

Queensland Health

Literature review

Best practice multicultural policy implementation

March 2012

**Attachment B to the
Queensland Health guideline for
multicultural health policy implementation**

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1. Introduction

In 2012 Queensland Health conducted a literature review to inform the development of the Queensland Health guideline to implement the Queensland Government's 2011 Multicultural Policy and 2011 Language Services Policy. The literature review identified emerging trends and best practice in the following seven outcome areas:

- Leadership
- Interpreter services
- Resource development and translation
- Community engagement
- Data collection
- Culturally competent staff
- Recruitment and retention

The review adopted a systematic approach to identify, critically evaluate and synthesise relevant information from international, Commonwealth and state documents, academic databases, refereed journal articles, government policy statements and government and non-profit organisation publications.

2. Literature review methods

2.1 Search strategy

A search of international, Commonwealth and state documents was conducted using various combinations of key words and phrases. For example, interpreter services; cultural diversity and cultural competence; culturally and linguistically diverse service standards; data standards and ethnicity data; safety and culture in health care, community engagement or community participation; safety and risk in health care settings; evidence best practice or benchmarks or trends for health services.

A further search was carried out using academic databases (Medline, CINAHL, PsycINFO, Cochrane and a range of online full text journals). The types of references used include systematic reviews, meta-analysis, literature reviews, government policy statements and standards.

2.2 Inclusion and exclusion criteria

2.2.1 Inclusion

The searches were conducted for publications dating back to 2005, English-language, systematic review, meta-analysis and literature review. No other limitations were set.

2.2.2 Exclusion

Articles in which the title and abstract clearly did not confirm a focus on the seven outcome areas were excluded.

2.3 Information sources

The above inclusion/exclusion criteria were applied to the following databases:

- Pubmed/Medline
- Cumulative Index to Nursing and Allied Health Literature (CINAHL)
- The Agency for Healthcare Research and Quality website
- Multicultural Australia and Immigration Studies (MAIS)
- Cochrane Library
- Proquest
- Sage Journals on-line
- Google Scholar
- Georgetown University- National Centre for Cultural Competence website
- European Commission Migrant Friendly Hospitals Project website
- Commonwealth Government Websites
- State Government Websites (New South Wales, Victoria, Queensland, South Australia, Australian Capital Territory, Western Australia and Northern Territory)
- Informit
 - PsycINFO
 - APA-FT
 - Families & Society Collection
 - Humanities & Social Sciences Collection
 - APAIS-Health
 - Health & Society
 - AMI
 - Health Collection
- ARCHI (Australian Resource Centre for Healthcare Innovations)
- CABI - Global Health

3. Leadership and partnership

3.1 Organisational cultural competency frameworks

In 2009, Queensland Health endorsed an organisational cultural competency framework. This framework was based on a review of existing organisational cultural competency guides and frameworks and a review of literature reviews and expert interviews as follows:

Existing frameworks

- National Health and Medical Research Council guidelines for policy and planning in culturally competent health care
- British Columbia Ministry for Children and Families Vancouver Ethnocultural Advisory Committee Cultural Competency Assessment Tool
- Georgetown University National Centre for Cultural Competence - Cultural competence: Definition and conceptual framework
- Victorian Department of Health - Cultural Diversity Planning framework and standards
- European Union Migrant-Friendly Hospitals – Amsterdam Declaration
- US Department of Health and Human Services - National Standards on Culturally and Linguistically Appropriate Services
- US Department of Health and Human Services Organizational Cultural Competency Assessment Framework.

Literature reviews

- Andrulis and Brach (2007)
- Johnstone and Kanitsaki (2008)
- Brach and Fraserictor (2000)
- Anderson, Scrimshaw, Fullilove, Fielding and Normand (2003)
- Pearson et al (2007)
- Betancourt, Green, Carrillo and Ananeh-Firempong (2003)

Expert interviews

Queensland Health consulted a number of experts working in the field in Australia (and overseas) to find out what they thought was key to building cultural competency (at both individual and organisational level) in a healthcare organisations. These included:

- Judith Miralles - Judith Miralles and Consultants (Co-author of the National Health and Medical Research Council cultural competency framework)
- Prof Hung Le - Director of Medical and Cultural Education, Northern Territory General Practice Education
- Dr Sharon Chalmers - Centre for Cultural Research, University of Western Sydney, Sydney Children's Hospital
- Dr Jo Travaglia - Medical Anthropologist, University of New South Wales
- Prof Megan-Jane Johnstone - Faculty of Health, Nursing and Medical Sciences, Deakin University
- Prof Alan Pearson - Joanna Briggs Institute, Royal Adelaide Hospital
- Prof Rani Srivistava - Deputy Chief, Nursing Practice, Centre for Addiction and Mental Health, Ontario Canada - (Published evidence synthesis and developed Ontario nursing cultural competency standards)
- Ms Lidia Horvat - Manager, Cultural Diversity Unit, Victorian Department of Health

3.2 Queensland Health Organisational Cultural Competency Framework

The Queensland Health definition of organisational cultural competency comprises eight elements as shown in Figure 1. Each of these elements are core outcome areas in the Queensland Health Strategic Plan for Multicultural Health 2007 – 2012. As shown in figure 1, the outcome areas align with the policy themes of the Queensland Government Multicultural Policy (shown in outer ring).

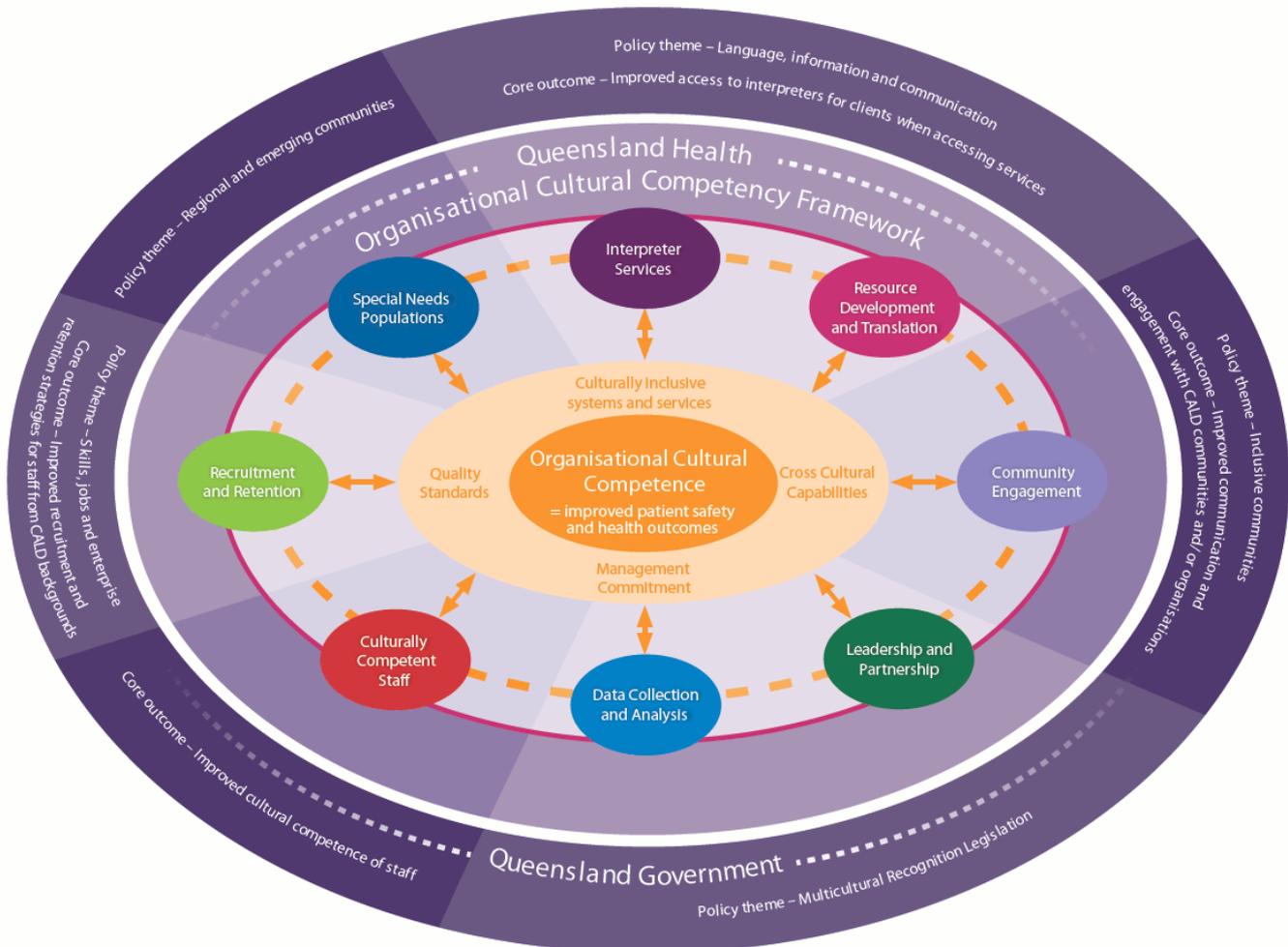


Figure 1: Queensland Health Organisational Cultural Competency Framework

The framework identifies the eight core outcome areas which require action and four foundation areas which are necessary to achieve organisational cultural competency.

The eight core outcome areas are:

- Interpreter services
- Resources development and translation
- Community engagement
- Leadership and partnership
- Data collection and analysis
- Culturally competent staff
- Recruitment and retention
- Special needs population

The four foundation areas are:

- Management commitment
- Quality standards
- Culturally inclusive systems and services
- Cross cultural capabilities

The current review of the literature did not identify any further literature reviews or frameworks since 2009 and therefore this framework remains current. However the review did identify self assessment tools for organisations to evaluate their performance in achieving cultural competency and to identify areas for improvement (Olavarria, Beaulac et al. 2009; Weech-Maldonado, Dreachslin et al. 2012).

In the paper by Weech-Maldonado and colleagues they report the development of the Cultural Competency Assessment Tool for Hospitals (CCATH) to assess adherence to the US national standards for culturally and linguistically appropriate services (CLAS) (Weech-Maldonado, Dreachslin et al. 2012). The aim of the 14 CLAS standards is to provide direction for hospitals to achieve cultural competency when delivering services to eliminate racial and ethnic health disparities (Weech-Maldonado, Dreachslin et al. 2012).

The CCATH for hospitals is based on the following 12 composite scales (subdomains):

- Leadership and strategic planning
- Data collection on inpatient population
- Data collection on service area
- Performance management systems and quality improvement
- Human resource practices
- Diversity training
- Community representation
- Availability of interpreter services
- Interpreter services policies
- Quality of interpreter services
- Translation of written materials
- Clinical cultural competency practices

These subdomains address each core outcome area identified in the Queensland Health Organisational Cultural Competency Framework, with the exception of Special Needs Populations.

The literature review by Olavarria and colleagues (Olavarria, Beaulac et al. 2009) examined the literature to:

- identify key standards to define culturally competent organisations
- outline the core elements for evaluating cultural competence.

