

Re-visioning cultural competence in community health services in Victoria

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Abstract

There are few studies exploring the need to develop and manage culturally competent health services for refugees and migrants from diverse backgrounds. Using data from 50 interviews with service providers from 26 agencies, and focus group discussion with nine different ethnic groups, this paper examines how the Victorian state government funding and service agreements negatively impact on the quest to achieve cultural competence. The study found that service providers have adopted "one approach fits all" models of service delivery. The pressure and competition for resources to address culturally and linguistically diverse communities' needs allows little opportunity for partnership and collaboration between providers, leading to insufficient sharing of information and duplication of services, poor referrals, incomplete assessment of needs, poor compliance with medical treatment, underutilisation of available services and poor continuity of care. This paper outlines a model for cultural consultation and developing needs-led rather than service-led programs.

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THE DEMOGRAPHIC PROFILE of the Australian population indicates that Australia is a rich and complex multicultural society with more than six million migrants resettling in Australia since 1945. Available data suggest that 30% of Australians are from a culturally and linguistically diverse (CALD) ancestry; almost a quarter (23%)

What is known about the topic?

Although Victoria is home to an increasing number of migrants and refugees there are few resources directed to assisting health care providers ensure cultural competence.

What does this paper add?

This paper found, from interviews and focus groups, that the provision of health and welfare services to culturally and linguistically diverse (CALD) communities was generalist. The major failing of this model is that it potentially ignores the need for partnership and organisational collaboration to maximise service delivery options while reducing service duplication.

What are the implications for practitioners?

Greater sensitivity to health needs of CALD communities and commitment to cultural competence will improve the quality of health care to the increasing number of CALD communities in Australia. This requires definition of strategies and benchmarks that accord with culturally competent services and subsequently building them into funding and service agreements.

of the Australian population were born overseas, and 15% of the population speak a language other than English at home.¹⁻⁵ About 36% of all Australian refugees and humanitarian entrants are relocated within Victoria.⁶ The State Department of Education, Employment and Training⁷ indicates that Victorian migrants originate from 208 countries, follow more than 100 religious faiths, and speak 151 languages. Half of the Victorian population (44.5%) have at least one parent born overseas while 20% come from countries where English is not the main or official language.

Meeting the health needs of the Victorian ethnic population requires considerations of cultural and linguistic diversity. The challenge for health and welfare agencies is to provide a system of services to respond to the needs of diverse communities and individuals regardless of their backgrounds. However, resources are scarce and not

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all needs can be met; needs must be prioritised. For small marginal ethnic groups, an ethno-specific response becomes arguably unjustifiable. Although the ethno-specific model of service delivery is long recognised as more viable for larger ethnic communities,⁸ small communities are left with fewer options where there are no alternative models of service delivery. This is particularly important as settlement experiences vary across individuals and communities.

Transition becomes more difficult than most migrants and refugees imagined. In this sense, settlement is well understood as a vexed process with the potential to impact upon health and wellbeing. For example, more than 250 000 CALD first generation adult Australians experience mental disorders in a year.⁴ Further, CALD Australians have been found to have high rates of suicide⁹ and a lower hospitalisation rate for mental disorders and all diagnoses when compared with their English speaking counterparts.^{10,11} In addition, CALD Australians have significantly higher rates of diabetes and diabetes-related hospital separations and deaths.¹² Other documented health needs have included dental problems, care for pregnancy and child health, and sexually transmitted diseases.

Cultural competence has emerged as a framework to help health care providers improve the health outcomes of CALD communities.¹³ The lack of awareness about cultural differences and CALD clients' lack of knowledge about the health system can result in two unwanted outcomes:¹⁴

- compromised patient-provider relationships, especially when miscommunication occurs, making it difficult for both providers and patients to achieve the most appropriate care; and
- effects on patients' health beliefs, practices, and behaviours.

Consequently, the National Center for Cultural Competence in the United States¹³ suggested a conceptual framework for cultural competence requiring organisations to:

- have a defined set of values and principles, and demonstrate behaviours, attitudes, policies, and structures that enable them to work effectively cross-culturally;

- have the capacity to (a) value diversity, (b) conduct self-assessment, (c) manage the dynamics of difference and institutionalisation of cultural knowledge, and (d) adapt to diversity and the cultural contexts of the communities they serve;
- incorporate the requirements above in all aspects of policy development, administration, and practice/service delivery and involve consumers systematically.

