
Diversity in Hospitals

Responding to the Needs of Patient and Client
Groups from Non-English Speaking Backgrounds

POLICY AND RESOURCE GUIDE

Prepared by the Acute Diversity Care Collaboration Program

Centre for Culture Ethnicity and Health

November 2003

1st Edition

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Introduction

Aim

Welcome to this comprehensive Policy Resource Guide. The Guide is written for Victorian hospital managers in the areas of direct service delivery, quality and financial management. It aims to assist with the incorporation of principles and practices into hospital planning, service provision and quality improvement programs that are responsive to the diversity of the patient group.

Designed as a practical 'how to' resource, the Guide contains extensive background information and specific policy suggestions to assist hospitals in responding more effectively to the diverse ethnic, cultural, religious and language needs of patient/client groups accessing their service.

This is the first time that such a comprehensive policy guide, setting bottom line standards in Victorian public hospitals for non-English speaking background patient and client groups, has been produced.

Focus

In line with the area of work and mission of the Centre for Culture Ethnicity and Health (CEH), this guide will concentrate on the policy responses necessary for service provision to Victorians from non-English speaking backgrounds.

The primary focus is patient/client groups from culturally and linguistically diverse backgrounds, especially those with low English proficiency who may experience significant language and cultural barriers to accessing health services. For the purpose of this document 'culturally and linguistically diverse' does not include indigenous Australians, although many of the issues and strategies cited may be common to both groups. The potential for broader application is thus acknowledged, with the information contained herein being potentially relevant to many other policy contexts.

Use of Terminology

Due to the complex influences of ethnicity, language and religion upon a person's understanding of and response to their own health, the use of terms such as 'non-English speaking background' or 'culturally and linguistically diverse' may be preferred in different contexts. The use of any term will emphasise certain aspects of diversity that best reflect the patient/client group population of that organisation. Often a single term can only partially describe the individual circumstances of each patient/client group. The use of the term 'non-English speaking background' in this guide reflects the chosen usage by CEH.

The terms 'non-English speaking background' and 'low English proficiency' will be used throughout the Guide for the sake of consistency, but at all times broader applicability is to be considered in the policy development process.

How to Use The Guide

The Guide consists of five major sections:

Context and Background: outlines the current Victorian context relating to cultural and language diversity in Victoria. The definition of 'diversity' is explored along with the benefits to service providers and recipients in responding to the needs of its non-English speaking background and low English proficiency patient/client groups. Key issues and potential responses that a hospital must consider when developing policy in respect to the needs of non-English speaking background patient/client groups are explored as a context for Victoria's response to cultural diversity in health care.

Diversity Responsiveness In Policy Development: describes the role and function of policy development. The underlying expectation is that diversity-responsive principles are relevant to all stages of policy development.

Developing Diversity Responsive Policy: outlines 6 basic steps in policy development and ways in which policy development can incorporate the needs of non-English speaking background patient/client groups.

Specific Policy Areas: takes a look at key hospital policy areas. Key considerations and performance indicators are also explored. A checklist aimed at facilitating the policy development process is listed at the end of each policy section.

The key policy areas discussed in this Guide are:

- Inclusive Planning, Infrastructure and Budgeting
- Inclusive Data Collection and Indicator Use
- Inclusive Consumer Participation
- Language Services
- Specific Cultural or Religious Requirements in the Health Setting
- Inclusive Staff Employment, Orientation and Training

Additional Resources: provides a range of practical reference materials designed to complement the content of the Guide and provide staff with additional information in an easy to use, accessible format.

Context and Background

1.1 Diversity in Victoria

Victoria has a longstanding indigenous history and background of successive settler migration from all regions of the world since the British colonisation of Australia in 1788. The Victorian population is characterised by cultural (this includes ethnic, linguistic and religious) diversity as highlighted in the following statistics¹:

- Victoria has a resident population of 4,612,097
- 23.4% of Victoria's population was born overseas
- 43.5% of Victorians were either born overseas themselves or have at least one parent born overseas
- 71.8% of all overseas born Victorians were born in non-main-English speaking countries
- 116 religions are practised in Victoria by 72.1% of Victoria's population
- 180 languages other than English are spoken by 21% of Victorians
- Out of all Victorians born overseas, 14%² live in rural regions and 86%³ live in Melbourne.

To respond to the needs of a diverse community, Victoria has developed many innovative health care models. However, responding to ethno-cultural, religious and linguistic diversity remains a complex and challenging area for public hospitals. An ageing population and shifting international migration patterns to and from Australia significantly impact on the demographics of hospital patient groups.

1.2 Defining Diversity

'Diversity' is a broad concept that includes all Victorians. Recognising that each person is a unique and complex being is integral to understanding and responding effectively to health care needs at an individual, family or community level. 'Diversity' is the term used to refer to groups or individuals that are perceived to be different from the general community. Facilitating access for these often marginalised groups and individuals must occur through consideration of characteristics such as ethnicity, disability, sexuality, age and socio-economic status. All of these characteristics are important for service planning and implementation in the health care sector.

¹ Source: Australian Bureau of Statistics, 2001 Census of Population and Housing, Special Tables, Persons counted at Place of Usual Residence.

² Source: Australian Bureau of Statistics, 2001 Census of Population and Housing, Special Tables, Usual Residence, compiled by the Victorian Office of Multicultural Affairs, Department of Premier and Cabinet, 2002: Table 2-1 Victoria, Top 30 Birthplaces in Metropolitan Melbourne (Melbourne Statistical Division) and Rest of Victoria: 2001 Census

³ Source: Australian Bureau of Statistics, 2001 Census of Population and Housing, Special Tables, Usual Residence, compiled by the Victorian Office of Multicultural Affairs, Department of Premier and Cabinet, 2002: Table 2-1 Victoria, Top 30 Birthplaces in Metropolitan Melbourne (Melbourne Statistical Division) and Rest of Victoria: 2001 Census

1.3 Difference Within Diversity

The needs of non-English speaking background population groups are made potentially more complex when the effects of other life factors are taken into consideration.

Some factors are particularly significant when planning or delivering service to patients from non-English speaking backgrounds:

- Age
- Education
- Family Support
- Gender
- Health status
- Impairment or disability
- Level of establishment of and attachment to expatriate community in Victoria
- Literacy and proficiency in English
- Migration experience
- Refugee or asylum seeker status
- Religious affiliation
- Sexuality
- Year of arrival in Australia

Understanding cultural, religious and language needs is an important part of providing responsive hospital-based health care. In addition to such considerations, it is important to acknowledge a person's individual situation and the potential impact this has on how the person will perceive, access and use a hospital. As patient/client group expectations vary, hospitals need to guide practices that increase responsiveness to individual health care needs within the mandate and resources available. By addressing these needs, barriers to accessing health care for non-English speaking background patient/client groups can be reduced and overall health outcomes improved.

1.4 Benefits of Responding to Diversity

Focussing on the needs of the patient/client group results in better health outcomes and has the potential to achieve efficiencies in health service provision. Implementing diversity-responsive policies in hospitals ensures that a service can meet the needs of non-English speaking background patient/client groups, whilst promoting safety and meeting policy and legislative requirements. This can support appropriate clinical and ancillary service provision, potentially resulting in resource efficiencies, such as:

- The reduction of unnecessary diagnostic testing
- The efficient use of staff time by booking the correct interpreter for appointment times
- The reduction of unnecessary re-admissions
- The reduction of adverse clinical reactions/complications

- An American study found that patients with access to interpreters were less likely to have readmissions to the emergency department and more likely to keep follow-up appointments. (Bernstein, J., Bernstein, E., et. al., 2000)
- The prevention of health status deterioration attributable to miscommunication resulting from:
 - Incomplete assessment
 - Sub-optimal treatment
 - Inadequate patient/client group education
 - Compromised patient/client group compliance
 - The reduction of Failure-to-Attend rates
 - The reduction of inpatient Length-of-Stay rates due to a less stressful hospital experience and improved discharge planning

Diversity-responsive health care may require initial resource increases in some areas (such as policy development, interpreting, translating, added clinician time and some systemic changes), yet it will achieve savings of resources overall⁴. For example, the use of interpreters can result in more appropriate, effective health care assessments and outcomes when a clinician and patient are able to communicate effectively. Minimising miscommunication results in improved assessment, appropriate intervention and improvement in health outcomes.

The use of diversity-responsive principles in a hospital will guide practices that support and improve the capacity of staff to respond to the needs of non-English speaking background patient/client groups competently, confidently and effectively. A hospital that promotes diversity-responsiveness in its planning, service provision and quality improvement activities has a greater capacity to respond to the needs of all patient/client groups.

Health is a culturally mediated concept that is understood in the context of a patient/client group's belief system⁵. Modern health systems themselves are culturally mediated and consideration of individual health views must be incorporated into health services to ensure they remain relevant and sensitive to different cultural world views and belief systems.

⁴ Bahro, Tatjana (2003) *Managing Demand in Acute Care*. Melbourne: Centre for Culture Ethnicity and Health.

⁵ World Health Organisation (2001) *WHO's Contribution to the World Conference Against Racism, Facial discrimination, Xenophobia and Related Intolerance: Health and freedom from discrimination*.

