CALD children or adults with disability	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO)	This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz only for CALD learners who have a CALD user account. This resource is for health practitioners working within the New Zealand health system. It is a supplement to the training programme Working with CALD Families – Disability Awareness. It provides some culture-specific information for health practitioners who have an understanding of the key issues in working with CALD families with disability. It is not a stand-alone document and does not provide information on general disability issues. **Section I** (Middle Eastern, South Asian and other Muslim based cultures) provides an overview of disability and the Muslim perspective since Muslims form the majority in the countries in this section. This information about Islam and disability may be applied to other cultures that are predominantly Muslim and shaped by Islamic practices. **Section II** (Indian culture) presents information on Indian culture and disability. India is separated from the South Asian countries in section I since it is not a Muslim based country and underlying religious values are relatively different. **Section III** (Somali, Sudanese, Ethiopian and Eritrean cultures) focuses on disability and cultures in the Horn of Africa,

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
			- Adults - Child & Youth - Older People	for although predominantly Muslim, the cultures of these countries differs significantly from those of the Middle East. The information on disability and Islam from Section I can be applied to Muslims in this group. Information for countries in this section is provided separately as practices and circumstances vary significantly across these cultures). Culture-specific information is summarised in the Middle Eastern, South Asian and African Table. **Section IV** (East Asian cultures) provides information on disability in Chinese culture and other cultures that share the Chinese heritage of Confucianism, Taoism and Buddhism.
Ref (S6) Working with Religious Diversity	CALD 1, 7 Also recommend to complete CALD 2, 3, 4, and as the resource only provide a recap	All staff providing assessment, screening, management, treatment for CALD clients	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz only for CALD learners who have a CALD user account. This online resource is for health practitioners working within the New Zealand health system. It is a supplement to the training programme "Working with Religious Diversity". It offers information on Confucianism and Taoism. It provides some religio-cultural information on traditional belief systems in East Asian cultures, and how these impact on health care and practices. **Section I** provides an overview of the systems of Confucianism, Taoism, Buddhism and Chinese Folk Religion. **Section II** presents information on how the principles from these philosophical systems and Traditional Chinese Medicine (TCM) interact in the New Zealand healthcare system. **Section III** provides the links to a Table on Interactions of some Western Drugs with Chinese Herbs, the comparative and summary table of East Asian Doctrines, a Bibliography and list of References for this resource, and an interactive Quiz.
Ref (S7) Working with Asian Mental Health Clients	CALD 1 and 9 Also recommend to complete CALD 2, 3, 4, 7 and as the resource only	All staff providing assessment, screening, management, treatment for Asian clients in a mental health	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's	This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz only for CALD learners who have a CALD user account. This online supplementary resource is for learners who have completed the CALD 1 and 9 training courses. Additional Asian culture specific information that applies to mental health assessment and intervention is provided in the resources. Topics include the following: • Cultural demographics • Re-cap on aspects of religious issues that impact on mental health