In this sense, cultural competence is much more than awareness of cultural differences¹⁵ and encompasses "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations".^{16,17}

The cultural competence framework has been in existence since the late 1980s and has extensively been applied in different fields from mental health,¹⁸⁻²¹ and chronic disease²²⁻²⁵ to refugee and migrant health in general.²⁶⁻²⁹ By 2001 the US government had already developed 14 National Standards for Culturally and Linguistically Appropriate Services that guide the American health care system.³⁰ However, despite the ever increasing cultural diversity of the Australian population, cultural competence is a new phenomenon in Australia. It is not until recently that guidelines for Cultural Competence in Health were developed by the National Health and Medical Research Council of Australia.¹⁷

In the absence of guidelines for cultural competence, service providers in Australia have traditionally regarded their service users as generic in nature and have often embraced the "one approach fits all" model of service delivery. As health service providers became more aware of the complexities inherent in working within a milieu of cultural and linguistic diversity, they were privy to a growing ethos of "customisation". Customisation would result in the development of service responses that are more meaningful and sensitive to diversity considerations. Thus, the purpose of this study was to document how service providers identify and develop services to meet the needs of CALD communities. The study

I Demographic characteristics of focus group discussion participants

Stakeholder (target)	Number of people per focus group discussion	Mean age of participants	Gender makeup	Places visited
Afghanis	12	38.3	100%F	Whittlesea
Cambodians	11	39.2	55%F, 45%M	Springvale
South Sudanese	13	32.5	35%F, 65%M	Springvale
Croatians	10	41.4	50%F, 50%M	Barwon
Spanish (Chile)	12	39.1	80% F; 20%M	Springvale
Vietnamese	11	40.8	30%F, 70%M	Richmond
Iraqis	11	37.4	100%F	Whittlesea
Bosnians	10	29.8	40%F, 60%M	St Albans
East Timorese	10	35.6	50%F; 50%M	Richmond

F = female. M = male.

further assessed CALD clients' experiences in dealing with health service providers from a service user's perspective.

Methods

The study was nested within a larger Victoria-wide study conducted between August 2001 and February 2002 which investigated factors that impact on health-seeking behaviours among migrants and humanitarian entrants. Consistent with best practice in community engagement and research,³¹ a steering committee was established of representatives from the Victorian Foundation for Survivors of Trauma and Torture, Women's Health in the North, Ecumenical Migration Centre, Women's Health in the West, Ethnic Community Council of Victoria, the Centre for Multicultural Youth Issues and Moreland Community Health Services. Each steering committee member was asked to map all government-funded health and welfare service providers assisting newly arrived migrants and humanitarian entrants in their geographic areas and/or networks. In total, 149 agencies were identified which included community health centres, migrant resource centres, women's health services, child and adolescent health services, and hospital-based community services. Based on geographic locations and distribution of humanitarian entrants across the state (country of birth per local govern-

ment area), 26 service providers were purposively selected to take part in this study.

Face-to-face interviews were used to seek service providers' opinions and perceptions regarding the nature of service delivery to CALD communities. Fifty interviews were completed and included both managers and direct service providers from the 26 agencies. These included 17 community health centres, 4 migrant resource centres, 3 women's health services, one children's services centre, and one disability service. Data from interviews with service providers were completed by focus group discussions (FGDs) with nine different ethnic groups: Afghanis, Cambodians, South Sudanese, Croatians, Spanish (Chile), Bosnians, East Timorese, Vietnamese and Iraqis. There were consultations with community gatekeepers and/or representatives before data collection for FGDs. In turn, community representatives informed their respective communities about the research and the importance of the research findings in informing council and state health policies. All consulted communities consented to the research and assisted with organising people for the FGDs. They were assured that all data provided would be treated with strict confidentiality.

The transcripts, together with written contemporaneous notes, were used for data analysis. Manual thematic coding methods were employed

2 Humanitarian entrants' needs as perceived by service providers (N = 48)

Perceived needs	Respondents
Lack of familiarity with services available/complexity of the systems	83.8%
Accommodation-related issues	80.3%
Chronic diseases, mainly diabetes and hypertension	65.0%
Lack of employment	63.5%
Underutilisation of health services	45.2%
Limited access to social security services	32.2%
Mental health: depression/posttraumatic stress/trauma	27.2%
Schooling-related issues for children*	13.9%
Material aid, mainly furniture	7.7%

* Include: Struggling to integrate, lack of focus due to lack of sleep and poor school performance.