The review identified five key areas applicable for community health and social service organisations:

- Organisational norms, principles and policies
- Asset and need identification
- Human resources management
- Services and service delivery
- Community consultation, partnership and information exchange.

The authors recommended using these five broad key areas to develop cultural competency standards relevant to their own organisation. Olavarria et al's definition of culturally competent organisations addresses:

- Leadership and partnership
- Data collection
- Recruitment and retention
- Interpreter services, resource development and translation
- Community engagement.

Queensland Health's Organisational Cultural Competency Framework is considered more comprehensive with additional recognition of special needs populations and culturally competent staff.

3.3 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

The Queensland Health Organisational Cultural Competency Framework remains current and is a comprehensive assessment. It should remain as the organisational framework for Queensland Health.

4. Interpreter services

4.1 Search strategy

A structured search was conducted for studies published from 2005–2012. The following search terms were used including the default medical subject heading terms:

- Communication Barriers or Foreign Language Translation or Language Proficiency or Medical Interpreter or Interpreters or Interpreter Services or limited English Proficiency or LEP
- Health Care Delivery or Health Care Services or Hospitals
- Quality of Care or Client Satisfaction
- Trend or Evidenced-Based Practice
- Ethnic Groups or Minority Groups.

The search terms were further limited to English-language, meta-analysis and review publications. An internet search was also conducted to identify national and international policies and standards.

4.2 Results

The initial search yielded 43 articles (18 systematic reviews, 1 randomised control study, 4 meta-analysis, 17 literature reviews, 1 clinical review, 1 qualitative analysis and 1 integrative review). The articles were screened for eligibility at the abstract review level and were excluded if they:

- did not directly relate to interpreter services
- had a mental health focus
- were on interpreter training.

From this screening, 17 articles were identified for full-text or article review. At this second level, three of the articles did not meet eligibility criteria. Therefore, for this review, data were synthesized from 14 eligible articles that focused specifically on interpreter services.

4.3 Common themes of policies and standards

Interpreter services is a core component of service delivery as evidenced by existing Australian health policies and standards, and international standards outlined in Attachment 1.

The policies and standards on interpreter services identified the following common themes:

- Consumer rights to an interpreter
- Qualified interpreters
- Family members, friends and children are not to be used as interpreters.

4.3.1 Consumer rights to an interpreter

National

All of the reviewed health department policies of other Australian jurisdictions state that consumers from a non-English speaking background are to be informed of their right to a professional health care interpreter (South Australia Health 2003; Victorian Government Department of Human Services 2005; NSW Health 2006; ACT Health 2008; Department of local Government and Housing 2009; Cultural Diversity Unit Public Health Division 2011).

The Australian National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care 2011) clearly outline (table 1) standards, criteria and actions required by hospitals to ensure consumers, families and carers are provided with information that is understood and meaningful.

Table 1. Australian National Safety and Quality Health Services Standards relevant to Interpreter Services

This criterion will be achieved by:	Actions required:
Patients rights and engagement	
1.18 Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment	1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand
Documentation of patient information	
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care	4.6.2 The medication history and current clinical information is available at the point of care
Communicating with patients and carers	
4.15 Providing current medicines information to patients in a format that meets their needs whenever new medicines are prescribed or dispensed	4.15.1 Information on medicines is provided to patients and carers in a format that is understood and meaningful
9.7 Ensuring patients, families and carers are informed about, and are supported so that they can participate in, recognition and response systems and processes	9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: <ul style="list-style-type: none"> • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration
9.9 Enabling patients, families and carers to initiate an escalation of care response	9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response 9.9.2 Information about the system for family escalation of care is provided to patients, families and carers

International

The United States National Standards for Culturally and Linguistically Appropriate Service (CLAS) mandate that health services must provide to consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services. Health services must also make available patient-related materials and signage in the commonly encountered languages of the commonly encountered groups (U.S. Department of Health and Human Services and Office of Minority Health 2011).

In the United Kingdom, the *Race Relations (Amendment) Act 2000* and the *Human Rights Act 1998* make it imperative for public organisations, including primary care trusts (PCT), other NHS bodies and local councils, to provide language and other communications support to individuals seeking help (Department of Health and Health and Social Care Information Centre 2005).

The New Zealand Core Standards for Safety and Quality in Health state that health services are responsible for providing appropriate information needs including processes for responding to language needs including interpreter services (Joint Accreditation System of Australia & New Zealand 2007).

4.3.2 Qualified interpreters

The Victorian Department of Human Services Language Services Policy, NSW Health Policy Directive on interpreter services, and the Australian Capital Territory Multicultural Strategy 2006-2009 recognise the importance of using qualified interpreters (Victorian Government Department of Human Services 2005; NSW Health 2006; Cultural Diversity Unit Public Health Division 2011).

The use of bilingual staff as interpreters is not supported in NSW or Victorian health policies (NSW Health 2006; Cultural Diversity Unit Public Health Division 2011).

4.3.3 Family members, friends and children are not to be used as interpreters

All policies and standards reviewed state that children are not to be used as interpreters. Most of the policies and standards do not recommend the use of family and friends as interpreters as the consumer may feel constrained talking about personal matters and the medical information may not be conveyed accurately. However, the policies and standard do acknowledge that they can be used in life threatening emergencies to ascertain immediate diagnosis or treatment. This is to be documented in the consumer's health record.

Many of the policies and standards do make allowance for cases when the consumer refuses an interpreter or when the consumer requests a family member or friend. The policies and standards recommend the development of a procedure by the health service for these occurrences and to always document this in the consumer's health record.

4.3.4 Related Queensland policies, procedures and standards

The Queensland policies, procedures and standards reviewed were:

- The Queensland Government Language Services Policy 2011
- Queensland Health Language Services Policy 2000
- Mater Health Services Interpreting Service Policy
- Princess Alexandra Communication Strategies (Language, Speech, Hearing) procedures
- National Safety and Quality Health Services Standards

These Queensland policies included the common themes identified in section 4.3.1-4.3.3.

4.4 Common themes from the literature

The articles on interpreter services in health care identified the following common themes:

- Patient safety and health outcomes
- Patient satisfaction/experience
- Barriers to accessing care.

4.4.1 Patient safety and health outcomes

The literature demonstrated that limited English proficiency is independently associated with adverse health outcomes and preventable medical errors. The literature review by Dragan found that "the evidence demonstrates adverse effects linked to the lack of appropriate interpreter service support" (Dragan 2009 p.11). The systematic review by Flores identified that the use of trained professional interpreters improved communication (Flores 2005) and was associated with less medical tests, less test costs, less frequent hydration and a lower risk of hospitalisation (Flores 2005 p.292).

Karliner and colleagues, in a systematic review on professional interpreters and clinical care, reported a similar outcome to Flores and Dragan. The researchers found that using professional interpreters was associated with improved clinical outcomes, patient satisfaction and less communication errors and additionally raised the quality of care to the same level as that of a consumer without language barriers (Karliner, Jacobs et al. 2007).

4.4.2 Patient satisfaction/experience

In randomised control trial, Bagchi and colleagues found that a key to improving satisfaction is to reduce language barriers for consumers with limited English proficiency and that professional interpreters greatly improved the satisfaction of both consumers and healthcare providers (Bagchi, Dale et al. 2011 p.1). Bagchi noted that consumer satisfaction of healthcare services is directly related "with improved patient understanding of self care and follow-up plans, reduced errors and better treatment adherence" (Bagchi, Dale et al. 2011 p.1).

Flores, in her systematic review, identified that trained professional interpreters positively affected the satisfaction of non-English speaking consumers (2005). The literature review by Poureslami and colleagues, found that the use of professional interpreters facilitated a positive experience of the healthcare system (Poureslami, Rootman et al. 2007).

4.4.3 Barriers to accessing care

In the literature reviewed, language and communication consistently emerged as the main barrier to accessing services. In their systematic review, Wilson and colleagues identified that the "providers' lack of cultural understanding and effective communication may be a barrier to improving access" for ethnic minorities living with diabetes (Wilson, Alam et al. 2011 p.5). A lack of understanding between patient and provider was regularly reported, highlighting the need for further strategies by health care services such as making full use of interpreter services (Wilson, Alam et al.

2011). Radermacher and colleagues (2008) reported a similar barrier in their review on service provision for older people from a culturally and linguistically diverse (CALD) background. They identified that the main barrier to service provision is not speaking the same language as the consumer (Radermacher, Feldman et al. 2008).

Schouten and Meeuwesen’s literature review reported that language barriers can lead to “an increased chance of non-compliance, feelings of fear and despair, and problems in achieving rapport” (2006 p.31). A number of European studies included in their review indicated that limited language proficiency is negatively related to the consumer’s perception of the quality of communication between themselves and the doctor. The systematic review by Poureslami and colleagues identified that the inability to speak the language of the doctor was regarded as an important obstacle in seeking care. (Poureslami, Rootman et al. 2007 p.48). They reported that the “main obstacle in patient-provider communication is considered to be linguistic difference, particularly when the patient’s first language, or the language spoken at home is not the prevalent language of the healthcare system”.

4.5 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

4.5.1 Summary of findings from policies, standards and literature

The literature review conducted for this paper identified links between the use of interpreters and improved health outcomes, patient safety, and patient satisfaction/experience. It also identified linguistic barriers as key to patient perceptions of the quality of care and communication received. The literature review supports the use of interpreters to improve the health outcomes and experience of consumers.

The policies and standards reviewed in this paper identified that the development of policy on the use of interpreters should address the following common issues:

- Informing consumers who are not proficient in English of their rights to an interpreter
- The use of qualified interpreters
- The use of family or friends as interpreters only in emergency situations and never using children as interpreters
- The use of bilingual staff as interpreters only in emergency situations
- A procedure developed on the notation of a consumer’s refusal to have an interpreter used in a health service.

The above common issues are included in the guideline and related documents as follows:

Included as considerations in guideline on best practice multicultural policy implementation
Consumers are informed of their right to an interpreter.
Staff use the highest qualified professional interpreter available as per <i>Queensland Health Interpreter Services order of preference for engaging interpreters protocol</i> .
Bilingual speakers (family, friends and people without interpreter qualifications) may be used for simple day to day communication.
Staff are aware of their responsibilities in the case of a medical emergency where no professional interpreter is available, either onsite, via VRI or telephone. In this situation, it is recommended that staff use bilingual speakers in the following order of preference as per the <i>Queensland Health Working with Interpreters Guidelines</i> : <ol style="list-style-type: none"> 1. local workforce (health professionals and other health employees), and 2. relatives or friends, except for children (under 18) who are never to be used as interpreters.
In circumstances where a bilingual speaker has been used, it is recommended that the workforce clearly document in the consumer’s health record that it was not possible to access a professional interpreter.
Staff are aware of their responsibilities if a consumer refuses an interpreter. In this situation, it is recommended that staff ensure the consumer understands the reason for using an interpreter, including that health professionals need to understand the information while it is being conveyed to the consumer. If the consumer still refuses, it is recommended that staff document the discussion and the reason for proceeding with the services without an interpreter in the consumer’s health record.

