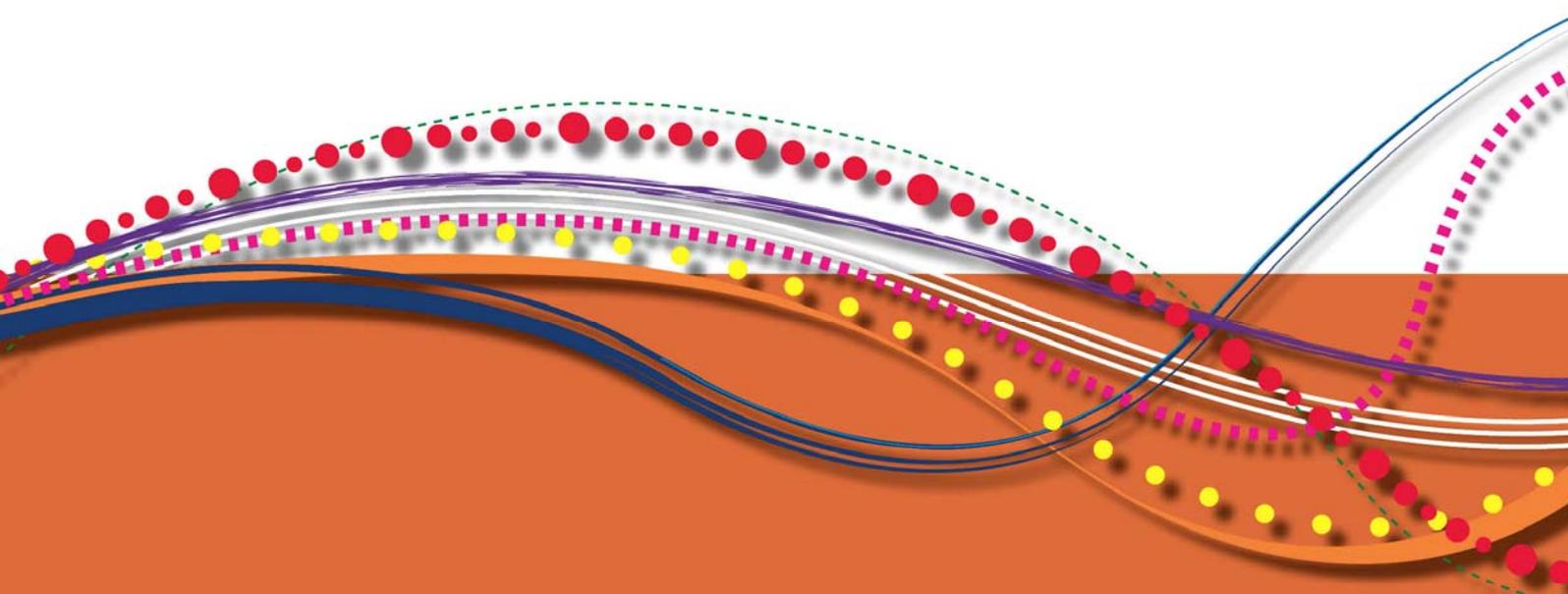


Queensland Health

Cross Cultural Capabilities

For clinical staff and non-clinical staff



Background paper



© State of Queensland (Queensland Health) 2010.

This document is licensed under a Creative Commons Attribution Non-Commercial 2.5 Australia licence. To view a copy of this licence, visit <http://creativecommons.org/licenses/by-nc/2.5/au>. You are free to copy, communicate and adapt the work for non-commercial purposes, as long as you attribute Queensland Health.

For permissions beyond the scope of this licence contact:

Intellectual Property Officer
Queensland Health
GPO Box 48
Brisbane Queensland 4001
email IP_Officer@health.qld.gov.au
phone 07 3234 1479

Suggested citation:

Queensland Health. *Cross Cultural Capabilities: For clinical staff and non-clinical staff: Background paper*. Division of the Chief Health Officer, Queensland Health. Brisbane 2010.

Project team:

Project manager: Ellen Hawes, Director, Queensland Health Multicultural Services
Principal Project Officer and author: Shelley Kulperger, Principal Project Officer, Queensland Health Multicultural Services
Project team: Lorella Piazetta and Ruth Rowan, Principal Project Officers, Queensland Health Multicultural Services

Productive Diversity Steering Committee members:

Emma Cuell and Glenda Richards, People and Culture Corporate, Queensland Health
Desmond Suttle, Darling Downs-West Moreton Health Service District
Ann Fitzgerald, Clinical Workforce Solutions, Policy, Planning and Resourcing Division, Queensland Health
Daniel Rowley, Human Resources Manager, Mount Isa Hospital
Ian Muil, Executive Manager, Ethnic Communities Council Queensland
Ann Crowhurst, Policy Branch, Queensland Health
Chris Jensen, Queensland Nurses Union
Lilly Matich, Employment Programs, Brisbane City Council
Melanie Tucker, Princess Alexandra Hospital
Jatinder Kaur, Multicultural Affairs Queensland
Greg Turner, Queensland Transcultural Mental Health Centre
Selwyn Button, Director, Aboriginal and Torres Strait Islander Health Strategy Unit