Note: multiple response analysis. Does not add up 100%.

to identify common threads or persistent words, phrases or concepts that extended throughout the interview transcripts and FGD notes.³²⁻³⁴ Related threads were combined and catalogued into coded themes.^{33,34} Coded themes were entered into SPSS, version 10 (SPSS Inc, Chicago, Ill, USA) to generate descriptive statistics. In summarising the findings, the author refers to the voices of the research participants.

Results

Characteristics of participants

Of the fifty service providers interviewed, 11 (22%) were middle managers, 5 (10%) were senior managers, 10 (20%) were nurses, 13 (26%) were social workers, 3 (6%) were medical doctors, 6 (12%) professional interpreters and 2 (4%) were receptionists. Characteristics of FGD participants are summarised in Box 1.

Four themes emerged from the interviews and FGD transcripts: service provision, underutilisation of services, issues related to interpreting services, and duplication of and gaps in service delivery. Each of them is discussed below.

Theme 1: Service provision is not needs based and responsibility to fill the gaps is both unclear and confronting

The study found that 90% of mainstream agencies assist CALD communities, but the provision

of services varied in scope and focus, with 89.3% of the mainstream organisations adopting a generalist approach. Only 10.7% developed programs based on findings from consultations with the CALD communities. Few (4%) of the mainstream organisations used group targeting and needs prioritisation when addressing the needs of CALD communities. Needs prioritisation was not informed by a needs assessment and consultation with stakeholders; it was based on funding opportunities. Thus, needs prioritised by service providers were not commensurate with needs

3 Most pressing needs identified by migrants during focus group discussions

- Social exclusion and lack of social support
- Needs for quality interpreting services
- Poor access to and understanding of the legal system
- Sending money back home to sponsor family reunion
- Greater needs for maternal and child health services
- Violence/domestic violence
- Dental services
- Safety and security for children in public housing
- Discrimination
- Drug and alcohol
- Assistance with immigration process

4 Reason for underutilisation (N = 47)

Reasons	Respondents
Culturally insensitive service delivery	85.8%
Humanitarian entrant unawareness of availability	61.4%
Complexity and sophistication of the system	55.1%
Language barriers	49.3%
Mainstream organisations' unwillingness to use interpreters	24.9%
Staff not trained in cross-cultural communication	24.6%
Humanitarian entrants not trusting providers	23.9%
Inadequate marketing and promotion of available services	12.1%
Providers not conducive to assisting refugees	6.8%
Lack of translated materials	6.1%
Lack of cohesion and duplication of services leading to confusion among stakeholders	4.6%

Note: Multiple response analysis. Does not add up 100%.

identified by CALD communities during FGDs (Box 2 and Box 3). One manager, who represented the views of many, noted: "That's one thing we have to do, identify what the people want in that community. It's okay that they are referred to us but we've got to find out what those people need."

In addition, the government and funding bodies assumed that primary health service providers were equipped and well able to recognise and deal with issues that arise from cultural, religious and ethnic differences, and also had the ability and willingness to change their organisational structures, attitudes and practices to optimally meet the needs of CALD communities without commensurate funding opportunities. Consequently, developing services and programs to meet the plethora of CALD communities' needs became less of a priority in the funding and service agreements (FASA). The most cited barriers that impeded providers' ability to implement policies that value and embrace cultural diversity were inflexible FASA. The study found that FASA do not require that cultural competence be built into all levels of programming (62%) and they do not provide sufficient funds to meet the extra needs, such as costs associated with interpreting services. A number of views were expressed to elucidate these findings:

... it's a really big issue in terms of any group that is from a non-English speaking background, whether it is a refugee, migrant or even Koori community, my view is that the generic services do not cater for those groups anywhere near sufficiently. And it is a real issue. What happened is [that] a lot of services have thought an ethno-specific [service] or another group looks after their needs. I think there is a bit of cultural mindset with services as well as the way funding has been more recently targeted for people in welfare. We [providers] have had to become more rigid with our general clients in terms of what we can and can't do.