1.5 Non-English Speaking Background Patient Rights

The Victorian Patient Charter

The Victorian Department of Human Services has developed a Patient Charter setting out patient rights and responsibilities for patients of public hospitals in Victoria. This document should be a basis for, and consistent with, any hospital policies referring to patient rights and responsibilities produced at the organisational level. The full document (including multi-lingual versions) can be accessed at <http://patientcharter.health.vic.gov.au/patients>

The Patient Charter is relevant to all non-English speaking background patient/client groups and includes the expectations of language service provision and cultural responsiveness. The expectations outlined below should be incorporated into any diversity-responsive policy development⁶.

The Victorian Patient Charter (<http://patientcharter.health.vic.gov.au>) states:

Where Necessary, an Accredited Interpreter and Services Provided In a Culturally Sensitive Way

- Public hospitals will offer patients where possible the use of accredited interpreters for essential communication. This includes use during admission to hospital and the taking of a medical history, for informed consent and for making an enquiry or a complaint
- Hospital staff will respect the cultural and religious background of patients
This includes attempting to meet the dietary needs of people from various backgrounds
- Where possible, hospital staff will attempt to ensure that care is provided by a health professional of the same gender, if there are specific religious or cultural factors requiring this
- Public hospitals will endeavour to make provision for patients to engage in prayers, attend religious services or meet with chaplains and other religious personnel⁷

A feature of diversity-responsive policy development is the inclusion and promotion of key government policy requirements and what patient/client groups can expect in terms of service provision.

⁶ Department of Human Services, Victorian Public Hospital Patient Charter Information, <http://patientcharter.health.vic.gov.au/patients.htm>

⁷ Department of Human Services, Victorian Public Hospital Patient Charter Information, <http://patientcharter.health.vic.gov.au/patients.htm>

Health Services Legislation

The Victorian Health Services (Conciliation and Review) Act 1987⁸ outlines a number of 'guiding principles' for health service providers;

...If an interpreter is not provided to someone who cannot communicate verbally in English, a medical practitioner risks:

- being liable for negligence if a practitioner fails to communicate the consequences of a procedure, or where the failure to communicate leads to a shortcoming in the reasonable standard of care
- being liable for other torts (eg. assault or trespass) if a procedure is performed without the consent of the patient, or her or his family
- being criminally charged with assault or criminal negligence if the practitioner was recklessly in disregard of the language situation

Anti-Discrimination Legislation

In considering non-discriminatory service provision to non-English speaking background patient/client groups, attention must be given to Commonwealth and Victorian State Government legislation relevant to hospital planning, policy, service provision and ongoing evaluation. Two key Acts are:

- The Racial Discrimination Act (1975), (Commonwealth)
- The Equal Opportunity Act (1995), (Victoria)

These two acts prohibit discrimination in Australia on the basis of race, colour, descent, national, religious or ethnic origin, being an immigrant or being a relative or associate of someone of a particular ethnicity.

References to Anti-Discrimination Legislation in policy needs to refer to both direct and indirect discrimination.

Direct discrimination

Direct discrimination occurs when someone who has one of the personal characteristics protected by law is treated less favourably than someone who doesn't have that personal characteristic⁹. It is important to note that in acting in a discriminatory manner, one does not have to have acted intentionally or to believe that the act is discriminatory.

Indirect discrimination

Discrimination can also happen when "a policy or rule that treats everyone in the same way has an unfair effect on more people of a particular race, colour, descent, or national or ethnic origin than others. Unlike direct discrimination, indirect discrimination may be justified if the policy or rule is reasonable and relevant to the particular circumstances"¹⁰.

Further information can be accessed at www.eoc.vic.gov.au/rights/discrimination

⁸ Victorian Health Services (Conciliation and Review) Act 1987, Section 1 Part 2, Victorian Equal Opportunity Commission website 13 January 2003 - www.eoc.vic.gov.au/rights/discrimination.

⁹ Victorian Equal Opportunity Commission website, 13 January 2003, www.eoc.vic.gov.au/rights/discrimination

¹⁰ Victorian Equal Opportunity Commission website, 13 January 2003, www.eoc.vic.gov.au/rights/discrimination

1.6 Quality Improvement¹¹

Quality improvement can provide a comprehensive framework for responding to the needs of non-English speaking background patient/client groups. Needs analysis, planning, service development and evaluation must incorporate responsiveness to non-English speaking background patient/client groups. This will ensure that issues are addressed as a part of a 'whole-of-organisation' response. Accreditation cycles need to be considered as a means of integrating quality improvement initiatives into a coherent, established framework that ensures safety and quality of service provision across the organisation to all patient/client groups.

In Victoria, the main hospital accreditation body is the Australian Council on Healthcare Standards (ACHS). ACHS administers the EQUiP health service accreditation framework. The Victorian Quality Council is currently developing clinical governance principles for health care in Victoria to complement the EQUiP system of the ACHS. Further information on clinical governance can be gained from the Victorian Quality Council (contact details are in the Additional Resources Section or can be found at <http://qualitycouncil.health.vic.gov.au>).

The ACHS EQUiP system provides a useful Quality Improvement framework for policy development. The ACHS quality improvement system assesses hospitals against six major areas of activity under the EQUiP process, which include all areas of hospital activity:¹²

- Continuum of Care
- Leadership and Management
- Human Resources Management
- Information Management
- Safe Practice and Environment
- Improving Performance

The following five characteristics are identified to be found in organisations that continually improve their performance:

- A patient/client group focus
- Strong leadership
- A culture of improving
- Evidence of improved outcomes
- A commitment to striving for best practice

¹¹ This section has been based upon information contained in the ACHS (June 2002) The EQUiP Guide, 3rd Ed. Further information can be gained from the ACHS website, www.achs.org.au

¹² ACHS (June 2002) The EQUiP Guide, 3rd Ed.

Continuum of Care

Processes related to the continuum of care can present barriers to non-English speaking background patient/client groups when service provision is not consistent across all areas of service provision. Four major areas are critical to the needs of non-English speaking background patient/client groups:

- **Access and entry into the hospital system**
This includes promotion of hospital services to non-English speaking background communities so that individuals know how to access the hospital, including interpreter services. Clear referral processes from community health providers, patient/client group self-referral and signage that supports physically navigating around the hospital are other examples.
- **Appropriate assessment and service provision**
This includes assessment and service provision that is carried out by staff competent in diversity-responsive practices. Considerations of culturally specific needs should be factored into the care provided, with interpreters used for patient/client groups with low English proficiency as a matter of standard service provision.
- **Ongoing care planning, reassessment and evaluation**
This includes involving the patient/client group and their family in care decisions and ongoing health education appropriate to the situation. Information should be reinforced with appropriate plain English information and translated material. Evaluation of the quality of care provided and staff competency in the areas of diversity-responsiveness and assessment of interpreter need should take place regularly.
- **Discharge planning, referral and ongoing management**
This includes assessment of post-acute care needs and identifying appropriate care and ongoing management providers. At this point, referrals should contain relevant information to care providers to ensure that diversity-responsiveness continues during and after the transition into the community. It is very important to ensure that patient/client groups understand this process, and are able to communicate with care providers. Putting into place a clear communication process for patient/client groups with low English proficiency will ensure that they are able to easily contact care providers, both in the hospital and in the community.

Policy planning across the continuum of care requires consideration of how services are communicated to non-English speaking background communities and patient/client groups. Communication is greatly improved with the timely and appropriate use of interpreters and translations. Communication also involves the competency of staff to undertake culturally responsive and appropriate assessments. Avoiding miscommunication during assessments supports safe, appropriate and effective care interventions, which in turn produce appropriate referrals to community-based services.

A part of quality improvement is the identification of areas that can be developed. An audit of current assessment processes can identify if quality improvements can be made regarding health assessment to ensure that language, religious and cultural needs are accurately communicated across the continuum of care.

Leadership and Management

For diversity responsive policy and practice to be effective, leadership and management support is essential. Support for diversity-responsive policies by managers, boards and executives will ensure that organisational culture promotes and responds effectively to non-English speaking background patient/client groups. Moreover, support by organisational leaders can ensure inclusive patient/client group consultation and participation in strategic directions. Such support facilitates genuine community participation in strategic planning and policy development, yet it requires management to have a high level of knowledge and skills in the area of diversity.

Human Resources Management

Effective human resource policies and practices promote a diverse, appropriately skilled workforce that should ideally reflect the diversity of the community it serves. This can be achieved by observing the requirements of Equal Employment Opportunity and Anti Discrimination legislation in the advertising, selection and ongoing training of all staff. In addition, human resource management must include comprehensive skill development and ongoing performance evaluation to ensure that staff are effectively supported and trained to undertake competent, safe and high quality service provision to non-English speaking background patient/client groups.

Key areas for staff education are:

- Assessing English proficiency and other language needs
- Accessing and working with interpreters
- Organising translations
- Assessing cultural and other specific needs
- Undertaking effective, culturally responsive communication
- Undertaking effective, culturally responsive intervention

Information Management

Information management is an effective tool in planning for diversity through the collection, management and timely distribution of data on non-English speaking background patient/client groups. It is critical that accurate and relevant information is collected together with auditing of data collection to support policy development.

The Australian Bureau of Statistics Standards for Statistics on Cultural and Language Diversity can be found at <http://www.abs.gov.au>

The CEH report 'Diversity in Victoria and Selected Victorian Hospitals' can be found at www.ceh.org.au

Safe Practice and Environment

An essential factor in responding to the needs of non-English speaking background patient/client groups is to employ relevant risk management techniques. This includes effectively communicating treatment options, medication provision and safety in hospital environments (appropriate signage, etc.). It is important to ensure that all patient/client groups have access to information that alerts them to safe practices and any risks to be aware of. This can be facilitated by the use of plain, accessible English and easily recognised symbols to support written and translated material. The active involvement of patient/client groups in their care can provide an additional source of quality control. It supports care options and facilitates better education and communication between care providers and patient/client groups.