Acknowledgements:

Many experts working in the area of cross cultural capability and cultural competency were consulted in the development of the Cross Cultural Capabilities. In particular, Queensland Health Multicultural Services would like to acknowledge and thank the following experts and practitioners:

Judith Miralles
Director, Judith Miralles and
Consultants Pty Ltd –
(Cultural Diversity Experts)
Melbourne, Victoria

Professor Alan Pearson
Executive Director
Professor of Evidence-
The Joanna Briggs Institute
Royal Adelaide Hospital

Professor Megan-Jane
Johnstone
Faculty of Health, Medicine,
Nursing and Behavioural
Sciences
Deakin University
Geelong, Victoria

Michal Morris
Executive Manager
Centre For Culture, Ethnicity
and Health
Melbourne, Victoria

Lidia Horvat
Policy and Strategy
Quality, Safety and Patient
Experience Branch
Victoria Department of
Health

Professor Lesley Anne
Hawthorne
Director, Faculty
International Unit
Faculty of Medicine,
Dentistry and Health
Sciences
The University of Melbourne
Melbourne, Victoria

Greg Turner
Statewide Policy and Policy
Coordinator
Queensland Transcultural
Mental Health Centre
Queensland Health

Dr. Hung The Nguyen
Director of Medical and
Cultural Education
Northern Territory General
Practice
(Consultant for Judith
Miralles and Associates)

Dr Sharon Chalmers
Centre of Cultural Research
University of Western
Sydney
Sydney Children's Hospital

Dr Joanne Travaglia
Medical Sociologist
Faculty of Medicine
University of New South
Wales

Professor Rani Srivastava
Deputy Chief, Nursing
Practice
Centre for Addiction and
Mental Health
Toronto, Ontario, Canada

For further information:

Queensland Health Multicultural Services
Division of the Chief Health Officer
Queensland Health
GPO Box 2368,
Fortitude Valley BC Queensland 4006



Brief overview

The purpose of the cross-cultural capabilities is to build the capacity of Queensland Health's workforce to deliver equitable, quality and safe care to culturally and linguistically diverse (CALD) people.

Cross-cultural capability refers to the range of skills, knowledge and behaviour Queensland Health expects in its workforce to enable and support the delivery of culturally safe services that meet the needs and expectations of CALD client groups.

Five capabilities are defined along with the skills, knowledge and behaviours that are required in the workforce, across clinical and non-clinical streams, to improve health outcomes and access for CALD consumers. While the performance of these capabilities will vary according to individual roles and responsibilities and encompass a greater focus on culturally competent care and service delivery for clinical streams, health care professionals at all levels across Queensland Health need to attain appropriate skills to either practice or to enable culturally capable service delivery. The cross-cultural capabilities are therefore equally applicable to non-clinical Queensland Health staff in areas such as policy, planning and resource allocation. In addition, in targeting workforce capability the five cross-cultural capabilities underpin effective diversity management by building staff's capacity to routinely take culture and communication issues into account in their everyday work activities and relationships.

By developing these cross-cultural capabilities, Queensland Health staff should be able to work, communicate and collaborate effectively with individuals from diverse cultural and linguistic backgrounds. This includes working with diverse patients and working in diverse teams.

Why are we doing it?

Expected outcomes of a culturally capable workforce are:

- to improve CALD health outcomes, safety, experience and satisfaction (and subsequently to reduce liability)
- to assure quality and efficiency and avoid readmissions, lengthy hospital stays and demand on services that can occur without cultural understanding
- to improve workplace relations and retention
- to translate policy into practice
- to provide a consistent approach across Queensland Health and set clear direction and benchmarks for the individual attainment of cross-cultural capability
- to provide recommendations for future directions to achieve organisational and system-level cross-cultural capability.

Context

1. Diversity is increasing

Australia is a multicultural country and, by some indicators, has the greatest diversity in the world with a third of the population identifying as being born overseas, more than 200 languages spoken at home, and the highest percentage of intercultural marriages. Queensland, particularly South-East Queensland, has been experiencing rapid growth in the past decade. Increasingly, Queensland's population growth is being driven by the number of migrants, refugees and humanitarian entrants with international immigration currently contributing nearly 50% of the state's growth. The Australian Bureau of Statistics reported that 17.9 per cent of Queensland's population were born overseas¹. According to 2006 Queensland Government Office of Economic and Statistical Research, South-East Queensland has the highest proportion of overseas-born residents from both English-speaking and non-English speaking countries with 24 per cent in Brisbane, 23.6 per cent in Logan, and 25.2 per cent in the Gold Coast². Brisbane has the highest proportion of non-English speaking overseas-born residents with 19.9 per cent¹.