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
	provide a recap	context	Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	• Traditional cultural and family values • Assessment guidelines for working with adults • Assessment guidelines for working with children and the elderly • Explanatory models of illness as relevant to the cultural groups • Appropriate and applicable treatment modalities and Interventions • Special issues when working with the respective cultures in mental health • CALD assessment tool for working with Children
Ref (S8) Working with MELAA Mental Health Clients	CALD 1 and 9 Also recommend to complete CALD 2, 3, 4, 7 and as the resource only provide a recap	All staff providing assessment, screening, management, treatment for Asian clients in a mental health context	General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People	This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz only for CALD learners who have a CALD user account. This online supplementary resource is for learners who have completed the CALD 1 and 9 training courses. Additional, and MELAA culture specific information that applies to mental health assessment and intervention is provided in the resources. Topics include the following: • Cultural demographics • Re-cap on aspects of religious issues that impact on mental health • Traditional cultural and family values • Assessment guidelines for working with adults • Assessment guidelines for working with children and the elderly • Explanatory models of illness as relevant to the cultural groups • Appropriate and applicable treatment modalities and Interventions • Special issues when working with the respective cultures in mental health • Refugee issues with specific groups e.g. children
Ref (S9)	CALD 1, 2 or 9	All staff	General Health:	This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
CALD Family Violence Resource Health Practitioners working with Asian and MEA clients	Also recommend to complete CALD 2, 3, 4, 7 and 9	providing partner abuse screening and interventions for Asian and MEA clients	(DHB Provider Arm, NGO, Primary Health) - Adults - Child & Youth - Older People - Physical Health - Disability - Older People - Child & Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Maternal Mental Health - Adults - Child & Youth - Older People	only for CALD learners who have a CALD user account The purpose of this resource is to enable health practitioners to gain understanding around what is required to provide culturally appropriate partner abuse screening and interventions. The resource aims to enable health practitioners to: ▪ Understand the risk factors for partner and child abuse in Asian, Middle Eastern and African communities ▪ Understand cultural perspectives about family violence (which includes partner abuse, child abuse and in-law abuse) in Asian, Middle Eastern and African communities ▪ Understand CALD family violence dynamics hindering disclosure and access to services for CALD women and children including immigration and residence issues ▪ Be aware and show sensitivity when dealing with shame and stigma, and other cultural issues when screening for partner abuse. ▪ Become familiar with how to provide culturally appropriate partner abuse screening and interventions, including child abuse and neglect ▪ Understand safe screening practice for CALD clients who are the victims of family violence especially when working with interpreters
Ref (S10) CALD Older People Resource for Health Providers working with Asian and MEA clients	CALD 1, 2 or 9 Also recommend to complete CALD 2, 3, 4, 7 and 9	For health practitioners working with CALD older people and their families in primary, community, mental health, secondary care, home-based support services	DHB Provider Arm, NGO, Primary Health, Mental Health - providing services to older People	This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz only for CALD learners who have a CALD user account The purpose of this resource is to provide: • General information about Asian, Middle Eastern and African older adult populations. • Cultural information of CALD communities including working with families, decision-making, religious and cultural practices and its implication for practice • Cultural perspectives, tips/tools and case scenarios for health practitioners working with CALD older people and their family in the following areas/services such as: ▪ Assessment, Treatment and Rehabilitation ▪ Dementia ▪ Stroke

CALD Resources for Working with CALD Service Users				
Cross Referenced to Table 1 Resource Name	**Pre-requisite**	**Useful for**	**Sector**	**Content**
		(HBSS) and residential aged care (RAC) settings.		▪ Mental Health ▪ Needs Assessment and Coordination (NASC) ▪ Residential Aged Care (RAC) ▪ Elder Abuse and Neglect ▪ Advance Care Plan and Advance Directive ▪ End-of-life Care • Resources available to support health practitioners working with CALD older people and their family
Ref (S11)CALD Children and Women's Health Resource – development underway for 2015-16				

Additional recommendations to managers and health and disability workforce:

For mental health, addictions forensics services (DHB, NGO, Primary Care), it is recommended that:

- Existing staff who have significant numbers of Asian clients complete CALD 1, 4 , 9 , followed by CALD 2 and 5, and then CALD 3 and CALD 7 to further expand their knowledge
- Existing staff with high numbers of refugee clients complete CALD 1, 4 and 9 , followed by CALD 3 and then to further expand their knowledge with CALD 2, 5 and 7
- New staff complete CALD 1, 4 and 9 within their first year as part of their essential skill base requirements, followed by other CALD courses as per above suggestions for existing staff

For physical and general health services (DHB, NGO, Primary Care), it is recommended that:

- Existing staff who have significant numbers of Asian clients complete CALD 1, 2, 4 , followed by CALD 7, and then CALD 3, 8, 9 to expand their knowledge
- Existing staff with high numbers of refugee clients complete CALD 1, 3, 4 followed by CALD 7 and then CALD 2, 8, 9 to expand their knowledge
- New staff complete CALD 1, 4 within their first year as part of their essential skill base requirements, followed by other CALD courses as per above suggestions for existing staff