5. Resource development and translation

5.1 Search strategy

A structured search was conducted for studies published from 2005–2012. The following search terms were used including the default medical subject heading terms:

- Translation or translating or translations or languages
- Consumer health information or health communication or communication
- Health care delivery or health care services or hospitals
- Quality of care or client satisfaction
- Trend or evidenced-based practice
- Ethnic groups or minority groups or multicultural or culturally diverse
- Publications or health messages or health information or media or resources.

The search terms were further limited to English-language, meta-analysis and review publications. An internet search was also conducted to identify national and international policies and standards.

5.2 Results

The initial search yielded 20 articles (10 systematic reviews and 10 literature reviews). The articles were screened for eligibility at the abstract review level and were excluded if they:

- did not directly relate to resource development and translation
- had a mental health focus
- focused on resources used during cultural competency training
- were of a clinical interventions rather than resource development and translation.

From this screening, 12 articles were identified for full-text or article review. At this second level, four of the articles did not meet eligibility criteria as they focused on decision aid tools, access to services and health perceptions. Therefore, for this review, data were synthesized from eight eligible articles that focused specifically on resource development and translation.

5.3 Common themes of policies and standards

National

All of the policies of other Australian jurisdictions reviewed recommend that appropriate written information be provided to consumers, carers and families in their own language (South Australia Health 2003; Northern Territory Government 2005; NSW Health 2005; Victorian Government Department of Human Services 2005; ACT Health 2008). The only jurisdiction that developed further specific information on the development of resources for ethnic and minority groups was NSW. The *Multilingual Health Resources by AHS, DoH and NGOs* guideline outlines the requirements for the development of multilingual resources for consumers (NSW Health 2005). The guideline recommends that the community must be taken into account, alternatives to written information such as signs/symbols and audiovisual formats should be considered, the language selected should reflect the need for the resource and accredited translators should be given the task of translating and checking the information.

Although the Victorian Department of Health has not created a similar guideline, the publication *Improving the Use of Translating and Interpreting Services: A Guide to Victorian Government Policy and Procedures*, produced by Victorian Office of Multicultural Affairs, contains standards for when and how to use interpreters and translators to guide government agencies (Victorian Office of Multicultural Affairs 2003). Health services are also required under the *Victorian Cultural Responsiveness Framework* to report on the number of community languages used in translated materials and resources (Victorian Department of Health 2009).

The Australian National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care 2011) clearly outline (figure 2) standards, criteria and actions required by hospitals to ensure consumers, families and carers are provided with information in a format that is understood and meaningful.

Table 2. Australian National Safety and Quality Health Service Standards relevant to resource development and translation

This criterion will be achieved by:	Actions required:
Consumer partnership in service planning	
2.4 Consulting consumers on patient information distributed by the organisation	2.4.1 Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients) 2.4.2 Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients
2.7 Informing consumers and/or carers about the organisation's safety and quality performance in a format that can be understood and interpreted independently	2.7.1 The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance
Communicating with patients and carers	
4.15 Providing current medicines information to patients in a format that meets their needs whenever new medicines are prescribed or dispensed	4.15.1 Information on medicines is provided to patients and carers in a format that is understood and meaningful 4.15.2 Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients
7.10 Providing information to patients about blood and blood product use and possible alternatives in a format that can be understood by patients and carers	7.10.1 Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful
8.9 Informing patients with a high risk of pressure injury, and their carers, about the risks, prevention strategies and management of pressure injuries	8.9.1 Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful
9.7 Ensuring patients, families and carers are informed about, and are supported so that they can participate in, recognition and response systems and processes	9.7.1 Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: <ul style="list-style-type: none"> • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration
9.9 Enabling patients, families and carers to initiate an escalation of care response	9.9.1 Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response 9.9.2 Information about the system for family escalation of care is provided to patients, families and carers

International

Internationally, the United States, New Zealand and the United Kingdom require health services to respond to the language needs of commonly encountered ethnic and minority groups in the service area through the use of easily understood materials (Standards New Zealand 2008; U.S. Department of Health and Human Services and Office of Minority Health 2011; United Kingdom Department of Health 2011).

5.3.1 Related Queensland policies, procedures and standards

The following existing Queensland policies, procedures and standards are consistent with the resource development and translation requirements outlined in the national and international policies and standards:

- The Queensland Government Multicultural Policy
- Queensland Health Multicultural Policy
- Queensland Health Practical guide to organising translations for staff
- Queensland Health Health Care Providers' Handbook on Muslim Patients (2nd edition)
- Queensland Health Health Care Providers' Handbook on Sikh Patients
- Queensland Health Health Care Providers' Handbook on Hindu Patients
- Queensland Health Multicultural Clinical Support Resource

5.4 Common themes from the literature

The articles on resource development and translation in health care identified the following common themes:

- The use of community resources to culturally tailor and promote health messages
- Inequality and barriers to access online resources
- The use of pictorial resources.

5.4.1 The use of community resources to culturally tailor and promote health messages

Culturally and linguistics diverse (CALD) communities have been identified as having considerable language and health literacy difficulties (Kreps and Sparks 2008). The literature review by Kreps and Sparks (2008) examines the strategies for providing vulnerable immigrant populations with appropriate health information to make informed decisions regarding their health. The review identified that cultural backgrounds need to be accounted for in health communication as it is a powerful influence on communication methods. It is also particularly important to determine the consumers' unique health beliefs, values, language skills, health literacy levels, health seeking behaviour and use of media (Kreps and Sparks 2008). The authors reported that stereotypical health information about communities has led consumers to seek information from health care providers that share similar cultural backgrounds and beliefs. Kreps and Sparks identified the critical factor to adapting health messages is the "unique needs and communication orientation of specific audiences" (2008 p.329) by using appropriate media, images and examples that reflect their belief and values. It is also essential with any health communication to pre-test sample health messages with the desired audience before implementation to enable refinement and shaping of the message.

The following practical strategies were identified in the literature review (Kreps and Sparks 2008):

- Involve consumers in health communication efforts
- Develop partnerships to support intervention efforts
- Communication training for both health care provider and consumer
- Use culturally appropriate messages and materials
- Use family and the community to deliver and reinforce messages
- Provide consumers with choices and options for promoting their health.

The systematic review by Neto and colleagues (Netto, Bhopal et al. 2010) identified five principles for adapting health education interventions for ethnic groups:

- Use community resources to promote and increase accessibility
- Identify and address barriers to access and participation
- Develop communication strategies which are sensitive to language use and information needs
- Work with cultural or religious values
- Accommodate varying degrees of culture identification.

The review revealed considerable support for adapting interventions to increase their cultural appropriateness for ethnic communities. If it is not possible to implement all the five principles, prioritising the first principle using community resources to increase awareness and accessibility "is likely to facilitate the application of other principles" (Netto, Bhopal et al. 2010 p.255). The literature review by Feldman also provides support for using community organisations or outreach sessions as a means of increasing accessibility (Feldman 2006). Feldman emphasised that written resources in relevant languages need to be accessible to the needs to the target population for them to be effective.

5.4.2 Inequality and barriers to accessing online resources

Research in the area of online health resources for CALD communities is limited and the evidence on this topic is related to online cancer information. Neuhauser and Kreps (2008) conducted a literature review on online cancer communication. The review found that over the past two decades "online communication can reduce cancer risks, improving screening and enhance patient care" (Neuhauser and Kreps 2008 p.372). Neuhauser and Kreps (2008) also found that online cancer information was less effective among diverse populations as they lacked adequate cultural tailoring for specific ethnic groups and did not meet the literacy, cultural and linguistic needs of diverse populations. They were often "generic, passively delivered and not sufficiently relevant to diverse people's lives" (Neuhauser and Kreps 2008 p.372). The research revealed that 80-90 per cent of searched health websites in 227 countries did not translate information into multiple languages, exceeded the reading levels of the average person and did not include issues that were specific for ethnic groups (Neuhauser and Kreps 2008).

The literature review on online use of African Americans by Fogel and colleagues (Fogel, Ribisl et al. 2008) reported that this group found online health information confusing and complex. The review also reported that Internet costs, lack of computer equipment and skill were barriers to accessing online health information (Fogel, Ribisl et al. 2008).

The review identified that African Americans lack trust in online information and have a cultural preference for face-to-face contact (Fogel, Ribisl et al. 2008).

While there is limited research in this area, the available research indicates that to decrease digital inequality in online communication, health services need to be aware of the importance of tailoring online communication to the needs of ethnic populations and to supplement with face-to-face contact and other media such as print and DVD resources if the online information is not adequate or the users do not trust the online information (Fogel, Ribisl et al. 2008; Neuhauser and Kreps 2008). Further research into the effectiveness of online information for CALD communities is required.

5.4.3 The use of pictorial resources

The literature review by Houts and colleagues found that pictures improve comprehension when “they show relationships among ideas or when they show spatial relationships” (Houts, Doakb et al. 2006 p.173). The use of spoken direction plus pictures or pictures with simple text can help consumers with low literacy skills and improve the recall of health education information when compared to text alone. Pictures also attract the attention of consumers and encourages them to concentrate on the information (Houts, Doakb et al. 2006). The literature review by Kreps and Sparks (2008) also support the use of pictures in health communication to assist consumers with limited health literacy and to reinforce health messages.

5.5 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

5.5.1 Summary of findings from policies, standards and literature

Health literacy, culture and language difficulties often create barriers to accessing and making sense of health information for ethnic and minority groups. To reduce the barriers and increase accessibility to health information, the resource development and translation section of the guideline at a minimum should include the following:

- Provide information to consumers and their carers in a format that is understood and meaningful
- Involve consumers in health communication efforts
- Tailor resources to the needs of CALD consumers taking into account cultural and/or religious values
- Develop communication strategies that accommodate community languages and information needs
- Use clear, plain English including pictures and diagrams
- Carefully consider the use of online resources as a stand alone strategy and evaluate effectiveness of this for CALD groups.

The above commons issues are included in the guideline and related documents as follows:

Included as considerations in guideline on best practice multicultural policy implementation
Staff provide translated information, where available, on services, policies and public health issues to consumers from CALD backgrounds.
Staff consider the involvement of consumers in health communication efforts.
Members of CALD communities are consulted on the cultural appropriateness of health messages.
Staff are encouraged to identify and use a variety of modes of information dissemination to communities, and hold regular engagement sessions with CALD communities to disseminate information on health services or issues and to receive feedback regarding the cultural competency of health services.
Staff are encouraged to develop information for CALD consumers, which is easily understood and supported with visual aids, such as pictures and diagrams, where possible.
Staff identify local CALD community leaders and non-government organisations and use this network and ethnic media as channels for information provision.

6. Community engagement

6.1 Search strategy

A structured search was conducted for studies published from 2005-2012. The following search terms were used including the default medical subject heading terms:

- Health care delivery or health care services or hospitals
- Quality of care or client satisfaction
- Trend or evidenced-based practice
- Ethnic Groups or minority groups or minority community
- Consumer participation or community involvement or stakeholder or community engagement or engaging patients
- Patient safety or cultural safety.

The search terms were further limited to English-language, meta-analysis and review publications. An internet search was also conducted to identify national and international policies and standards.

