Best Practice Principles:
CALD Cultural Competency Standards and Framework

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Contents

1. OVERVIEW ........................................................................................................................................3
  1.1 Purpose ........................................................................................................................................3
  1.2 Scope ...........................................................................................................................................3

2. Definitions .........................................................................................................................................3

3. Demographic Overview .................................................................................................................5
  3.1 Asian population profile and characteristics ...........................................................................5
  3.2 Middle Eastern and African population profile and characteristics ....................................6

4. Workforce Diversity .......................................................................................................................8
  4.1 Asian and Migrant Workforce ....................................................................................................8
  4.2 Increasing Workforce Diversity ..................................................................................................8

5. Service barriers .............................................................................................................................9
  5.1 Language and Cultural Issues .....................................................................................................9

6. Why the need for cultural competence? ........................................................................................10
  6.1 Cultural Competence Concepts ................................................................................................10

7. Best Practice Principles: CALD Cultural Competency Standards ............................................12
  7.1 Standard 1: Service Planning and Evaluation ............................................................................12
  7.2 Standard 2: Community Engagement and Consultation .........................................................12
  7.3 Standard 3: Evaluation, Research and Service Delivery Development ..................................14
  7.4 Standard 4: Equitable Access ....................................................................................................14
  7.5 Standard 5: Workforce/Staff Development ..............................................................................16
  7.6 Standard 6: Consumer Participation .........................................................................................17
  7.7 Standard 7: Planning, Funding, Contracting, Monitoring .........................................................18
  7.8 Standard 8: Management Support ............................................................................................18

8. CALD Cultural Competencies for Working with Service Users ....................................................19

9. CALD Cultural Competency Training and Resources – Working with Service Users ..............20
  9.1 CALD Training Programme - Working with Service Users ......................................................20
  9.2 CALD Resources – Working with Service Users ..................................................................21
  9.3 Cultural Competency Framework - Working with CALD Service Users ............................22

10. Workforce Working in a Multicultural Health Environment ....................................................42
  10.1 Multicultural Health Environment .........................................................................................42
  10.2 Guidelines for Staff Working in a Multicultural Health Environment ..................................43
  10.3 Competencies Required for Working in a Multicultural Health Environment ....................44
  10.4 Training and Resources ..........................................................................................................45

11. Appendix 1: Asian Population ......................................................................................................48
  11.1 Definition of ‘Asian’ ................................................................................................................48
  11.2 Asian population profile .......................................................................................................49
  11.3 Population Projections ..........................................................................................................51
  11.4 Level 3 Asian Ethnic Groups .................................................................................................53
  11.5 Level 2 Asian Categories – Statistics NZ .............................................................................54
  11.6 Asian cultural and language diversity ...................................................................................58

12. Appendix 2: Middle Eastern, Latin American and African Population ....................................59
  12.1 Definition of “MELAA” ........................................................................................................59
  12.2 “MELAA” Population Characteristics ...............................................................................59


14. Appendix 4: Stakeholder Consultation .......................................................................................69

15. Appendix 5: Glossary ..................................................................................................................71

16. Appendix 6: References ..............................................................................................................72
1. OVERVIEW

1.1 Purpose

The purpose of this document is to:

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

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

1.2 Scope

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

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

2. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Asian</td>
<td>Asian refers to people originating from Asia countries including countries in West Asia (Afghanistan and Nepal) South Asia (covering the Indian sub-continent), East Asia (covering China, North and South Korea, Taiwan, Hong Kong, Japan), and South East Asia (Singapore, Malaysia, the Philippines, Vietnam, Thailand, Myanmar, Laos and Cambodia). This definition is commonly used within the health sector and is the basis of the Statistics New Zealand Asian ethnicity categories.</td>
</tr>
<tr>
<td>CALD</td>
<td>CALD refers to culturally and linguistically diverse</td>
</tr>
<tr>
<td>CALD populations</td>
<td>CALD populations in this document refer to culturally and linguistically diverse populations from Asian, Middle Eastern, Latin American and African backgrounds.</td>
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<tr>
<td>MELAA</td>
<td>MELAA in this document refers to Middle Eastern, Latin American and African groups</td>
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<tr>
<td>Migrants</td>
<td>Migrants (also known as immigrants) refer to people who were born overseas who settle in New Zealand.</td>
</tr>
<tr>
<td>Refugees</td>
<td>The term ‘refugee’ refers to people from a refugee background. Refugees arrive in New Zealand under one of three categories which are as:</td>
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Page: Page 3 of 73

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<table>
<thead>
<tr>
<th>Consumers</th>
<th>The terms “Consumers”, “Service Users” and “Clients” and “Patients” used in this document refer to the same group of people who are receiving services from the health and disability sectors (DHB provider services, primary health services and non-government organisations)</th>
</tr>
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<tbody>
<tr>
<td>Service Users</td>
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<td>Patients</td>
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<td>Clients</td>
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<tr>
<td>Carers</td>
<td>The terms “Family members”, “Families” and “Carers” used in this document refers to the group of people who provide unpaid or paid care, that is they are looking after</td>
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<tr>
<td>Families</td>
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<tr>
<td>Family members</td>
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<tr>
<td></td>
<td>• people who are receiving services from the health and disability services provided by DHB provider services, primary health and NGO sectors</td>
</tr>
<tr>
<td></td>
<td>• people who are recovering at home after receiving services from the health and disability services provided by DHB provider services, primary health and NGO sectors</td>
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</tbody>
</table>

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

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

3.1 Asian population profile and characteristics

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

3.1.1 Demography

Changes to New Zealand’s immigration policy in 1986 led to significant increases in Asian migration to New Zealand which peaked in 1995. Since this time, Asian migration has continued to lead the net migration figures with an average of over 15,000 people per year over 1996 to 2002, making Asian people the fastest growing population in New Zealand.

The Auckland Asian population currently represents 22% of the total population in the Auckland region, and is projected to increase more than 60% by 2026 (Mehta, 2012). See projection details under Appendix 1. Of the three DHBs, ADHB has the largest Asian population, with an estimated 27% of people identifying as being Chinese, Indian or Other Asian. In Waitemata and Counties Manukau DHBs Asian groups are respectively 18% and 19% of the populations served. Across the Auckland region, an estimated 9% of people identified as being Chinese, 7% as being Indian and 6% as being Other Asian in 2010.

3.1.2 Asian population characteristics

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

3.2 Middle Eastern and African population profile and characteristics

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

The Middle Eastern, Latin American and African (MELAA) ethnicity grouping consists of extremely diverse cultural, linguistic and religious groups. In the 2006 census, 1% of the New Zealand population identified as MELAA and half resided in the Auckland region. Today, more than 28,637 people in Auckland identify as being MELAA: approximately 14,000 are Middle Eastern, 3000 are Latin American and 11,000 are African. This group is one of the fastest growing population groups and has unique health needs.

3.2.1 Middle Eastern people

3.2.1.1 Demography and socioeconomic determinants

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

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

3.2.2 African people

3.2.2.1 Demography and socioeconomic determinants

African people are the second largest MELAA group in Auckland. Similar to Middle Eastern people, many came to New Zealand as refugees from the late 1980s (predominantly from the Horn of Africa). By the early 2000s, the majority came as migrants from South Africa and Zimbabwe. As these two ethnicities are classified as ’European’ in New Zealand, Ethiopians and Somalis are the largest identifiable African groups in Auckland. Most Africans identify as Christians (65%). African people:

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

3.3.3 Latin American people

3.3.3.1 Demography
Latin American people make up the smallest proportion of the MELAA group. Chilean refugees arrived in the 1970s but by the 2000s, voluntary migrants from Brazil made up the largest Latin American population, most coming as students and working holiday visitors. Latin Americans had the highest PHO enrolment growth compared with other MELAA ethnicities from 2006 to 2010. The majority are Christians (70%) and are mainly Catholic. Latin American people have:
• a more mobile and younger population (consisting mainly of 20-34 year olds) than Europeans
• the largest proportion of people with post school qualifications of all compared ethnicities but had a higher unemployment rate and a lower mean income than Europeans.

3.3.4 Perumal’s (2011) health needs analysis of MELAA populations in the Auckland regions showed that health service providers (HSP) had:
• Key concerns around MELAA populations social issues such as isolation and poverty and the impact on health and mental health of Middle Eastern and African communities.
• Key cultural differences noted in these communities included the importance of faith and family engagement in health/mental health, the differences in gender roles and the varying perceptions of illness and disability.
• The main barriers to health care provision was language and communication difficulties, health illiteracy, cost of health care, the lack of cultural understanding by Health Service Providers and the lack of trust and fear of Western health care models.
• Enhancers to healthcare include having HSPs that understand their backgrounds, the appropriate use of interpreters, having targeted services, engaging with religious leaders and communities and providing well coordinated services.
• Prioritised improving access to mental health services by ensuring that secondary mental health services offered culturally appropriate and timely services
• Understood the stigma and shame attached to mental health issues and the need for mental health destigmatisation and community awareness programmes in communities and faith communities
4. Workforce Diversity

4.1 Asian and Migrant Workforce

The Asian workforce is under-represented in the WDHB mental health, addictions, child, women and family, health of older adult services and corporate/management areas as per the 2011 report produced by the workforce development consultant (See Appendix 3).

However, the Asian health workforce is well-represented overall in the Auckland region health sector. The number of Asians employed in the healthcare industry nationally has grown almost three times from 3,291 in 1996 to 11,496 in 2006 (Economic Settlement Action Leadership. 2011, Overview of Auckland’s Labour Market and Migration Trends 2011).

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

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

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

4.2 Increasing Workforce Diversity

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

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

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

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

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

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

5.1 Language and Cultural Issues

There has been ample research into the language barriers which impact on initial access and communication between health providers and service users and the effect on health diagnosis and treatment. In the first instance, communication barriers impact the assessment and care; subsequently there is an impact on the quality of care obtained. When language is an issue, non-English speaking service users generally prefer interacting with a health professional who can speak their first language, (Bowen, 2001; Holt, Crezee, & Rasalingam, 2001).

In the health sector, where diagnosis relies significantly on affective understanding and verbal communication, it has been suggested that the preferred approach for health providers is to match a qualified professional to the client’s first language where possible, to ensure adequate diagnosis and appropriate treatment (Craig, 1999). While this would improve access to services it is not considered a feasible option given the great diversity of cultures, languages and dialects represented in our Asian and MELAA communities.

The second best approach suggested by research is to use skilled professional interpreters to address the communication barrier (Bulwada, 2004). However, the use of interpreters who have not been specifically trained to work in psychiatry can be problematic and can hinder the communication process. This increases the risk of misinterpretation, non-diagnosis or misdiagnosis of the client’s illness, and may lead to treatment errors and/or non-compliance. It may have a negative impact on treatment compliance or result in termination of prescribed treatment, and/or a reluctance to seek further or early medical intervention, leading to more serious or prolonged illness and unnecessary cost (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988; Hattar-Pollara & Meleis, 1995; Craig, 1999; Lin & Cheung, 1999; Kleinman, 2004; Tse, 2004).

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

A healthcare organisation that is ‘culturally competent’ is able to provide culturally responsive services and is able to benefit from diversity in the workforce. Cultural competence in organisations improves access and equity, as well as improving the quality of care that is linked to improved client outcomes (Betancourt et al 2003; Brach & Fraser 2002; DHFS & AIHW 1998). Specifically, the benefits of delivering culturally competent healthcare include:

- Improved access and equity for all groups in the population
- Improved consumer ‘health literacy’ and reduced delays in seeking healthcare and treatment
- Improved communication and understanding of meanings between service users and service providers, resulting in: better compliance with recommended treatment; clearer expectations; reduced medication errors and adverse events; improved attendance at ‘follow-up’ appointments; reduced preventable hospitalisation rates; improved client satisfaction; improved client safety and quality assurance; improved ‘public image’ of health and disability services; better use of resources; and better health outcomes for service users and for culturally diverse populations.

Conversely, it follows that there are substantial risks that are likely to incur costs if healthcare provision is culturally incompetent. Therefore understanding the concepts of cultural competence is important. The following section explores the concepts.