For disability health services (DHB, NGO, Primary Care), it is recommended that:

- Existing staff who have significant numbers of Asian clients complete CALD 1, 2, 4 ,8 followed by CALD 7, and then CALD 3, 9 to expand their knowledge
- Existing staff with high numbers of refugee clients complete CALD 1, 3, 4 ,8 followed by CALD 7 and then CALD 2, 9 to expand their knowledge
- New staff complete CALD 1, 4, 8 within their first year as part of their essential skill base requirements, followed by other CALD courses as per above suggestions for existing staff

For all of above it is recommended that staff access the supplementary cultural resources to increase their cultural knowledge. There are also other cultural-specific courses, resources and workshops that are useful for enhancing cultural knowledge which may not be listed in this document.

10. Workforce Working in a Multicultural Health Environment

10.1 Multicultural Health Environment

As described in Section 4 the workforce is increasingly diverse and there is a need to prepare the workforce to be culturally competent to work in a multicultural health environment.

Sections 3.1 and 3.2 characterise Asian and MELAA populations and therefore the Asian and MELAA health workforce could be local born, first generation, 1.5, second, third and fourth generation migrants. The Asian and MELAA workforce who are local born or 1.5, second, third, fourth generation migrant may not have bi-lingual language skills or a good understanding and knowledge of cultural practices and beliefs. Overseas trained health practitioners from Non-English Speaking Background may require support to improve English language requirements.

Working in a multicultural health environment, the challenges are not only about health professionals offering services to patients and to the patients who receive these services, but also about how staff interact in their collegial relationships with each other. In particular working in multicultural team settings requires the following:

Acknowledging, understanding and respecting differences, as well as appreciating cultural diversity within the workforce (and population) is essential for:

- Team member relationships (this includes all staff working within a team, i.e. relating to staff from different cultural values including Western, Maori, Pacific Nations, Asian and others)
- Manager-staff relationships and the ability to facilitate a multicultural team
- Staff-patient (including customer service staff-patient and clinician-patient) relationships

Being aware of the significant variations in communication that occur across cultures in:

- Language and verbal communication
- Non-verbal communication
- Identity and inter-group communication
- Intercultural relating
- The way people adapt to an unfamiliar culture.

Building understanding how language and communication styles (used both consciously and subconsciously) differ across cultures can create:

- More awareness about the issues that affect communication
- Better understanding of the challenges that arise
- Tolerance and acceptance between colleagues in meeting these challenges.

10.2 Guidelines for Staff Working in a Multicultural Health Environment

The following are principles taken from the Ministry of Health's "Lets Get Real" project (Te Pou, 2009). The principles provide useful guidelines for all staff within the health system.

VALUE	EXRESSED IN PRACTICE		
	Staff to Staff Interaction	Between Manager and staff	Staff to patient interaction
Respect	Show respect by accommodating differences, by enquiring about differences, by sharing some differences	Show respect for each staff member's cultural differences, verbally and non-verbally	Try to accommodate patients' expectations and explain differences in procedures. Give reasons when asking patients to do something unusual
Human Rights	Allow people to dress, eat, communicate and worship in ways that are customary	Discourage staff from judging or discriminating amongst themselves in the team. Set an example.	Allow service users and their families to express their differences in the ways that are customary, as much as is possible without compromising best practice
Service	Serve your colleagues by performing your role to your best ability. Keep the team purpose in mind.	Serve your team by following the best protocol you can, and by being respectful and supportive	Serve clients with excellence at all levels and phases of delivery
Recovery	Assist colleagues in their efforts to provide excellent service for recovery for patients by sharing knowledge about different cultural needs when this would be helpful	Ensure your staff have the necessary information and training to provide a good recovery programme, including cross-cultural information in order to assist patients	Assist patients to return to the best quality of life they can have. This would including knowing and incorporating cultural needs
Communities	Develop community in your teams in order to develop team identity and to support best quality practice	Provide opportunities for your team to develop community by holding appropriate forums and providing a structure that encourages relating and sharing	Ensure that patients are linked with community resources to assist in full recovery and support when they leave care
Relationship	Authentic relating is crucial to supportive team maintenance	Be authentic in your relating to each staff member as this will engender trust and respect, and model this for the team	Authentic relating is an essential element of healthcare and communicates respect and trustworthiness to patients