2. New norms and cultures

Migration patterns have changed in the past 15 years. Unlike earlier waves of 20th century migration which brought an influx of white Europeans, particularly Italians, Greeks, Germans and Eastern Europeans, the vast majority of migrants entering Australia will be younger on average than most Australians and will arrive from non-European countries where most citizens are not white. New migrants bring with them different cultural norms and traditions, different cultural values about health, illness and treatment, all of which will influence their views about and interactions with mainstream health services. Multicultural Affairs Queensland has indicated that new arrivals from Africa arrive with greater complexities and higher levels of need as a result of pre-arrival conditions (including prolonged refugee status, war and trauma, and unfamiliarity with highly-developed infrastructure, technology and bureaucracy). According to the latest Census data, India and China now comprises the fastest growing migrant groups in Queensland¹.

3. Ageing population

Australia, like many other developed nations, is experiencing the effects of an ageing population. The ageing population is also increasingly diverse. It is estimated that by 2045, people aged 65 years and over will constitute a quarter of the Australian population³. The population of older, overseas-born immigrants is also expected to age at a rate more rapidly than the population of Australian-born older people, with the number of those aged 80 years and over (the ageing aged) projected to increase from 13 per cent in 1996 to 22 per cent (approximately one in five) by the year 2011⁴. The supposed 'health advantage' of post-Second World War immigrants no longer holds, given the increasing health disparities between ethnic and Anglo-Celtic white Australian older people. For example, ageing Greek-born persons have been found among the groups identified as being the highest users of pain relievers, sleeping tablets and tranquilizers.⁴

4. Workforce diversity

Queensland Health workforce is also increasingly diverse and reliant on overseas-trained, experienced health professionals. The need to better integrate, accommodate and retain the different expertise that overseas-trained professionals bring to our organisation is critical. By national estimates, a quarter of Australia's workforce is now comprised of overseas-trained and recruited health professionals. Queensland Health is one of the biggest employers and sponsors of 457 Visas, with nurses the top occupational group being recruited under that visa category. The cost of sponsoring and recruiting a nurse under the 457 Visa for one Queensland Health facility was approximately \$18,000 per nurse recruit in 2008. The considerable investment Queensland Health currently makes in recruiting human resources needs to be retained.

5. Ensuring a health system is able to respond to diversity in clients and in staff

Client impact

Significant gaps and inequities in the treatment and level of care experienced by CALD consumers have been found across the Australian health care system. Research indicates a strong link between cultural incompetence and poor quality outcomes and significant risks.

- A 2005 Australian study found that patients who did not speak the same language as the health care professional were at double the risk of receiving less than optimal care, compared to patients who shared the same language as the health care providers⁵.
- Longitudinal studies on refugee and humanitarian entrants reveal that the cumulative effects of the social determinants of health, including a range of pre- and post-arrival socioeconomic conditions, have resulted in a high burden of physical and mental disease in these groups⁶. In addition, significant access barriers exist for refugees and a number of highly publicised cases of preventable adverse events have occurred in Australia. For example, in November 2005, a newly arrived two-year-old refugee child from Burundi died in an apartment in Sydney of a treatable disease. He entered the country with medical records outlining his medical condition, but when he became ill within days of arrival, his parents did not know how to access medical care or contact emergency services⁷.

Staff impact

As stated above under workforce diversity, Queensland Health expends considerable funds to recruit overseas-trained staff and it is therefore important to retain these workers.

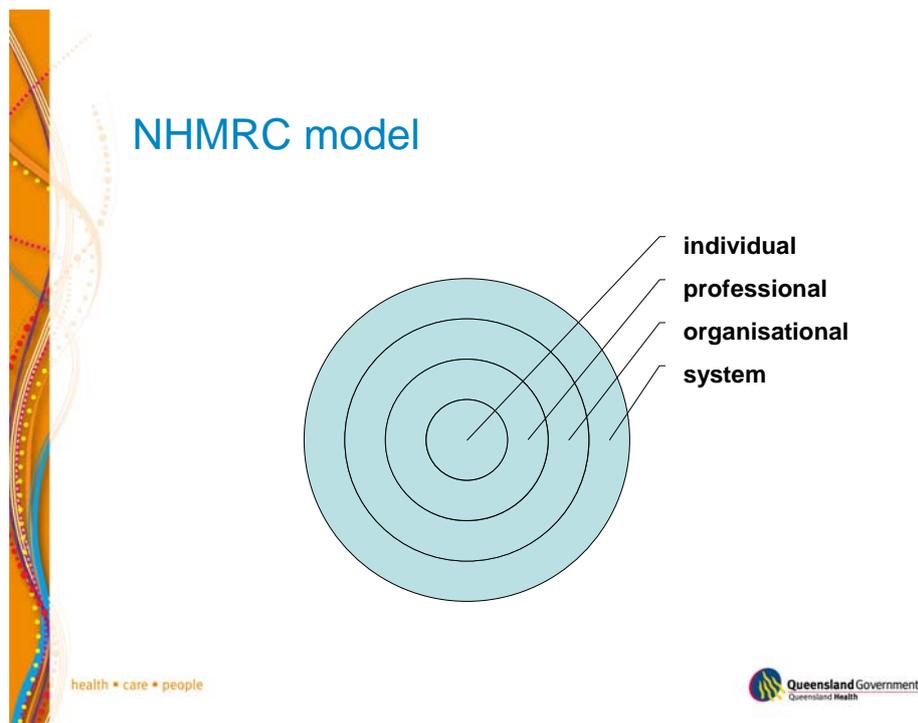
Poor interpersonal work relations, misunderstanding and intercultural conflict has a negative impact on workforce retention, employee satisfaction and productivity. Communication issues are one of the major contributing factors in patient safety and quality, particularly when communication breakdown occurs across teams⁸. These issues also affect occupational health and safety and team functioning. Poor integration of overseas-trained staff, leading to cross-cultural misunderstanding and conflict, are likely to heighten unhealthy inter-group dynamics⁹.