... Governments are constantly minimising the cost of providing services, they're privatising it, and they're shrinking the dollars that are there to provide the most decent humane programs for people. They have spent \$400M in the last couple of years setting up jails and have jailed 6000 people [asylum seekers]. If you let 5000 of those people stay and if you put \$100M into the community sector to assist these people, our problems would be resolved.

Here are people who have got obvious unmet needs and we've got quite a lot of resources. So do we take services away from

5 Reasons for poor use of interpreting services: results from focus group discussions

Theme	Major issues
Barriers to using professional interpreters	<ul style="list-style-type: none"> ■ Confusion of interpreting costs: who bears the cost? How much does it cost to use a professional interpreter? ■ Lack of support and frustration, ie, lack of service coordination in relation to booking interpreters, negative emotions towards services, feeling of abandonment, providers' indifference, alienation, limited information related to humanitarian entrants' right to interpreting services, inappropriate and inadequate provision of information related to access to interpreters, insufficient number of interpreters and translated materials (in limited languages only) ■ Differential access to information, ie, different visa categories with different restrictions in terms of what information and accessible services are made available on arrival, some accommodation flats being more equipped with translated materials than others
Interpreters' interpersonal issues	<ul style="list-style-type: none"> ■ Discrimination and racism ■ Cultural and communication insensitivity, eg, issues related to communication between the client and interpreters, interpreter–language mismatch, errors in, and sometimes offending translation for existing materials ■ Interpersonal style, behaviours and competence of interpreters, ie, rudeness, ethical issues and professionalism related to disclosure, not always punctual ■ Lack of complaint mechanisms
Organisational issues	<ul style="list-style-type: none"> ■ Doctors' inflexibility, eg, doctors do not like to use interpreters, specialist doctors are often too busy to have time for interpreting services ■ Organisation self interest and not the interest of the clients, eg, only have few interpreters covering a myriad of languages due to the "time is money" attitude and thus a Croatian interpreter sometimes being asked to interpret for a Macedonian client because they are close languages ■ Procedure too complex and/or inappropriate, eg, bureaucracy, longer waiting time, failing to book an interpreter on request

elsewhere to help fill that gap? And we tend to say "no" to this fundamental question because humanitarian program isn't really our area and perhaps confuses the thing. So it's a dilemma for us, one that's been thrown up. So there's lots of needs that we can't meet and at the moment don't see as our prime role but we might be interested in seeing it that way if we were funded. . .

Consequently, the service system remained generic in nature and scope, and was geared toward "fitting in" consumers rather than a needs-based approach to programming. Where specific programs existed, they occurred as a result of opportunistic funding/tendering and in most cases the services were not commensurate with the refugees' stated needs. Sixty two percent of

service providers believed that the current system was ineffective in addressing the needs of CALD communities, while 96.2% suggested that there were occasions where needs were identified but they could not intervene. The main reasons for not intervening were:

- Lack of organisational focus on refugee and humanitarian entrants, due to a combination of insufficient funding and inflexible FASA;
- Structural barriers: too many management levels and lack of flexibility within the organisation;
- Political sensitivity: management stalling on proposed changes if the identified needs were perceived to be potentially sensitive, such as in cases of Temporary Protection Visas;
- Fear to overlap with other providers such as city councils and ethno-specific services;

- No appropriate services to refer clients to when identified needs fall outside the organisation's core business.

As one participant, who represented the views of many, put it:

... well, it's up to me to do that isn't it? It's about having a commitment to doing it. And I guess having the knowledge that you're not meeting the needs, being reminded that you're not. I think we are meeting them to an extent but it hasn't been a conscious thing of our agency to really separate out whether the women who we work with are from migrant or refugee backgrounds. We haven't been really conscious about that. So, that's where we are in a position where I don't even know if we are meeting the needs or to what extent we are meeting the needs. Except to know that there are a lot of languages that we don't cover and they tend to be the ones that are from the more newly emerging communities. So, yeah, it's a matter of having a commitment to doing it.