6.2 Results

The initial search yielded 39 articles (21 systematic reviews, 3 meta-analysis and 14 literature reviews). The articles were screened for eligibility at the abstract review level and were excluded if they:

- did not directly relate to community engagement
- had a mental health focus
- did not directly relate to CALD communities
- discussed barriers to accessing health services only.

From this screening, 23 articles were identified for full-text or article review. At this second level, three of the articles did not meet eligibility criteria. Therefore, for this review, data were synthesized from 20 eligible articles.

6.3 Common themes of policies and standards

All Australian jurisdictions recognise the importance of involving consumers, carers and the community in health care planning, decisions and service provision.

National

The Victorian Department of Health through the *Doing it with us not for us: Strategic direction 2010-13* supports consumer participation in decision-making, health policy, service development and quality improvement. The policy incorporates participation standards and performance indicators for health services. It is recommended that health services, as part of monitoring the implementation of the policy, collect and report on the five standards. Standard one *the organisation demonstrates a commitment to consumer, carer and community participation appropriate to its diverse communities* directly relates to CALD communities (Victorian Government Department of Health 2009).

While other Australian jurisdictions do not have community engagement strategies that specifically target CALD communities, they must each abide by the Australian Charter of Health Care Rights (2008).

The Australian National Safety and Quality Health Service Standards (Australian Commission on Safety and Quality in Health Care 2011) detail the criteria and actions required by hospitals to ensure consumers and/or carers are actively involved in the service planning and evaluation of health services.

Table 3: Australian National Safety and Quality Health Service Standards relevant to community engagement

This criterion will be achieved by:	Actions required:
Consumer partnership in service planning	
2.1 Establishing governance structures to facilitate partnerships with consumers and/or carers	2.1.1 Consumers and/or carers are involved in the governance of the health service organisation 2.1.2 Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback
2.2 Implementing policies, procedures and/or protocols for partnering with patients, carers and consumers in: <ul style="list-style-type: none"> • strategic and operational/services planning • decision making about safety and quality initiatives • quality improvement activities 	2.2.1 The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality
Consumer partnership in service measurement and evaluation	
2.8 Consumers and/or carers participating in the analysis of safety and quality performance information and data, and the development and implementation of action plans	2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements
2.9 Consumers and/or carers participating in the evaluation of patient feedback data and development of action plans	2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

International

Internationally, the United States, New Zealand, Canada and the United Kingdom all recognise the importance of participatory and collaborative partnerships with communities to inform policy, service decisions and quality improvement. Each health service has implemented standards and policies outlining formal and informal engagement strategies to assist health workers (Zena Simces & Associates 2003; U.S. Department of Health and Human Services and Office of Minority Health 2011; United Kingdom Department of Health 2011; The Department of Internal Affairs Local Government and Community Branch 2012).

The following existing Queensland policies, procedures and standards are consistent with the community engagement requirements outlined in the above national and international policies and standards.

The Queensland policies, procedures and standards include:

- The Queensland Government Multicultural Policy
- Queensland Health Multicultural Policy
- Department of Communities, Engaging Queenslanders: an introduction to working with culturally and linguistically diverse (CALD) communities CALD Community Engagement Strategy
- Health Consumers Queensland Consumer and Community Engagement Framework
- Queensland Health guidelines for engaging multicultural communities and consumers.

6.4 Common themes of the literature

The articles on community engagement with CALD communities identified the following common themes:

- Cultural tailoring of programs and resources
- Identifying and addressing barriers for CALD consumers to engage
- Use of CALD community workers
- Community embedded strategies

6.4.1 Cultural tailoring of programs and resources

Involving consumers and communities in health education and healthcare decisions has become an essential element of healthcare services and outcomes. Bailey and colleagues conducted a Cochrane review on culture-specific programs for children and adults from minority groups who have asthma (Bailey, Cates et al. 2009). They identified that culturally specific asthma programs were more effective than generic programs in improving quality of life and asthma knowledge (Bailey, Cates et al. 2009). The systematic review by Hawthorne and colleagues also found that culturally appropriate diabetes health education was more effective than generic programs in improving short to medium term knowledge (Hawthorne, Robles et al. 2010). They found for diabetes health education to have the most impact it is to be “couched in a learner-centred manner, understanding and respecting linguistic, cultural and religious needs” (Hawthorne, Robles et al. 2010 p.621).

The systematic review by Netto and colleagues using community resources such as ethnic-specific media, networks and community leaders increased accessibility to health interventions (Netto, Bhopal et al. 2010). The review also highlighted that it is important to culturally tailor interventions to the target community to reduce barriers to access and participation (Netto, Bhopal et al. 2010). Peek and colleagues in their systematic review found that culturally tailored programs improved health outcomes and reduced health disparities in quality of care for CALD communities, while the general diabetes training interventions received modest outcomes (Peek, Cargill et al. 2007). Culturally tailored interventions included diet education; health education at local sites such as schools and churches; the incorporation of a community health worker in programs to increase community outreach and peer support; and the use of appropriate health literacy levels (Peek, Cargill et al. 2007). The systematic review by Eyles and Mhurchu also identified that tailored nutrition education was effective for improving the diets of adults from ethnic population groups compared to generic nutrition education (Eyles and Mhurchu 2009).

Strategies for the management of health conditions in CALD communities require support to overcome cultural and linguistic barriers to accessing health care services. In the literature review by Lirussi, interventions on diet and exercise with CALD communities were shown to be effective when delivered over a long period, in the community setting, were culturally tailored and used community educators (Lirussi 2010). Interventions that took place in the community setting and were aimed at fostering self management skills, self-efficacy or self-empowerment resulted in better outcomes (Lirussi 2010). A key recommendation reported by Lirussi in improving diabetes education was to maintain communication and interaction between communities and health care providers.

6.4.2 Identifying and addressing barriers for CALD consumers to engage

A lack of trust by the community in health services was shown to be a barrier to implementing community engagement strategies (Swainston and Summerbell 2008). The literature review by Swainston and Summerbell (2008) reported a range of barriers:

- Lack of skills and competencies of staff in community engagement
- Lack of meeting places to hold community meetings
- Capacity and willingness of health service staff and community members to foster engagement
- Health services imposing their own structures and solutions on communities
- Dominance of professional cultures and ideologies.

The systematic review by Scheppers and colleagues provides an overview of the barriers at the patient and provider level that may restrict CALD communities from engaging with health services. The review identified that differences in health beliefs and attitudes and lack of knowledge of health services were barriers for CALD communities. Cultural knowledge by the service provider was reported as essential to health promotion and preventative care and ignoring beliefs and practices could be a barrier to engagement by CALD communities (Scheppers, van Dongen et al. 2006).

6.4.3 CALD community workers

Community health workers or lay health advisors appear to be important for bridging the gaps between the health service providers and the community they serve. They are an important tool for fostering engagement between health care providers and communities. As they are usually members of the local community they are able to gain access to “marginalised and isolated CALD communities in a more efficient manner than any other type of health worker” (Henderson, Kendall et al. 2011 p.247). Community health workers are able to use social networks and culturally sensitive strategies tailored to the needs of the community (Martinez-Donate 2009). The systematic review by Brownstein and colleagues identified that community health workers contributed to improved health outcomes in the community by providing culturally appropriate education, facilitating access to care and enhancing compliance with treatments (Brownstein, Chowdhury et al. 2007). Community workers are able to work effectively with community members to achieve “required behaviours that contribute to their own continuity of care and improved health outcomes (Brownstein, Chowdhury et al. 2007 p.446).

It is often the lack of knowledge by health care providers that results in less than optimal health services for CALD populations. Providing culturally safe and competent services improves communication, trust in the health system, greater knowledge of CALD communities and cultural understanding within the health system (Henderson, Kendall et al. 2011). To achieve a culturally safe and competent service, Henderson and colleagues reported that the use of bilingual community health workers with CALD communities improved screening rates, health status, health behaviour, health knowledge and greater completion of health promotion programs (Henderson, Kendall et al. 2011). The review showed that CALD communities “reported that health education programs delivered by their own people were culturally sensitive and appropriate” (Henderson, Kendall et al. 2011 p.247) and health care workers were able to increase the uptake of immunisation and health monitoring. The systematic review on the use of lay health workers for the delivery of maternal and child health by Lewin and colleagues found that the use of lay health workers in health programs improved the uptake of immunisation and breastfeeding in low and middle income countries in comparison to usual health programs (Lewin, Babigumira et al. 2006).

The systematic review by Rhodes and colleagues discuss the benefits of using lay health advisors as a strategy to reduce or eliminate health disparities among Hispanics and Latinos (Rhodes, Foley et al. 2007). Rhodes and colleagues conclude that lay health advisors are essential as they are able to serve as health advisors, referral sources, distribute resources and advocate on behalf of the community. Community members are able to approach the lay health advisor for advice and support. The review reported that community members viewed healthcare providers and educators as outsiders to whom they did not feel comfortable disclosing health information. It appears that lay health advisors understand the community needs and are best placed to educate the community on specific health issues (Rhodes, Foley et al. 2007). The systematic review by Goris and colleagues also provides the evidence that the use of multicultural health workers is associated with positive chronic disease prevention and self-management outcomes. As trusted peers in the community, multicultural health workers are able to provide social support, health education, outreach services and enhanced case management to facilitate improvement in health outcomes for CALD communities (Goris, Komaric et al. 2012).

The meta-synthesis on community empowerment by Amendola revealed that empowering Hispanic and Latino community members was one approach to achieving positive healthcare outcomes (Amendola 2011). One strategy of engagement and empowerment was through the use of a local promotora (health promoter). The promotora was responsible for organising community health fairs and health education sessions that involved community members and local agencies. With the assistance of the community health nurse the promotora was able to organise information material for the fair and the health education sessions that responded to the health issues of the community in the context of their beliefs and practices. The shared care between the community health nurse, promotora and the culturally tailored resources promoted “more personal responsibility” from community members in making health changes (Amendola 2011 p.87).

The U.S. National Centre for Cultural Competence, Georgetown University recognises that communities are complex and diverse and community engagement requires healthcare services to be culturally and linguistically competent. For healthcare services to engage successfully they need to understand their own culture and the culture of their staff; the diverse communities they serve; the social, political and economic climates of communities within a cultural context; and the inherent ability of communities to recognise their own problems (Goode 2001). The systematic review by Milton and colleagues explores the impact of community engagement strategies on population health (Milton, Attree et al. 2011). The review provided support for using the existing skills of community members to support others to engage in community led activities and to improve the information flow with service providers.

6.4.4 Community embedded strategies

Ryan conducted a literature review on stroke awareness among British ethnic minorities. He concluded that embedding programs within local communities through links with churches, housing projects, businesses and residential facilities is a key theme in increasing stroke awareness (Ryan 2010). It is also important for health professionals to consider long term engagement with CALD communities and cultural sensitivity when designing and planning interventions (Ryan 2010). Community workshops used in the design and delivery of an intervention was reported by Swainston and Summerbell (2008) as a strategy to maintain a high level of participation among community members. This strategy demonstrated sustainable health behaviour changes and strengthened community relations.