6. Developing an effective response to a diverse population

Given the range of demographic and workplace shifts and pressures, it is imperative that Queensland Health staff know how to respond appropriately to CALD patients, and understand that culture is an integral aspect of patient-centred care. Central to this is the need to recognise spirituality and spiritually-based beliefs and approaches to health and treatment, particularly in relation to the services delivered by Queensland Health. It is imperative that staff know how to work with and across diverse cultures given the increasing number of CALD teams within the workplace.

As the population grows and becomes increasingly multicultural, the need to have cross-cultural capability embedded and routinely practiced within health service delivery, policy development and planning is vital. Multiculturalism is no longer a 'minority' issue but a whole-of-population concern that needs to be substantially integrated in all of our work and complementary to the sustained efforts to overcome the disparities in Aboriginal and Torres Strait Islander health and wellbeing.

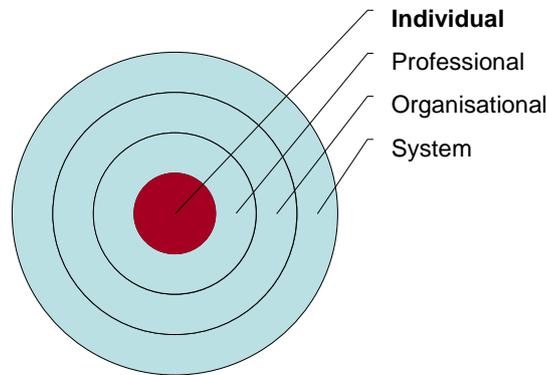
The National Health Medical Research Council (NHMRC) identifies that a culturally competent organisation requires action at four levels:



The Aboriginal and Torres Strait Islander Health Strategy Unit is progressing work that will identify the capabilities at the organisational and system levels, with these having application for both Aboriginal and Torres Strait Islander and CALD populations.



Our target



This project focuses on the individual cross-cultural capabilities that all health employees need. There are a range of systemic, organisational and behavioural changes that are required to develop organisational and statewide cross-cultural capability. This work is being led by the Queensland Health Multicultural Program and will take some time to progress as does any major cultural shift across organisations. However, both ‘top-down’ and ‘bottom-up’ approaches are needed for organisational cross-cultural capability to occur. In addition to an organisational commitment to cultural competency, individuals within the organisation also need to attain individual cultural competency.

“Whether or not an organisation embraces cultural competency, change must begin with each individual by engaging with others to challenge and question behaviours of institutional practices.”¹⁰ (p. 31)

Currently, there is a great deal of work in the area of developing cultural competency but a number of competing definitions and lack of practical applications continues to render this field unclear^{11,12}. This document addresses this gap by clarifying what it means to provide culturally competent care for CALD consumers.

7. Defining the field

The field of cultural competency in health services has been increasingly seen as integral to health services worldwide. There are a number of approaches, frameworks and standards currently being used. These developments are further outlined under Section 8 - Methodology.

Cross-cultural competence is defined as “the ability of systems, organisations, professions and individuals to work effectively in culturally diverse environments and situations. Cross-cultural training, which aims to develop the awareness, knowledge and skills needed to interact appropriately and effectively with culturally diverse customers and co-workers, is an important element in the development of cultural competence¹³” (p. 2)

Other terms such as ‘cultural security’ or ‘cultural safety’ are used to describe the way organisations are able to make clients from CALD backgrounds feel ‘safe’ and ‘secure’ in the dominant Anglo-Celtic institutional culture. These terms have been particularly used in the Indigenous health care context, firstly in Maori-focused health services in New Zealand and in Western Australia and the Northern Territory. Other terms such as cultural awareness, cultural sensitivity and culturally appropriate care are used to describe responsive ways of delivering individual patient-centred care that also considers cultural factors.

Defining cross-cultural capability

Cross-cultural capability refers to an individual’s capacity to enable and provide quality, safe and efficient services to people from different cultural and linguistic backgrounds, starting with accounting for different cultural perspectives on health and health care. It also builds the capacity of individuals to work in diverse teams, with colleagues with different perspectives and from various cultural and linguistic backgrounds.