Improving Performance

Improving performance of service delivery to non-English speaking background patient/client groups requires that hospitals outline measurable performance indicators relating to service provision to diverse communities. This requires a 'whole-of-organisation' approach, and is facilitated by data analysis of language and ethnicity indicators (e.g. Country of Birth, Preferred Language, Need for an Interpreter) to identify areas for improvement, potential barriers to care or differences in health outcomes for client groups. Current performance indicators (such as Length of Stay, Elective surgery waiting times, Hospital in the Home substitution rates, etc.) can also be measured according to patient/client group or population group to identify differences in impact or access.

Strategies for improving performance include:

- Improved data collection to ascertain which groups of patients are less likely to access services
- Professional development for health service providers to support them to develop and promote culturally appropriate service delivery
- Access to interpreters
- Culturally appropriate admission processes and discharge planning

Improving performance includes providing avenues for patient/client group feedback and complaints processes that are accessible. Strategies that enable patient/client groups from non-English speaking backgrounds to provide feedback include:

- Culturally appropriate mechanisms for providing feedback where the patient/client groups may view it as culturally inappropriate to complain
- Victorian 'Patient Rights' brochures (currently available in a number of community languages) to be handed out by interpreters as a matter of course
- Cultural Awareness Competencies compulsory for patient representatives
- A community education campaign in ethno-specific media

2. Diversity-Responsiveness In Policy Development

2.1 The Function of Policies

Policies are important statements that guide hospital practice, ensuring a consistency of approach that is congruent with the mission of the hospital and the expectations of staff and patient/client groups alike. Policies provide a clear outline of what can be expected from the organisation. Organisational policy statements and principles provide a basis for implementing service systems by providing a set of standards regarding the type and nature of the service provided.

The function of a policy can vary across organisations, depending upon how policies are used, and what outcomes are expected. A policy document should state clearly what principles will inform a given practice area, which legislative and extra-organisational policy requirements must be met, and the responsibilities of the organisation and staff carrying out functions covered by the policy. Policies also address how processes will be implemented to achieve specific outcomes according to the policy principles.

Policies can assist in ensuring that non-English speaking background patient/client groups have:

- Equitable access to hospital services
- Their needs met in an environment that is inclusive of diverse cultural expressions and language backgrounds
- Staff who are appropriately trained and skilled to be diversity-responsive in all service provision
- Essential services such as interpreting and translation
- A clear framework for delivering care that ensures a systematic approach to patient/client group needs

Policies can also set the benchmark against which the hospital will:

- Measure its responsiveness to non-English speaking background patient/client groups
- Identify either gaps in service provision or aspects of care that require further development
- Ensure that patient/client group feedback and service evaluation is inclusive of non-English speaking background patient/client groups

To evaluate the effectiveness of a policy, performance measures need to be developed that measure outcomes related to the goals of the policy. Performance measures then feed back into the policy review, which starts the development cycle again.

2.2 Diversity-Responsive Principles as a ‘Whole-of-Organisation’ Process

Diversity-responsive principles should be developed as a ‘whole-of-organisation’ process to ensure that all organisational policies respond equally and consistently to the needs of non-English speaking background patient/client groups. Diversity-responsive policy in the hospital sector is characterised by seven core principles¹³ that address the needs of non-English speaking background patient/client groups. These principles are:

Access requires that all non-English speaking background patient/client groups (both current and potential) can use a service easily and in a manner that is responsive and appropriate to their specific needs.

Equity requires that the resources and services of an organisation are fairly and equally distributed to all patient/client groups as is appropriate to their specific needs. Equity requires a consistent approach to decision-making and resource allocation that does not involve barriers to patient/client groups, irrespective of culturally specific or language needs.

Communication is a reciprocal principle, which requires that a service communicates in accessible ways what services are available to all potential and actual non-English speaking background patient/client groups, whilst at the same time providing accessible and appropriate methods to seek and gain non-English speaking background patient/client group views on how a service can best meet their needs.

Responsiveness requires that in working with non-English speaking background patient/client groups, a service is able to understand, address and meet their needs in a manner that is timely, flexible and appropriate. Responsiveness requires a genuine dialogue between the non-English speaking background patient/client group and the service-provider.

Effectiveness requires that, where possible, the outcomes of service provision benefit and meet the needs of each non-English speaking background patient/client group irrespective of cultural specificity or language needs.

Efficiency requires that the optimum service be provided in the most timely and resource-effective manner possible.

Accountability requires that patient/client groups, governments, staff, external agencies and communities can scrutinise all aspects of the service. Accountability requires that there are no barriers to public scrutiny, including scrutiny by people from non-English speaking backgrounds.

¹³ Department of Immigration and Multicultural Affairs (1998) Charter of Public Service in a Culturally Diverse Society. Canberra, AGPS.

2.3 Measuring Performance

An important element of quality improvement programs is outcome evaluation. Key Performance Indicators (KPIs) that could be used to measure effectiveness of programs in addressing the needs of non-English speaking background patient/client groups are set out below. KPIs within already developed hospital performance targets can be used to ascertain the impact on policy changes of potential differences in health outcomes for patients.

Hospital-in-the-Home (HITH) substitution rates

Are patients with low English fluency referred to HITH at the same rate as those who speak English well, when interpreters are not available for the HITH program? Does this change when a language services policy is developed and implemented?

Readmission rates

Are patients from non-English speaking backgrounds more likely to have readmissions? Does this change when a staff training policy relating to culturally responsive practice is developed and implemented?

Length of Stay

Are patients with low English fluency more likely to stay longer in hospital when interpreters are not available for discharge planning? Does this change when a language services policy is developed and implemented?

Elective Surgery waiting times

Are patients from non-English speaking backgrounds likely to have longer waiting times for elective surgery? Does this change when a data collection policy addresses issues such as improving accuracy of recording of patient details?

Examples of other Performance Measures:

- Quality improvement activity evaluations that include factors of language and culturally specific needs
- Consumer consultations that are reflective of the patient demographics and inclusive of patients with low English fluency

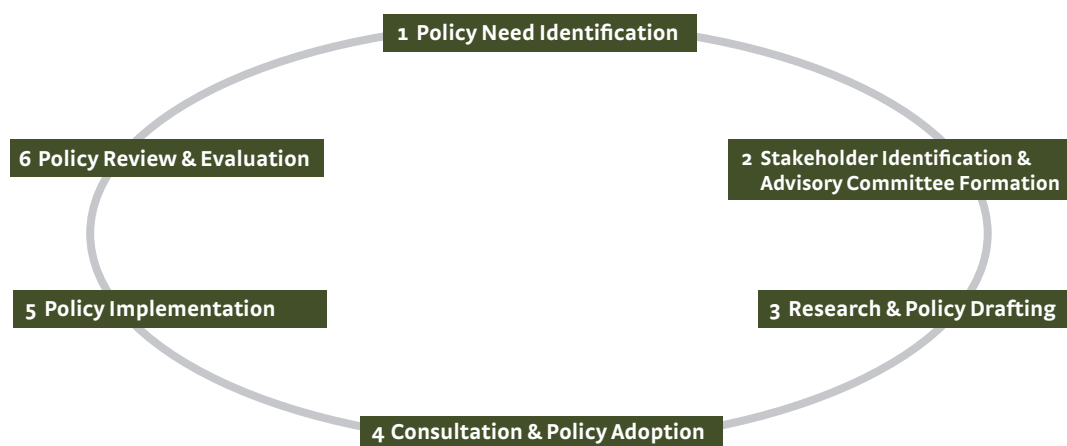
3. Developing Diversity Responsive Policy

There are six general phases in policy development that should be considered when undertaking diversity responsive policy development processes:

- 1 Policy Need Identification:** research and consultation regarding the needs for specific policies versus inclusion of diversity issues in general policy
- 2 Stakeholder Identification/Advisory Committee Formation:** relevant stakeholders (internal and external) are identified and a policy Advisory Committee is set up to guide the policy development process, especially for its content
- 3 Research and Policy Drafting:** research into the nature of the needs, response options and policy directions are investigated and defined in the draft policy
- 4 Consultation and Policy Adoption:** the draft policy is put out for comment and consultation. After the policy has been refined the relevant hospital body then ratifies it
- 5 Policy Implementation:** an implementation plan is developed, staff and stakeholders are provided with the necessary training and the policy and associated practice is implemented
- 6 Policy Review and Evaluation:** policy implementation is assessed against the expected outcomes and fed back to stakeholders to evaluate outcomes and make recommendations regarding the policy. A new cycle of policy planning commences from this point

At each phase there are different issues to consider and different methods for incorporating non-English speaking background patient/client group considerations. The diagram below featuring the six main stages in a policy development process clearly shows policy as an ongoing and circular process. As needs change in the service provision environment, then so too must policy change to explore and respond to these shifting needs. The cycle of policy evaluation and review will be determined by each hospital depending upon local need, external pressure, resources and the nature of the hospital.

Principle Policy Development Stages¹⁴



¹⁴ Adapted from Tsapogas (1998), p. 143.

3.1 Policy Need Identification

A hospital can undertake a number of strategies to identify the need for specific policies for non-English speaking background patient/client groups. Consultation with consumers and relevant communities is an important strategy to assess areas of need. This could be undertaken in conjunction with a number of other strategies, for example staff surveys or policy audits. Gaps can be identified against each of the seven diversity principles prompted by the following questions:

Access

Response: Are there any non-English speaking background/low English fluency population groups who are under-represented in the patient/client group population? Could this be due to access barrier/s? If so, what are these?