6.5 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

6.5.1 Summary of findings from policies, standards and literature

From the policies and standards reviewed, there are two broad standards that apply nationally:

- The involvement of consumers in the planning and evaluation of health services
- Information is provided to patients and carers in a format that is understood and meaningful.

From the literature reviewed, effective engagement with CALD communities/consumers involves:

- cultural tailoring of programs and resources
- identifying and addressing barriers for CALD consumers to engage
- use of CALD community workers where available
- embedding engagement in CALD communities.

The above common issues are included in the guideline and related documents as follows:

Included as considerations in guideline on best practice multicultural policy implementation
Staff engage consumers and communities in the planning and evaluation of services.
Staff provide translated information, where available, on services, policies and public health issues to consumers from CALD backgrounds.
CALD communities are consulted on the cultural appropriateness of health messages.
Staff identify and address barriers to engagement with CALD consumers and communities.
Dedicated multicultural health workforce roles are considered for use, where available, to assist with implementation of interventions and address barriers to access to health information and health services for CALD communities.
Engagement with CALD consumers is embedded into broader engagement strategies, including with Medicare Locals.

7. Data collection and analysis

7.1 Search strategy

A structured search was conducted for studies published from 2005–2012. The following search terms were used including the default medical subject heading terms:

- Data collection or ethnicity data or racial data or data standards
- Data interpretation or statistical or data analysis or statistics or numerical data
- Health care delivery or health care services or hospitals or records management
- Ethnic groups or minority groups or minority community
- Best practice or trend or evidenced-based practice.

7.2 Results

The initial search yielded 27 articles (five systematic reviews, seven literature reviews, one report, nine standards, one strategic forum and three national studies). The articles were screened for eligibility at the abstract review level and were excluded if they:

- did not directly relate to data collection and analysis of CALD
- had a mental health focus
- did not directly relate to health care provision
- focussed on the collection of ethnicity data in clinical trials.

From this screening, none of the articles related directly to data collection and analysis of CALD or were general health focused. Therefore, this section therefore focuses on policies and standards rather than evidence from the literature.

7.3 Common themes of policies and standards

7.3.1 Data collection

In 1999, the Australian Bureau of Statistics (ABS) published the *Standards for Statistics on Cultural and Language Diversity* (the standards) to identify, define, classify and disseminate particular attributes that relate to cultural and language background. The minimum data set contains four variables (country of birth, main language other than English spoken at home, proficiency in spoken English and Indigenous status) and the standard set contains an additional eight variables (ancestry, country of birth of father, country of birth of mother, first language spoken, languages spoken at home, main language spoken at home, religious affiliation, year of arrival in Australia.)

In 2007, Queensland Health endorsed a multicultural minimum data set which was based on the national standards. This minimum data set was endorsed to be collected across Queensland Health's major data collections. It comprises:

- country of birth
- interpreter required
- preferred language
- religion (this variable is collected locally and not centrally extracted).

In October 2011, the ABS announced that the standards were under review and invited submissions to the review.

Queensland Health's submission to the review stated that the current standards are inadequate to capture the cultural diversity in the Queensland population. The identification of cultural and ethnic groups is essential to targeting effective government programs and services. However, the variables country of birth and main language other than English cannot identify many important and disadvantaged population groups.

Queensland Health's three priority population groups are very poorly identified by country of birth and main language other than English:

- Refugees (persecuted minority ethnic groups often stay for extended lengths of time in a second or third country and their children are subsequently born in those second or third countries and may speak the host country's language)
- Australian South Sea Islander people (born in Australia and speak English – Queensland has Australia's largest Australian South Sea Islander population)
- Pacific Islander and Maori people (many migrate through New Zealand or were born in New Zealand and many speak English – Queensland has Australia's largest Pacific Islander and Maori population).

Although the standards stipulate that using “a single standard variable, such as country of birth...is inadequate” (p. 8), in practice this has been the widespread level of implementation of the standards in the health sector. A review of national health data dictionaries, national data sets and national surveys found (Blignault and Haghshenas 2005):

- of seven national data dictionaries used ABS standards and classifications, only one included all the minimum data set indicators for CALD
- of 17 national datasets reviewed, 12 included country of birth, three also included language but none included all three indicators
- two data sets (injury surveillance and cancer) did not include any data concerning the client’s cultural background.

In short, the standards have not been implemented as intended, and ‘country of birth’ is often used as a single variable. Given the evidence of poor implementation, Queensland Health’s submission has recommended that the standards be redesigned to provide another variable in the minimum data set that can better identify ethnic groups. The proposed solution was to transfer ancestry into the minimum data.

The collection of ethnicity will contribute greatly to the availability of better quality data on CALD communities and in particular identify populations that current data collection methods do not capture. The advantages of using ethnicity includes being able to capture data on:

- children born in Australia but brought up in a culturally diverse environment
- people who migrated from places such as New Zealand, the UK, and the USA who affiliate with a different cultural background or ethnicity
- people who can only be identified by ethnicity or sometimes language such as refugees who were persecuted because of their ethnicity (e.g. Karen born in Thailand).

Collecting ethnicity would bring Australia in line with comparable countries. There is a preference internationally in comparable countries to Australia for the collection of ‘ethnicity’ as a primary indicator of cultural diversity (Ministry of Health 2004; Bhopal 2007; National Institutes of Health 2007).

7.3.2 Data analysis

The Queensland Government’s Multicultural Policy 2011 aims for CALD consumers to have equitable access to the services provided or funded by the state. It is therefore important that Queensland Health’s policy reflects this intent and analyses data to identify if access, and ultimately health outcomes, are equitable for CALD communities.

The Chief Health Officer produces a report on the health status of the Queensland population every two years. The next report will be informed by recently produced reports on the health status, and service utilisation, of a number of CALD communities, including Vietnamese, Indian, Italian, Pacific Islanders, and Australian South Sea Islanders. Data on death rates and hospitalisation measures is also available for Queenslanders from non-English speaking backgrounds, compared to the general Queensland population. Regional analysis is also available. Data is available at www.health.qld.gov.au/multicultural/health_workers/multictrl_comm.asp.

Given that the health status of the Queensland population is reported on a two-yearly basis, the *Queensland Health Guide to Implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a Health Context* should include a consistent timeframe for the analysis of data on the health status of CALD communities.

7.4 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

7.4.1 Summary of findings from policies, standards and literature

Queensland Health should continue to collect the multicultural minimum data set in core information systems, and work with the Australian Bureau of Statistics to consider collection of ethnicity in the CALD national minimum data set instead of country of birth.

Given that the health status of the Queensland population is reported on a two-yearly basis, it is recommended that a consistent timeframe for the analysis of data on the health status of CALD communities be considered. It is recommended that the accessibility of services by CALD communities be assessed on a similar timeframe.

The above recommendations for implementation were identified in both the community and district consultations conducted to inform the development of the guideline and have been included in this and related documents.

8. Culturally competent staff

8.1 Search strategy

A structured search was conducted for studies published from 2005–2012. The following search terms were used including the default medical subject heading terms:

- Health care delivery or health care services or hospitals or health personnel
- Attitude of health personnel
- Cultural competence or cultural competency or professional competence or cultural sensitivity or health knowledge or professional development or clinical competence
- Training or education or inservice training
- Cultural diversity or ethnic groups or minority groups or cultural values
- Nurse-patient relations
- Trend or evidenced-based practice.

The search terms were further limited to English-language, meta-analysis and review publications. An internet search was also conducted to identify national and international policies and standards.

8.2 Results

The initial search yielded 51 articles (19 systematic reviews, 1 Cochrane protocol and 32 literature reviews). The articles were screened for eligibility at the abstract review level and were excluded if they:

- did not directly relate to culturally competent staff
- had a mental health focus
- related to construct testing
- focussed on culturally competent interventions rather than building the cultural capability of staff.

From this screening, 19 articles were identified for full-text or article review. At this second level, four of the articles did not meet eligibility criteria. Therefore, for this review, data were synthesized from 15 eligible articles that focused specifically on culturally competent staff.

8.3 Defining cultural capability

To determine the knowledge and skills staff require to deliver culturally safe services, in 2010 Queensland Health reviewed the literature on cross cultural competency and interviewed experts in the field. Five cross cultural capabilities were subsequently defined and endorsed; these are shown in Table 4. The main vehicle to build the cross cultural capabilities of staff is through specific cross cultural training.

8.3.1 Defining cross cultural training

Cross cultural training specifically addresses the cultural and communication issues of people from culturally and linguistically diverse communities (Bean 2006). Within the health care context it goes further to include differing health beliefs, systems and practices as well as issues and barriers which impact on their well-being. Therefore, cross cultural training is an important mechanism of providing health care staff with access to cross cultural knowledge and skills. It has traditionally been conducted as specific, stand-alone training and is generally understood as such (Queensland Health 2010).

Queensland Health has four standard cross cultural training packages, based on the five cross cultural capabilities. These are:

- Customer Service in a Culturally Diverse Society
- Cultural Issues in Clinical Practice
- Working in Culturally Diverse Teams
- Managing a Culturally Diverse Workplace.

Table 4. Queensland Health's Cross Cultural Capabilities

1. Self-reflection

An individual staff member should be able to:

- Consider what their own culture is and how they feel about different cultural beliefs and values.
- Demonstrate a complex understanding of "culture"
- Conduct a cultural self-assessment to identify their own culture, and position their cultural beliefs against that of the health system.
- Conduct an assessment of the organisational and professional cultures to which they belong

2. Cultural understanding

An individual staff member should be able to:

- Gain a better understanding of culture, and potential cultural differences
- Conduct a client cultural assessment to determine and accommodate different needs
- Elicit client explanatory models for health and respond appropriately
- Understand different consumer behaviours may be influenced by culture.
- Employ self-reflection to explore differences and similarities across cultures.

3. Consider Context

An individual staff member should be able to:

- Acknowledge and consider the range of social and economic factors that may impact on consumers (with culture sometimes not being the most important e.g. transport, food).
- Understand impact of migration and exile on individuals
- Consider the interplay of other individual factors such as gender, sexuality, age on identity.
- Understand that individuals may not identify with their own culture, or that of their parents, and many individuals within Australia consider themselves 'bicultural'
- Understand there are differences within cultures.

4. Communication

An individual staff member should be able to:

- Be sensitive and adaptive to varying cultural norms in relation to verbal and non-verbal communication
- Communicate effectively across cultures
- Be aware of, and overcome, potential barriers to effective cross-cultural communication
- Deliver information in culturally appropriate and targeted ways.
- Avoid making assumptions or judgements about individuals based on their communication style
- Assess the need for an interpreter and ability to work effectively with interpreters.

5. Collaboration

An individual staff member should be able to:

- Build trust and relationships with individuals across cultures
- Work towards consensus with individuals and families from diverse backgrounds
- Involve culturally diverse clients in decision-making processes and collaborative care
- Conduct community consultation and engagement
- Work across disciplines to provide appropriate care
- Facilitate linkages with community organisations and other agencies including development of referral pathways
- Be skilled at establishing formal and informal collaborative networks
- Value and facilitate the exchange of information across health and other disciplines.