The cross-cultural capabilities will define what Queensland Health expects of staff when they commence their careers with Queensland Health and as their career progresses. Staffs are not expected to be cultural experts – not even of their own culture. One’s own culture is often so ‘natural’ and feels so ‘normal’ it is entirely invisible from an insider perspective. It is not possible to gain insider knowledge of a different culture, nor is it ethical to presume that in-depth knowledge and understanding of a different culture can be gained in a short time. The purpose of the cross-cultural capabilities is not to impose impossible standards on staff. Staffs in a healthcare setting are not expected to have an anthropological, in-depth and rich understanding of an unfamiliar culture. However, drawing on some of the tools that cultural and medical anthropologists and other experts in social disciplines have developed, allows staff to gain a richer conceptualisation of culture and skills when working across cultures. It can also help build the capacity of staff to identify what they may need to know and to draw on existing resources and expertise to improve the responsiveness and flexibility of their services.

Cross-cultural capabilities are a continuous improvement model. This is an important starting point because 'culture' is not easy or simple, nor is it homogenous or fixed. There is a great deal of discrepancy within particular cultures and communities, despite the existence of dominant traits and characteristics. The Australian multicultural context is subject to change, including shifts in demographics and transformations in community profiles and composition. External forces around global migration, economics, social conditions and conflicts, domestic and international labour markets are all factors that must be considered.

Given the dynamic nature of culture itself, the cross-cultural capabilities are adaptable to any number of local cultural and intercultural contexts, over time.

The knowledge, skills, and behaviour outlined in this paper outline the key considerations and foundational principles. These are not specific to a particular CALD community, although some information and case scenarios are based on the interaction of different cultural norms and communities within the mainstream health system. These knowledge, skills and behaviours can be applied to a range of intercultural situations whether this be working with a CALD patient or working across cultures within a team. While we need to recognise that Queensland Health is based on Western biomedical models of health and organisational culture, there is a great deal of diversity within and across Queensland Health.

8. Methodology

A literature review was undertaken to develop the cross-cultural capabilities. A summary is provided below.

Search terms: Cultural competency/standards/guidelines/strategies; cross-cultural; cultural competency training; diversity management; multicultural.

Years searched: 2000-2008

Databases in scope: CINAHL, OVID and CKN.

Results: 188 articles deemed in scope, including both grey literature and peer-reviewed journal articles.

From this initial search 59 peer-reviewed articles were selected for review and clustered around identified themes: link to patient safety and quality; effectiveness of cultural competency and training; the business case for cultural competency and any article which comprised a systematic review of the literature. This literature has been integrated into supplementary material for the cross-cultural capabilities (background paper; cross-cultural learning and development strategy) and has informed the basis of the cross-cultural capabilities.

Parameters: Articles that were deemed out of scope were those that were too specific in terms of region, ethno-cultural community, locality or health specialities. Aboriginal and Torres Strait Islander cultural competency material was reviewed on a 'case-by-case' scenario to determine relevance and applicability to the project.

The literature review identified the most commonly accepted elements of:

- a) individual cultural competency
- b) organisational cultural competency
- c) cultural competency assessment tools

A consultation strategy was developed based on the following criteria:

- identification of Australian experts in the field working on large research projects and systematically developing an evidence base in this area
- identification of similar activities and projects occurring across Queensland Health
- what is happening in other departments in cultural competency (consultation with Multicultural Affairs Queensland (MAQ) as the coordinating point for cross-cultural training activities as well as Main Roads, Shared Services Agency, Department of Communities and Queensland Transport)
- identifying Aboriginal and Torres Islander cultural competencies and some of the transferable principles
- consultation with other jurisdictions such as Victoria, New South Wales, Northern Territory and Western Australia
- identification of best practice and consultation with international experts.

Summary of Australian and International developments regarding cross-cultural capabilities

In addition to these themes, the following responses and approaches have been developed internationally and in Australia.

New Zealand (NZ): The concept of cultural safety originally developed in NZ nursing and midwifery practice. Cultural safety initiatives and models have been strongly embedded in nursing curriculum and a bi-cultural social framework has been instituted and observed at many levels in the NZ health system. Cultural safety has been taken up in Australia and Canada in Aboriginal health services and training programs.

United States of America (USA): When The Institute of Medicine's Report, Unequal Treatment was released, it presented overwhelming evidence that African-American, Hispanic and other minority, non-English-speaking persons experience vast differences in health care which contributes to disparities in health outcomes. Both system-level entrenched racism and individual incompetency are documented in the literature, as well as a number of adverse events and litigation. The Commonwealth Institute has been leading research in this area, and has found that gross disparities occur even when factoring in health insurance coverage and comparing across both tiers of the health system. A landmark clinical study on asthma care for CALD consumers found a causal relationship between culturally competent care and improved outcomes¹⁴. Further small scale studies have found that culturally appropriate and targeted health promotion and outreach activities have recorded increased awareness and self-care practice¹⁵. In addition, a number of precedent setting cases where negligence, malpractice and incompetence were at fault have resulted in large compensations and a spotlight on the issue of negligence and cultural incompetency. Out of these developments, national standards such as Culturally and Linguistically Appropriate Services in Health Care (CLAS) were set by the United States Department of Department of Health and Human Service (Office of Minority Health). Cultural competency training is attached to accreditation for nurses and doctors and is a widely endorsed and accepted practice. A number of good online modules can be accessed.