6.1 Cultural Competence Concepts

One definition of culturally competent care which has wider application across the primary and secondary health workforce is the one used by the Medical Council of New Zealand. The Medical Council uses the following definition in their 2006 Statement on Cultural Competence:

```
Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:

- That New Zealand has a culturally diverse population
- That a [health practitioner’s] culture and belief systems influence his or her interactions with patients and accepts this may impact on the [health practitioner’s-client] relationship
- That a positive [client] outcome is achieved when a [health practitioner’s and client] have mutual respect and understanding
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The importance of this definition is that it recognises that health care workers need to be able to recognise and to respect differing cultural perspectives for the purpose of effective clinical functioning, and in order to improve health outcomes for the client groups served.

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

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

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

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

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

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

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

The domains include organisational values, governance, planning, monitoring, evaluation (quality), communication, workforce/staff development, organisational infrastructure and services/interventions.
7. Best Practice Principles: CALD Cultural Competency Standards

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

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

7.1 Standard 1: Service Planning and Evaluation

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

7.1.1 Principle

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

7.1.2 Performance Measures

The service has:

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

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

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

7.2 Standard 2: Community Engagement and Consultation

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

7.2.1 Principle

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

7.2.2 Performance Measures

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

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

- Asian health support service and/or other relevant services
- Migrant resource centres
- Places of worship
- Ethnic community organisations
- CALD consumer and carer advisory groups

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

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

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

- Illness prevention
- Suicide prevention
- Recovery
- Health service promotion
- Health service information
- Stigma reduction
- Benefits and rights of service users and their carers to different cultural groups at community venues, including but not limited to:
  - Community centres
  - Places of worship
  - Schools
  - Ethnic community organisations
  - Refugee services and services for survivors of torture and trauma
  - CALD Consumer Advisory Groups (CAGs)
  - Children’s, youth and women’s centres
  - Other meeting places deemed important for the specified communities

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

- Existing alternative or complementary health and/or health service providers (e.g., traditional ‘folk healers’)
- Key individuals in the specified community who may be consulted on religious and spiritual beliefs influencing assessment, treatment and management.
7.3 Standard 3: Evaluation, Research and Service Delivery Development

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

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

7.3.2 Performance Measures
The service has:

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

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

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

7.3.2.4 generated, through a mapping and needs exercise, or other appropriate information gathering or research, a profile of the CALD communities within its service region, which includes information, such as:
- population size of each community
- demographic and religious characteristics
- socio-economic status
- language requirements
- relevant community organisations
- how best to access the specified communities
- cultural sensitivities

7.3.2.5 conducted research or projects in collaboration, or independently, to measure the needs of the CALD population in its region. Examples of projects could be:
- looking at the referral patterns or pathways typically taken by CALD consumers who access health services in the service catchment area
- determining what kind of programs the CALD communities would like to attend that may be congruent with their explanatory model of psychosocial remediation
- looking at the proportion of people from CALD backgrounds accessing service.

7.4 Standard 4: Equitable Access
The service ensures equitable access for people from culturally and linguistically diverse backgrounds, and their carers and families.
7.4.1 Principle
The rights of people from CALD backgrounds, and their carers and families, as set out in the Code of Family Rights and The Code of Health and Disability Services Consumers’ Rights (1996) and other legislated rights, must be ensured when delivering health services.

7.4.2 Performance Measures
The service:

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

7.4.2.2 has promoted awareness of its programs by disseminating information in English and in appropriate languages, via one or more modalities including print, audio-visual or community information sessions and forums, to different cultural groups in places including, but not limited to:
  • local doctors
  • hospitals
  • community centres
  • places of worship
  • schools
  • libraries
  • other meeting places deemed important for the specified communities
  • chemists
  • family courts
  • ethnic radio and TV
  • the service website, if available

7.4.2.3 has developed policies and procedures to facilitate the accommodation of specific culture-based needs of its CALD consumers, their carers and families, such as:
  • childcare needs
  • family roles and obligations
  • dietary needs
  • religious needs

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

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

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

The following are specifically for services providing assessment, screening, diagnosis that relies significantly on affective understanding and verbal communication such as psychiatrist and psychological services:
7.4.2.7 has employed formally qualified and culturally competent bi-lingual clinicians (psychiatrists and psychologists) whose language matches with the client’s first language, where possible, to conduct assessment, diagnoses or treatment (at least to meet the needs of the large non-English speaking Asian groups eg Mandarin, Cantonese and Korean)

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

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

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

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

7.5 Standard 5: Workforce/Staff Development

The service makes available and encourages:

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

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

7.5.2 Performance Measures
The service has:

<table>
<thead>
<tr>
<th>Issue by</th>
<th>Sue Lim and Dr Annette Mortensen</th>
<th>Issued Date</th>
<th>June 2013</th>
<th>Classification</th>
<th>070-001-01-003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Authorised by</td>
<td>CEO</td>
<td>Review Period</td>
<td>36 months</td>
<td>Page</td>
<td>Page 16 of 73</td>
</tr>
</tbody>
</table>

This information is correct at date of issue. Always check on Waitemata DHB Controlled Documents site that this is the most recent version.
7.5.2.1 ensured that all staff undertake the essential and highly recommended CALD cultural competency training courses within the first 12 months of employment at the health service and ongoing annual professional development thereafter.

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

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

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

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

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

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

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

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

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

7.6 **Standard 6: Consumer Participation**

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

7.6.1 **Principle**

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

7.6.2 **Performance Measures**

The service has:

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

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

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

- inform continuous improvement
- determine cultural appropriateness of various programs delivered by the service
- determine cultural competence of staff.
7.7 Standard 7: Planning, Funding, Contracting, Monitoring

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

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

7.7.2 Performance Measures
The organisation/service has:

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

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

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

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

7.8 Standard 8: Management Support

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

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

7.8.2 Performance Measures
The organisation/service has:

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

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

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

1. Attitudes
   a) A willingness to understand your own cultural values and the influence these have on your interactions with patients.
   b) A commitment to the ongoing development of your own cultural awareness and practices and those of your colleagues and staff.
   c) A preparedness not to impose your own values on patients.
   d) A willingness to appropriately challenge the cultural bias of individual colleagues or systemic bias within health care services where this will have a negative impact on patients.

2. Awareness and knowledge
   a) An awareness of the limitations of your knowledge and openness to ongoing learning and development in partnership with patients.
   b) An awareness that general cultural information may not apply to specific patients and that individual patients should not be thought of as stereotypes.
   c) An awareness that cultural factors influence health and illness, including disease prevalence and response to treatment.
   d) A respect for your patients and an understanding of their cultural beliefs, values and practices.
   e) An understanding that patients’ cultural beliefs, values and practices influence their perceptions of health, illness and disease; their health care practices; their interactions with medical professionals and the health care system; and treatment preferences.
   f) An understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings.
   g) An awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the clinical situation.

3. Skills
   a) The ability to establish a rapport with patients of other cultures.
   b) The ability to elicit a patient’s cultural issues which might impact on the doctor-patient relationship.
   c) The ability to recognise when your actions might not be acceptable or might be offensive to patients.
   d) The ability to use cultural information when making a diagnosis.
   e) The ability to work with the patient’s cultural beliefs, values and practices in developing a relevant management plan.
   f) The ability to include the patient’s family in their health care when appropriate.
   g) The ability to work cooperatively with others in a patient’s culture (both professionals and other community resource people) where this is desired by the patient and does not conflict with other clinical or ethical requirements.
   h) The ability to communicate effectively cross culturally and:
      - Recognise that the verbal and nonverbal communication styles of patients may differ from your own and adapt as required.
      - Work effectively with interpreters when required.
      - Seek assistance when necessary to better understand the patient’s cultural needs.
9. CALD Cultural Competency Training and Resources - Working with Service Users

9.1 CALD Training Programme - Working with Service Users

The CALD Cultural Competency Training Programme was developed by WDHB Asian Health Support Services and funded by the Auckland Regional Settlement Strategy Refugee and Migrant Health Action Plan. This is part of the programme of work for the Auckland Regional Settlement Strategy Refugee and Migrant Health Action Plan. The cultural competency training programmes are in addition to the bicultural and Pacific cultural competency programmes which are already in place in the Auckland region District Health Boards.

9.1.1 Rationale for the provision of CALD Cultural Competency Training:

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

9.1.2 Health Practitioners Competency Assurance Act (HPCA Act)

The Health Practitioners Competency Assurance Act (HPCA Act) includes a requirement for registration bodies to develop standards of cultural competence and to ensure that practitioners meet those standards. Increasingly groups such as the New Zealand Medical Council, Public Health Physicians and the Nursing Council of New Zealand have an interest in developing the cultural competence frameworks related to the culturally and linguistically diverse (CALD) groups in New Zealand. The issues of relevance for the development of CALD cultural competencies in Auckland region DHBs includes:

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

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

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

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

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Issued Date: June 2013  
Classification: 070-001-01-003

Authorised by: CEO  
Review Period: 36 months  
Page: Page 20 of 73

This information is correct at date of issue. Always check on Waitemata DHB Controlled Documents site that this is the most recent version.
9.1.3 CALD Cultural Competency Training Programme for Working with Service Users includes:

CALD 1: Culture and Cultural Competency (Pre-requisite)
CALD 2: Working with Migrant Patients
CALD 3: Working with Refugees Patients
CALD 4: Working with Interpreters
CALD 5: Working with Asian mental health clients
CALD 7: Working with Religious Diversity
CALD 8: Working with CALD families-Disability Awareness