Theme 2: Underutilisation of available services

Mainstream organisations estimated that on average 35.7% of the population in the surveyed catchments were CALD communities and 67.6% of these CALD communities were not using available services. Reasons for the poor utilisation of services are summarised in Box 4. While these statistics framed the evidence, the poignancy of the findings was well expressed by one participant who stated:

... I think also it's the appropriateness of the service. I think the research will show that some of those people may have had an initial contact and that hasn't been a positive one. Perhaps waiting in a queue, perhaps rudely being told to sit down, perhaps not understanding the queuing or numbering system. You are never going to go back ... Because I suppose when we talk about the health system this is very huge isn't it? I know for a fact that you will get lots of people that say — well I went but I had no idea you had to wait so I approached the counter and this

woman said "Oh, sit down". You are embarrassed. So that person will just walk out the door. Now, God knows where they will go then. They'll go shopping around, maybe if they know where to go. Sometimes many months will lapse because of what I call an inappropriate cultural and linguistic experience.

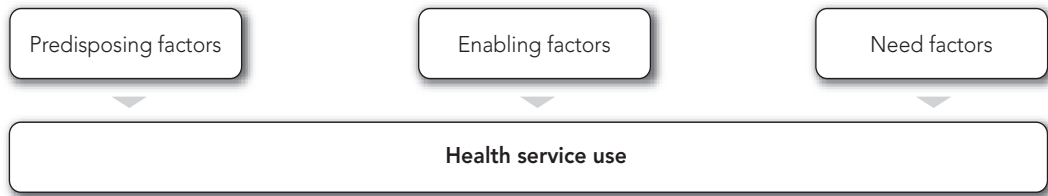
These findings were corroborated by the FGDs. FGD participants established that the underutilisation of services was a result of numerous factors with the most significant being:

- inadequate interpreting services (see Box 5);
- lack of information related to refugees' rights and entitlements;
- lack of non-English-language-specific information about health services, schools and accommodation; and
- the considerable number of CALD communities with poor educational attainment, thus unable to read translated materials that are available.

Theme 3: Interpreting services as a challenge

FGD participants suggested that they prefer using professional interpreters only in emergency situations, or in case of too sensitive and complex medical issues. They indicated that they prefer to rely on family members for normal consultations, and children were the most used interpreters to facilitate communication for general consultations. Where a professional interpreter was used, face-to-face interpreting was preferred over telephone interpreting services. The need for gender-specific interpreters was considered indispensable, especially when discussing private and sensitive issues such as gynaecological matters. FGD participants nevertheless recognised the consequence of using family and/or community members as interpreters. They noted that children's interpreting ability affects the accuracy of information, making the treatment and diagnosis very difficult. They also noted that when family members are used as interpreters they become privy to sensitive information such as the diagnosis of a terminal illness and this affects confidentiality and comfort. Issues related to opportunity cost

6 The health care utilisation model



Source: Adapted from Weller et al.³⁷

were also raised, notably family members missing school, skipping work and the subsequent stress resulting from such a burden of being used as an interpreter.

Theme 4: Duplication of and gaps in service delivery

Duplication of services and lack of coordination among mainstream organisations were consistent themes identified by 68.8% of service providers. As one service provider summed it up:

But if there is an issue however, if I can speak, probably more from a management perspective, I believe there should be a concern about the duplication of services and definitely I believe there should be more talking to and liaison between the Commonwealth, regional and local government because sometimes they are literally all doing the same thing — competition. The accountability is different, the worker conditions are different and it can become very confusing. So I actually believe in the area of newly arrived service when there are planning mechanisms that already bring the Commonwealth and the state together they should be discussed. And I think the reaction to how people who are being released from detention has been dealt with I suppose is an indictment on the fact that there was not enough cooperation between the local government, state and the Commonwealth.

In support of these findings another manager lamented:

Why the hell are they referring the people to us? They are getting funding for the same issues our programs are addressing. We see clients from all over Melbourne but sometimes the nature of the referral is such that we question it ... It's a bit of a game.

The duplication of services and the adoption of a service-led approach have resulted in a high level of unmet health needs. The most unmet health and social needs identified by FGD participants were:

- education in reproductive health, especially birth spacing;
- addressing parenting challenges related to child bearing;
- drug counselling, especially for young single mothers and single-mother-headed households;
- men's health with focus on health-seeking behaviours, men's knowledge and perceptions of diseases and risks, and health screening opportunities for men;
- men's counselling services in relation to family relationships, body image and domestic violence.