Equity

Response: What programs are currently undertaken to address the needs of non-English speaking background patient/client groups? Have they been evaluated to ensure they promote equity of resource allocation against identified needs?

Communication

Response: What processes of communication exist for patient/client groups with low English proficiency in general to assist in providing feedback on care?

Responsiveness

Response: What professional training and other strategies have been provided to hospital staff to ensure that they have diversity-responsive skills appropriate to their function? What is the level of training take-up by staff?

Effectiveness

Response: What indicators are collected and analysed, both clinical and non-clinical, to ensure that both provider and non-English speaking background patient/client group needs have been met by the services provided?

Efficiency

Response: Are comparisons made with English-speaking patient/client groups to ensure services are equally timely and resource-appropriate?

Accountability

Response: What mechanisms exist to promote and facilitate service scrutiny by non-English speaking background patient/client groups? How do the take-up rates compare between the non-English speaking background and English-speaking patient/client group ratios?

More resources can be found in the resource section of this Guide.

3.2 Stakeholder Identification and Advisory Committee Formation

The role of an Advisory Committee is to give support to the policy development process by providing specific expertise relevant to the policy area, stakeholder representation and decision-making support. Relevant stakeholders need to be identified to ensure representation and ownership of the process. In principle, all hospital areas affected by a particular policy (including patients) need to be represented. If there is limited internal expertise relating to non-English speaking background patient/client groups in the hospital, hospitals must seek external expertise.

Internal Stakeholders

- 1 Executive Representatives:** gaining the support of Executive Management is essential for relevant policy development. Executive stakeholders can provide a 'big picture' perspective regarding planning and service provision, as well as information on factors in the external policy and funding environment
- 2 Nursing Unit Managers and Nurse Educators:** as the largest single direct-service discipline in hospitals, nursing staff require representation to ensure policy implications on nursing care and nursing education regarding non-English speaking background patient/client groups is considered. It is important to include representation from hospital-based Home Nursing programmes to ensure the continuum of care is also addressed
- 3 Patient Representatives/Consumer Advocates:** will have an understanding of the nature of non-English speaking background patient/client group complaints
- 4 Medical Representatives:** medical practitioners require input into policy development to ensure that clinical issues, standards and training are addressed
- 5 Allied Health Representatives:** as with nursing and medical disciplines, allied health related non-English speaking background patient/client group issues need to be incorporated. In addition, many of the allied health practitioners work with community providers and with non-English speaking background patient/client groups in their homes, providing a valuable perspective for policy development external to the hospital and across the continuum of care
- 6 Language Services or Interpreting Representatives:** these stakeholders may be able to provide internal perspectives regarding patient/client groups with low English proficiencies, interpreter/translator accreditation and standards, and logistical issues
- 7 Ethnic Health Services Coordinators/Transcultural Coordinators:** if available, due to their expertise in working from an organisational systemic approach with non-English speaking background patient/client groups, Ethnic Health Coordinators can provide a detailed overview on how hospital systems may affect non-English speaking background patient/client groups, and have expertise in responding to their needs
- 8 Health Information Services Managers:** provide an important perspective on the management of patient/client group information, which can enhance the collection of accurate non-English speaking background patient/client group data to inform policy planning

9 Admission/Clerical Representatives: staff in these areas provide an additional perspective on the capacity to collect non-English speaking background patient/client group information during registration processes, and have valuable expertise on the initial experience of non-English speaking background patient/client groups entering the hospital system

External Stakeholders

External ethnic community representation is necessary when the policy under development has an impact on non-English speaking background communities accessing hospital services, or when internal expertise may be insufficient for the requirements of the policy to be developed. It is essential to be clear on how the external expertise is to be used, and what outcomes are expected from this involvement. It is essential to establish which communities will be consulted. Individual patients may not be able to be representative of either their own ethnic community, nor of other non-English speaking background communities. In such instances, consideration of non-English speaking background community advocates or representatives may be one strategy to provide more comprehensive expertise.

Additional sources of information on potential stakeholder representatives in the hospital catchment region can be obtained from:

- Non-English Speaking Background Stakeholders consult the Victorian Multicultural Resources Guide 2002/2003 available as a download from www.voma.vic.gov.au/domino/web_notes/voma/vomasite.nsf/Frameset/VOMA?OpenDocument under the publications directory with a complete listing of multicultural services in Victoria
- Ethnic Communities Council of Victoria who can advise on the local non-English speaking background community resources. The ECCV website can be accessed at www.eccv.org.au. The ECCV website has an Online Multicultural Services Directory that can be used to identify local ethnic service agencies and agencies across the state
- Regional Ethnic Community Councils for a listing access the Victorian Multicultural Resources Guide 2002/2003 or view the ECCV Online Multicultural Resources Directory
- Regional Migrant Resource Centres for a listing access the Victorian Multicultural Resources Guide or view the ECCV Online Multicultural Resources Directory
- Ethno-specific Service Agencies for a listing access the Victorian Multicultural Resources Guide or view the ECCV Online Multicultural Resources Directory
- National Resource Centre for Consumer Participation in Health (NRCCPH) the NRCCPH website can be accessed at <http://home.vicnet.net.au/~hissues/nrccph>

More resources can be found in the resource section of this Guide.

3.3 Policy Research and Drafting

The policy research phase involves an exploration of the available resources to identify what policy responses may be available and what legislative and government policy must be observed regarding the identified needs of non-English speaking background patient/client groups. Sources of information that can inform the policy research and drafting process include:

- **Language Services Policy**
‘Improving the Use of Translating and Interpreting Services: A Guide to Victorian Government Policy and Procedures’ - www.voma.vic.gov.au
- **Non-English speaking background service usage data**
such as the Victorian Admitted Episodes Dataset (VAED), the Victorian Emergency Minimum Dataset (VEMD) and interpreter usage data collected by the hospital
- **Feedback and Complaints Data**
- **Australian Bureau of Statistics Data**
(regional population perspective) - www.abs.gov.au
- **Department of Immigration, Multicultural and Aboriginal Affairs Website**
for information on recent arrivals - www.dimia.gov.au
- **Centre for Culture Ethnicity and Health**
for Victorian Public Hospital non-English speaking background patient/client group usage data for 2001 - www.ceh.org.au
- **Government Department Websites**
 - Health legislation - www.health.vic.gov.au/legislation/index
 - General index - www.health.vic.gov.au
 - Public Hospital Patient Charter outlines service provision, including language services and cultural sensitivity - <http://patientcharter.health.vic.gov.au>
- **Privacy Victoria Website**
includes comprehensive summaries of relevant legislation and links
www.privacy.vic.gov.au/dir100/priweb.nsf
- **Equal Opportunity Commission of Victoria’s Employers Responsibilities Section**
www.eoc.vic.gov.au/responsibilities/employers
- **Human Rights and Equal Opportunity Commission**
with specific sections for employers regarding sex and race discrimination and policy responses - www.hreoc.gov.au

More resources can be found in the resource section of this Guide.

3.4 Consultation and Policy Adoption

When undertaking policy draft consultations, it is necessary to identify what outcomes are required of the consultation, and who are the most appropriate stakeholders to consult with. It is important not only to consult managers but also staff whom the policy impacts on directly. Comprehensive consultation contributes to the policy implementation process, raising awareness of the policy amongst staff and increasing a sense of ownership.

Methods for consultation with staff can include:

- Circulating the policy via email bulletin or other organisation wide communication means and requesting feedback
- Introducing the policy at staff meetings and requesting verbal feedback
- Facilitating specific focus groups
- Interviews with individual staff

Direct non-English speaking background patient/client group consultation is vital where the policy impacts on service users need to be assessed. When consulting with non-English speaking background communities it is important to identify:

- Who to consult: individual consumers versus consumer representatives, small versus large communities, newly arrived versus established communities, gender and age considerations
- The best possible consultation method: interviews, focus groups, ethnic media, including radio
- What language support is required: budgets for and organisation of translation and interpreting

Community Advisory Committees that include non-English speaking background community representatives can advise on consultations. Migrant Resource Centres and regional Ethnic Communities Councils can provide local assessments of these needs and provide community contacts.

Both groups can be located via the Ethnic Communities Council of Victoria (www.eccv.org.au).

For more general information regarding consumer consultation the National Resource Centre for Consumer Participation in Health has information online (http://nrccph@latrobe.edu.au).

Interpreting services can assist to advise the most appropriate option regarding language support provision.

3.5 Policy Implementation

In order for a policy to be followed effectively, appropriate support procedures and a comprehensive communication strategy for staff and service users needs to be implemented.

Developing support structures

When a policy has been developed, appropriate strategies to support staff to implement it need to be established. This important aspect may involve:

- Allocating certain staff or departments to undertake a support role relating to a particular policy developed. For example: Who books interpreters? Who can help with consumer consultations?
- Providing information material. For example: an information sheet about interpreter booking procedure or order forms for specific ethnic meals ordering
- Budget allocation to ensure the policy can be implemented effectively

Distributing the policy

Feedback to ALL stakeholders who were consulted in earlier phases of the policy development is essential. A variety of means of distribution for new policies can be utilised. For staff, this can include distribution via internal communication structures:

- Email
- Newsletters
- Awareness weeks or days
- Presentations at staff meetings
- Posters
- Attaching policies to pay slips
- Targeted training for specifically concerned staff members

Non-english speaking background patients and communities may be informed through:

- Posters or brochures in English and relevant community languages
- Ethno-specific media, including local newspapers and radio
- Targeted correspondence to patients or organisations
- Events, such as forums or awareness days

3.6 Policy Evaluation and Review

Policy evaluation and review enables hospitals to assess the efficacy of the policy implementation and the principles developed to respond to the needs of non-English speaking background patient/client groups. Collating information about policy implementation and outcomes from a variety of sources and from different KPIs can give a comprehensive picture of how the policy has been used over time and how it has affected health outcomes for non-English speaking background patient/client groups.