CALD 9: Working in a Mental Health Context with CALD clients

For more information about the courses, go to [www.caldresources.org.nz](http://www.caldresources.org.nz)

The above courses are CME/CNE and MOPS accredited.

All the above courses are available in face to face and e-learning formats except for CALD 5 which is only offered in face to face format.

9.2 CALD Resources - Working with Service Users

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

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

Some of these resources have pre-requisites before it can be accessed. See Table 3 for more information:

(S1) Toolkit for Staff Working in a CALD Health Environment
(S2) Cross Cultural Resource for Health Practitioners working with CALD clients
(S3) Refugee Health Care: A Handbook for Health Professional
(S4) Ayurvedic Medicine
(S5) Working with CALD Families – Disability Awareness
(S6) Working with Religious Diversity
(S7) Working with Asian mental health clients
(S8) Working with MELAA mental health clients
(S9) Asian Family Violence Resource (avail 2013 Sept)
(S10) MELAA Family Violence Resource (avail 2013 Sept)
(S11) Asian Older People Resource (avail 2014)
(S12) MELAA Older People Resource (avail 2014)
(S13) CALD Children and Women’s Health Resource (avail 2015)
(S14) CALD Youth and Intergenerational issues (avail 2016)

NB: There are also other cultural-specific courses, resources and workshops that are useful for enhancing cultural knowledge which may not be listed in this document.
9.3 Cultural Competency Framework - Working with CALD Service Users

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

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

Cultural Competence Continuum

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

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

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

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

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

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

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---|---
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The following pages contain the following diagram and tables:

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

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

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

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

Tikanga: Training and Recommended Best Practice

Cultural and Linguistic Diversity (CALD) Group
Cultural Competency Training

CALD GROUPS
BEST PRACTICE
Cultural Competencies

PACIFIC BEST PRACTICE
Cultural Competencies

Core Training – Working with Interpreters
(All interpreters and health and disability practitioners work effectively together)

Case studies specifically for clinical specialty areas

Mental Health and Addictions and Forensics
Women’s health
Child Health Youth Health
Older Adults
General Health
Disability
Primary Health and NGOs

Health Practitioners: Ongoing mentoring/supervision of cultural practice, peer review of case management
Interpreters: Mental Health, Forensics, Family Violence, Addictions Training, ongoing supervision and support

Issued by Sue Lim and Dr Annette Mortensen
Issued Date June 2013
Classification 070-001-01-003
Authorised by CEO
Review Period 36 months
Page 24 of 73

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

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

<table>
<thead>
<tr>
<th>Cultural Courses</th>
<th>Mental Health &amp; Addictions</th>
<th>Physical Health and Disability</th>
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<tr>
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<td>Forensics (DHB Provider Arm, NGO)</td>
<td>(DHB Provider Arm, NGO, Primary Health)</td>
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<tr>
<td>Cultural Courses</td>
<td>Adults</td>
<td>Child Youth Family</td>
</tr>
<tr>
<td>Additional Online Supplementary Resources</td>
<td>Ongoing supervision/peer review</td>
<td></td>
</tr>
</tbody>
</table>

#### Cultural Courses

1. Maori Tikanga/Treaty - foundation course (not discussed in this document)  
   - M  
2. CALD 1 Culture & Cultural Competency - foundation course  
   - M  
3. Working with Pacific clients (not discussed in this document)  
   - R  
4. CALD 2 Working with Migrant (Asian) Patients  
   - R  
5. CALD 3 Working with Refugee Patients  
   - R  
6. CALD 4 Working with Interpreters  
   - HR  
7. CALD 7 Working with Religious Diversity  
   - R  
8. CALD 8 Working with CALD Families – Disability Awareness  
   - R  
9. CALD 9 Working in a Mental Health Context with CALD Clients  
   - Optional HR  
10. CALD 5 Working with Asian Mental Health Clients  
    - HR  
11. Toolkit for Staff Working in a CALD Health Environment  
    - R  
12. Cross Cultural Resource for Health Practitioners working with CALD Clients  
    - R  
    - R  
14. Ayurvedic Medicine  
    - Optional  
15. Working with CALD Families – Disability Awareness  
    - Optional HR  
16. Working with Religious Diversity  
    - R  
17. Working with Asian Mental Health Clients  
    - Optional R  
18. Working with MELAA Mental Health Clients  
    - Optional R  
    - R  
20. MELAA Family Violence Resource (avail 2013 Sept)  
    - R  
21. Asian Older People Resource (devt planned for 2014)  
    - Optional R  
22. MELAA Older People Resource (devt planned for 2014)  
    - Optional R  
23. CALD Children and Women’s Health Resource (devt planned for 2015)  
    - Optional R  
24. CALD Youth and Intergenerational issues (devt planned for 2016)  
    - R

#### Additional online supplementary resources with case studies: (www.caldresources.org.nz) for ongoing CALD cultural competency development

(S1) (S2) (S3) (S4) (S5) (S6) (S7) (S8) (S9) (S10) (S11) (S12) (S13) (S14)

**Health Workforce:** Ongoing mentoring/supervision of cultural practice, peer review of case management  
**Interpreter Workforce:** Ongoing mentoring/supervision /training and support

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

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**Classification:** 070-001-01-003

**Authorised by:** CEO  
**Review Period:** 36 months  
**Page:** Page 25 of 73

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### Table 2: CALD Cultural Competency Training Courses for Working with CALD Service Users

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

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

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

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**Authorised by**: CEO  
**Review Period**: 36 months  
**Page**: Page 26 of 73

This information is correct at date of issue. Always check on Waitemata DHB Controlled Documents site that this is the most recent version.
## CALD Cultural Competency Training Courses – Working with CALD Service Users

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

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<td>Who</td>
<td>Sector</td>
<td>Course Outline</td>
<td>Aligned with Core Cultural Competencies</td>
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<tr>
<td>Course Name:</td>
<td>Pre-Requisite</td>
<td>Mental Health Addictions</td>
<td>Forensics (DHB Provider Arm, NGO)</td>
<td>- Adults - Child &amp; Youth - Older People</td>
<td>Participants taking the course will be able to:</td>
</tr>
</tbody>
</table>

- Know what to consider to accommodate health beliefs and faith-based practices.
- Know what to consider when raising sensitive issues with migrant patients.

### Skills
- Have more confidence how to establish a rapport with patients of other cultures.
- Gain the ability to elicit a patient’s cultural issues which might impact on the health practitioner-patient relationship.
- Gain the ability to recognise actions that might not be acceptable or might be offensive to patients.
- Gain the ability to use cultural information when making a diagnosis.

### Ref (5)
**CALD 3 Working with Refugee Patients**

- Level 2: Capable Recommended
- Pre-Requisite: CALD 1 (Highly recommend – to complete CALD 4)
- All staff working with refugees patients
- General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women’s Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child & Youth - Older People

- Gain an understanding of pre and post-settlement challenges for refugees.
- Gain knowledge of the psychological and physical challenges that refugees face.
- Deal with sensitive issues with refugees.
- Demonstrate the ability to use strengths of refugees in interventions.
- Gain skills in working with refugee patients.

### CALD 3 will enhance awareness, knowledge and understanding when working with refugee clients

The courses will continue to remind participants about what they learn from CALD 1 in terms of attitudes and will:

- Awareness and knowledge
  - Gain awareness that cultural factors influence health and illness, including disease prevalence and response to treatment.
  - Understand how to respect different cultural beliefs, values and practices.
  - Understand that patients’ cultural beliefs, values and practices influence their perceptions of health, illness and disease; their health care practices; their interactions with medical professionals and the health care system; and treatment preferences.

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

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<td>Course Outline</td>
<td>Aligned with Core Cultural Competencies</td>
</tr>
<tr>
<td>Course Name:</td>
<td>Pre-Requisite</td>
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<td>Participants taking the course will be able to:</td>
<td>Section 8</td>
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<table>
<thead>
<tr>
<th>Ref (10)</th>
<th>CALD 5 Working with Asian Mental Health Clients</th>
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<tr>
<td>Level 3:</td>
<td>Enhanced</td>
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<tr>
<td>Pre-Requisite:</td>
<td>Highly Recommended</td>
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<tr>
<td>CALD 1 (Highly recommended to complete CALD 4 and 9) and also recommended to complete CALD 2 and/or 3, and CALD 7</td>
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<tr>
<td>For practitioners providing assessment, screening, treatment, management plans, medication for Asian clients in a mental health context</td>
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<tr>
<td>Mental Health Addictions Forensics (DHM Provider Arm, NGO)</td>
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<tr>
<td>- Adults</td>
<td></td>
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<tr>
<td>- Child &amp; Youth</td>
<td></td>
</tr>
<tr>
<td>- Older People</td>
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</tr>
<tr>
<td>It is also useful for any clinicians working in non-mental health services who provide assessment, screening, treatment for Asian, MELAA clients in a mental health context</td>
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<tr>
<td>• Understand the correlation between culture, religion and healing and how to apply this in a mental health setting.</td>
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<tr>
<td>• Understand the various modalities for treatment and implications.</td>
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<tr>
<td>• Increase awareness of different cultures and how to communicate with people of different cultures.</td>
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<tr>
<td>• Understand the principles and gain skills of cultural assessment/management.</td>
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</table>

CALD 5 will enhance understanding of Asian clients’ beliefs and explanations around mental health, and of the impact these may have on the acceptance of treatment and interventions. It will also provide skills in clinical assessments and management.

The course will continue to remind participants about what they learn from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge:

- Understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings.
- Awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the clinical situation.

**Skills**

- Gain the ability to establish a rapport with patients of other cultures.
- Gain the ability to elicit a patient’s cultural issues which might impact on the health practitioner-patient relationship.
- Gain the ability to recognise when actions might not be acceptable or might be offensive to patients.
- Gain the ability to use cultural information when making a

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**Issued by** Sue Lim and Dr Annette Mortensen  
**Authorised by** CEO  
**Issued Date** June 2013  
**Review Period** 36 months  
**Classification** 070-001-01-003  
**Page** Page 30 of 73  

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<td>Course Name:</td>
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<td>Participants taking the course will be able to:</td>
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</table>

| CALD 7 Working with Religious Diversity | Level 2: | For practitioners providing assessment, screening, treatment, management plan, medications | General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women’s Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) | • Gain an understanding of the rationale for developing religio-cultural competence in practice when working with CALD patients of different faiths and religious practices. | CALD 7 will enhance understanding of and skills for religio-cultural competence. The course will continue to remind participants about what they learn from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge:

- Understanding the different concept of religious practices and faiths
- Awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the clinical situation. |

Skills

- Gain the ability to establish a rapport with patients of other cultures.
- Gain the ability to elicit a patient’s religio-cultural issues which might impact on the health practitioner-patient relationship. |

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<tr>
<th>Pre-Requisite</th>
<th>Pre-Requisite: CALD 1 (Highly recommended to complete CALD 4) and also recommended to complete CALD 2 and/or 3</th>
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<td>June 2013</td>
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<td>Page 31 of 73</td>
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<tr>
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<td>Who</td>
<td>Sector</td>
<td>Course Outline Participants taking the course will be able to:</td>
<td>Aligned with Core Cultural Competencies Section 8</td>
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<td>Course Name:</td>
<td>Pre-Requisite</td>
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<tr>
<td>CALD 8 Working with CALD Families – Disability Awareness</td>
<td>Level 3: Enhanced Highly Recommended</td>
<td>CALD 1 (Highly recommended to complete CALD 4) and also recommended to complete</td>
<td>For practitioners providing assessment, screening, treatment, management plan for disability clients</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women’s Health - Primary Health Mental Health Addictions</td>
