cultural integrity in service delivery

Presentation delivered by Michal Morris on 29 July 2010
Department of Health *Chronic Disease and CALD Communities Forum*

Hello and thank you for inviting me to present today. It's great to see so many people interested in coming to hear about what is happening and discuss the latest ideas, initiatives and opinions in the cultural diversity space.

a bit about CEH …

Firstly a little bit about CEH – the Centre for Culture, Ethnicity and Health assists health and community services to deliver a high quality of care to refugee and migrant clients. We provide training, information and support on health and wellbeing. Our key activities include:

- research and information
- resource development
- project management
- education and support
- social marketing

We have a library that specialises in health and wellbeing and is free to join, and to stay in touch there is an e-newsletter that you can subscribe to. Just check us out at www.ceh.org.au.

cultural integrity in service delivery

While the term I am here to explore is new, the ideas behind it are not. I have pulled together cultural integrity in service delivery to place a focus on certain aspects of how we do things. This morning I will explore these ideas– and this afternoon, workshop it a bit more.

In early June, CEH presented the Diversity in Health conference, and in the build up to that I was responsible for developing the themes for the conference. I was very conscious that I wanted something that had meaning, that when people heard the term they would stop and think.

where cultural integrity came from

Cultural integrity is historically used in relation to indigenous cultures when referring to wholeness. Keeping integrity is maintaining the culture in its purest form – undiluted, whole, complete.

And in terms of multicultural service delivery that is the opposite of what I wanted to do – in cultural integrity in service delivery - the service needs to change, develop, respond to the cultural and linguistic needs of the client.

It would mean that service delivery would *always change* – not be undiluted, whole or complete.

The integrity I am talking about refers to the soundness of moral principle and character; uprightness; honesty[1].

It has an aspirational component.

As well, it is a concept that focuses on the service provider – that's right, not the client or the organisation, or the interrelations between, but the third part of the relationship of quality service delivery – us.

Cultural integrity in service delivery describes a holistic service response that recognises the diverse cultural and linguistic needs of individual clients. Aspirational and developmental in nature, cultural integrity is relevant in all service settings from the bricks and mortar of hospitals and community health centres to the less conventional approaches of outreach and community education programs.

Cultural integrity in service delivery is framed around the notions of consistency of action, values, methods, measures, principles, expectations and outcomes and places the client or service recipient in the centre of that response.

context for cultural integrity

There must be recognition that what I am attempting to do is place the term cultural integrity into an already crowded space. We have:

- cultural diversity
- cultural awareness
- cultural competency
- cultural sensitivity
- cultural responsiveness

And I am sure that those of you who have been in the game longer than me will know even more terms than that. Most of these terms are used interchangeably within the service sector, even when they are trying to mean different things. **Cultural competence** is a case in point.

[1] The Macquarie Concise Dictionary. Third edition. Macquarie University 2001. p.587

There are many times I go to meetings or receive requests and they want the project to be 'culturally competent'. Which if you look at the true meaning isn't actually what they want. They are, in my opinion, wanting something that is culturally responsive, or culturally sensitive or maybe, culturally aware.

Cultural competence is specific. It's big, it's hard to do – even harder to do well, and it is not the same as cultural sensitivity. Over the past few years CEH has done a lot of work around cultural competence and if you want to know more please check out our website as there is a plethora of information and resources.

With cultural competence there are four dimensions:

1. **Systemic** - effective policies and procedures, monitoring and resources

2. **Organisational** – cultural competency is valued, it's core business, it's supported and evaluated

3. **Professional** - training and professional development

4. **Individual** - knowledge, attitudes and behaviours

These levels interrelate so that cultural competence at an individual or professional level is underpinned by systemic and organisational commitment and capacity. Cultural competence requires a co-ordinated plan that addresses outcomes to be achieved within each level.

In summary cultural competence is big, strategic and multi-layered. It needs a systemic plan, you can't just wing cultural competency.

so how does cultural integrity in service delivery fit in?

Cultural integrity in service delivery does not replace anything – it places a focus on health professionals and their planning and actions within their role in working with refugee and migrants.

Hopefully today can provide you with a guide as to what you could be thinking about in this space. Questions like:

- What do I need to do to have cultural integrity in my service delivery?
- What does it look like?
- What changes are to be made?
- How do I know if I got it right?
- How do I know if I got it wrong?

Within cultural integrity in service delivery we can add some well-established concepts to guide us. Concepts we are familiar with – like cross cultural communication, health beliefs and health literacy – to build on our understanding, and develop our practice.