The following considerations may assist in the policy evaluation process and identify areas for further action:

- Consumer feedback: collecting feedback from non-English speaking background patient/client groups allows for their continued participation in the policy process and indicates the real effects of the policy
- Review of internal or external policy or legislative changes affecting the policy area
- Staff feedback: in particular from staff who are directly affected
- Review of policy against developed performance measures: an analysis of data collection and performance indicators against expected policy outcomes for non-English speaking background patient/client groups. Evaluation includes assessing the cost-benefits of providing care in the methods arising from the policy

Once the evaluation has been completed, it is important to check with stakeholders, including non-English speaking background patients and community representatives, to ensure that any recommendations for changes to the policy are sound. Outcomes and recommendations from the evaluation may result in additional areas requiring a policy response. At this point, the cycle of policy development begins again.

4 Specific Policy Areas

4.1 Policy Area: Inclusive Planning, Infrastructure and Budgeting

Responding to the needs of non-English speaking background patient/client groups should be a 'whole-of-organisation' response.

Infrastructure, planning and budgeting considerations have significant implications for non-English speaking background patient/client groups. Indirect barriers or unintended outcomes are prevented through early recognition. When essential equipment such as speaker phones in consultation rooms, or non-denominational prayer spaces are not included in early planning, significant costs can be incurred.

Resources to meet the needs of non-English speaking background patient/client groups must be incorporated as a core component for all planning, infrastructure and budgeting. Measuring performance on this basis may include the development of specific key performance indicators relating to strategic directions of a hospital.

Key Considerations

The needs of non-English speaking background patient/client groups impact upon organisational planning, infrastructure and budgets in the following areas:

- Planning and budgeting for interpreter and translation costs in all care
- Infrastructure considerations such as three-way speaker telephone sets or portable telephone units with speakers to allow for the use of a telephone interpreter
- Data collection and distribution that includes such variables as Country of Birth and need for interpreter must be considered across all data collected
- Infrastructure requirements include ecumenical worship spaces and flexible interior design
- Consideration of providing for specific dietary needs, such as halal, kosher and vegetarian meals

The following areas need to be incorporated into budget estimates where relevant:

- Language services in direct service provision
- Translations of patient/client group information and multi-lingual service promotion
- Multi-lingual and symbol based signage
- Staff training in interpreter use and diversity competent service provision
- The use of interpreters and appropriate translated materials for consultations and patient/client group feedback activities

Measuring Performance

Examples of qualitative evaluation can include:

- Staff satisfaction with infrastructure to support diversity responsive practice
- Consumer feedback

Examples of quantitative indicators can include:

- Measure of decrease in delays in outpatient waiting times due to adequate timing of appointments when interpreters are required

Policy Checklist: Inclusive Planning, Infrastructure and Budgeting

Step	Requirements	Considerations
1 Need Identification	Effective communication	<ul style="list-style-type: none"> ▪ How are qualified interpreters accessed? ▪ How are language services managed? ▪ How are language services budgeted? ▪ How are telephone interpreter services accessed? ▪ Is there access to three-way speakerphones in all consulting areas? ▪ What assistance is given to patients with Low English Fluency (LEF) to find their way about the hospital? ▪ What sort of signage exists and in what languages? ▪ Is there a handout with locations available? ▪ Do patients receive internally produced written health information (e.g. translated service brochures and appointment letters)? ▪ Do patients receive externally produced written health information?
	Welcoming Environment	<ul style="list-style-type: none"> ▪ How are patients made to feel welcome? ▪ Are there bi-lingual reception staff? ▪ Is the interior design suitable? ▪ Are there welcome signs in different languages?
	Patients' dietary needs are met	<ul style="list-style-type: none"> ▪ How are individual patients' specific dietary needs identified (e.g. access to Kosher, Halal, Hindu, vegetarian and other culturally specific cuisines)?
	Patients' spiritual needs are met	<ul style="list-style-type: none"> ▪ What provision is made for pastoral care? ▪ How are religious leaders accessed? ▪ Are there non-denominational prayer spaces within the hospital?
2 Stakeholder Identification & Advisory Committee Formation	Internal consultation & advice	<ul style="list-style-type: none"> ▪ Who are the internal stakeholders? (Executive Management, CAC, Internal infrastructure and IT departments, ▪ Who are the external stakeholders? (Regional Ethnic Community Council, Migrant Resource Centres, ethno-specific organisations) ▪ How will issues be raised with stakeholders?
	External consultation & advice to be considered	<ul style="list-style-type: none"> ▪ How will stakeholder group deliberations be incorporated? ▪ How will the Committee's program be implemented (e.g. emails, meetings, information gathering, individual consultations)?
3 Research & Policy Drafting	Identify internal data	<ul style="list-style-type: none"> ▪ What type of data is necessary to inform the policy development (e.g. age, country of birth, preferred language, year of arrival)? ▪ What departments within the hospital are responsible for data collection?
	Identify external data	<ul style="list-style-type: none"> ▪ How is this data accessed? ▪ What external data will assist in informing the policy (e.g. ABS, DIMIA newly arrived immigrants, Centrelink, VOMA)?
	Determine budget implication	<ul style="list-style-type: none"> ▪ What are the cost implications? ▪ What internal funding is available (e.g. infrastructure grants)? ▪ What external funding is available?
	Identify work undertaken in other hospitals	<ul style="list-style-type: none"> ▪ Have solutions already been found in similar environments? (Innovative projects in similar hospitals) ▪ What can be learnt from other people's successes/failures?
4 Consultation & Policy Adoption	Appropriateness of policies	<ul style="list-style-type: none"> ▪ Which stakeholders are the most appropriate to be consulted? ▪ How will stakeholders be consulted (e.g. newsletter, patient focus groups, staff focus groups, posters, awareness week)?
	Ownership of stakeholders	
5 Implementation	Adherence to policies	<ul style="list-style-type: none"> ▪ How will staff be informed about the policy? ▪ What measures will be implemented to ensure adherence to policies?
6 Evaluating Effectiveness	Impact on access	<ul style="list-style-type: none"> ▪ How will policy application be evaluated and reviewed?
	Impact on quality	<ul style="list-style-type: none"> ▪ How will patient and staff satisfaction be measured?

4.2 Policy Area: Inclusive Data Collection and Data Use

Accurate, useful data can assist a hospital to plan appropriately and effectively negotiate adequate levels of funding for service provision. While some information on country of birth and language is collected, Victorian hospital data collection remains largely uncoordinated and is often not accessible for relevant staff.

The incorporation of non-English speaking background data indicators in all activities, including research, patient/client group satisfaction and quality improvement can provide a rich source of planning information. Data collection on language preference facilitates efficient service provision by enabling the appropriate interpreter to be booked in advance and the relevant language services to be provided. Service usage is an important information source for service planners and should be a priority for hospitals.

The Federal Government has published a comprehensive set of standards that can be used to standardise data collection in relation to language need and ethnicity,

www.dima.gov.au/multicultural/_inc/publications/statistics_guide/index¹.

The Victorian Dataset² includes:

- Country of Birth
- Preferred language
- Need for interpreter
- Indigenous status

Key Considerations

Adherence to Department of Human Services policy guidelines is necessary, yet it is possible to improve the information collected. Inclusion of data items such as religion, gender, age, language, interpreter required, etc in performance reports can assist in identifying issues that may be specific to a certain patient group. Ensuring that staff are skilled to elicit accurate information from all patient/client groups is important. Issues requiring consideration include:

- Assessment of current data collection, accuracy and use in the hospital
- Identification of future data needs to guide the policy
- Incorporation of reporting requirements (consider also privacy legislation)
- Staff training in collection and entry of accurate data
- Mechanisms of quality control to ensure that the data collected is accurate over time
- Using hospital accessed data to compare with catchment area

Measuring Performance

Examples of qualitative evaluation can include:

- Staff satisfaction with accessibility of relevant data

Examples of quantitative indicators can include:

- Measure of decrease in incorrect data collection (i.e. people recorded as not needing an interpreter when later they did)
- Percentage of admission staff trained in cross cultural communication