An evaluation of the outcomes of the implementation of CLAS found that there have been improvements in subjective, self-assessed measures of provider knowledge and patient satisfaction where there have been culturally sensitive interventions. Increases in uptake, program completion and knowledge were reported in programs that use interpreters, community workers and translated materials. More information can be found at <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

Canada: A number of reports on the need for cultural competency for a multicultural society can be found on the Health Canada website (<http://www.hc-sc.gc.ca>). There have also been a number of landmark legal cases involving lack of competency and negligence in relation to CALD patients¹⁶. Cultural competency has gained a lot of traction particularly in nursing. Position statements and training modules have been developed by various provincial colleges of nurses and have been incorporated into the curriculum.

Canada Health has developed a framework for cultural competency and has identified four elements to cultural competence:

- self-awareness and awareness of one's personal value system
- understanding of the term culture and its place in a health care setting
- sensitivity to the cultural issues of each individual client
- comprehension and ability in using specific methods to deal with cultural issues.

While there is a discrete national First Nations health agenda, program and policy in relation to diversity and multiculturalism in Canada usually includes both migrant/ CALD populations and First Nations. However, the 'cultural safety' movement and Indigenous-specific health services and competency measures are maintained. There is also a strong preference for the term 'underserved' (in the American context) to maintain focus on access and equity issues. The term 'under service' means "there is an increased likelihood that individuals who belong to a certain population, and people can belong to more than one, may experience difficulties in obtaining needed care, receive less care or a lower standard of care, experience different treatment by health care providers, receive treatment that does not adequately meet their needs, or that they will be less satisfied with health care services than the general population."¹⁷

(p. 131)

United Kingdom (UK): The National Health Service (NHS) in the UK focuses on race and difference in spirituality-based cultural issues, as reflective of its racial and cultural make-up. Black and Minority Ethnic (BME) is the terminology used in the UK. Although marginalisation of the overseas-trained and CALD nursing workforce has been found to be a factor in all developed nations studied, studies of CALD nurses' experiences in the UK, USA and Canada have identified issues of racial discrimination, in comparison to other countries with large CALD nurse workforces.

Central and North West London NHS has developed a cultural competency statement and has identified the following steps to cultural competence:

- develop cultural awareness by reflecting on and examining your own values, beliefs and cultural identity
- understand and challenge discrimination and racism in all its forms
- raise awareness of similarities and differences, social disadvantage and healthcare inequalities
- develop cultural understanding by fostering relationships with different cultural groups
- recognise and continuously develop the skills, roles and functions needed to perform cultural assessments; to plan, implement and evaluate culturally sensitive care; and challenge discrimination and prejudice
- arrange cultural encounters and opportunities for healthcare staff to observe culturally sensitive care in action where a model has been implemented successfully
- develop an environment that recognises that managing diversity is a routine aspect of clinical work, not an exceptional event.

European Union: The Amsterdam Declaration was signed by 12 European Union Nations as part of the migrant-friendly hospitals pilot project. A number of recommendations were made for system at individual and professional levels. More information can be found at http://www.interpretsolutions.com/eng/uploads/Descargas/Amsterdam_Declaration.pdf

Australia: In Australia, there is a national agenda in relation to cultural competency in mental health services. The Queensland Transcultural Mental Health Centre has been developing and delivering cultural competency modules for mental health workers for a number of years. Cultural competency is also now part of the university curriculum for mental health.

- Lacks a cohesive national agenda or drive for CALD-specific cross-cultural capability/cultural competency. Key word search of the Department of Health and Ageing (DoHA) website yields very little; some State/Territory initiatives in Aboriginal and Torres Strait Islander cultural awareness (under the cultural respect framework) and cultural competency measures in mental health (National Mental Health Policy) and maternity services. Otherwise fragmented and no clear national policy position, direction or statement on diversity management in health services.
- **Victoria:** The Victorian Department of Health has developed a Cultural Responsiveness Framework – Guidelines for Victorian Health Services. It contains six standards to measure cultural responsiveness in health services. These standards are based on four key domains of quality and safety:
 1. organisational effectiveness
 2. risk management
 3. consumer participation
 4. effective workforce.

The six standards are:

Standard 1: A whole-of-organisation approach to cultural responsiveness is demonstrated.

Standard 2: Leadership for cultural responsiveness is demonstrated by the health service.

Standard 3: Accredited interpreters are provided to patients who require one.