Today I plan on talking about two of those familiar concepts – health literacy and cross-cultural communication – to expand on the notions of cultural integrity in service delivery.

health and culture

To set up our conversation on health literacy and cross-cultural communication I need to state my underlying premise.

A key barrier in cultural integrity in service delivery is recognising the role of culture – *ours* not the clients.

That's because it's easy to see *their* culture and language barriers. Identifying what makes someone else different is simple - their English isn't very good or they don't know how to effectively use public transport.

But what about us?

The Australian health system is a cultural construct.

No other country in the world has the same health system that we have. It has been built on the experiences and values of Australians, and more specifically Victorians. It's also complex and messy. It's a continual balance of relationships between three levels of government plus the charity and not-for-profit sectors.

We have unwritten rules as to when to go to the doctor or the hospital. When we are too sick to go to work or when we should just suck it up. When we should go to the doctor for tests because we are 'at risk' – let alone show symptoms of an illness.

Medical intervention pre-illness requires a high level of health literacy.

This is why a holistic approach that incorporates conceptual health issues, as much as the clinical ones, is required for effective health service delivery and good health outcomes.

And this holistic approach is essential in cultural integrity in service delivery.

This is because health is not a black and white – there is no single right or wrong choice. When making decisions about our health we need to pull together a number of usually complex factors to determine what is best for us, in our circumstances.

cross-cultural communication

Victorian Health Commissioner Beth Wilson, in a speech she gave recently, pointed out that the vast majority of complaints she received have at their core a failure of communication. For something that we do pretty much every day of our lives we can be surprisingly bad at it.

Add in the CALD factor – the barriers of communicating through language and culture - and effective communication can be one of the most complex activities of the job.

If we go back to the questions that I posed about cultural integrity with the focus of the practitioners, put a cross-cultural communication lens on, the questions become:

- What do I need to do to have effective communication my service delivery?
  What are the language barriers?
    - How much English can the client understand?
    - Are there any in-language tools available?
    - When will I need an interpreter?

  What are the cultural barriers?
    - Do they understand why they are coming to see me?
    - Do they understand the purpose of a care plan?
    - Can they interpret the eating plan into their daily eating habits?

- What are the critical communication points I need to make?
- What changes are to be made?
- How do I know if I got it right?
- How do I know if I got it wrong?

Some considerations when communicating with migrant and refugee clients that will include how you respond to the above questions include:

- **Literacy** - some refugee clients may have had a disrupted education through unrest in their home country and/or migration experiences. Skilled migrants are required to have a high level of English to receive their visa.
- **Proficiency in English**
- **Understanding** - Understanding of English may diminish in stressful situations such as illness or injury. Also, understanding may diminish with age
- **Listening and Observation** - Giving the client your full attention will enable you to pick up both verbal and non verbal cues

example

An example of the need for elasticity when cross-culturally communicating can be provided through the work of CEH's Multicultural Gambler's Help Program.

MGHP works to ensure that the needs of migrant and refugee communities are addressed in state-wide responses to problem gambling. One key activity is the

development of community language resources.

Every year we pick a number of key small to medium sized communities and work with them to develop collateral to inform their community about both the risks of gambling and where to seek help. Each poster or flyer is developed with the community. And each poster or flyer is very different.

These posters are the result of asking the same questions but listening to the different answers and from there negotiating new meaning. And you can see from the look and feel of the material, each community has interpreted the message differently. They have used different images and triggers to connect to their peers.

health literacy

As well as cross cultural communication, health literacy has the capacity to inform our practice – to make it more holistic, integrated and effective.

Health literacy is the capacity to obtain, interpret and understand basic health information and services and the competence to use such information and services to enhance health. (Ratzan and Parker, 2000, Institute of Medicine, 2004)

Many of the people who walk through your doors have complex health issues.

This is particularly true for people with a chronic illness. It is very rare that if a person has one chronic illness that is the only thing medically wrong with them. One example that most of you would be very familiar with is the relationship between type two diabetes and depression.

But what about if one of their health issues was not a clinical problem but a conceptual one?

If we go back to the definition of cultural integrity in service delivery, health literacy will play a key role in the roll out.

A low level of health literacy has a direct impact on a person's health status. If we are to support a person to self-manage their chronic disease we need to work with them to improve their health literacy.

And here I am not taking about understanding the words we are using but the ability to interpret the meaning of the words to change behaviour, and make informed choice.