<td>• Gain an understanding of the rationale for culturally competent practice and disability awareness when working with CALD families. • Be more aware and have more knowledge of the cultural perspectives of the CALD population relating to disability and the impact it has on service providers. • Gain skills to work effectively and</td>
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<tr>
<td></td>
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<td></td>
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<td>religious practices.</td>
<td>CALD 8 will enhance understanding of cultural perspectives of the CALD population relating to disability and the impact it has on service providers and gain skills to work effectively with CALD children and adults and their families with impairments. The course will continue to remind participants about what they learnt from CALD 1 in terms of attitudes. It will also provide additional awareness and knowledge: • Understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings. • Awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the</td>
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</table>

- Adults
- Child & Youth
- Older People

- Know how to find and use resources related to religious needs and practices of CALD patients.

- Gain the ability to recognise when actions might not be acceptable or might be offensive to patients.
- Gain the ability to use religio-cultural information when making a diagnosis.
- Gain the ability to work with the patient’s religio-cultural beliefs, values and practices in developing a relevant management plan.
- Gain the ability to include the patient’s family in their health care when appropriate.
- Gain the ability to work cooperatively with others in a patient’s culture (both professionals and other community resource people) where this is desired by the patient and does not conflict with other clinical or ethical requirements.
- Gain the ability to communicate effectively cross culturally and:
  - Recognise that the verbal and nonverbal communication styles of patients may differ from your own and adapt as required.
  - Work effectively with interpreters when required.
  - Seek assistance when necessary to better understand the patient’s cultural needs.

For practitioners providing assessment, screening, treatment, management plan for disability clients

General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child & Women’s Health - Primary Health Mental Health Addictions

• Gain skills to work effectively and

• Gain an understanding of the rationale for culturally competent practice and disability awareness when working with CALD families.

• Be more aware and have more knowledge of the cultural perspectives of the CALD population relating to disability and the impact it has on service providers.

• Gain skills to work effectively and

<table>
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<tr>
<td>Course Name:</td>
<td>Pre-Requisite</td>
<td>Forensics (DHB Provider Arm, NGO) - Adults - Child &amp; Youth - Older People</td>
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<td>Participants taking the course will be able to:</td>
<td>Section 8</td>
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<tr>
<td>CALD 2 and/or 3 and CALD 7</td>
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<td>broach sensitive issues with CALD children and adults with impairments and their families.</td>
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<td>• Know how to find and use resources to work with CALD children and adults with impairments and their families.</td>
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<td></td>
<td>• Gain the ability to establish a rapport with patients of other cultures.</td>
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<td>• Gain the ability to elicit a patient’s cultural issues which might impact on the health practitioner-patient relationship.</td>
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<td></td>
<td>• Gain the ability to use cultural information when making a diagnosis.</td>
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<td>• Gain the ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan.</td>
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<td>• Gain the ability to include the patient's family in their health care when appropriate.</td>
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<td>• Gain the ability to work cooperatively with others in a patient’s culture (both professionals and other community resource people) where this is desired by the patient and does not conflict with other clinical or ethical requirements.</td>
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<td>• Gain the ability to communicate effectively cross culturally and:</td>
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<td>• Recognise that the verbal and nonverbal communication styles of patients may differ from your own and adapt as required.</td>
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<td>• Work effectively with interpreters when required.</td>
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<td>• Seek assistance when necessary to better understand the patient’s cultural needs.</td>
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### Table 3: CALD Resources for Working with CALD Service Users

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

| CALD Resources for Working with CALD Service Users |

**Issued by** Sue Lim and Dr Annette Mortensen  
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**Page** Page 33 of 73

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<table>
<thead>
<tr>
<th>Cross Referenced to Table 1 Resource Name</th>
<th>Pre-requisite</th>
<th>Useful for</th>
<th>Sector</th>
<th>Content</th>
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</thead>
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<tr>
<td>Ref [S1] Toolkit for Staff Working in a CALD Health Environment</td>
<td>No pre-requisite</td>
<td>Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment)</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women’s Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child &amp; Youth - Older People</td>
<td>This online toolkit is produced by WDHB and CMDHB Learning and Development team and is available in online format on the website <a href="http://www.caldresources.org.nz">www.caldresources.org.nz</a> under CALD Resources-Cross Cultural Resources. It offers some guidance for staff and managers who work in primary and secondary care in a CALD health environment in New Zealand’s WDHB. Section A of this toolkit is very useful for all staff to understand the cultural competence principles for working with patients, and colleagues in multicultural teams. It provides reflective questions and case examples to illustrate some of the principles in question.</td>
</tr>
<tr>
<td>Ref [S2] Cross Cultural Resource for Health Practitioners working with CALD clients</td>
<td>No pre-requisite</td>
<td>Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment for CALD clients)</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women’s Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child &amp; Youth - Older People</td>
<td>This online toolkit is produced by WDHB Asian Health Support Services and Refugees-As-Survivors NZ This toolkit is available in two formats, that is, a Booklet format and an online format. The booklet can be purchased from the website <a href="http://www.caldresources.org.nz">www.caldresources.org.nz</a> under CALD Resources - Cross Cultural Resources. The online format is available at no cost accessible via the website. The Booklet format is a very useful Desk-top guide which contains a summary of the online (e-Toolkit) version which includes • cross-cultural pre-interview checklist, interview questions, and guidelines for working with interpreters • Sections on 7 Asian cultures and 7 Middle Eastern cultures containing greetings, communication tips and guidelines for practitioners working with each of these cultures The e-toolkit (online format) the comprehensive version of the above BOOKLET • It includes explanation, examples and background information on the points in the booklet. • It also includes additional issues, comparative tables, generalized sections on Asian, Eastern Mediterranean and African Cultures and video and audio clips of the greetings in each language.</td>
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# CALD Resources for Working with CALD Service Users

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<td>Ref (S3)</td>
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<td>Clinical Leaders, Managers, All staff (frontline reception to staff providing assessment, screening, management, treatment for CALD clients)</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women's Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child &amp; Youth - Older People</td>
<td>It is not intended as a definitive guide on each culture, but contains information we considered useful to practitioners in a health setting who will work with CALD clients. It is divided into four sections. The first contains general information about cultural competency, effective communication and working with interpreters. Section II contains generalised information about Asian cultures and then specific individual cultures which includes brief background information, greetings and communication tips, health beliefs and practices, family values, tips for practitioners working with culture-specific clients, health risks, women's and youth health, and spiritual practices. Section III contains information about Eastern Mediterranean and African cultures in the same format as Section II. Section IV contains additional resources. This toolkit is produced by the Ministry of Health and available free for health practitioners. It can be ordered from the MOH website <a href="http://www.health.govt.nz/publication/refugee-health-care-handbook-health-professionals">http://www.health.govt.nz/publication/refugee-health-care-handbook-health-professionals</a>. The handbook covers the following topics: - Refugees – Who they are and where they come from - Refugee Resettlement in New Zealand - The Consultation – Communicating Effectively with Refugee Clients - Physical Health Care - Mental Health Issues - Refugees with Special Health and Disability Needs - Contact List</td>
</tr>
<tr>
<td>Ref (S4)</td>
<td>CALD 1, 2 courses</td>
<td>All staff providing assessment, screening, management,</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health</td>
<td>This online toolkit is produced by WDHB Asian Health Support Services and Refugees as Survivors and is available via <a href="http://www.caldresources.org.nz">www.caldresources.org.nz</a> only for CALD learners who have a CALD user account. This resource is an informative video describing the ayurveda explanatory health model. An ayurveda practitioner explains the ayurveda model, beliefs and demonstrates an ayurvedic diagnosis and treatment procedures. The video is</td>
</tr>
</tbody>
</table>

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**Authorised by** CEO

**Review Period** 36 months

**Page** Page 35 of 73

This information is correct at date of issue. Always check on Waitemata DHB Controlled Documents site that this is the most recent version.
## CALD Resources for Working with CALD Service Users

<table>
<thead>
<tr>
<th>Cross Referenced to Table 1 Resource Name</th>
<th>Pre-requisite</th>
<th>Useful for</th>
<th>Sector</th>
<th>Content</th>
</tr>
</thead>
</table>
| CALD 1, 8 courses                        |               | treatment for CALD clients | - Disability  
- Older People  
- Child & Women’s Health  
- Primary Health  
- Mental Health  
- Addictions  
- Forensics (DHB Provider Arm, NGO)  
- Adults  
- Child & Youth  
- Older People | divided into different sections to provide easy access to relevant information. |

Ref (S5) Working with CALD Families – Disability Awareness

Also recommend to complete CALD 2, 3, 4, 7 and as the resource only provide a recap

| Ref (S5) Working with CALD Families – Disability Awareness | CALD 1, 8 courses | All staff providing assessment, screening, management, treatment for CALD children or adults with disability | General Health: (DHB Provider Arm, NGO, Primary Health)  
- Physical Health  
- Disability  
- Older People  
- Child & Women’s Health  
- Primary Health  
- Mental Health  
- Addictions  
- Forensics (DHB Provider Arm, NGO)  
- Adults  
- Child & Youth  
- Older People | This online toolkit is produced by WDHB Asian Health Support Services and is available via www.caldresources.org.nz only for CALD learners who have a CALD user account.  
This resource is for health practitioners working within the New Zealand health system. It is a supplement to the training programme Working with CALD Families – Disability Awareness. It provides some culture-specific information for health practitioners who have an understanding of the key issues in working with CALD families with disability. It is not a stand-alone document and does not provide information on general disability issues.  
Section I (Middle Eastern, South Asian and other Muslim based cultures) provides an overview of disability and the Muslim perspective since Muslims form the majority in the countries in this section. This information about Islam and disability may be applied to other cultures that are predominantly Muslim and shaped by Islamic practices.  
Section II (Indian culture) presents information on Indian culture and disability. India is separated from the South Asian countries in section I since it is not a Muslim based country and underlying religious values are relatively different.  
Section III (Somali, Sudanese, Ethiopian and Eritrean cultures) focuses on disability and cultures in the Horn of Africa, for although predominantly Muslim, the cultures of these countries differ significantly from those of the Middle East. The information on disability and Islam from Section I can be applied to Muslims in this group. Information for countries in this section is provided separately as practices and circumstances vary significantly across these cultures. Culture-specific information is summarised in the Middle Eastern, South Asian and African Table. |

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**Page** Page 36 of 73

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<th>Useful for</th>
<th>Sector</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref (S6) Working with Religious Diversity</td>
<td>CALD 1, 7 and 9</td>
<td>All staff providing assessment, screening, management, treatment for CALD clients</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women’s Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child &amp; Youth - Older People</td>