8.4 Common themes of policies and standards

National

All Australian jurisdictions except Western Australia provide cross cultural training for health care staff. NSW Health and the Victorian Department of Health link cross cultural training to the risk management and quality processes. Training is also integrated into corporate orientation programs for new staff. Training for NSW Health is developed and coordinated by the statewide multicultural units (e.g. Refugee, Mental Health, Torture and Trauma, Multicultural HIV Aids Service) in conjunction with local training coordinators and is targeted to local need. In Victoria, South Australia and Tasmania (except in major public hospitals) cross cultural training for health care staff is outsourced to recognised providers. To provide day to day support and build the cultural competency knowledge and skills of staff the Victorian Department of Health and the Department of Health and Human Services in Tasmania employ Cultural Diversity Officers/Migrant/Refugee Liaison Officers. Within the Northern Territory Department of Health training and information on CALD communities is often provided by either a local community refugee organisation or the Clinical Nurse Consultant (Queensland Health 2010).

International

Internationally, the United States, New Zealand and the United Kingdom require health services to provide staff at all levels with ongoing cultural competency education and training to ensure consumers and carers receive effective and respectful care that is compatible with their cultural beliefs and practices (Standards New Zealand 2008; U.S. Department of Health and Human Services and Office of Minority Health 2011; United Kingdom Department of Health 2011).

Related Queensland policies, procedures and standards

The existing Queensland policies, procedures and standards reviewed were:

- Queensland Multicultural Policy 2011 – requires reporting against the number and percent of staff who attend training each year. The expectation underlying this requirement is that departments build the cultural capability of staff by conducting ongoing training.
- Queensland Health Multicultural Health Policy 2000 – requires at the corporate level inclusion of cultural diversity training in corporate training as well as people management strategic plans and the inclusion of cultural diversity principles in the development of performance management systems. At the Health Service District level, requires the provision of education for staff on cultural issues in health care.
- Queensland Health Cross Cultural Capabilities (Clinical staff; Non-Clinical staff) – defines the cross cultural knowledge and skill that staff need to provide culturally capable care, and the behaviour that should result.
- Queensland Health Cross Cultural Learning and Development Strategy 2009-2012 – identifies five strategic priorities to build the cultural capabilities of Queensland Health’s current and future workforce:
 - Conduct specific cross cultural training (face to face and e-learning)
 - Integrate cross cultural capabilities into relevant non-cross cultural training programs (face to face and e-learning)
 - Integrate cross cultural capabilities into departmental outsourced non- cross cultural training programs
 - Build the cultural competency of the future Queensland Health Workforce
 - Ensure a quality approach to cross cultural training, which includes evaluating the effectiveness of training
- Queensland Health Orientation and Induction Human Resources Policy – specifies cultural diversity as a mandatory module.

8.5 Common themes of the literature

The articles on culturally competent staff identified the following common themes:

- Training the future health care workforce
- Effectiveness of cross cultural training.

8.5.1 Training the future health care workforce

One literature review was identified on improving cross-cultural care in nursing education in Australia (Allen, 2009). This review supported the ongoing development of curricula on cultural competency, identifying that “nurses need to be educationally prepared for effective cross-cultural practice in increasingly diverse communities” (Allen 2009 p.320).

In the United States, doctors are increasingly required to undertake education in cultural competency as a condition of professional registration (Like 2011). The competency standards outlined by the U.S. Accreditation Council for

Graduate Medical Education (ACGME) state that junior doctors are required to “communicate effectively and demonstrate caring and respectful behaviours while interacting with patients and their families” (Hobgood, Sawning et al. 2006 p.1289).

While medical students are increasingly being taught cultural competency in medical school, a 2006 literature review found that they are often exposed to conflicting messages in the clinical setting; senior staff were reported as often demonstrating maladaptive or poor cultural competency behaviours and knowledge (Hobgood, Sawning et al. 2006). Hobgood and colleagues concluded that this often leaves the student confused about “which values to uphold and appropriate behaviours to demonstrate” (Hobgood, Sawning et al. 2006 p.1289), and that over time students may learn to value cultural competency knowledge and skills less in patient evaluations. While ensuring that the university curricula for the future health workforces include cultural competency, the workplaces which will employ these future workforces also require cultural competency training to support and promote culturally competent practices being implemented.

8.5.2 Effectiveness of cross cultural training

Betancourt and colleagues’ interview of experts in cultural competency found that many providers were resistant to cultural competence training as it was regarded as a ‘soft science’ (Betancourt, Green et al. 2005). In the same year, Littrell and Salas (2005), in their literature review, identified that one of the barriers to the implementation of cross cultural training was the lack of evidence to support its effectiveness.

A 2005 Australian report developed by the Australian Department of Immigration and Multicultural Affairs for the Joint Commonwealth, State and Territory Research Advisory Committee investigated cross-cultural training programs across Australia, the methods of delivery and their effectiveness, and found that cross cultural training is of direct benefit to employees, organisations and clients.

The following outcomes were reported immediately post-training:

- Increased understanding of organisation policies and issues
- Increased knowledge of cross cultural skills and understanding of other cultures
- Improvements in understanding of the effects of one’s culture on oneself
- Improvement in the awareness of the effects of cultural differences on interactions and confidence in dealing with people from different cultures
- Increased knowledge of and improved service to culturally diverse customers and transfer of their learning to co-workers.

Reported outcomes 12 months post-training were:

- Increased understanding of organisational policies and issues regarding cultural diversity
- Increased knowledge of cross cultural communication skills
- Increased knowledge and understanding of the customs, values and beliefs of diverse cultures.

There are also two systematic reviews of the effectiveness of cross cultural training published since 2005:

- Pearson et al found that training in cultural competency can improve outcomes for both healthcare providers and patients. The review also found that individual workers need to have appropriate skills to be able to successfully deliver culturally competent care and that cross cultural training leads to better team functioning (e.g. communication) which is an important issue to consider for Queensland Health with its increasingly diverse staffing profile (Pearson, Srivastava et al. 2007).
- The U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) found evidence to support improvement in the knowledge, attitude and skills of the health care professional, and increased patient satisfaction after cross cultural training (Agency for Healthcare Research and Quality 2010).

In addition, two literature reviews found positive outcomes on the attitudes and skills of health professionals after cross cultural training (Beach, Price et al. 2005; Chipps, Simpson et al. 2008).

While the above reports make clear positive statements about the effectiveness of cross cultural training on the cultural competency of health care staff and patient outcomes, there is no broader literature on the effectiveness of cross cultural training on patient outcomes, largely due to poor design of many studies in this area. A number of authors have noted the need for better designed and more rigorous evaluations of the effectiveness of cross cultural training in this regard (Beach, Price et al. 2005; Chipps, Simpson et al. 2008; Charbonneau, Neufeld et al. 2009; Dykes and White 2011; Horvat, Horey et al. 2011; Lie, Lee-Rey et al. 2011).

8.6 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

8.6.1 Summary of findings from policies, standards and literature

Most other Australian jurisdictions require cross cultural training to be conducted for health care staff. The Queensland Government expects that agencies will build the cultural capabilities of their staff through cross cultural training and agencies are required to report against this annually. Queensland Health's Cross Cultural Learning and Development Strategy 2009-2012 includes strategies to:

- build the cultural capability of the future health workforce
- build the cultural capability of the current health workforce by:
 - conducting dedicated face-to-face and online cross cultural training
 - integrating the Queensland Health Cross Cultural Capabilities into existing training for staff
 - integrating the Queensland Health Cross Cultural Capabilities into outsourced training
- ensure a quality approach to cross cultural training, including by evaluating the effectiveness of training conducted.

While the literature review findings point to the need for improved evaluation of the effectiveness of cross cultural training, particularly on patient outcomes, there is evidence that supports the effectiveness of cross cultural training in terms of the cross cultural knowledge and skill of health care providers and patient outcomes, as measured by patient satisfaction. In 2009, the steering committee which directed the development of the Queensland Health Cross Cultural Learning and Development Strategy 2009-2012 identified the strategies identified above as the best mechanisms to build the cultural capabilities of current and future staff. These remain the best mechanisms and it is proposed that these strategies be considered for implementation.

The above common issues are included in the guideline and related documents as follows:

Included as considerations in guideline on best practice multicultural policy implementation
Work is undertaken with the tertiary sector to incorporate the Queensland Health Cross Cultural Capabilities into the tertiary curriculum for health professions.
<p>The cultural capabilities of the current health workforce is built by:</p> <ul style="list-style-type: none"> • promoting cross cultural training being conducted using the available dedicated packages at least twice a year, targeting staff with the largest intersect with CALD consumers • considering integration of the Queensland Health Cross Cultural Capabilities into new training programs on communication, clinical health assessment and policy development. • considering integration of Queensland Health Cross Cultural Capabilities into externally provided training on communication, clinical health assessment and policy development.
Evaluation of cross cultural training is undertaken by using the <i>Cross Cultural Capability Training Pre and Post Evaluation Survey</i> forms, and providing completed forms to corporate office for annual analysis.

9. Recruitment and retention

9.1 Search strategy

A structured search was conducted for studies published from 2005-2012. The following search terms were used including the default medical subject heading terms:

- Personnel selection or health personnel or medical personnel or health workers or health staff or health human resources
- Cultural diversity or diversity in the workplace
- International educational exchange or international medical graduates or foreign trained or overseas qualified or multicultural workforce
- Personnel retention or retention or employee retention
- Strategies or interventions
- Ethnic groups or minority groups or minority community
- Best practice or trend or evidenced-based practice).

A Queensland Health 2009 literature review on this subject was also included (Queensland Health 2009).

9.2 Results

The initial search yielded 45 articles (10 systematic reviews, 33 literature reviews, 1 meta-analysis and 1 best practice) and the 2009 Queensland Health review. The articles were screened for eligibility at the abstract review level and were excluded if they:

- did not directly relate to recruitment and retention of CALD
- had a mental health focus
- did not directly relate to health
- focused on clinical care.

From this screening, 21 articles were identified for full-text or article review. At this second level, two of the articles did not meet eligibility criteria. Therefore, for this review, data were synthesized from 19 eligible articles and the 2009 Queensland Health review.

9.3 Common themes of policies and standards

National

All Australian jurisdictions have developed individual policies on the recruitment and retention of staff from CALD backgrounds or make reference to the overarching equal employment opportunity and anti-discrimination acts. All jurisdictions support culturally diverse and culturally competent workforces and promote work environments that are inclusive, respectful and value people from a wide range of backgrounds.

International

The United States, the United Kingdom and New Zealand support strategies to recruit, retain, and promote at all levels of the organisation a diverse workplace that is representative of the demographic characteristics of the service area (Zena Simces & Associates 2003; U.S. Department of Health and Human Services and Office of Minority Health 2011; United Kingdom Department of Health 2011).