Standard 4: Inclusive practice in care planning is demonstrated, including but not limited to dietary, spiritual, family, attitudinal and other cultural practices.

Standard 5: CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis.

Standard 6: Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness.

- Victorian health services are required to submit a new plan to the Statewide Quality Branch. Reporting on the achievements of the plan will continue to take place annually, through the health services' quality of care report.
<http://www.health.vic.gov.au/cald/cultural-responsiveness-framework#standards>
- The framework resulted from a review commissioned by the Victorian Department of Human Services (now Department of Health) for cultural competency reporting requirements, benchmarks and standards. Health services must submit annual plans and reports.
- Newly registered doctors in Victoria must undertake cultural competency training.
- **New South Wales:** Multicultural units are established across districts but lack a statewide framework. Some excellent work has been done through the Sydney Children's Hospital.
- **Northern Territory:** Strong emphasis on Aboriginal and Torres Strait Islander cultural competency.
- **Western Australia:** Currently also developing cultural competency standards.

Summary of the literature – key themes to date

The Queensland Health Cross-Cultural Capabilities are informed by a comprehensive literature review and consultation with a range of experts working in the field of cultural competency. From this literature review and consultation process, several themes emerged:

- understanding and operating from self-reflection as a means to developing a sustainable and richer appreciation of culture is a critical element of CALD-specific health service
- developing an understanding of 'culture' and development of conceptual models and principles, thereby going beyond culturally and linguistically-specific knowledge and the 'check-list' model
- articulating and defining what cross-cultural capability means for everyday practice at an individual, system, organisational and professional level. Cross-cultural capability needs to be elevated as a workforce and organisation function but individuals need to know what it means for them and how to operationalise it
- the need to provide applicable and measurable knowledge and skill sets (the capabilities) to both provide culturally competent care and to value diversity in the workplace
- the need to strengthen the link between cultural competency and patient safety and quality of care, as well as strengthen standards for cultural competency for professional performance measurement.

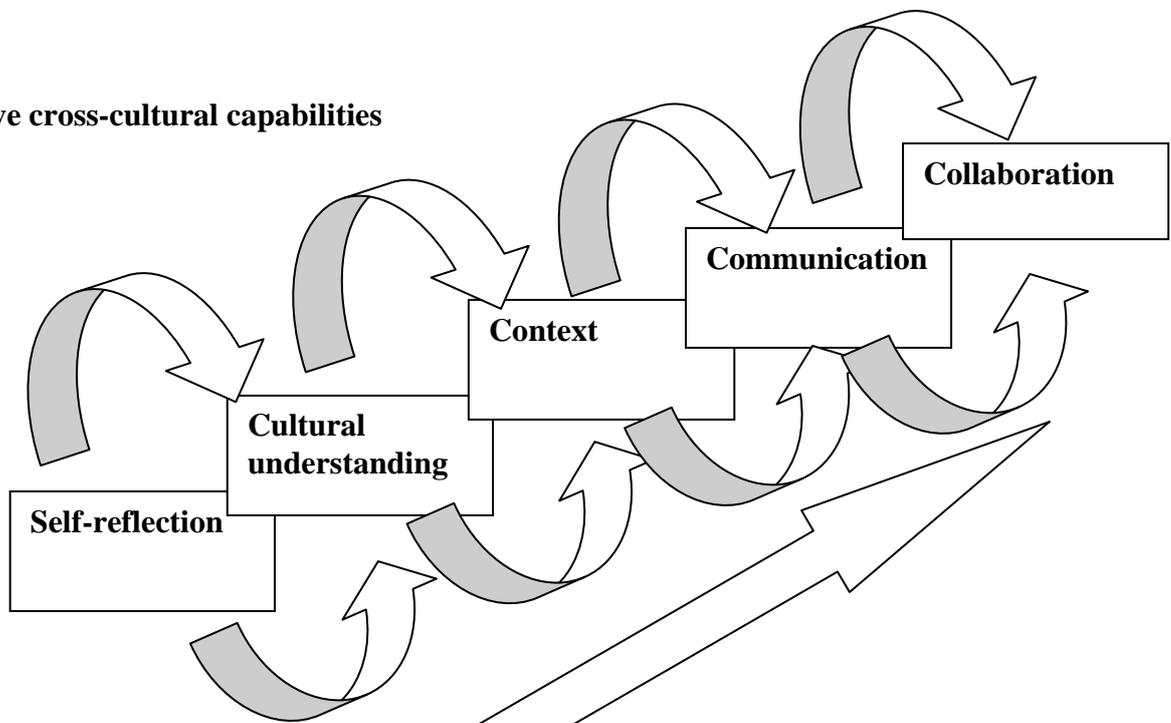
Format of the cross-cultural capabilities

Each cross-cultural capability contains a definition or description of the capability. It identifies what you need to know (knowledge), how you can apply this capability (skills) and the behaviour that should follow from possessing and practicing this capability.