<td>This online toolkit is produced by WDHB Asian Health Support Services and is available via <a href="http://www.caldresources.org.nz">www.caldresources.org.nz</a> only for CALD learners who have a CALD user account. This online resource is for health practitioners working within the New Zealand health system. It is a supplement to the training programme “Working with Religious Diversity”. It offers information on Confucianism and Taoism. It provides some religio-cultural information on traditional belief systems in East Asian cultures, and how these impact on health care and practices. <strong>Section IV</strong> (East Asian cultures) provides information on disability in Chinese culture and other cultures that share the Chinese heritage of Confucianism, Taoism and Buddhism. <strong>Section I</strong> provides an overview of the systems of Confucianism, Taoism, Buddhism and Chinese Folk Religion. <strong>Section II</strong> presents information on how the principles from these philosophical systems and Traditional Chinese Medicine (TCM) interact in the New Zealand healthcare system. <strong>Section III</strong> provides the links to a Table on Interactions of some Western Drugs with Chinese Herbs, the comparative and summary table of East Asian Doctrines, a Bibliography and list of References for this resource, and an interactive Quiz.</td>
</tr>
<tr>
<td>Ref (S7) Working with Asian Mental Health Clients</td>
<td>CALD 1 and 9</td>
<td>All staff providing assessment, screening, management, treatment for Asian clients in a mental health context</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women’s Health - Primary Health Mental Health</td>
<td>This online toolkit is produced by WDHB Asian Health Support Services and is available via <a href="http://www.caldresources.org.nz">www.caldresources.org.nz</a> only for CALD learners who have a CALD user account. This online supplementary resource is for learners who have completed the CALD 1 and 9 training courses. Additional Asian culture specific information that applies to mental health assessment and intervention is provided in the resources. Topics include the following: • Cultural demographics • Re-cap on aspects of religious issues that impact on mental health • Traditional cultural and family values • Assessment guidelines for working with adults • Assessment guidelines for working with children and the elderly • Explanatory models of illness as relevant to the cultural groups</td>
</tr>
</tbody>
</table>
## CALD Resources for Working with CALD Service Users

<table>
<thead>
<tr>
<th>Cross Referenced to Table 1 Resource Name</th>
<th>Pre-requisite</th>
<th>Useful for</th>
<th>Sector</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>Ref (S8) Working with MELAA Mental Health Clients</td>
<td>CALD 1 and 9</td>
<td>All staff providing assessment, screening, management, treatment for Asian clients in a mental health context</td>
<td>General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health - Disability - Older People - Child &amp; Women’s Health - Primary Health Mental Health Addictions Forensics (DHB Provider Arm, NGO) - Adults - Child &amp; Youth - Older People</td>
</tr>
</tbody>
</table>

This online toolkit is produced by WDHB Asian Health Support Services and is available via [www.caldresources.org.nz](http://www.caldresources.org.nz) only for CALD learners who have a CALD user account.

This online supplementary resource is for learners who have completed the CALD 1 and 9 training courses. Additional, and MELAA culture specific information that applies to mental health assessment and intervention is provided in the resources. Topics include the following:

- Cultural demographics
- Re-cap on aspects of religious issues that impact on mental health
- Traditional cultural and family values
- Assessment guidelines for working with adults
- Assessment guidelines for working with children and the elderly
- Explanatory models of illness as relevant to the cultural groups
- Appropriate and applicable treatment modalities and Interventions
- Special issues when working with the respective cultures in mental health
- Refugee issues with specific groups e.g. children

<table>
<thead>
<tr>
<th>Cross Referenced to Table 1 Resource Name</th>
<th>Pre-requisite</th>
<th>Useful for</th>
<th>Sector</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
| Ref (S9) CALD Family Violence Resource – Working with | CALD 1, 2 or 9 | All staff providing assessment, screening, management, | General Health: (DHB Provider Arm, NGO, Primary Health) - Physical Health | This online toolkit is produced by WDHB Asian Health Support Services and is available via [www.caldresources.org.nz](http://www.caldresources.org.nz) only for CALD learners who have a CALD user account, once it is available.

The purpose of this resource is to enhance the knowledge, attitudes and skills of practitioners in providing appropriately culturally appropriate Family Violence assessment and interventions to Asian clients. The following information will be included in this resource:

- Cultural demographics
- Assessment guidelines for working with adults and children
- Assessment guidelines for working with the elderly
- Explanatory models of illness as relevant to the cultural groups
- Refugee issues with specific groups

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### CALD Resources for Working with CALD Service Users

<table>
<thead>
<tr>
<th>Cross Referenced to Table 1 Resource Name</th>
<th>Pre-requisite</th>
<th>Useful for</th>
<th>Sector</th>
<th>Content</th>
</tr>
</thead>
</table>
| Asian Clients (available Sept 2013)      | CALD 2, 3, 4, 7 and 9 as the resource only provide a recap | treatment for Asian clients in a mental health context | - Disability  
- Older People  
- Child & Women’s Health  
- Primary Health  
Mental Health  
Addictions  
Forensics (DHB Provider Arm, NGO)  
- Adults  
- Child & Youth  
- Older People | - Defining Family Violence and how people of different cultures may define family violence  
- Providing partner abuse screening which is sensitive to cultural and religious diversity in the client groups screened  
- Skills to gain rapport and trust with CALD clients who are victims of family violence  
- Tools to guide culturally appropriate FV assessment and interventions  
- Using interpreters for family violence screening, intervention, plan of safety and support for CALD women and children  
- Culturally appropriate management of the physical, psychological, and behavioural sequelae of abuse in CALD families  
- Understanding how violence operates in families in diverse cultural/religious contexts and the impact that the stressors of migration, the refugee experience and settlement/resettlement have in families.  
- Understanding in-law violence in CALD families  
- Understanding the Immigration New Zealand (2009) residence policy for victims of family violence  
- Sensitivity and understanding when dealing with shame and stigma, and other cultural issues when screening for family violence. |
| Ref (S10) CALD Family Violence Resource – Working with Middle Eastern and African Clients (available Sept 2013) | CALD 1, 3 or 9 Also recommend to complete CALD 2, 3, 4, 7 and 9 as the resource only provide a recap | All staff providing assessment, screening, management, treatment for Asian clients in a mental health context | General Health: (DHB Provider Arm, NGO, Primary Health)  
- Physical Health  
- Disability  
- Older People  
- Child & Women’s Health  
- Primary Health  
Mental Health  
Addictions  
Forensics (DHB Provider Arm, NGO)  
- Adults  
- Child & Youth  
- Older People | This online toolkit is produced by WDHB Asian Health Support Services and is available via [www.caldresources.org.nz](http://www.caldresources.org.nz) only for CALD learners who have a CALD user account, once it is available.  
- Same as above – but with a focus on the Middle Eastern and African cultures |

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**Authorised by**: CEO  
**Review Period**: 36 months  
**Page**: Page 39 of 73

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<table>
<thead>
<tr>
<th>Cross Referenced to Table 1 Resource Name</th>
<th>Pre-requisite</th>
<th>Useful for</th>
<th>Sector</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ref (S11) CALD Asian Older People Resource – planned to be available in 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref (S12) CALD MELAA Older People Resource – planned to be available in 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref (S13) CALD Children and Women’s Health Resource – under planning for development in 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ref (S14) CALD Youth and Intergenerational Issues – under planning for development in 2016</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Additional recommendations to managers and health and disability workforce:

For mental health, addictions forensics services (DHB, NGO, Primary Care), it is recommended that:
- Existing staff who have significant numbers of Asian clients complete CALD 1, 4, 9, followed by CALD 2 and 5, and then CALD 3 and CALD 7 to further expand their knowledge
- Existing staff with high numbers of refugee clients complete CALD 1, 4, and 9, followed by CALD 3 and then to further expand their knowledge with CALD 2, 5 and 7
- New staff complete CALD 1, 4 and 9 within their first year as part of their essential skill base requirements, followed by other CALD courses as per above suggestions for existing staff

For physical and general health services (DHB, NGO, Primary Care), it is recommended that:
- Existing staff who have significant numbers of Asian clients complete CALD 1, 2, 4, followed by CALD 7, and then CALD 3, 8, 9 to expand their knowledge
- Existing staff with high numbers of refugee clients complete CALD 1, 3, 4 followed by CALD 7 and then CALD 2, 8, 9 to expand their knowledge
- New staff complete CALD 1, 4 within their first year as part of their essential skill base requirements, followed by other CALD courses as per above suggestions for existing staff

For disability health services (DHB, NGO, Primary Care), it is recommended that:
- Existing staff who have significant numbers of Asian clients complete CALD 1, 2, 4, 8 followed by CALD 7, and then CALD 3, 9 to expand their knowledge
- Existing staff with high numbers of refugee clients complete CALD 1, 3, 4, 8 followed by CALD 7 and then CALD 2, 9 to expand their knowledge
- New staff complete CALD 1, 4, 8 within their first year as part of their essential skill base requirements, followed by other CALD courses as per above suggestions for existing staff

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

10.1 Multicultural Health Environment

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

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

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

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

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

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

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

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

- More awareness about the issues that affect communication
- Better understanding of the challenges that arise
- Tolerance and acceptance between colleagues in meeting these challenges.
### 10.2 Guidelines for Staff Working in a Multicultural Health Environment

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

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

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

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

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

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

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

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

10.4.1 Training Requirements

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

10.4.2 Training and Resources for Staff

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

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10.4.2.1 Resources for Managers and Health and Disability Workforce

10.4.2.1.1 List of WDHB Quality Controlled Documents

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

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

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

10.4.2.1.2 CALD Courses and Resources for working with CALD service users

Refer to Section 9 for details of these resources.

10.4.2.1.3 Toolkit for Staff Working in a CALD Health Environment

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

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

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

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

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

Section C is for managers who lead multicultural teams. This section should be read by ALL MANAGERS including CALD managers.
Section D lists training, resources and supports for staff working in WDHB. This section is for ALL STAFF. Section E contains appendices, which include information on: Cultural Competence Standards, Policies, Legislation, and acronyms and idioms that are commonly used in New Zealand. References for the toolkit are included. This section is for ALL STAFF

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

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

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

10.4.2.1.5 English Language Literacy and Numeracy

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

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

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

NB: There are other cultural-specific courses, resources, and workshops that are useful for enhancing cultural knowledge which may not be listed in this document.
11. Appendix 1: Asian Population

Extracts from the Health Needs Assessment of Asian people living in the Auckland region (Mehta, 2012)

The term ‘Asian’ is used in New Zealand to describe culturally diverse communities with origins from the Asian continent. The Auckland Asian population currently represents 22% of the total population in the Auckland region, and is projected to increase more than 60% by 2026.

11.1 Definition of ‘Asian’

The level 1 category ‘Asian’ refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the west to Japan in the east. This definition of ‘Asian’ excludes people originating from the Middle East, Central Asia (except Afghanistan) and Asian Russia.

The ethnicity protocols subdivide the level 1 group ‘Asian’ into five level 2 categories: ‘Other Asian’, ‘Chinese’, ‘Indian’, South East Asian’ and ‘Asian NFD’. Table 1 details the population groups that comprise each of these five categories.

Table 1: Level Two Asian Categories defined by Statistics New Zealand

<table>
<thead>
<tr>
<th>Level 2 Asian Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Asian (Code 44)</td>
</tr>
<tr>
<td>Japanese</td>
</tr>
<tr>
<td>Korean</td>
</tr>
<tr>
<td>Afghani</td>
</tr>
<tr>
<td>Sri Lankan NFD*</td>
</tr>
<tr>
<td>Sri Lankan Tamil</td>
</tr>
<tr>
<td>Sri Lankan NEC*</td>
</tr>
<tr>
<td>Sinhalese</td>
</tr>
<tr>
<td>Bangladesh</td>
</tr>
<tr>
<td>Nepalese</td>
</tr>
<tr>
<td>Pakistani</td>
</tr>
<tr>
<td>Tibetan</td>
</tr>
<tr>
<td>Eurasian</td>
</tr>
<tr>
<td>Asian NEC*</td>
</tr>
</tbody>
</table>

Source: Dr Prabani Wood, Statistics New Zealand
- NEC=not elsewhere classified; NFD=not further defined
11.2 Asian population profile