Related Queensland policies, procedures and standards

The Queensland policies, procedures and standards reviewed were:

- Queensland Government Multicultural Policy
- Queensland Health Multicultural Policy 2000
- *Public Service Act 2008*
- *Anti-Discrimination Act 1991*
- *Racial Discrimination Act 1991*
- *Human Rights and Equal Opportunity Act 1986*
- Queensland Health Anti-Discrimination Human Resources Policy (E2)
- Queensland Health Workplace Harassment Human Resources Policy (E13)
- Queensland Health Recruitment and Selection Human Resources Policy (B1)
- Queensland Health Diversity Human Resources Policy (G1)
- Queensland Health Equal Employment Opportunity Human Resources Policy (G2).

The Queensland Government Multicultural Policy commits all departments to improved recruitment and retention strategies for staff from CALD backgrounds.

9.4 Common themes of the literature

The articles on recruitment and retention identified the following common themes:

- Benefits of a diverse workforce on patient outcomes
- Recruitment strategies
- Retention strategies
- Racism and discrimination.

9.4.1 Benefits of a diverse workforce on patient outcomes

Workforces are becoming more culturally diverse through increased levels of migration and the recruitment of overseas trained health care staff. This trend provides workplaces with a number of benefits. For health care organisations, two literature reviews present evidence that a diverse workforce improves patient outcomes and reduces health care disparities (Nkansah, Youmans et al. 2009). The literature review by Mittman and Downs (2008 p.302) also provides evidence that diversity in the workforce is associated with “increased access to care, greater patient choice and satisfaction and better patient-provider interactions”. The authors also report that diverse workforces “challenge stereotypes, enhances cultural competence and fosters lasting relationships” (Mittman and Downs 2008 p.302).

While the above literature reviews conclude that workforce diversity is positively related to improved patient outcomes, the literature review by Curtis and Dreachslin (Curtis and Dreachslin 2008) identified that workforce diversity does not always have a positive impact on organisational performance. For example, they suggest that effective training and development to support valid selection processes to increase diversity does not necessarily increase the talent pool, that increased diversity does not necessarily build commitment, improve motivation or reduce conflict, and that increased diversity does not necessarily lead to higher group performance. It may be that diverse workforces require dedicated strategies to manage this diversity for organisational performance to be enhanced.

9.4.2 Recruitment strategies

Recruiting a future health workforce – targeting students

The literature review by Charbonneau and colleagues identified that many students from a CALD background may not pursue a career in health as they are not aware of the career paths available (Charbonneau, Neufeld et al. 2009). The literature review by Otto and Gurney (2006) identified that promoting health professions to high school students increased their awareness of health related careers. The authors reported that mentoring programs by health care staff, exposure to the academic setting and preparatory university activities had a positive influence on CALD recruitment into the health sciences (Otto and Gurney 2006). Gillis and colleagues also reported that approaching students from CALD backgrounds early in their career decision making was an effective strategy for advising them of future careers in health (Gilliss, Powell et al. 2010). Institutions in the U.S. are working with local high schools to prepare students from CALD backgrounds for college admissions into health sciences. This is regarded as one strategy to improve the representation of CALD in the health workforce (Pacquiao 2007). Noone’s (2008) literature review reported that many colleges in the U.S. have developed summer internships and camps where students receive college preparation assistance, credit towards college and information on health careers while living on campus. The literature review by Mittman and Downs (2008) found that to recruit students from CALD backgrounds into genetic counselling profession the use of an aggressive campaign is required. This involves the use of “one stop shop” website that provides all the information a potential applicant would need to prepare for a career in genetic counselling.

Recruiting overseas trained professionals

There is limited research on strategies for recruiting and supporting overseas workers in finding employment in health services. The literature review by Pearson and colleagues (Pearson, Srivastava et al. 2007) reported a number of barriers that skilled overseas workers identified to entering the workforce, including a lack of knowledge of application processes, poor employer contacts, a lack of work experience, and a lack of knowledge of the labour market and employment advertisements. The authors identified that involvement from all stakeholders including governments, educational institutions, licensing bodies, employers and voluntary organisations is needed to assist overseas workers to integrate into the workforce (Pearson, Srivastava et al. 2007).

9.4.3 Retention strategies

In 2009, Queensland Health funded the conduct of a literature review to:

- explore and identify the factors inhibiting CALD staff retention and to determine if cultural and communication issues are part of or all of CALD staff's reasons for leaving, or considering to leave the workforce, and to identify strategies to address these issues
- investigate CALD staff retention issues within Queensland Health including examining and summarising data collected on equal employment opportunity employment, CALD staff satisfaction, and reasons for staff departure from the Queensland Health workforce and anecdotal evidence for factors contributing to and inhibiting CALD staff retention within Queensland Health.

This section presents the findings of this literature review and further literature reviews conducted since the time of this 2009 review.

The 2009 literature review conducted by Queensland Health (Queensland Health 2009) found that the following factors had been shown to have the potential to inhibit the retention of staff from a CALD background:

- *Language, dialect and communication difficulties*: English proficiency can prevent overseas staff from entering the workforce. People from a CALD background can experience practical difficulties in accessing English language courses. Local dialects, professional language used in a clinical setting and the use of local slang, particularly in country areas, present difficulties.
- *Differences in cultural norms and the inability to demonstrate attributes appropriately*: Working in an environment that has different cultural norms (e.g. levels of formality, hierarchy, working in teams, use of protocols) to their country of training can present challenges to adjustment for CALD staff. Overseas trained staff may have difficulty demonstrating their attributes in a way deemed appropriate in the new setting.
- *Differences in technology and work practices in country of qualification and destination country*: Overseas qualified nurses experience shock when they are required to carry out direct patient care, which in many cases is carried out by the family members of the patients in their country of training. These nurses experience frustration in the lack of recognition of their technical skills. In many cases overseas trained doctors report being placed in positions that don't match their previous experience or skills.
- *Lack of social support, including absence of support during adaptation period, preventing a smooth transition into the workplace*: Inadequate awareness and access to formal and informal support in the workplace, particularly in the initial twelve months, makes adaptation to the workplace difficult, contributes to loneliness and isolation, and has a negative impact on staff satisfaction.
- *Conflict with management and peers*: The perception that they are not trusted by management and colleagues and that they are constantly being "watched" negatively impacts on the work-life of overseas qualified health professionals.
- *Diminished professional and social status - reinforcement of patterns of disadvantage*: Overseas trained health staff experience a devaluing of their professional worth when no value is placed on their past experience, which in turn undermines their confidence in the workplace. A lack of respect for status engenders a diminished professional and personal social status.
- *Perceived and actual overt and covert racial discrimination*: Discrimination in the workplace exists both as overt racism and as 'aversive racism' that identifies overseas qualified health staff as social outsiders and places them in inferior positions where their personal and professional competencies are constantly questioned and undermined.
- *Lack of information*: An absence of adequate information prior to starting work is a major obstacle to adapting to the workplace for overseas trained health professionals. Equally relevant is the lack of relevant information available to managers and co-workers about the overseas trained professionals and what working with them may involve.
- *Differences between pre-migration expectation and post-migration reality*: Overseas trained doctors and nurses often have expectations of the workforce that are not met when they enter the workforce. This mismatch between expectations and reality is closely related to differences in work practices and technology and a lack of information, and causes frustration, anxiety and in many cases, an unexpected experience of decreased professional status.
- *Lower than expected remuneration*: In some cases, the income of overseas trained health professionals does not correspond to expected remuneration levels and is insufficient to both keep up with the cost of living and to send money to family in their country of origin. Lower than expected remuneration is a factor potentially negatively impacting on job satisfaction and retention of overseas trained doctors.
- *Family and personal issues*: Lack of suitable employment opportunities for spouses, adequate schooling for children, and access to cultural and religious activities and isolation from family and ethnic community may have a major impact, particularly in regional areas.

The literature reviewed on facilitating the retention of staff from a CALD background identified the following main factors:

- One-on-one mentoring support
- Communication and cultural support programs
- Comprehensive orientation and induction
- Culturally competent workplace including equal opportunity
- Education and training of workplace leaders
- Dealing with assumptions and expectations
- Transparent human resource management processes.

Three more recent literature reviews have been conducted. Kawi and Xu (2009) reported that many international nurses felt unsupported by management and peers in their adjustment to the new work environment. They also felt there was a lack of assistance with relocation such as finding accommodation, transport and registration. The authors recommended targeted orientation programs specifically for international nurses to assist in the transition, and the implementation a *buddy* system to provide clinical and emotional support in the workplace (Kawi and Xu 2009). The paper by Gillis and colleagues on best practice in recruiting and retaining a diverse workforce in nursing found that mentorship was not as effective as anticipated (Gilliss, Powell et al. 2010).

Similar to the 2009 Queensland Health literature review findings, Nichols and Campbell (2010) found that many international nurses had higher expectations of nursing in other countries and a different view of the role and purpose of nurses to that which occurred in the workplace. This difference contributed to low levels of job satisfaction and difficulty in adjusting to the new work environment. It was also reported that many international nurses felt frustration that their previous experience and skills were not recognised and that they were junior to other nurses with fewer skills (Nichols and Campbell 2010). Many internationally recruited nurses did not feel personally or professionally valued when working in other countries (Nichols and Campbell 2010). The authors recommended that when recruiting international nurses it is important to accurately describe the health system, the role of the nurse and the expectations, and to recognise prior skills and experience through professional development activities.

9.4.5 Racism and discrimination

The literature review by Giga and colleagues (Giga, Hoel et al. 2008) and Nichols and Campbell (2010) found that many black and minority ethnic groups are often exposed to racism and bullying by colleagues and patients in the workplace. The authors found that BME groups regularly experience “verbal experience, being ignored, racist literature, name calling/mimicking, lack of access to training, arbitrary policies and unfair/excess monitoring” in the workplace (Giga, Hoel et al. 2008). The review found that workplace bullying contributed to negative experiences of black and minority ethnic employees such as poor job satisfaction, poor health, absenteeism, turnover, conflict with other staff, and limited promotion opportunities (Giga, Hoel et al. 2008). The literature review by Lin (2009) found that the anger and frustration that international nurses experienced as a result of racism and discrimination may affect the care they provide to patients. The authors reported that to improve the experience of black and minority ethnic employees in the workplace support structures from peers, managers and employee representatives need to be developed and implemented (Giga, Hoel et al. 2008).

The literature review by Giga and colleagues also found that there is underreporting of bullying as many black and minority ethnic employees fear they will appear “vulnerable and weak” or fear the situation will lead to further exclusion (Giga, Hoel et al. 2008 p.15). However, the authors also reported that bullying was often denied by staff and the organisation due to the negative association and the possibility of action against the perpetrators (Giga, Hoel et al. 2008).

In their literature review, Kawi and Xu (2009) reported that many international nurses felt there was an inequality of opportunity towards promotions and professional development activities. The literature review by Lin (2009) reported that international nurses in the U.S. felt they were denied promotions or opportunities for career advancement due to their immigrant status. The literature review by Giga and colleagues reported that black and minority ethnic employees received lower scores on their job performance and as a result were more likely to experience a plateau in career opportunities (Giga, Hoel et al. 2008). Kawi and Xu identified that many international nurses felt that to be successful in obtaining a promotion they were required to conform to the ways of the host country and assert themselves more (Kawi and Xu 2009). Lin (2009) reported that many international nurses were “discriminated against in terms of opportunities for favoured shifts or higher wages as they were not aware of the wages and working hours.