As one community representative noted:

... [our] husbands coming to Australia and seeing a very different woman and the immediate promotion of very slim, tall and aesthetically attractive women. CALD women are feeling that they are not as attractive as European women they see on TV and they supposedly are under constant pressure from their husbands to slim. So there have been those sorts of issues that have been coming through loud and clear.

Discussion

This is the first state-wide study to explore barriers to cultural competence in mainstream organisations and CALD clients' experiences in dealing with health and welfare service providers. The study found that the provision of health and welfare services to CALD communities is generalist in nature. The major failing of this model is that it potentially ignores the need for partnership and organisational collaboration as a mechanism to maximise service delivery options while reducing service duplication. Partnership, consultation, needs assessment and ultimately responsive programming should underpin primary health care provision. This is particularly important for CALD communities as their needs vary depending on each person's experiences and expectations, including those associated with the migration process, settlement and adaptation to the host country.

Primary health and welfare service providers may be better served by a greater awareness of the range of services offered by other organisations. However, this must be understood in the context of "competition and competitive tendering" as an ethos that underpinned organisational responses in Victoria during the coalition state government (1992–1999). This ethos often fostered a climate of mistrust and poor inter-agency communication. Therefore, the fact that mainstream organisations' services remain generic in nature and resulted from opportunistic funding/tendering rather than needs assessment means that CALD communities have a high level of unmet needs. This was compounded by the fact that service providers did not see the needs of CALD communities as their primary responsibility. This acted as a disincentive for clients as they dealt with multiple stakeholders with each contact. These findings are consistent with those reported by Kirmayer and colleagues.³⁵ They found that clinicians made demands for cultural consultation services (CCS) that went beyond consultation to include emergency intervention, and at times the transfer of patients for long-term treatment or case management. The authors noted that, "in several consultations, the referring clinician became inac-

cessible or stopped treating the patient, presumably on the assumption that the CCS would become responsible for the patient's subsequent care".

The underutilisation of available services by CALD communities concurs with Fortier's¹⁴ observation that the lack of knowledge of cultural differences between service providers and CALD clients can inevitably lead to a potentially damaging belief that either these differences are not significant or that our common humanity transcends such differences. For other providers it may be fear of the unknown or the new, which challenges and perhaps threatens the dominant world view, and the Health Care Utilisation Model³⁶ provides us with a framework to understand this phenomenon. The model identifies three clusters of analysis: predisposing, enabling and need factors (Box 6). Predisposing factors include demographic factors such as age, gender, religion and educational attainment³⁷ as well as the attitudes, beliefs, and knowledge that motivate people to act, such as the general attitudes towards health services, knowledge about the illness and so forth. Enabling factors are the resources including availability of services, the location of or distance to the health facility, financial resources to purchase services such as health insurance, and social network support. The need factors include perception of severity, total number of sick days for a reported illness, total number of days in bed, days missed from work or school, and help from outside providing care. This is particularly important when providers believe or perceive that there is insufficient time to allow for a more comprehensive assessment of CALD clients' needs,¹⁴ especially in an environment where health professionals are generally trained to view a disease as a biomedical issue³⁸ while many CALD communities experience a natural union between spiritual beliefs, social relationships and health outcomes which in their country of origin would otherwise require a more integrated response. However, what the model does not address are the external or reinforcing forces, which are beyond the consumers' control. These include legal frameworks, organi-

7 Conceptual framework for problem definition and intervention for culturally and linguistically diverse (CALD) communities*

Problem definition and intervention

Appraisal questions ... the "dos"

How are your and your organisation's cultural assumptions and values affecting the identification of the problem and the possible interventions?

Have communities been consulted about their needs or ideas of health and illness, how they see the problems and the possible interventions?

Have access issues been considered?

What are the socio-environmental/cultural issues effecting the situation?

Have ethnic communities been consulted? Have a broad range of people within communities been consulted?

Are immigrant communities involved in the process?

Translated materials

Consider ...

- Not all people are literate
- Many refugees have experienced disrupted schooling in their countries of origin
- Australia receives immigrants from over 120 countries, but translated materials tend to be in 10 main languages
- Many immigrants from the 1950s were illiterate and received no language classes on arrival
- Some communities and cultures favour and rely upon oral forms of information sharing

Then ask ...