Policy Checklist: Inclusive Data Collection and Data Use

Step	Requirements	Considerations
1 Need Identification	Reporting requirements (consider also privacy legislation)	<ul style="list-style-type: none"> What data needs to be collected (e.g. Country of Birth, language, religion, age)? Where is the data sourced? How is the data collected? Who collects the data? Who receives reports on data? How is the data used?
	Additional requirements	<ul style="list-style-type: none"> What other areas require statistical information (e.g. research, service planning)?
	Staff training	<ul style="list-style-type: none"> How do staff acquire the necessary skills (e.g. working with interpreters, identifying language needs)? How are staff informed about changes in data collection?
	Data Quality	<ul style="list-style-type: none"> How are data errors recognised and amended?
2 Stakeholder Identification & Advisory Committee Formation	Internal consultation & advice	<ul style="list-style-type: none"> Who are the internal stakeholders (e.g. Executive, Management, Health Information Services/Medical Records Admission, Outpatients, Bookings, IT Department, Department of Human Services, Regional Ethnic Community Council, Migrant Resource Centres)? What input is required from the Advisory Committee? How will the Committee work (e.g. emails, meetings, information gathering, individual consultations)?
	External consultation & advice to be considered	
3 Research & Policy Drafting	Identify statutory requirements & other needs	<ul style="list-style-type: none"> What are the minimum requirements (e.g. Department of Human Services reporting, Annual Report)?
	Identify systems capabilities & gaps	<ul style="list-style-type: none"> What can the current system do? How can the current system be improved to meet need? Are other systems/procedures are required?
	Determine resource implication	<ul style="list-style-type: none"> What are the cost implications? What are the training implications? Who is responsible for policy implementation?
	Identify resources available	<ul style="list-style-type: none"> Who can develop data reports? Who can provide staff training?
4 Consultation & Policy Adoption	Appropriateness of policies	<ul style="list-style-type: none"> Which stakeholders will be consulted? Is there a resource implication for IT department, Department of Human Services? How will stakeholders be consulted (e.g. interviews, focus groups)?
	Ownership of stakeholders	
5 Implementation	Adherence to policies	<ul style="list-style-type: none"> Who will be informed about the policy? How will people be informed (e.g. training, internal newsletter)?
6 Evaluating Effectiveness	Impact on access	<ul style="list-style-type: none"> How will access, use of space and facilities, etc. be measured? What Key Performance Indicators are in place?
	Impact on quality	<ul style="list-style-type: none"> How will patient and staff satisfaction be measured (e.g. surveys, focus groups)?

¹ Commonwealth Interdepartmental Committee on Multicultural Affairs (2001), The Guide: Implementing the Standards for Statistics on Cultural and Language Diversity, www.dima.gov.au/multicultural/_inc/publications/statistics_guide/index

² www.hdss.health.vic.gov.au

4.3 Policy Area: Inclusive Consumer Participation

The participation of non-English speaking background patient/client groups in hospital planning, development and evaluation is a vital source of information and ensures that service responses are inclusive of non-English speaking background patient/client group needs. Such information provides a perspective on how overall hospital services, infrastructure and processes affect non-English speaking background patient/client groups and what their specific needs may be. It is important to decide whether direct consultation is required, and how such participation can be representative of all patient/client groups.

Key Considerations

When considering non-English speaking background consumer participation in hospital planning and service evaluation, the underlying principal is equal participation and representation of non-English speaking background communities. It is important to identify exactly what is required of participants, how participation can be facilitated, and to be clear on what can be reasonably expected of participants. In some areas non-English speaking background community representatives may be better informed about community needs than individual consumers, and on other occasions, non-English speaking background consumers themselves will provide the most useful perspective. Sometimes a combination is required.

Key areas for ongoing non-English speaking background consumer participation and feedback are:

- Hospital Board
- Community Advisory Committees
- Consumer Feedback strategies
- Complaint mechanisms
- Consumer input in specific projects, such as service planning or resource development

The following considerations may assist in the development of an inclusive consumer participation policy:

- Identify how and when non-English speaking background patient/client group participation is required
- Identify how consultation with consumers who have low English proficiency will be facilitated
- Ensure that consultations and translated materials are accessible in preferred languages of those participating
- Ensure that all processes are gender-sensitive
- Consider appropriate practical support such as travel remuneration, child-care support, disability access and timing for workers

Specific mechanisms to enable non-English speaking background consumer representation include:

- Consider portfolio development within the Community Advisory Committee
- Consider subcommittee of the Board/Community Advisory Committee or specific staff Cultural Diversity Committee

- Translated or interpreted patient/client group satisfaction surveys
- Language specific consumer focus groups
- Accessible suggestions and complaints processes that encourage non-English speaking background patient/client groups to communicate in their preferred language

It may be necessary to target consultations with specific communities where additional barriers exist.

Measuring Performance

Examples of quantitative indicators can include:

- Measuring membership on consumer committees against patient demographics
- Measuring participation in feedback strategies against patient demographics
- Measuring proportion of complaints data against patient demographics

Policy Checklist: Inclusive Consumer Participation

Step	Requirements	Considerations
1 Need Identification	Representation of patient population in consumer participation	<ul style="list-style-type: none"> How can equitable representation be achieved (e.g. representation on existing committees, creation of new committees, developing of portfolios in existing committees)? Who is not represented/who needs to be represented (e.g. people with low English Fluency, established communities, newly arrived communities, carers)?
	Representation of patient population in consumer feedback strategies	<ul style="list-style-type: none"> Are current feedback strategies accessible? How can feedback strategies used be made inclusive (e.g. interpreters, gender and ethno specific strategies)?
	Feedback mechanisms accessed by all patient groups	<ul style="list-style-type: none"> Is the current complaints system accessible?
2 Stakeholder Identification and Advisory Committee Formation	Internal consultation	<ul style="list-style-type: none"> Who are the internal stakeholders (e.g. Executive, Management, CAC Coordinator, Patient Complaints Manager)? Who are the external stakeholders (e.g. Regional Ethnic Community Council, Migrant Resource Centres, ethno-specific service providers, special interest groups)? What input is required from the Advisory Committee? How will the Committee work (e.g. emails, meetings, information gathering, individual consultations)?
	External consultation & advice	
3 Research & Policy Drafting	Identify existing participation & feedback structures	<ul style="list-style-type: none"> What participation structure exists? Is there equitable participation? What are the identifiable gaps?
	Comparison of current representation with patient/regional demographics	<ul style="list-style-type: none"> Are there patient groups that participate to a lesser degree (e.g. newly arrived, women, young people, low English fluency)?
	Determine resource implication	<ul style="list-style-type: none"> What are the budget implications? What are the training implications? Who is responsible for policy implementation?
	Identify resources available	<ul style="list-style-type: none"> What structures have been effective in similar organisations? How can this experience be accessed and applied? What external agencies might assist?
4 Consultation & Policy Adoption	Appropriateness of policies	<ul style="list-style-type: none"> Which stakeholders will be consulted (e.g. Management Board, Executives, CAC, external agencies, patients)?
	Ownership of stakeholders	<ul style="list-style-type: none"> How will stakeholders be consulted (e.g. interviews, focus groups)?
5 Implementation	Adherence to policies	<ul style="list-style-type: none"> Who will be informed about the policy (e.g. all staff, patients)? How will people be informed (e.g. training, internal newsletter)?
6 Evaluating Effectiveness	Impact on access	<ul style="list-style-type: none"> How will representation be measured (e.g. numbers of non-English speaking background representatives on committees, percentage of non-English speaking background patients participating in feedback mechanisms)?
	Impact on quality	<ul style="list-style-type: none"> How will effectiveness be measured (e.g. surveys, focus groups)?

Consideration should be given to the mix of on-site, externally contracted and telephone-based interpreters that best meet the language needs of each hospital and its patient/client group population.

This policy area may require significant staff training in the use of interpreters and how to access language services in the hospital. Language service and interpreter training needs to be part of all staff orientations and should be refreshed regularly.

Initial Contact

Language and other specific needs must be collected from the point that a patient/client group is first referred. To maximise this response, it is important to ensure that all staff are trained to gain the necessary language and other specific needs from patient/client groups or their referrers. First contact encompasses direct and indirect contact, such as telephone and facsimile-based referrals.

The promotion of language services needs to be included on all patient/client group information, and an education strategy for frequent patient/client group referrers to ensure they are aware how to communicate patient/client group language needs to the hospital can assist in the effective implementation of the policy.

Measuring Performance

Examples of qualitative evaluation can include:

- Staff and consumer satisfaction with language services

Examples of quantitative indicators can include:

- Percentage of patients who are recorded as requiring an interpreter receiving language services
- Measure of decrease in unplanned late notice interpreter request against increase in planned interpreter bookings

Policy Checklist: Language Services

Step	Requirements	Considerations
1 Need Identification	Definition of patient right to an interpreter	<ul style="list-style-type: none"> Who has access to interpreters? Who assesses interpreter need?
	Interpreter qualification	<ul style="list-style-type: none"> What qualifications do interpreters need (e.g. NAATI level 3)? What happens when qualified interpreters are not available for certain languages (e.g. newly emerging communities, small patient groups)?
	Protecting bi-lingual staff & family members	<ul style="list-style-type: none"> How can the organisation make sure that bi-lingual staff and family members are not used inappropriately?
	Effective management of language services	<ul style="list-style-type: none"> In what manner will interpreter services be provided? Who are possible providers (e.g. in-house, CHIS, Translating & Interpreting Service (TIS), Victorian Translating and Interpreting Service (VITS), private providers)? How will telephone interpreting be facilitated (e.g. three-way speakerphones in all consulting areas)? How will language services (including budget) be managed?
	Resource implications	<ul style="list-style-type: none"> What are budget implications (e.g. increased consultation time, cost of interpreter services)? What impact does lack of language services have on hospital management (e.g. informed consent, increased length of stay, poor adherence to treatment)?
2 Stakeholder Identification & Advisory Committee Formation	Internal consultation & advice	<ul style="list-style-type: none"> Who are the internal stakeholders? (e.g. Executive Management, management, clerical staff, medical staff Nursing staff, Language service providers)
	External consultation & advice to be considered	<ul style="list-style-type: none"> What input is required from the advisory committee? How will the committee work (i.e. emails, meetings, information gathering, individual consultations)
3 Research and Policy Drafting	Identify need	<ul style="list-style-type: none"> What languages are required and how often? Is data to determine need collected from both internal sources and external agencies (e.g. Australian Bureau of Statistics, Migrant Resource Centres)?
	Determine budget implication	<ul style="list-style-type: none"> What are the current resources? What are the unmet resource needs? Who is responsible for policy implementation?
4 Consultation & Policy Adoption	Appropriateness of policies	<ul style="list-style-type: none"> Which stakeholders will be consulted? How will stakeholders be consulted (e.g. newsletter, patient focus groups, staff focus groups, posters, awareness week)?
	Ownership of stakeholders	
5 Implementation	Adherence to policies	<ul style="list-style-type: none"> Who will be informed about the policy (e.g. staff, patients)? How will people be informed (e.g. email, internal newsletter, patient focus groups, staff focus groups, posters, awareness week)?
6 Evaluating Effectiveness	Impact on access	<ul style="list-style-type: none"> How will access be measured? What are the Key Performance Measures?
	Impact on quality	<ul style="list-style-type: none"> How will patient and staff satisfaction be measured (e.g. surveys, focus groups)?