Typically those that are health illiterate:

- don't understand what their clinicians are saying to them;
- can't read signs posted in hospitals or clinics;
- unable to fill out patient forms including informed consent forms;
- can't read prescription bottles;
- can't take medications appropriately;
- can't read and understand patient education materials; and
- don't understand public health messages.[2]

America is currently leading the research in health literacy. The Agency for Health care Research and Quality (AHRQ) supported a systematic review of evidence about the relationship of health literacy and health outcomes. That report found that adults with lower health literacy have worse health care and poorer health outcomes. It also found that well-conceived interventions can improve the outcome of knowledge for those with both higher and lower literacy levels (Berkman et al., 2004 sourced from Measures of Health Literacy Institute of Medicine).

what about Australia?

In 2006 the Australian Bureau of Statics undertook the first Australian audit of Adult Literacy and Life Skills. Health literacy is defined as:

> *The knowledge and skills required to understand and use information relating to health issues such as drugs and alcohol, disease prevention and treatment, safety and accident prevention, first aid, emergencies, and staying healthy[3].*

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[2] Sharon Barrett, Diversity in Health 2010 http://www.ceh.org.au/dih-program/dih-daily-program-guides/8-june/health-literacy-keynote.aspx

[3] Australian Bureau of Statistics. Health Literacy, Australia 4233.0. Australian Government 2008.

The audit used the scale of 5 domains - with level 1 being the lowest measured level of literacy and 5 the highest. The middle level 3 was regarded by the survey developers, as the minimum required for individuals to meet the complex demands of everyday life and work.

The findings identified that those born in Australia achieved a health literacy rating of approximately 40% at level 3 or above[4].

So, 60% of Australians are functionally health illiterate. And while this seems high, health literacy for those born in a mainly non-English speaking country is worse. Only 26% of migrants have a health literacy rating of 3 or higher.

So my question to you is – how does this information – or how should this information – impact your service response with a client?

Having a migrant client with low health literacy means that our response will need to be recalculated.

When we first assess a client we need to assess their literacy level, as this will directly impact any further assessments – including their intake assessment. Levels of health literacy will determine how the client will understand your questions and how they will respond to you, and how together you will work out the best care plan.

health literacy and intelligence

It is important to separate health literacy and intelligence, or even simply understanding the meaning of the words that someone says to you.

There are skills that relate to health literacy including:

- Reading, writing, numeracy
- Ability to communicate and question
- Ability to recognize risk, sort through conflicting information
- Make health-related decisions
- Navigate the health care systems
- Advocate for change if system doesn't meet your needs[5]

care team practices

So what are the key concepts for practitioners in addressing health literacy?

Much is framed around notions of patient centred care – it's not anything new either. There was a health literacy best practice survey in primary health settings in America. What is found was

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[4] Australian Bureau of Statistics. Health Literacy, Australia 4233.0. Australian Government 2008.

[5] Sharron E. Barrett. Presentation Diversity in Health Conference http://www.ceh.org.au/dih-program/dih-daily-program-guides/8-june/health-literacy-keynote.aspx

that many services were engaged in addressing health literacy issues of their clients but few were doing it under the umbrella of 'health literacy', nor were many using formal strategies. Some of the most useful actions identified include:

- Create a comfortable, nonjudgmental environment
- Assess readiness for change
- Listen to the tone in the patient's voice
- Face the patient and sit at eye level
- Use simple language, short sentences and define technical terms
- Organise information so that the most important points stand out and repeat this information
- Ask patients to explain your instructions (teach back method) or demonstrate the procedure
- Ask questions that begin with 'how' and 'what', rather than closed-ended 'yes/no' questions
- Offer assistance with completing forms

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finale

What this presentation hopefully does is provide you with an understanding of how cultural integrity in service delivery can be applied. By changing our practice to open up for both the literal meaning and comprehension, we as practitioners become better, and improve the health outcomes of our clients.

To me cultural integrity has a component of the active participation of the client or service recipient.

Both times – cross cultural communication and health literacy - the client world view, and the clients understanding, has been the base of our service response, (not what we need to tell them).

When effective the client becomes more informed, will understand the context of your work better, and hopefully utilise the service more appropriately.

There are some other non-communication/ comprehension policy concepts that also fall in line with cultural integrity in service delivery – social inclusion, human rights and health equality.

I think that we have enough ideas out there at the moment – we don't really need any new ones. What will be useful is if we consolidate a bit. By bringing in cultural integrity as a focus for out practice, I am hopefully helping to consolidate some important and useful concepts (or just confused you).

Thank you.