- Are your messages appropriate?
- How will the information be disseminated?
- How will you message test and evaluate the proposed material?
- Are the appropriate access strategies in place?

Increase communities' capacity to promote better health knowledge

Approach *all* health education initiatives from a diversity framework.

Ensure health strategies take into account the social and economic environments of the target group.

Design health messages which are appropriate to the understandings and cultural norms of the target group.

Message focus-test all promotion materials for accuracy, cultural appropriateness and simplicity.

Inclusiveness: the role of effective cross cultural communications

Whenever possible include ethnic communities in all stages of the promotion campaign (problem definition, goal and outcome setting and evaluation).

Deliver messages in an appropriate format (verbal, printed, visual, audio).

Education methods should appeal to learning styles preferred by the target group.

Use appropriate dissemination strategies (peer education, bilingual workers, ethnic media, social clubs).

Consultation with CALD communities

Seek the advice of community leaders and "gatekeepers" and always assume diversity within communities.

Establish an ongoing relationship such as establishing a CALD Review Panel or Advisory committee.

Create relevant and appropriate avenues for developing a working relationship such as resourcing communities to enable participation (knowledge, access, support, time, language services), promoting a sense of ownership by involving CALD consumers in every stage of the planning, implementation and development process.

Be aware of "consultation fatigue".

Seek a range of opinions in a respectful and culturally appropriate way and always be prepared to compromise.

Also, make sure consultation has real and tangible effects.

Enquire about the best way to consult with a community.

Key skills and knowledge for working cross culturally

Learn ...

- About your own culturally mediated assumptions values and practices
- About the values and assumptions underlying your organisational and professional cultures
- About a clients' or co-workers' own perspectives, meanings and priorities

But value ...

- Perspectives other than your own
- Diversity between and within communities and cultures

Understand ...

- You cannot fully comprehend the meanings of the cultural practices of another group
- Every interaction with another person is in some senses cross cultural

Watch for ...

- Ethnocentrism
- Assumptions that anyone else's cultural experiences are any less complex than your own

* Modelled on public health approaches which identify four interdependent levels: defining the problem; identifying risk factors; developing and evaluating intervention; and implementation. Source: Mohan et al.³⁹

sation or government policies, peer pressures or pressure from the media. Building on these observations, we suggest a conceptual framework for problem definition and intervention for CALD communities (Box 7).

Implications for behavioural health and policy considerations

Primary health and welfare service providers are funded to work in specific areas proscribed by their FASA. The first step in promoting cultural competence would be to overcome FASA-related barriers by defining strategies and benchmarks that accord with providing culturally competent services and subsequently building them into FASA. The development of Community Health Plans by the Department of Human Services and local government within a particular catchment^{40,41} needs to include criteria that government and funding bodies can apply to judge whether or not service providers are comprehensively meeting the needs of CALD and emergent communities. The pressure and competition for resources allows little opportunity for partnership and collaboration between service providers. This results in insufficient sharing of information and duplication of services, the consequence of which includes poor referrals, incomplete assessment and poor compliance with medical treatment. The insufficient planning on the basis of needs analysis and prioritisations could be a result of service providers planning programs based on historic funding structures, as well as lack of skill in cross cultural consultations and/or communications. New approaches to dealing with CALD communities are required where service providers would be compelled to design strategies that improve access and utilisation of services by:

- developing and implementing policies that promote continuing cross-cultural training of their staff and building the applications gained from cultural training into individual staff's performance appraisals;
- promoting cross-cultural competence into work plans and evaluation practices;
- assisting training organisations to develop accredited cross-cultural training standards and

ensuring that cross-cultural competence is built into training organisations' accreditation procedure;

- ensuring that services clearly stipulate where and to what extent their assistance to CALD communities integrates with other similar service providers in a particular catchment as a component of accreditation; and
- determining and supporting strategies that enhance the recognition of qualifications gained in countries outside Australia in order to facilitate successful resettlement and ensure full participation in community initiatives.

Conclusion

Service providers have limited approaches to the provision of CALD services, tending to adopt a "one size fits all" policy. Greater sensitivity to health needs of CALD communities and commitment to cultural competence will improve the quality of health care to the increasing number of CALD communities in Australia

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Competing interests

The author declares that he has no competing interests.

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