9.5 Implications for implementing the Queensland Multicultural Policy 2011 and Language Services Policy in a health context

9.5.1 Summary of findings from policies, standards and literature

From the policies and standards reviewed, it is clear that there is support nationally and internationally (US, UK, New Zealand) for strategies that recruit, retain, and promote workforces that are representative of the demographic characteristics of the population served. The Queensland Government Multicultural Policy commits all departments to improved recruitment and retention strategies for staff from CALD backgrounds.

The literature reviewed provides evidence of the benefits of a diverse workforce on patient outcomes and reduced health care disparities and that to achieve these benefits, dedicated strategies to manage workforce diversity may be required.

From the literature reviewed, improved recruitment of staff from CALD backgrounds involves:

- promoting health professions to high school students and supporting students to undertake tertiary study
- educating overseas trained professionals about job advertisement and job application processes.

Improved retention of staff from CALD backgrounds is likely to result from:

- dedicated strategies targeting overseas trained staff which address assistance with language and dialects to assist communication
- education about the cultural norms of the new workplace and among newly arrived overseas trained staff
- explanations of the role of specific health care workers in Australia/Queensland prior to employment
- social support to assist transition to new workplace/country
- training for managers and teams on working with diverse teams
- the promotion of anti-discrimination practices.

Effective strategies for consideration include mentoring programs, comprehensive orientation and induction programs, cultural diversity training to improve the cultural competency of the workplace and reduce discrimination practices.

The above issues are included in the guideline and related documents as follows:

Included as considerations in guideline on best practice multicultural policy implementation
Promotion of health professions to high school students and support of students to study tertiary.
Education of overseas trained professionals about the job advertisement and job application processes.
Managers receive cross cultural training using the available dedicated packages. The packages include: <ul style="list-style-type: none"> • Working in Culturally Diverse Teams • Managing a Culturally Diverse Workplace.
Implementation of dedicated strategies to retain overseas trained professionals.

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Appendix 1: National and international policies and standards

National/ international	State/ country	Policy/standard	Site	Description
Australia	Queensland	Language Services Policy	www.health.qld.gov.au/multicultural/policies/language.pdf	This policy outlines Queensland Health's responsibility in providing interpreter services.
	New South Wales	Interpreters - Standard Procedures for Working with Health Care Interpreters	www.mhcs.health.nsw.gov.au/policiesandguidelines/pdf/PD2006_053.pdf	The policy describes the roles and functions of the Health Care Interpreter Service, situations in which interpreters must be used, what to do if an interpreter is not available, and the responsibilities of health care providers when using interpreters.
		Non-English Speaking Background - Standard Procedures - Improved Access Area/Public Health Services	www.mhcs.health.nsw.gov.au/policiesandguidelines/pdf/PD2005_483.pdf	Outlines the standard procedures for improved access to Area and Other Public Health Services by People of Non-English Speaking Background
	Victoria	Language Services Policy	www.dhs.vic.gov.au/__data/assets/pdf_file/0008/594926/language_service_policy.pdf	The Department of Human Services Language services policy states the minimum requirements, as well as key strategies, to ensure that people with low English proficiency or people who use Auslan as their first language have access to a quality service.
		Cultural Responsiveness Framework		Minimum requirements (1) critical points for language service provision (2) using qualified language services (3) protecting children
		'Doing it with us not for us: Strategic direction 2010-13	www.health.vic.gov.au/consumer/downloads/strategic_direction_2010-13.pdf	1. The organisation demonstrates a commitment to consumer, carer and community participation appropriate to its diverse communities. 2. Consumers, and, where appropriate, carers are involved in informed decision-making about their treatment, care and wellbeing at all stages and with appropriate support. 3. Consumers, and, where appropriate, carers are provided

National/ international	State/ country	Policy/standard	Site	Description
				<p>with evidence-based, accessible information to support key decision-making along the continuum of care.</p> <p>4. Consumers, carers and community members are active participants in the planning, improvement, and evaluation of services and programs on an ongoing basis.</p> <p>5. The organisation actively contributes to building the capacity of consumers, carers and community members to participate fully and effectively.</p>
	South Australia	Primary health care policy statement 2003-2007	www.publications.health.sa.gov.au/phc/24/	<p>The policy outlines the government's five pillars for building good health:</p> <ol style="list-style-type: none"> 1. Improving the quality and safety of services 2. Strengthening and reorienting services towards prevention and primary health care 3. Developing service integration and cooperation 4. Adopting whole of Government approaches to advance and improve health status 5. Greater opportunities for inclusion and community participation
	Australian Capital Territory (ACT)	<p>Cultural Awareness and Interpreter Service Policy</p> <p>Multicultural Strategy 2006-2009</p>	<p>www.health.act.gov.au/c/health?a=dlpubpoldoc&document=96</p> <p>www.health.act.gov.au/c/health?a=dlpubpoldoc&document=903</p>	<p>The policy provides information on culturally sensitive services to people from culturally and linguistically diverse backgrounds including interpreter services.</p> <p>Sets out the key principles for a whole-of-government approach to fostering, promoting and sustaining cultural diversity in the ACT and defines strategies that will give expression to the principles and themes that underpin the Multicultural Strategy</p>
	Western Australia	WA Health Language Services Policy	www.health.wa.gov.au/languageservices/docs/1%20WA_Health_L_S_Policy.pdf	<p>The policy outlines the following:</p> <ul style="list-style-type: none"> • Provision of interpreting and translating services <ul style="list-style-type: none"> – People who may access interpreting and

National/ international	State/ country	Policy/standard	Site	Description
				<p>translating services</p> <ul style="list-style-type: none"> – Assessing the need for an interpreter or translator – Providing competent interpreters and translators – Assessing health risks and matching with appropriate levels of interpreter and translator competence – Types of interpreting services – Dealing with consumer preferences – Feedback, compliments and complaints <ul style="list-style-type: none"> • Workforce knowledge and skills. • Reporting and continuous improvement
	Northern Territory	<p>Northern Territory Government Language Services Policy</p> <p>Northern Territory Multicultural Policy</p>	<p>www.dlgh.nt.gov.au/__data/assets/pdf_file/0007/64537/language_services_poilcy_web.pdf</p> <p>www.dcm.nt.gov.au/__data/assets/pdf_file/0004/43753/Multicultural_Policy.pdf</p>	<p>The Language Services Policy outlines how and where language services can be accessed, why it is important to use these services and how they should be used.</p> <p>All Territorians, regardless of their background, have a right to fair and equitable access to government services and programs, while recognising the different needs arising from Territorians' cultural and linguistic diversity.</p>
	Tasmania	Nil		
National Standards	Australia	National Safety and Quality Health Services Standards	<p>www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/CA1C4B7F4C5B5547CA257793000528D5/\$File/NSQHS-Standards-Sept2011.pdf</p>	<p>The Standards provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. The Standards address the following areas:</p> <ul style="list-style-type: none"> • Governance for Safety and Quality in Health Service Organisations • Partnering with Consumers • Preventing and Controlling Health Associated Infections • Medication Safety • Patient Identification and Procedure Matching

National/ international	State/ country	Policy/standard	Site	Description
				<ul style="list-style-type: none"> • Clinical Handover • Blood and Blood Products • Preventing and Managing Pressure Injuries • Recognising and Responding to Clinical Deterioration in Acute Health Care • Preventing Falls and Harm from Falls
International Standards	United States	National Standards for Culturally and Linguistically Appropriate Service (CLAS)	www.minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15	<p>Standard 1 Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.</p> <p>Standard 2 Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.</p> <p>Standard 3 Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.</p> <p>Standard 4 Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.</p> <p>Standard 5 Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.</p> <p>Standard 6 Health care organizations must assure the competence of language assistance provided to</p>

National/ international	State/ country	Policy/standard	Site	Description
				<p>limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).</p> <p>Standard 7 Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.</p> <p>Standard 8 Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.</p> <p>Standard 9 Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.</p> <p>Standard 10 Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.</p> <p>Standard 11 Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond</p>

National/ international	State/ country	Policy/standard	Site	Description
		Patient-Centered Communication Standards for Hospitals		<p>to the cultural and linguistic characteristics of the service area.</p> <p>Standard 12 Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.</p> <p>Standard 13 Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.</p> <p>Standard 14 Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.</p> <p>The patient-centered communication standards, approved in December 2009 and released in January 2010, will be effective July 1, 2012.</p>
	Canada	Leadership Standards (Accreditation Canada)	www.accreditation.ca/accreditation-programs/qmentum/standards/	The relevant standard; <i>Creating and sustaining a caring culture</i> addresses the need for health care organisations to create a culture that supports a safe and healthy work environment and ongoing quality improvement.
	New Zealand	Core Standards for Safety and Quality in Healthcare (JAS-ANZ is the government-appointed accreditation body for Australia and New Zealand)	www.jas-anz.com.au/images/stories/Documents/Procedures/Core_Standards_for_Safety_and_Quality_in_Healthcare.pdf	Core Standards for Safety and Quality in Healthcare outline five Core Standards Core Standard 5 - Consumer rights. The Health Service must be able to demonstrate that they have:

National/ international	State/ country	Policy/standard	Site	Description
		<p>responsible for providing accreditation of conformity assessment bodies (CABs)</p> <p>Health and Disability Services (Core) Standards</p>		<ol style="list-style-type: none"> 1. Documented policies with regard to patient rights and responsibilities and complaints mechanisms 2. Ready access to appropriate information on the health care provided to consumers including information on patient/client rights and responsibilities and complaints mechanisms. Providing access to appropriate information needs include processes for responding to language needs and any specific needs for persons with disabilities 3. Documented processes to ensure consumer participation in decision-making regarding their care including informed consent to treatment 4. Interpreting services available to the patient/client/carer 5. Systems to ensure that: <ol style="list-style-type: none"> (i) Well designed, valid and reliable patient/client satisfaction/feedback mechanisms are in place and are used to evaluate the health service (ii) The Health Service acts upon the consumer feedback (iii) Access to patient/client records is strictly protected to ensure privacy and confidentiality (iv) The Health Service recognises the need to consider cultural differences and diversity. <p>The Health and Disability Services Standards are mandatory for health and disability service providers that are subject to the Health and Disability Services (Safety) Act 2001. The Standard NZS 8134:2008 includes Standards on consumer rights, organisational management, continuum of service delivery, and safe and appropriate environment.</p>

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	United Kingdom	The NHS Outcomes Framework 2012/13	www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700	<p>This document outlines the outcomes and corresponding indicators that will be used to hold the NHS Commissioning Board to account for the outcomes it delivers through commissioning health services from 2012/13. The framework sets the direction of travel in the journey towards improving outcomes, and offers an opportunity for the NHS to begin to understand what an NHS focussed on outcomes means for individuals, organisations and health economies.</p> <p>Five Domains:</p> <ol style="list-style-type: none"> (1) Preventing people from dying prematurely (2) Enhancing quality of life for people with long-term conditions (3) Helping people to recover from episodes of ill health or following injury (4) Ensuring people have a positive experience of care (5) Treating and caring for people in a safe environment and protecting them from avoidable harm