The migration influx of Asian people into New Zealand began in the late 1980’s, peaked in 1995 and continued to lead the net migration figures with an average of over 15,000 people per year over 1996 to 2002, making Asian people the fastest growing population in New Zealand.

Of the three DHBs, ADHB has the largest Asian population, with an estimated 27% of people identifying as being Chinese, Indian or Other Asian. In Waitemata and Counties Manukau DHBs Asian groups are respectively 18% and 19% of the populations served. Across the Auckland region, an estimated 9% of people identified as being Chinese, 7% as being Indian and 6% as being Other Asian in 2010.

Asian communities comprise a notable proportion of Auckland’s population. Figure 1, Figure 2 and Figure 3 present the ethnic composition of each DHB and Figure 4 presents the ethnic breakdown of the Auckland region according to the 2010 estimated resident population approximations (Mehta, 2012).

Figure 1: Composition of ethnicities in ADHB according to prioritised ethnicity, 2010 estimated resident population

![Pie chart showing ethnicities in ADHB](image)

Source: Statistics New Zealand and CMDHB, standard prioritised ethnicity.

*European/Other refers to all European, and non-Maori/Pacific/Asian peoples

Figure 2: Composition of ethnicities in CMDHB according to prioritised ethnicity, 2010 estimated resident population

![Pie chart showing ethnicities in CMDHB](image)
Figure 3: Composition of ethnicities in WDHB according to prioritised ethnicity, 2010 estimated resident population

Source: Statistics New Zealand and CMDHB, standard prioritised ethnicity. *European/Other refers to all European, and non-Maori/Pacific/Asian peoples.
**Figure 4: Composition of ethnicities in the Auckland region according to prioritised ethnicity, 2010 estimated resident population**

![Composition of ethnicities in the Auckland region according to prioritised ethnicity, 2010 estimated resident population](image)

**Source:** Statistics New Zealand and CMDHB, standard prioritised ethnicity. *European/Other refers to all European, and non-Maori/Pacific/Asian peoples

### 11.3 Population Projections

Extracts from the Health Needs Assessment of Asian people living in the Auckland region (Mehta, 2012)

Table 2 shows the expected growth of all populations in the Auckland region based on current immigration trends. The populations of Chinese, Indian and Other Asian peoples across Auckland are expected to increase more than 60% by 2026. However, future changes to immigration policy, as well as the economic climate and job availability could significantly influence population counts for Asian communities in Auckland.

**Table 2: Projected population counts by prioritised ethnicity from 2006 to 2026**

<table>
<thead>
<tr>
<th>DHB</th>
<th>Ethnicity</th>
<th>Year</th>
<th>% change from 2010 to 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2010</td>
<td>2016</td>
</tr>
<tr>
<td>ADHB</td>
<td>Chinese</td>
<td>55,935</td>
<td>66,440</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>40,190</td>
<td>50,175</td>
</tr>
<tr>
<td></td>
<td>Other Asian</td>
<td>27,940</td>
<td>33,810</td>
</tr>
<tr>
<td></td>
<td>European/Other*</td>
<td>239,120</td>
<td>249,660</td>
</tr>
<tr>
<td>CMDHB</td>
<td>Chinese</td>
<td>35,945</td>
<td>45,845</td>
</tr>
</tbody>
</table>

This information is correct at date of issue. Always check on Waitemata DHB Controlled Documents site that this is the most recent version.
<table>
<thead>
<tr>
<th></th>
<th>Indian</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Asian</td>
<td>20,960</td>
<td>25,975</td>
<td>30,480</td>
<td>34,935</td>
<td>+67%</td>
<td></td>
</tr>
<tr>
<td>European/Other*</td>
<td>202,800</td>
<td>204,660</td>
<td>204,810</td>
<td>204,870</td>
<td>+1%</td>
<td></td>
</tr>
</tbody>
</table>

**WDHB**

<table>
<thead>
<tr>
<th></th>
<th>Chinese</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>20,145</td>
<td>25,810</td>
<td>30,280</td>
<td>34,475</td>
<td>+71%</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td>35,165</td>
<td>43,790</td>
<td>51,485</td>
<td>59,240</td>
<td>+68%</td>
<td></td>
</tr>
<tr>
<td>European/Other*</td>
<td>355,770</td>
<td>379,520</td>
<td>387,990</td>
<td>+10%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Auckland region**

<table>
<thead>
<tr>
<th></th>
<th>Chinese</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian</td>
<td>100,350</td>
<td>126,705</td>
<td>147,700</td>
<td>167,185</td>
<td>+67%</td>
<td></td>
</tr>
<tr>
<td>Other Asian</td>
<td>84,065</td>
<td>103,575</td>
<td>120,635</td>
<td>137,385</td>
<td>+63%</td>
<td></td>
</tr>
<tr>
<td>European/Other*</td>
<td>797,790</td>
<td>842,890</td>
<td>860,500</td>
<td>+8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source:* Statistics New Zealand, PHO datamart and CMDHB.
11.4 Level 3 Asian Ethnic Groups

Extracts from the Health Needs Assessment of Asian people living in the Auckland region (Mehta, 2012)

Table 3 presents Census 2006 usual resident counts of Auckland Asian communities using Level 3 groupings and a total response definition of ethnicity. Chinese and Indian populations are the largest Asian communities in Auckland. Among other Asian groups in Auckland, Koreans have the largest population. The ‘Other’ group included includes people with origins from Afghanistan, Bangladesh, Nepal, Pakistan and Tibet.

Table 3: Level 3 Asian ethnic group population numbers using total response ethnicity, census 2006 usual resident counts

<table>
<thead>
<tr>
<th>Level 3 Asian Ethnic Groups</th>
<th>DHB</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADHB</td>
<td>CMDHB</td>
<td>WDHB</td>
<td>Auckland region</td>
</tr>
<tr>
<td>Chinese</td>
<td>43,128</td>
<td>28,092</td>
<td>27,327</td>
<td>98,547</td>
</tr>
<tr>
<td>Indian</td>
<td>29,901</td>
<td>29,733</td>
<td>15,018</td>
<td>74,652</td>
</tr>
<tr>
<td>Filipino</td>
<td>2,376</td>
<td>2,529</td>
<td>4,941</td>
<td>9,375</td>
</tr>
<tr>
<td>Cambodian</td>
<td>447</td>
<td>2,115</td>
<td>813</td>
<td>3,375</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>927</td>
<td>1,983</td>
<td>267</td>
<td>3,177</td>
</tr>
<tr>
<td>Other Southeast Asian</td>
<td>3,291</td>
<td>1,905</td>
<td>3,717</td>
<td>8,913</td>
</tr>
<tr>
<td>Sri Lankan</td>
<td>3,252</td>
<td>936</td>
<td>870</td>
<td>5,058</td>
</tr>
<tr>
<td>Japanese</td>
<td>2,781</td>
<td>693</td>
<td>1,830</td>
<td>5,304</td>
</tr>
<tr>
<td>Korean</td>
<td>4,785</td>
<td>4,422</td>
<td>12,207</td>
<td>21,414</td>
</tr>
<tr>
<td>Other</td>
<td>3,417</td>
<td>1,353</td>
<td>1,941</td>
<td>6,711</td>
</tr>
<tr>
<td><strong>Total Asian</strong></td>
<td><strong>93,519</strong></td>
<td><strong>73,053</strong></td>
<td><strong>68,148</strong></td>
<td><strong>234,720</strong></td>
</tr>
</tbody>
</table>

*Source: Statistics New Zealand, total response ethnicity*
### 11.5 Level 2 Asian Categories - Statistics NZ

(Mehta, 2012) – Page 2

Table 4: Projected population counts by prioritised ethnicity from 2006 to 2026

<table>
<thead>
<tr>
<th>DHB</th>
<th>Ethnicity</th>
<th>Year</th>
<th>% change from 2010 to 2026</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2010</td>
<td>2016</td>
</tr>
<tr>
<td>ADHB</td>
<td>Chinese</td>
<td>55,935</td>
<td>66,440</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>40,190</td>
<td>50,175</td>
</tr>
<tr>
<td></td>
<td>Other Asian</td>
<td>27,940</td>
<td>33,810</td>
</tr>
<tr>
<td></td>
<td>European/Other*</td>
<td>239,120</td>
<td>249,660</td>
</tr>
<tr>
<td>CMDHB</td>
<td>Chinese</td>
<td>35,945</td>
<td>45,845</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>40,015</td>
<td>50,720</td>
</tr>
<tr>
<td></td>
<td>Other Asian</td>
<td>20,960</td>
<td>25,975</td>
</tr>
<tr>
<td></td>
<td>European/Other*</td>
<td>202,800</td>
<td>204,660</td>
</tr>
<tr>
<td>WDHB</td>
<td>Chinese</td>
<td>35,575</td>
<td>44,965</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>20,145</td>
<td>25,810</td>
</tr>
<tr>
<td></td>
<td>Other Asian</td>
<td>35,165</td>
<td>43,790</td>
</tr>
<tr>
<td></td>
<td>European/Other*</td>
<td>355,770</td>
<td>370,290</td>
</tr>
<tr>
<td>Auckland region</td>
<td>Chinese</td>
<td>127,455</td>
<td>157,250</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>100,350</td>
<td>126,705</td>
</tr>
<tr>
<td></td>
<td>Other Asian</td>
<td>84,065</td>
<td>103,575</td>
</tr>
<tr>
<td></td>
<td>European/Other*</td>
<td>797,690</td>
<td>824,610</td>
</tr>
</tbody>
</table>

**Source:** Statistics New Zealand, PHO datamart and CMDHB.

*European/Other refers to all European, and non-Maori/Pacific/Asian peoples*
### 4.2.3 Level 3 Asian Ethnic Groups

Table 5 presents Census 2006 usual resident counts of Auckland Asian communities using Level 3 groupings and a total response definition of ethnicity. Chinese and Indian populations are the largest Asian communities in Auckland. Among Other Asian people in Auckland, Koreans have the largest population.

#### Table 5: Level 3 Asian ethnic group population numbers using total response ethnicity, census 2006 usual resident counts

<table>
<thead>
<tr>
<th>Level 3 Asian Ethnic Groups</th>
<th>DHBK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ADHB</td>
</tr>
<tr>
<td>Chinese</td>
<td>43,128</td>
</tr>
<tr>
<td>Indian</td>
<td>29,901</td>
</tr>
<tr>
<td>Filipino</td>
<td>2,376</td>
</tr>
<tr>
<td>Cambodian</td>
<td>447</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>927</td>
</tr>
<tr>
<td>Other Southeast Asian</td>
<td>3,291</td>
</tr>
<tr>
<td>Sri Lankan</td>
<td>3,252</td>
</tr>
<tr>
<td>Japanese</td>
<td>2,781</td>
</tr>
<tr>
<td>Korean</td>
<td>4,785</td>
</tr>
<tr>
<td>Other Asian</td>
<td>3,417</td>
</tr>
<tr>
<td><strong>Total Asian</strong></td>
<td><strong>93,519</strong></td>
</tr>
</tbody>
</table>

**Source:** Statistics New Zealand, total response ethnicity
### Table 6: Projected Population by prioritised ethnicity for 2010

The following table looks at the composition of the Chinese, Indian, Other Asian population, Pacific and Maori, European groups in ADHB, CMDHB and WDHB.

<table>
<thead>
<tr>
<th>DHB</th>
<th>Composition of Asian Ethnicities</th>
<th>Composition of Asian, Pacific, Maori and European groups</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chinese</td>
<td>Indian</td>
</tr>
<tr>
<td>ADHB</td>
<td>12%</td>
<td>9%</td>
</tr>
<tr>
<td>CMDHB</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>WDHB</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>55,935</td>
<td>40,190</td>
</tr>
<tr>
<td>CMDHB</td>
<td>35,945</td>
<td>40,015</td>
</tr>
<tr>
<td>WDHB</td>
<td>35,575</td>
<td>20,145</td>
</tr>
<tr>
<td>Total No</td>
<td>127,455</td>
<td>100,350</td>
</tr>
</tbody>
</table>

Source: Statistics New Zealand, PHO datamart and CMDHB.

- The data above is extracted from the Health Needs Assessment of Asian people report (Metha, 2012)
- The above analysis endeavours to calculate the 2010 population projection for Asian, Pacific, Maori and European groups of ADHB, WDHB and CMDHB
- There seems to be discrepancies with the total projected numbers and this analysis uses the percentages to calculate the European, Pacific and Maori numbers
- From the above analysis Asian population is the second largest Asian population in ADHB, 27% (124,000) of people identified as Chinese (55,935), Indian (40,190), Other Asian (27,940) in 2010
- Asian population is the second largest population in CMDHB, 18% (96,920) of people identified as Chinese (35,945), Indian (40,015) and Other Asian (20,960) in 2010
- Asian population is the second largest population in WDHB, 18% (90,885) of people identified as Chinese (35,575), Indian (20,145) and Other Asian (35,165) in 2010
Table 7: An Analysis of the Composition of Projected Population for the Chinese, and Korean residents in 2010
The following is an analysis of the composition of the Chinese and Korean population to compare with the composition of Pacific and Maori ethnic groups in ADHB, CMDHB and WDHB.

| Analysis of Projected Population of Chinese and Korean ethnicities in 2010 |
|---|---|---|---|---|
| # ADHB | 55,935 | 6,524 | 62,459 | 39,950 | 29,055 |
| # CMDHB | 35,945 | 6,086 | 42,031 | 65,938 | 50,952 |
| # WDHB | 35,575 | 16,636 | 52,352 | 31,261 | 44,659 |
| Total No | 91,510 | 29,246 | 156,701 | 137,150 | 124,666 |

The purpose of this analysis is to work out the total number of Chinese and Korean population of ADHB, CMDHB and WDHB.
Below described the method used to calculate the Korean population:

- The ratio of the ADHB Korean population in the 2006 Census Level 3 Asian ethnic group population numbers = 23.4%; the ratio of the CMDHB Korean population =29%, the ration of the WDHB Korean population in the 2006 Census Level 3 Asian ethnic group population numbers = 47.3%
- ADHB Korean projected population = 23.4% x 27,940 (ADHB Other Asian projected population, 2010) = 6,524; the CMDHB Korean projected population = 29% x 29,960 = 6,086; and the WDHB Korean projected population = 47.3% x 35,165 (WDHB Other Asian projected population, 2010) = 16,777

Notes:
- The analysis shows that majority of the Korean people resides in the WDHB district (16,636) while ADHB and CMDHB have a much smaller number of Korean residents.

Table 8: An Analysis of the Composition of Projected Chinese, Indian and Korean Population in 2010
The following is an analysis of the composition of the Chinese, Indian and Korean population to compare with the composition of Pacific and Maori ethnic groups in ADHB, CMDHB and WDHB.

| Analysis of Projected Population of Chinese, Indian and Korean ethnicities in 2010 |
|---|---|---|---|---|
| # ADHB | 55,935 | 40,190 | 6,524 | 102,649 | 39,950 | 29,055 |
| # CMDHB | 35,945 | 40,015 | 6,086 | 82,046 | 65,938 | 50,952 |
| # WDHB | 35,575 | 20,145 | 16,636 | 72,356 | 31,261 | 44,659 |
| Total No | 91,510 | 60,335 | 16,736 | 257,051 | 137,150 | 124,666 |

Notes:
- The analysis shows that majority of ADHB have the largest number of Chinese, Korean and Indian residents compared with CMDHB and WDHB

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Issued Date: June 2013
Classification: 070-001-01-003
Authorised by: CEO
Review Period: 36 months
Page: Page 57 of 73

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### Asian cultural and language diversity

#### Table 9: % Non-English Speaking and % Overseas-Born by Ethnicity

The following table shows the percentage of Non-English speakers of each ethnic groups and percentage of people in each ethnic group identified as overseas born.

<table>
<thead>
<tr>
<th></th>
<th>Comparison by Asian ethnicity</th>
<th>Comparison by Asian, Pacific, Maori</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chinese</td>
<td>Indian</td>
</tr>
<tr>
<td><strong>English Competency:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Non-English Speakers</td>
<td>17.9%</td>
<td>5.3%</td>
</tr>
<tr>
<td>% Overseas-born (Migrant)</td>
<td>83%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Source: Statistics New Zealand

**Notes:**

- Chinese (17.9%) and Korean (29.6%) have the highest percentage of people identifying as Non-English speakers compared with Indian (5.3%), Other Asian (7.4%), Pacific (5.7%) and Maori (0.9%)
- Overall Asian population (15.4%) has a higher percentage of people identified as Non-English speakers compared with Pacific (5.7%) and Maori (0.9%)