4.5 Policy Area: Specific Cultural or Religious Requirements

Responding to specific cultural and religious needs has significant positive effects upon patient/client group health outcomes, including reduced bed days, stress reduction associated with care, increased treatment regime compliance and greater patient/client group participation in their health care decisions. It is also required by government policy (Victorian Patient Charter).

This area of policy development requires targeted community consultation and external advice on how to incorporate organisational flexibility to respond to diverse ethno-cultural or religious needs. Community consultation may be beneficial in providing feedback to the hospital on how it is currently perceived, and which areas may be a priority to address for various non-English speaking background communities.

Key Considerations

Due to the potential breadth of this policy area, and the likelihood that implementation would be over time, it is important to identify strategic priorities. Some areas may require additional infrastructure funding, as well as funding for consultancies to gain the required expertise. A staged implementation plan would therefore be most likely, with areas of high priority addressed early in the process. Many of the suggestions below can be applied to the needs of all patients, and are not always considerations common to one group or another. Assessment of specific needs must occur with each patient/client group.

Key areas to address include:

- Dietary requirements, e.g., Kosher, Halal, Hindu, ethno-specific and vegetarian
- Communication strategies that incorporate non-English speaking background patient/client group needs and the needs of people with low English proficiency
- Appropriate consideration of gender-sensitive care across all areas of service provision
- Multi-faith religious observance spaces
- Options for appropriate spiritual support and pastoral care as required
- Recognition of a variety of religious/spiritual holidays
- Organisational awareness of religious restrictions, e.g., use of blood products or fasting (this may also apply to certain medications)
- Multi-lingual and symbol-based signage and information throughout the hospital

Measuring Performance

Examples of qualitative evaluation can include:

- Non-English speaking background patient satisfaction with meals, provision of pastoral care, etc.
- External stakeholders survey of perception of culturally appropriate care options at the hospital
- Availability of culturally appropriate alternative interventions (gender specific providers, pork-product free medication, etc.)

Examples of quantitative indicators can include:

- Uptake rates of diverse meal options, spiritual care support

Policy Checklist: Specific Cultural or Religious Requirements

Step	Requirements	Considerations
1 Need identification	Patients dietary needs are met	<ul style="list-style-type: none"> How are individual food considerations identified (e.g. Access to Halal, Kosher, Vegetarian or other culturally specific cuisines)?
	Patients cultural needs are met	<ul style="list-style-type: none"> How are cultural needs identified? What access is there to gender specific care? What access is there to medication that does not contain cultural taboo products? What recognition is there of the impact on religious/cultural holidays on health (e.g. fasting, physical restrictions)?
	Patients spiritual needs are met	<ul style="list-style-type: none"> What provision is made for pastoral care? How are religious leaders accessed? Are there non-denominational prayer spaces within the hospital?
	Welcoming Environment	<ul style="list-style-type: none"> How are patients made to feel comfortable? Are there bi-lingual reception staff? Is there a welcoming interior design? Are there welcome signs in different languages clearly displayed?
2 Stakeholder Identification & Advisory committee formation	Internal consultation & advice	<ul style="list-style-type: none"> Who are the internal stakeholders (e.g. Executive, Management, CAC, Internal Infrastructure and IT Departments)? Who are the external stakeholders (e.g. Regional Ethnic Community Council, Migrant Resource Centres, ethno-specific organisations)? How will issues of concern be raised with stakeholders? How will stakeholder group deliberations be incorporated? How will the Committee's program be implemented (e.g. emails, meetings, information gathering, individual consultations)?
3 Research & Policy Drafting	External consultation & advice to be considered	<ul style="list-style-type: none"> What type of data is necessary to inform the policy development (e.g. age, country of birth, preferred language, religions, year of arrival)? What external data will assist in informing the policy (e.g. ABS, DIMIA newly arrived immigrants, Centrelink, VOMA)? What other resources exist to support the policy? Are there spaces that could be converted? Is it possible to make arrangements with external food providers? What external organisations are willing to help?
	Identify internal data/resources	
4 Consultation & Policy Adoption	Identify external data/resources	<ul style="list-style-type: none"> What are the cost implications? Which internal funding is available? (Infrastructure grants) Which external funding is available?
	Determine budget implication	
	Identify work undertaken in other hospitals	<ul style="list-style-type: none"> Have solutions already been found in similar environments? (Innovative projects in similar hospitals)
	Appropriateness of policies	<ul style="list-style-type: none"> Which stakeholders are the most appropriate to be consulted (e.g. external bodies, patients carers, religious leaders)? How will stakeholders be consulted (e.g. newsletter, focus groups, posters)?
5 Implementation	Ownership of stakeholders	<ul style="list-style-type: none"> How will staff be informed about the policy? What staff training will be required? What measures will be implemented to ensure adherence to policies?
	Adherence to policies	
6 Evaluating Effectiveness	Impact on access	<ul style="list-style-type: none"> How will policy application be evaluated and reviewed?

4.6 Policy Area: Inclusive Staff Employment, Orientation and Training

The active promotion and development of a culturally diverse workforce creates a rich source of expertise that can greatly improve the responsiveness of the hospital to its diverse patient/client groups. Staff development, training and orientation is necessary to ensure that all staff have the required skill bases in diversity-responsiveness from the first day and should be refreshed regularly.

Key Considerations

Employment, orientation and training policies are primarily internally focussed. The promotion of the organisation as an Equal Employment Opportunity (EEO) employer and of the hospital's commitment to diversity-responsiveness across its activities and employment practices does, however, involve components of external promotion. The inclusion of EEO and inclusive statements in all information and promotional documents such as employment advertisements are examples of this. Incorporating a progress report regarding the organisation's ongoing development of a diverse and diversity competent workforce should also be included in annual reports.

Employment

- Incorporate affirmative action employment strategies to encourage a generally diverse hospital workforce across all levels
- Identify populations that may require targeted employment strategies to employ ethno-specific workers, e.g. large volume communities or communities having difficulty accessing the organisation, as one avenue to facilitate responsiveness to specific needs
- Ensure that all staff take equal responsibility for diversity-responsiveness, and incorporate this expectation in all position descriptions and employment advertisements
- Team building activities that focus on diversity in the workforce

Potential external sources of expertise and advice regarding employment issues include the DHS Workforce Development Unit and the Equal Opportunity Commission.

Orientation

- Incorporate diversity competency into orientation and continuing professional education programs
- Ensure that relevant staff are fully trained in the use of interpreters, the organisational policies and cross-cultural communication, with these expectations being linked to individual employment appraisal processes
- Ensure that policies are of ongoing relevance and that all new employees are trained at the earliest possible time to ensure that competent service is consistently provided

Training

- Arrange education and training for staff relevant to their duties and professional responsibilities, and organise training accordingly e.g. nursing, medical and allied health staff, reception staff and all Emergency Department staff
- Develop and implement an ongoing training system that can be sustained and developed to meet organisational needs over time

Measuring Performance

Examples of qualitative evaluation can include:

- Consumer feedback on staff performance regarding diversity competency
- Staff peer assessment and self assessment

Examples of quantitative indicators can include:

- Percentage of staff who have participated in cultural diversity training and working with interpreters

Indicators of workforce diversity (country of birth, speaking language other than English at home) across all levels and in all areas.