These elements are plotted on matrices with real-life scenarios, drawn from qualitative data from Queensland Health, as well as a range of evidenced-based training vignettes to help illustrate the cross-cultural capability and facilitate an understanding of its relevance and practical application for each individual.

- Knowledge dimension includes specific knowledge of cultural groups, the role of cultural ethnicity in help-seeking behaviours within the health system, and understanding of the barriers encountered by CALD communities.
- Skills dimension includes what you should be able to do and put in practice with the knowledge. This dimension refers to the practical application of the knowledge, and the translation of knowledge and attitudes into culturally correct intervention strategies, involving effective communication with CALD patients and families, and the ability to obtain assistance and access resources.
- Behaviour dimension details the kind of conduct that should be evident and practiced.

Five cross-cultural capabilities



Building culturally competent Queensland Health staff

The five cross-cultural capabilities are expressed as a series of transitions, starting with self-reflection. While becoming culturally competent is, as already stated, based on a continuous improvement model, and is not a simple, linear process, the process for building knowledge and skills needs to be simple. A systematic literature review of cultural diversity and competency found that a critical missing link in approaches is a defined and readily applicable practitioner skill set¹¹. In addition, experts agree that cultural competency needs to begin with self-awareness and self-reflection. The cross-cultural capabilities fill this gap, by identifying and defining tangible capabilities. A linear process is therefore proposed for this purpose. It is therefore recommended that each of the capabilities is worked through in order.

References

1. Department of Immigration and Citizenship. *The People of Queensland Statistics from the 2006 Census*. Department of Immigration and Citizenship: Canberra; 2008. <http://www.multicultural.qld.gov.au/services-resources/documents/People-of-QLD-Publication-Vol-1.pdf>.
2. Office of Economic and Statistical Research. Country of birth by selected local government area (reformed), Queensland, 2006. <http://www.oesr.qld.gov.au/products/tables/country-birth-lga-reformed-qld/index.php>, 2008.
3. Productivity Commission. *Economic Implications of an Ageing Australia*. Productivity Commission: Canberra; 2005. <http://www.pc.gov.au/projects/study/ageing/docs/finalreport>.
4. Johnstone MJ, Kanitsaki O. Population ageing and the politics of demographic alarmism: implications for the nursing profession. *Australian Journal of Advanced Nursing* 2007;26.
5. Johnstone M-J, Kanitsaki O. *Cultural Safety and Cultural Competence in Health Care and Nursing: An Australian Study*. RMIT: Melbourne; 2005.
6. Smith M. Refugees in Australia: changing faces, changing needs. *Medical Journal of Australia* 2006;185:587-588.
7. Mohamud Sheikh-Mohammed CRM, Nicholas J Wood, Julie Leask and David Isaacs. Barriers to access to health care for newly resettled sub-Saharan refugees in Australia. *Medical Journal of Australia* 2006;185:594-597.
8. Hewett DG WB, Gallois C, Ward M, Leggett BA. Intergroup communication between hospital doctors: implications for quality of patient care. *Social Science and Medicine* 2009;69:1732-1730.
9. Dreachslin JL HP, Sprainer E. Workforce diversity: implications for the effectiveness of health care delivery teams. Dreachslin JL, Hunt PL, Sprainer E. *Social Science and Medicine* 2000;50:1403-1414.
10. Adams E. *Positive Practice Frameworks: dKey Cknsiderations for the Development of a Framework to Support the Integration of International Nurses*. International Centre on Nurse Migration: Geneva; 2006. http://www.intlnursemigration.org/assets/pdfs/ICNM_Pos_Practice_Env.pdf.
11. Pearson Aea. Systematic review on embracing cultural diversity for developing and sustaining a healthy work environment in healthcare. *International Journal of Evidence-Based Heathcare* 2007;5:54-91.
12. Dogra N BJ, Park ER, Sprague-Martinez L. The relationship between drivers and policy in the implementation of cultural competency in health care. *Journal of the National Medical Association* 2009;101:127-133.
13. Bean R. *The Effectiveness of Cross Cultural Training in the Australian Context*. Commonwealth of Australia: Canberra; 2006. http://www.immi.gov.au/media/publications/research/cross_cultural/Contents_Executive_Summary.pdf.
14. Lieu Tea. Cultural Competence Policies and Other Predictors of Asthma Care Quality for Medicaid-Insured Children *Journal of the American Academy of Pediatrics* 2004;114:102-111.
15. Wang Jea. Development and Evaluation of a Culturally Tailored Educational Video: Changing Breast Cancer-Related Behaviors in Chinese Women *Health Education and Behaviour* 2008;35:806-820.
16. Solomon R. A Primer on Law for Social Workers: Consent, Competency and Substitute Consent. *Political is Personal*. Ontario: University of Western Ontario; 2005.
17. Canada H. *Certain Circumstances: Issues in Equity and Responsiveness in Access to Health Care in Canada*. Ontario; 2001. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2001-certain-equit-acces/2001-certain-equit-acces-eng.pdf.