- Korean population (93%) has the highest number of people identified as overseas-born (migrants), compared with Chinese (83%) and Indian (80%)
- Majority of Asian population (84%) are migrants
12. Appendix 2: Middle Eastern, Latin American and African Population

12.1 Definition of “MELAA”

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

The MELAA ethnicity grouping is one of the six top level ethnicity groups created by SNZ (MELAA = Level 1 code 5). The other Level 1 ethnicity groups include European (Level 1 code 1), Maori (Level 1 code 2), Pacific peoples (Level 1 code 3), Asian (Level 1 code 4) and Other (Level 1 code 6). Census first used the MELAA ethnicity grouping in 2006.

The current Ethnicity Standards and Classification protocol poses several difficulties when analysing data for the MELAA group.

- Zimbabweans are classified as belonging in the ‘Other European’ group. Zimbabweans however, consist of a combination of people who may identify as ‘African’ or ‘European’. As there was no meaningful way of extracting data for people who may identified as African Zimbabweans, no data is presented for them in this report. This is a significant limitation as the number of African Zimbabweans in Auckland could be 3500 people1 and they could be the largest African subgroup in Auckland.

- Similar difficulties in ethnicity coding exist for people who may identify as ‘African’ rather than ‘European’ South Africans as all South Africans are classified as ‘Other European’.

- Afghani people (who may identify as Middle Eastern) are classified as ‘Asian’ and not as ‘Middle Eastern’.

12.2 “MELAA” Population Characteristics

Middle Eastern people in New Zealand

Middle Eastern people have origins from southwest Asia, where the European, Asian and African continents meet. No universally agreed definition on which countries are included in the Middle East exists. Some countries may be geographically aligned, but not politically or culturally. Historically, traditional membership to this region have included countries such as Turkey, Armenia, Egypt and Azerbaijan, to the more modern concept today of including Afghanistan and Pakistan. It is also a term that is sometimes used to refer to the Muslim countries in the region rather than purely based on geographical location. SNZ classifies the following ethnicities as Middle Eastern: Algerian, Arab, Assyrian, Egyptian, Iranian/Persian, Iraqi, Israeli/Jewish/Hebrew, Jordanian, Kurd, Lebanese, Libyan, Moroccan, Omani, Palestinian, Syrian, Tunisian, Turkish (including Turkish Cypriot), Yemeni, Middle Eastern not further defined and Middle Eastern not elsewhere classified. This system of classification may be confusing for some as geographical locations (countries) are also used to identify ethnicities rather than ethnic groups themselves, e.g. Iraqi is not an ethnicity, but ‘Arab’ and ‘Kurdish’ are.

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1 As per the Zimbabwe Association of New Zealand’s Auckland membership numbers, personal correspondence, Tuwe K, programme manager African Communities for New Zealand AIDS Foundation, March 2010.
Since 1994, refugees from Iran and Iraq have formed a large proportion of New Zealand’s refugee intake and overall these groups make up the largest Middle Eastern populations. These ethnic groups are extremely complex by way of having diverse languages and ethnic affiliations.

Most Iranians arrived as refugees in New Zealand during the 1990s as opposed to voluntary migration. In Iran, improvements in health care and public health measures made during its period of economic growth were lost following the long conflict with Iraq. Access to health care is poor, especially in rural areas where folk medicine is still practised and access to specialist services is initiated by patients themselves (in contrast to the Westernised New Zealand health care system).

Many Iraqi refugees who came to New Zealand in the 1990s were Assyrian Christians who were oppressed by the ruling Muslim Sunni class and suffered greatly from the Iran-Iraq conflict and the Gulf Wars.

Lebanese people have been present in New Zealand since the late 1800s. They have a long history of settlement and the original migration was preceded by young people leaving Lebanon seeking economic opportunities elsewhere. Many eventually established successful businesses. Lebanese people have settled in Auckland since the 1890s and have become well established in their local communities. This situation contrasts with the forced migration faced by the aforementioned Iranian and Iraqi refugees who have come to New Zealand more recently.

Other smaller Middle Eastern groups from Kuwait, the United Arab Emirates, Turkey, Saudi Arabia, Syria, Jordan and Bahrain have mainly come to New Zealand in the 2000s.

**Figure 5: Map of countries with Middle Eastern groups (within the red line)**

Note: Map obtained from Te Ara - the Encyclopaedia of New Zealand (online).(9)

**Table 10: Summary of the major religions, ethnic groups and languages from Iran and Iraq**

<table>
<thead>
<tr>
<th>Country</th>
<th>Religion and ethnic groups</th>
<th>Languages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td>Mainly Islamic (with Shias predominantly), other Muslim groups, Bahais, Catholics, Jews, Zoroastrians, also some Kurdish people</td>
<td>Farsi (Persian), other minority languages</td>
</tr>
<tr>
<td>Iraq</td>
<td>Mainly Islamic with Shias in south and Sunnis in north, Christian Assyrians, Kurds and other minorities</td>
<td>Arabic, Kurdish and Assyrian</td>
</tr>
</tbody>
</table>

Note: Table adapted from ‘Refugee Health Care: A handbook for health professionals’ published by the Ministry of Health.

**African people in New Zealand**

African people can trace their ancestry to the continent of Africa, which has 53 sovereign countries. The ethnicities classified as African by SNZ are: Creole (US), Jamaican, Kenyan, Nigerian, African American,
Ugandan, West Indian/Caribbean, Somali, Eritrean, Ethiopian, Ghanaian, African not further defined and Other African not elsewhere classified.

Africans had little opportunity to migrate to New Zealand before the 1990s due to New Zealand’s ‘traditional source country’ immigration policy favouring migrants from the United Kingdom and Ireland. By the late 1980s and early 1990s, more refugees from Africa came to New Zealand with the adoption of a formal refugee quota in 1987. They were predominately from Somalia, Ethiopia, Eritrea, Djibouti and Sudan. Many were fleeing political unrest and famine. African refugees come from extremely diverse backgrounds which include various religions, ethnic affiliations and a variety of spoken languages. By the early 2000s however, the majority of African people in New Zealand were made up of migrants rather than refugees. Between 2002 and 2004, 46,806 migrants from Africa came to New Zealand, mainly from South Africa and Zimbabwe. Again, changes in the political climate were a key factor in their migration.

Prior access to health care was poor for most people coming from countries within the Horn of Africa. The health care coverage is poor, with significant disparity between urban and rural health care services. In these countries, most health care is provided by community-based clinics and delivered by health workers (e.g. nurses or birthing attendants). Traditional healers are also used extensively. People from these countries would be unfamiliar with the New Zealand health care system especially relating to general practice services and formalised appointment systems.

**Figure 6: Map of some countries with African groups (below the red line)**

Note: Map obtained from Te Ara - the Encyclopaedia of New Zealand (online).
Table 11: Summary of the major religions, ethnic groups and languages from some African countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Religion</th>
<th>Ethnic Groups/Clans</th>
<th>Languages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eritrea</td>
<td>Coptic Christian, Islam, Catholic and Protestant minorities, some traditional religions</td>
<td>Includes Tigrinya, Tigre, Bilen, Afar, Saho, Kunama, Nara, Hidareb, Rashaida</td>
<td>Mainly Tigrinya or Tigray, Arabic, some local languages, some English and Italian</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>Ethiopian orthodox, Islam, some traditional African religions</td>
<td>Includes Amhara, Oromo, Tigre, Gurage, Niloti, Somali, Danakil</td>
<td>Amharic, Oromo, Tigrinya, some local languages, some English and Italian</td>
</tr>
<tr>
<td>Somalia</td>
<td>Mainly Islam, some Christians</td>
<td>Includes the Dir, Issaq, Hawiye, Digil, Rahawayn, Darood</td>
<td>Somali and Arabic, some English and Italian</td>
</tr>
<tr>
<td>Sudan</td>
<td>Mainly Islam, minority Christians, some traditional religions</td>
<td>North: Mainly Arabs, inc. Nubian, Jamla, Beja and other groups South: Nilotic Africans, inc. Dinka, Nuer, Shiluk and others</td>
<td>Arabic (including Creole Arabic in the South), many local languages, some English</td>
</tr>
</tbody>
</table>

Note: Table adapted from ‘Refugee Health Care: A handbook for health professionals’ published by the Ministry of Health.

**Latin American people in New Zealand**

Latin America is a region of the Americas. It is a diverse area where the main spoken languages are the Romance languages and there is a mixture of ethnicities. Statistics New Zealand classifies the following ethnicities as Latin American: Argentinean, Bolivian, Brazilian, Chilean, Columbian, Costa Rican, Creole (Latin America), Ecuadorian, Guatemalan, Guayanese, Honduran, Malvinian (Spanish-speaking Falkland Islander), Mexican, Nicaraguan, Panamanian, Paraguayan, Peruvian, Puerto Rican, Uruguayan, Venezuelan, Latin American/Hispanic not further defined and Latin American/Hispanic not elsewhere classified.

Very few Latin Americans came to New Zealand before the 1970s. Latin Americans were part of the mid-19th century’s population of gold seekers and in 1874, it was noted that there were less than 80 people who were Brazilian, Chilean, Mexican or Peruvian in New Zealand. Chilean refugees arrived in New Zealand after the military coup of 1973. Large numbers of Brazilians came in early 2000, and by 2006 their numbers had outstripped Chileans. In 2001, a working holiday scheme was introduced in Chile and currently has 1000 places. A similar working holiday scheme was introduced for Argentina and since December 2006, 1000 visas have been available per year. Brazil is New Zealand’s ninth largest education market and around 3500 Brazilians currently study in New Zealand per annum. A working holiday scheme was ratified at the end of 2009 which has up to 300 places.

In the Latin American region, non-communicable disease rates are rising. People who live in rural villages, people of indigenous and mixed African ethnicities and women have difficulties accessing heath services. It is difficult to evaluate the differences in health care systems in Latin America compared with New Zealand as there are enormous variations between the different Latin American countries. Countries such as Brazil, Chile and Argentina have more positive demographic and health indicators than Guatemala or Haiti.
Figure 7: Map of countries in Latin America

Note: Map obtained from Te Ara - the Encyclopaedia of New Zealand (online)

Table 12: Summary of major religions, ethnic groups and languages from Latin American countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Religion</th>
<th>Ethnic Groups</th>
<th>Languages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>Catholic predominantly</td>
<td>European 97%, Mestizo (mixed European and Amerindian), Amerindian (aboriginal population of Latin America) or other non-European groups 3%</td>
<td>Spanish</td>
</tr>
<tr>
<td>Brazil</td>
<td>Roman Catholic 73%, Protestant 15%</td>
<td>European 54%, Mulatto (mixed European and African) 39%, African 6%</td>
<td>Portuguese</td>
</tr>
<tr>
<td>Chile</td>
<td>Catholic (67.7%), Protestant/Evangelical (15.1%)</td>
<td>European and Mestizo 95%, Mapuche (indigenous tribe) 4%</td>
<td>Spanish</td>
</tr>
</tbody>
</table>
The Usefulness of the MELAA ethnicity grouping
In part 1.4, the different ethnicities within the MELAA ethnic group were discussed. Clearly, the MELAA ethnicity grouping is made up of three very diverse populations. Within each subgroup ethnicity (Middle Eastern, Latin American and African), there exists a huge variety of languages, religions, tribal affiliations, geographical origins, shared history and reasons for migration.

Some of the newer African refugees have experienced extremely poor health care systems, health care practices and socio-economic living conditions in their home countries compared with New Zealand. Again, their situation is very different to that experienced by some Iraqi and Iranian people, who pre-Gulf War had relatively good health care infrastructures and standards of living. The majority of Latin Americans presently in New Zealand are voluntary migrants who are here seeking better economic and learning opportunities.

The MELAA ethnicity grouping is an artificial grouping of three very diverse ethnic groups, mainly for the purpose and convenience of statistical analysis. In order to understand the health needs of these populations in a meaningful way, the three groups within the larger MELAA grouping need to be looked at individually- Middle Eastern, Latin American and African.

The following is an extract of the WDHB Asian Workforce Representation, 2011 report produced by Bradley Clarke to inform the Asian Health Governance Group WDHB Asian workforce representation as at December, 2011.

INTRODUCTION

Waitemata DHB uses data sourced from LEADER, the healthAlliance payroll system. This data is requested as at 31 December 2011 and mapped against organisational information relating to service structure, professional groups, etc. Data is reported as percentage of total Full Time Equivalent (FTE), actual numbers are not reported to help prevent identification of individuals within each service.

Ethnicity is self-reported at the time of employment. Employees state the ethnic group that they identify with. Asian ethnicity categories collected include Indian, Chinese, Southeast Asian, Other Asian. Therefore Asian workforce data can be broken down by these ethnic sub-group categories. LEADER allows for the reporting of multiple ethnicities, and where this is the case all ethnicities identified have been included in both the numerator and denominator.

The report below includes all staff identifying as Asian and employed by Waitemata DHB.

Staff who are casual or invoicing contractors, are classified as 0 FTE in the LEADER payroll system. In order to accurately reflect the impact these staff have on our workforce data, casual staff have been included in the report with the following proviso:

1. For all employees with a 0 FTE, actual hours worked over the last 12 months were totalled then turned into a ‘proxy FTE’.

‘Targets’ (bracketed under ethnicity headings) are based on between census 2011 linear population projections for the WDHB Asian population (prepared by Keming Wang, CMDHB).
LIMITATIONS