10.3 Competencies Required for Working in a Multicultural Health Environment

The following are the competencies required from staff working in a multicultural health environment:

Attitudes

- Compassion for others
- Genuineness in interaction
- Honesty and integrity
- Non-discrimination and non-judgemental attitude
- Open-mindedness: culturally aware, self-aware, innovative, creative, positive risk takers
- Optimism: positive, encouraging, enthusiastic attitude
- Patience: tolerance and flexibility
- Professionalism: accountability, reliability and responsibility
- Resilience
- Supportiveness: validating, empowering, accepting with colleagues as well as service users
- Understanding: healing is more than putting a plaster on the wound.

Skills

- Ability to work with colleagues, staff, services users and families/whanau from different cultures (Western, Maori, Pacific Nations, Asian and others)
- Ability and willingness to challenge stigma and discrimination
- Ability to implement legislation, regulations, standards, codes and policies relevant to role
- Ability to actively reflect on work and practice in ways that enhance collaboration and support service users, and to engage in professional and personal development.

The skills above can be seen as performance indicators and staff can assess themselves against these to establish their skill level. Three different levels of performance indicators would be expected for:

- Staff
- Practitioners
- Managers / Team Leaders.

The above are adapted from TEPOU Lets Get Real Skills: Values, Attitudes and Skills (see www.tepou.co.nz/page/752-Values-attitudesandthe-seven-Real-Skills)

For working with service users, also refer to the Competence Standards set up by the various professional groups.

10.4 Training and Resources

10.4.1 Training Requirements

	TRAINING		
	Staff To Staff Interaction	**Between Manager and staff**	**Staff to patient interaction**
Training Required	Training to improve intercultural communication skills between staff to staff Training to improve culturally diverse team relationship Training to improve (English language) literacy and numeracy if these impact on staff to staff interaction	Training to improve how to manage culturally diverse teams	Tikanga: Training and Recommended Best Practice Pacific: Training and Recommended Best Practice CALD Population: CALD Cultural Competency Training and Best Practice Principles Training to improve (English language) literacy and numeracy if these impact on staff to patient interaction

10.4.2 Training and Resources for Staff

- Staff need to have access to Maori /Tikanga Best Practice Guidelines
- Staff need to have access to Pacific Training Best Practice Guidelines
- Staff need to have access to Maori and Pacific advisors for cultural knowledge.
- Staff need to have access to Asian or Migrant and Refugee advisors for cultural knowledge if available in their organisations
- Staff need to have access to Best Practice Principles for CALD Cultural Competency Standards if available in their organisations
- Staff need to have access to the CALD cultural competency training for working with services described in Section 9
- Staff need to have access to an Interpreting policy if available in their organisations
- Managers/staff need to request numeracy and literacy courses via Learning and Development if these are available in their organisations
- Staff need to have access to training or resources to improve their inter-cultural communication and culturally diverse team relationships between staff and staff, if available in their organisations
- Managers need to have access to courses for managing cultural diversity if available in their organisations

10.4.2.1 Resources for Managers and Health and Disability Workforce

10.4.2.1.1 List of WDHB Quality Controlled Documents

The Waitemata DHB Controlled Documents site (http://staffnet/qualitydocs/) contains the following and many other organisational policies pertaining to The Waitemata DHB Controlled Documents site (http://staffnet/qualitydocs/) contains the following and many other organisational policies pertaining to Tikanga best practice, Pacific best practice, and Asian and other CALD group best practice:

- WDHB Mo Wai Te Ora
- WDHB – Maori Values and Concepts (Tikanga)
- WDHB – Te Taumata Kaumatua O Te Wai Awhina – ToR
- WDHB – Taka a Fohe – Pacific Mental Health & Addictions Service – Staff Levels and Skill Mix
- WDHB – Pacific Support Services
- WDHB Pacific Support Services – General Inpatient
- WDHB Service Description – Takanga a Fohe
- WDHB – Asian Health Support Services Access
- WDHB – Quality Action Plan – Asian Health Support Services 2013-2016
- WDHB – Asian Patient Support Service – Socio Cultural Assessment Form
- WDHB – Interpreting and Document Translation

NB: These and others are found on the WDHB Intranet site under Quality Controlled Documents. The documents are routinely updated and reviewed. Additionally new documents are added when required

10.4.2.1.2 CALD Courses and Resources for working with CALD service users

Refer to Section 9 for details of these resources.

10.4.2.1.3 Toolkit for Staff Working in a CALD Health Environment

This was developed by WDHB and CMDHB Learning and Development teams. The development team consulted widely with WDHB and CMDHB stakeholders in 2010.

It is available in an online format and accessible via the website www.caldresources.org.nz under CALD Resources, under Cross Cultural Resources.

It is divided into five sections, colour coded for easy reference and bookmarked for easy navigation. It offers some guidance for staff and managers who work in primary and secondary care in a CALD health environment in WDHB.

Section A provides a general guide for staff working with colleagues in multicultural teams. Reflective questions are included, and case examples illustrate some of the principles in question. This section should be read by ALL STAFF.

Section B offers additional information for CALD staff working within a multi-cultural health environment. This includes a diagrammatic representation on the New Zealand Health system and case examples illustrate some of the principles in question. This section should be read by ALL CALD STAFF (including CALD managers).

Section C is for managers who lead multicultural teams. This section should be read by ALL MANAGERS including CALD managers.

Section D lists training, resources and supports for staff working in WDHB. This section is for ALL STAFF. Section E contains appendices, which include information on: Cultural Competence Standards, Policies, Legislation, and acronyms and idioms that are commonly used in New Zealand. References for the toolkit are included. This section is for ALL STAFF

10.4.2.1.4 Courses for Improving Intercultural Communication between staff and between manager and staff

The following are courses available for improving intercultural communication between staff and between manager and staff, however this may require to be funded by requesters:

- WDHB Learning & Development - Management Training Programme: Managing a Culturally Diverse Team Course
- WDHB CALD Course: www.caldresources.org.nz - Working in a Culturally Diverse Team
- Office of Ethnic Affairs: Intercultural awareness and communication course

10.4.2.1.5 English Language Literacy and Numeracy

Intensive Literacy and Numeracy fund provides support for the provision of literacy, language and numeracy learning opportunities for migrants (patients or workforce) with low level literacy and numeracy skills to support them with their basic functioning. To be eligible for Intensive Literacy and Numeracy funding, learners must:

- be a NZ citizen or permanent resident
- have low levels of literacy and/or numeracy, as assessed against the Learning Progressions Framework, including Starting Points found under National Centre of Literacy and Numeracy for Adults - https://www.literacyandnumeracyforadults.com/resources/354426

A list of providers offering courses funded by the Intensive Literacy and Numeracy Fund is available on the Tertiary Education Commission website: www.tec.govt.nz/Funding/Fund-finder/Intensive-Literacy-and-Numeracy/

NB: There are other cultural-specific courses, resources, and workshops that are useful for enhancing cultural knowledge which may not be listed in this document.

11. Glossary

ADHB	Auckland DHB
AHSS	Asian Health Support Services
CALD	Culturally and Linguistically Diverse/Diversity
CMDHB	Counties-Manukau DHB
DHB	District Health Board
HPCAA	Health Practitioners Competence Assurance Act
MELAA	Middle Eastern, Latin American, and African
MOH	Ministry of Health
NGO	Non-government organisations
NRA	Northern Regional Alliance Ltd
PHO	Primary Health Organisation
WDHB	Waitemata DHB

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