Data is only as accurate as the information that is entered into the LEADER system. There are some known inconsistencies between information that business leaders (unit managers/professional leaders) hold and what is recorded within the payroll system.

Data is only available for staff employed by Waitemata DHB. There are no easily accessible sources of data for the primary care or community-based workforces. LEADER also does not hold information on location of staff, so we are unable to report by physical location (i.e., our workforces located within the Waitakere City vs Rodney District or North Shore City). Inability to provide locality-specific data is particularly problematic for regional (Auckland-wide) service provision.

Level of representation is identified based on WDHB catchment profile(s), and may not accurately reflect what is truly required to provide effective service provision. Moreover, low numbers in some services can be problematic for assessing appropriate representation.

DEFINITIONS

’South East Asian’ includes: Filipino, Indonesian, Malaysian, Singaporean, South East Asian, and Thai

‘Other Asian’ includes: Asian, Bangladeshi, Burmese, Cambodian, Japanese, Korean, Laotian, Nepalese, Pakistani, Sri Lankan, and Vietnamese

<table>
<thead>
<tr>
<th>Corporate</th>
<th>CHINESE (6.8%)</th>
<th>INDIAN (3.9%)</th>
<th>SE ASIAN (2.5%)</th>
<th>OTHER ASIAN (4.2%)</th>
<th>ASIAN TOTAL (17.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO</td>
<td>2.0%</td>
<td>2.7%</td>
<td>2.0%</td>
<td>0.0%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Deputy CEO</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<tr>
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<tr>
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<td>0.0%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Maori</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Provider Management</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Quality</td>
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<td>6.8%</td>
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<td>0.0%</td>
<td>18.2%</td>
</tr>
<tr>
<td>WDHB Governance and Funding</td>
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<td>5.5%</td>
<td>3.7%</td>
<td>0.0%</td>
<td>12.9%</td>
</tr>
</tbody>
</table>
### Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>CHINESE (6.8%)</th>
<th>INDIAN (3.9%)</th>
<th>SE ASIAN (2.5%)</th>
<th>OTHER ASIAN (4.2%)</th>
<th>ASIAN TOTAL (17.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health Services</td>
<td>1.5%</td>
<td>3.2%</td>
<td>3.7%</td>
<td>0.5%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Alcohol and Drug</td>
<td>2.5%</td>
<td>1.7%</td>
<td>1.7%</td>
<td>0.6%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Child and Youth Dist Mental Health</td>
<td>2.1%</td>
<td>3.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.1%</td>
</tr>
<tr>
<td>District Mental Health Admin</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Forensic</td>
<td>3.2%</td>
<td>5.6%</td>
<td>4.3%</td>
<td>1.4%</td>
<td>14.5%</td>
</tr>
<tr>
<td>Mental Health General Mgmt</td>
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<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Mental Health Maori</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.2%</td>
<td>2.2%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Mental Health Pacific Island</td>
<td>0.0%</td>
<td>2.5%</td>
<td>4.9%</td>
<td>2.5%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

### Child, Women & Family Services

<table>
<thead>
<tr>
<th>Service</th>
<th>CHINESE (6.8%)</th>
<th>INDIAN (3.9%)</th>
<th>SE ASIAN (2.5%)</th>
<th>OTHER ASIAN (4.2%)</th>
<th>ASIAN TOTAL (17.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Services</td>
<td>3.0%</td>
<td>4.2%</td>
<td>4.8%</td>
<td>1.7%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Child Women and Family GM</td>
<td>0.0%</td>
<td>14.3%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td>CWFS/HOAS Shared Services</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Regional Dental</td>
<td>6.9%</td>
<td>7.8%</td>
<td>5.6%</td>
<td>1.4%</td>
<td>21.7%</td>
</tr>
<tr>
<td>Womens Health</td>
<td>1.8%</td>
<td>3.4%</td>
<td>1.9%</td>
<td>0.3%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

### Hospital Operations

<table>
<thead>
<tr>
<th>Service</th>
<th>CHINESE (6.8%)</th>
<th>INDIAN (3.9%)</th>
<th>SE ASIAN (2.5%)</th>
<th>OTHER ASIAN (4.2%)</th>
<th>ASIAN TOTAL (17.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian Health</td>
<td>29.3%</td>
<td>59.3%</td>
<td>0.0%</td>
<td>5.7%</td>
<td>94.3%</td>
</tr>
<tr>
<td>Clinical Equipment Pool</td>
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<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Daily Operations</td>
<td>2.4%</td>
<td>2.1%</td>
<td>3.2%</td>
<td>13.1%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Hospital Operations</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>13.2%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Inpatient Pharmacies</td>
<td>6.1%</td>
<td>3.2%</td>
<td>7.4%</td>
<td>3.0%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Laboratories</td>
<td>0.0%</td>
<td>5.3%</td>
<td>7.1%</td>
<td>7.7%</td>
<td>20.1%</td>
</tr>
<tr>
<td>Maori Health</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non Clinical Support</td>
<td>2.2%</td>
<td>1.9%</td>
<td>9.0%</td>
<td>8.8%</td>
<td>21.8%</td>
</tr>
<tr>
<td>Outpatient Pharmacy</td>
<td>0.0%</td>
<td>16.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Pacific Support</td>
<td>0.0%</td>
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<td>0.0%</td>
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</tr>
<tr>
<td>Surgical Pathology</td>
<td>4.5%</td>
<td>4.5%</td>
<td>0.0%</td>
<td>9.0%</td>
<td>18.1%</td>
</tr>
</tbody>
</table>
### Medical & Health of Older Persons Services

<table>
<thead>
<tr>
<th>Service</th>
<th>CHINESE (6.8%)</th>
<th>INDIAN (3.9%)</th>
<th>SE ASIAN (2.5%)</th>
<th>OTHER ASIAN (4.2%)</th>
<th>ASIAN TOTAL (17.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute General Medical</td>
<td>16.6%</td>
<td>9.0%</td>
<td>3.4%</td>
<td>6.5%</td>
<td>35.5%</td>
</tr>
<tr>
<td>Allied Health</td>
<td>3.1%</td>
<td>4.3%</td>
<td>1.3%</td>
<td>1.3%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>5.2%</td>
<td>7.1%</td>
<td>7.7%</td>
<td>3.2%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Diabetes Endo Palliative</td>
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<td>0.0%</td>
<td>3.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Emergency</td>
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<td>6.4%</td>
<td>9.2%</td>
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<td>20.6%</td>
</tr>
<tr>
<td>Gastro Resp Neuro Stroke</td>
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<td>7.8%</td>
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<td>15.7%</td>
</tr>
<tr>
<td>General Medicine Admin</td>
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<td>12.5%</td>
</tr>
<tr>
<td>Haemo Renal Dern Rheu</td>
<td>5.4%</td>
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<td>8.7%</td>
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<tr>
<td>Medical Wards</td>
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<td>15.5%</td>
<td>16.4%</td>
<td>5.2%</td>
<td>43.9%</td>
</tr>
<tr>
<td>Older Adults &amp; Home Health</td>
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<td>5.1%</td>
<td>7.9%</td>
<td>1.6%</td>
<td>19.1%</td>
</tr>
</tbody>
</table>

### Surgical & Ambulatory

<table>
<thead>
<tr>
<th>Service</th>
<th>CHINESE (6.8%)</th>
<th>INDIAN (3.9%)</th>
<th>SE ASIAN (2.5%)</th>
<th>OTHER ASIAN (4.2%)</th>
<th>ASIAN TOTAL (17.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesth &amp; Op Theatres</td>
<td>6.5%</td>
<td>5.2%</td>
<td>9.1%</td>
<td>2.9%</td>
<td>23.7%</td>
</tr>
<tr>
<td>Breast Screening</td>
<td>1.7%</td>
<td>1.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>2.8%</td>
</tr>
<tr>
<td>ICU</td>
<td>8.8%</td>
<td>14.0%</td>
<td>10.4%</td>
<td>0.0%</td>
<td>33.2%</td>
</tr>
<tr>
<td>OP Booking</td>
<td>3.2%</td>
<td>0.0%</td>
<td>7.2%</td>
<td>0.0%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Radiology</td>
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<td>7.7%</td>
<td>3.9%</td>
<td>2.3%</td>
<td>16.8%</td>
</tr>
<tr>
<td>Surgical Admin</td>
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<td>0.0%</td>
<td>14.7%</td>
</tr>
<tr>
<td>Surgical Services</td>
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<td>16.6%</td>
<td>11.6%</td>
<td>4.3%</td>
<td>41.2%</td>
</tr>
</tbody>
</table>
# 14. Appendix 4: Stakeholder Consultation

This document has been consulted with the WDHB Asian Mental Health & Addiction Governance Group for input and guidance.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Representing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Murray Patton</td>
<td>Clinical Director District Mental Health &amp; Addiction Services</td>
<td>Chair</td>
</tr>
<tr>
<td>Sue Lim</td>
<td>Service Manager Asian Health Support Services</td>
<td>Project Lead</td>
</tr>
<tr>
<td>Kelly Feng</td>
<td>Team Leader – Asian mental health cultural support coordination service</td>
<td>Asian mental health service responsiveness</td>
</tr>
<tr>
<td>Jean-Marie Bush</td>
<td>Programme Manager: Mental Health, Asian, Migrant and Refugee Services</td>
<td>Funding perspective</td>
</tr>
<tr>
<td>Dr Susanna Galea</td>
<td>Service Clinical Director Regional CADS</td>
<td>Asian Community Alcohol and Drug services</td>
</tr>
<tr>
<td>Rebecca Zhang</td>
<td>CADS Asian Service Coordinator &amp; CADS counsellor</td>
<td>Asian Community Alcohol and Drug services</td>
</tr>
<tr>
<td>Patrick Hinchey</td>
<td>Team Leader WDHB Adult MH Service - North 2</td>
<td>Adult MH service responsiveness</td>
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<tr>
<td>Heather Stewart</td>
<td>Team Leader WDHB Adult MH Service - North 1</td>
<td>Adult MH Service responsiveness</td>
</tr>
<tr>
<td>Robyn Buskin</td>
<td>MHSOP Team Manager MHSOA North &amp; Rodney Community Teams</td>
<td>Mental health service for older people responsiveness</td>
</tr>
<tr>
<td>Charles Joe</td>
<td>Pouwhakahaere:Associate Service Manager Mason Clinic</td>
<td>Forensic service responsiveness</td>
</tr>
<tr>
<td>Dr Margaret Mitchelle-Lowe</td>
<td>Psychiatrist – WDHB Child, Youth, Family MH Service</td>
<td>Child Youth MH Service responsiveness</td>
</tr>
<tr>
<td>Robyn Buskin</td>
<td>Manager, WDHB MHSOA North</td>
<td>Older Adult MH Service Responsiveness</td>
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<tr>
<td>Alix McGinity</td>
<td>WDHB MH &amp; A Workforce Consultant</td>
<td>Workforce development</td>
</tr>
<tr>
<td>Dr Lifeng Zhou</td>
<td>Epidemiologist</td>
<td>Asian health needs assessment and overview of the Asian health action plan 2010-2012</td>
</tr>
<tr>
<td>Dr Annette Mortensen</td>
<td>Project Manager, Auckland Regional Settlement Strategy Northern Region Alliance</td>
<td>Migrant and Refugee service responsiveness</td>
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<tr>
<td>Bradley Clarke</td>
<td>Workforce Consultant</td>
<td>Workforce Development</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Responsiveness</td>
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<tr>
<td>Dr Sai Wong</td>
<td>Psychiatrist, ADHB, CMDHB and WDHB</td>
<td>Asian MH responsiveness</td>
</tr>
<tr>
<td>Patrick Au</td>
<td>Private practice: Family and Relationship Counsellor; ADHB Asian MH Service</td>
<td>Asian MH responsiveness</td>
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<tr>
<td>Charlie (Sheng) Tang</td>
<td>Mental Health Foundation</td>
<td>Asian mental health promotion</td>
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<tr>
<td>John Wong QSM</td>
<td>Director: Asian Family Services at Problem Gambling Foundation, Chairperson: Chinese Positive Ageing Charitable Trust, ACC Older Persons’ Advisory Group</td>
<td>Asian MH older adult programme</td>
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<td>David Lee</td>
<td>Manager, Cultural Advisors Team – ACC</td>
<td>ACC responsiveness</td>
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<td>Kitty Ko</td>
<td>Asian Service Development Coordinator – CMDHB</td>
<td>Asian MH responsiveness</td>
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<tr>
<td>Elizabeth Johnson</td>
<td>Your Choice Coordinator/Social Worker Te Puna Manawa/HealthWest Community Service</td>
<td>NGO service responsiveness</td>
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<tr>
<td>Dr Elsie Ho</td>
<td>Assoc Professor, Director of Population Mental Health – Social and Community Health – Tamaki Campus School of Pop Health</td>
<td>Asian MH responsiveness</td>
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<tr>
<td>Janice Stirling</td>
<td>Connect (NGO)</td>
<td>NGO service responsiveness</td>
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<tr>
<td>Min Maggie Zheng</td>
<td>Consumer</td>
<td>Consumer perspective</td>
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<tr>
<td>Clare Brennan</td>
<td>Registered Nurse: Marinoto Service</td>
<td>Child Youth MH Service responsiveness</td>
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<tr>
<td>Dr Aram Kim</td>
<td>Registrar Psychiatrist</td>
<td>Korean perspective</td>
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<tr>
<td>Khalid Shah</td>
<td>Locality Service Coordinator, WDHB</td>
<td>Pakistani, Indian, Muslim perspectives</td>
</tr>
<tr>
<td>Juan Chen</td>
<td>Psychologist, WDHB</td>
<td>Chinese perspective</td>
</tr>
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</table>

The document was sent to the following for comments /feedback on 17 May 2013:

- Naida Glavish - GM Maori Health – ADHB and WDHB
- Timoti George – WDHB Manager Maori Mental Health
- Lita Foliaki – ADHB and WDHB Manager Pacific Health Gain
- Bruce Levi – WDHB Manager Pacific Mental Health Service
- Sulu Samu- WDHB Manager Pacific Family Support Service
15. Appendix 5: Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<td>ADHB</td>
<td>Auckland DHB</td>
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<tr>
<td>AHSS</td>
<td>Asian Health Support Services</td>
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<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse/Diversity</td>
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<tr>
<td>CMDHB</td>
<td>Counties-Manukau DHB</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>HPCAA</td>
<td>Health Practitioners Competence Assurance Act</td>
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<tr>
<td>MELAA</td>
<td>Middle Eastern, Latin American, and African</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>NDSA</td>
<td>Northern DHB Support Agency</td>
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<td>NGO</td>
<td>Non-government organisations</td>
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<td>NRA</td>
<td>Northern Regional Alliance Ltd (previously NDSA)</td>
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<td>PHO</td>
<td>Primary Health Organisation</td>
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<td>WDHB</td>
<td>Waitemata DHB</td>
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16. Appendix 6: References


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