Policy Checklist: Inclusive Staff Employment, Orientation and Training

Step	Requirements	Considerations
1 Need Identification	Affirmative action in employment	<ul style="list-style-type: none"> How are staff from non-English speaking backgrounds encouraged to apply for hospital jobs? How are staff from non-English speaking backgrounds encouraged to remain in the organisation?
	Awareness of policies	<ul style="list-style-type: none"> How are policies made available to staff?
	Skills to implement policies	<ul style="list-style-type: none"> How are staff resourced to adhere to policy? What additional training is required?
	Managing staff diversity	<ul style="list-style-type: none"> Are there programs that assist staff to work in a multicultural workforce?
2 Stakeholder Identification & Advisory Committee Formation	Internal consultation & advice	<ul style="list-style-type: none"> Who are the internal stakeholders (e.g. Human Resources, Training and Education staff, Unit Manager)? Who are the external stakeholders (e.g. professional bodies)?
	External consultation & advice to be considered	<ul style="list-style-type: none"> How will issues of concern be raised with stakeholders? How will stakeholder group deliberations be incorporated? How will the Committee's program be implemented (e.g. emails, meetings, information gathering, individual consultations)?
3 Research & Policy Drafting	Identify internal HR standards	<ul style="list-style-type: none"> What type of data is necessary to inform policy development (e.g. age, country of birth, preferred language, year of arrival)?
	Identify external resources	<ul style="list-style-type: none"> What departments within the hospital are responsible for the collection? How is this data accessed? What external data will assist in informing the policy (e.g. ABS, DIMIA newly arrived immigrants, Centrelink, VOMA)?
	Determine budget implication	<ul style="list-style-type: none"> What are the cost implications (e.g. training and HR budget allocations)? What internal funding is available? Which external funding is available (e.g. Workcover, DHS grants)?
	Identify work undertaken in other hospitals	<ul style="list-style-type: none"> Have solutions already been found in similar environments? (Identify innovative projects in similar hospitals). What can be learnt from other people's successes/failures?
4 Consultation & Policy Adoption	Appropriateness of policies	<ul style="list-style-type: none"> Which stakeholders are the most appropriate to be consulted?
	Ownership of stakeholders	<ul style="list-style-type: none"> How will stakeholders be consulted (e.g. newsletter, staff focus groups, posters, awareness week, awards)?
5 Implementation	Adherence to policies	<ul style="list-style-type: none"> How will staff be informed about the policy? What measures will be implemented to ensure adherence to policies?
6 Evaluating Effectiveness	Impact on access	<ul style="list-style-type: none"> How will policy application be evaluated and reviewed?
	Impact on quality	<ul style="list-style-type: none"> How will staff satisfaction be measured?

Resources

Victorian and Hospital Demographics

Defining Health

Responding to Language Needs

- When is an interpreter needed?
- How can you tell if a person's English is adequate for the situation?
- Interpreter Booking Checklist
- Working with an Interpreter Onsite

Information Sheet on Countries and Languages Spoken

Cultural Competency Checklist

Migrant Resource Centres

Regional Ethnic/Migrant Communities' Councils

Data Resources

Resource Documents

- General
- Language
- Data Collection
- Services
- Specific Groups

Internet Resources

- Consumer Resources
- Health Accreditation and Quality Resources
- Health Information Resources
- International Health and Human Rights Resources
- Language and Translation Resources
- Legislative Resources
- Mental Health Resources
- Multicultural Resources
- Policy Resources
- Population and Statistical Resources

Consumer Consultation

Top Ten Non-English Speaking Background Countries of Birth for Victoria and Victorian DHS Metropolitan and Rural Regions

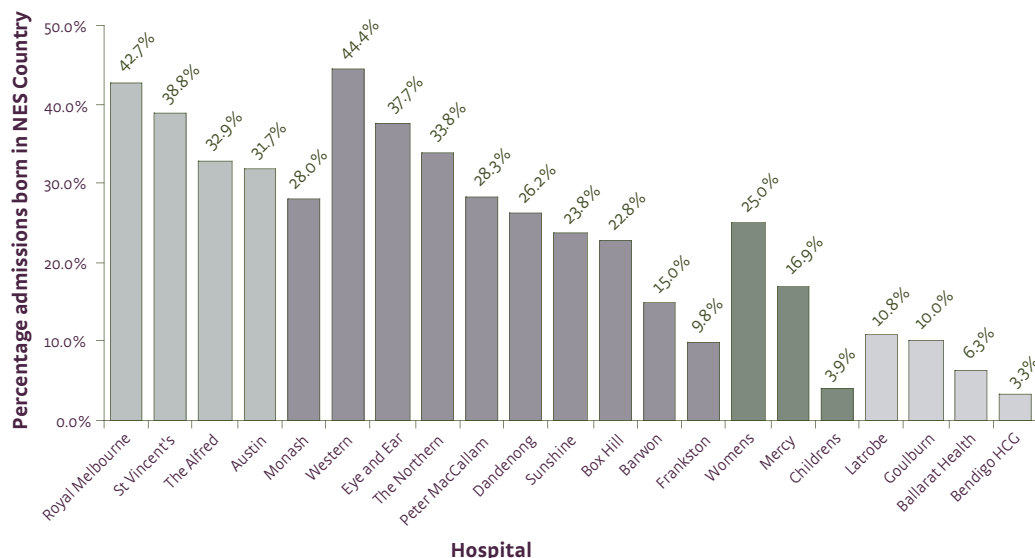
VICTORIA		EASTERN		SOUTHERN		NORTHERN		WESTERN	
Italy	90,056	China*	15,698	Greece	13,820	Italy	35,756	Viet Nam	25,570
Greece	57,595	Italy	15,350	Viet Nam	13,658	Greece	19,459	Italy	25,570
Viet Nam	56,563	Greece	14,406	Italy	11,502	Viet Nam	9,853	Malta	12,070
China*	36,791	Malaysia	12,575	Sri Lanka	11,292	Macedonia	8,974	Philippines	7,959
India	30,628	Hong Kong*	9,199	India	11,165	Turkey	8,561	Greece	7,889
Germany	28,704	India	8,712	China*	8,516	Lebanon	7,993	Macedonia*	6,980
Sri Lanka	26,556	Sri Lanka	7,864	Poland	8,246	China*	6,681	Croatia	6,156
Malaysia	24,713	Germany	7,166	Germany	7,504	Malta	5,178	Yugoslavia*	5,785
Netherlands	23,503	Viet Nam	6,728	Netherlands	6,217	India	4,670	China*	4,951
Philippines	22,474	Netherlands	6,132	Yugoslavia*	5,878	Sri Lanka	4,406	India	4,856

BARWON		GIPPSLAND		GRAMPIANS		HUME		LODDON MALLEE	
Netherlands	2,605	Netherlands	2,375	Netherlands	1,108	Italy	3,265	Italy	1,748
Italy	2,473	Italy	1,947	Germany	737	Germany	1,565	Germany	925
Germany	2,098	Germany	1,579	Italy	509	Netherlands	1,284	Netherlands	765
Croatia	1,794	Malta	663	Malta	256	Philippines	498	Turkey	563
Yugoslavia	1,318	Philippines	528	Croatia	240	Yugoslavia	471	Greece	469
Macedonia*	876	Poland	405	Yugoslavia*	236	Greece	417	Philippines	354
Poland	835	Yugoslavia*	325	Philippines	225	Turkey	373	Malta	300
Philippines	660	Greece	322	Greece	187	Croatia	340	Yugoslavia*	279
Greece	626	Malaysia	228	India	180	Poland	324	Croatia	253
Malta	443	India	218	Poland	170	India	316	India	197

Table constructed by Totikidis (2003) – from Australian Bureau of Statistics Basic Community Profiles (2002; based on 2001 Census data).

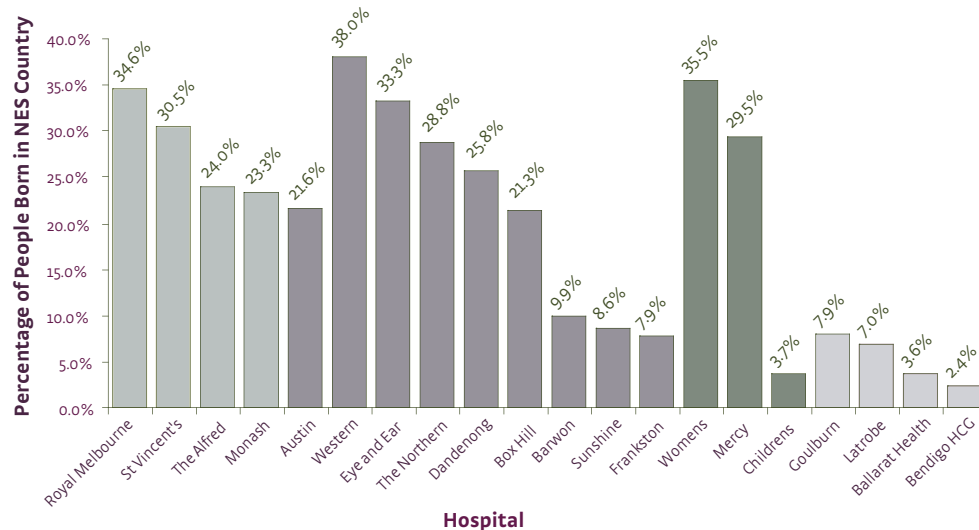
*See Appendix A for further details regarding these countries.

Figure 1
Summary of NES COB* Admissions in Selected Victorian Hospitals



Note
 Graph constructed by Totikidis (2003) from Department of Human Services 01-02 Victorian Admitted Episode Dataset (2002a)
 *NES COB: Non-English Speaking Country of Birth. Columns colour coded according to DHS (2002b) hospital classifications. L to R: A1, A2, HWC, B1. Note that the Children's hospital is an A1 hospital and the Mercy and Royal Women's are A2 hospitals and that HWC is not a DHS term. The term was added by the present author to distinguish Women's & Children's hospitals.

Figure 2
Summary of NES COB* Emergency Presentations in Selected Victorian Hospitals



Note
 Graph constructed by Totikidis (2003) from Department of Human Services 01-02 Victorian Emergency Minimum Dataset (2002)
 *NES COB: Non-English Speaking Country of Birth. Columns colour coded according to DHS (2002b) hospital classifications. L to R: A1, A2, HWC, B1. Note that the Children's hospital is an A1 hospital and the Mercy and Royal Women's are A2 hospitals and that HWC is not a DHS term. The term was added by the present author to distinguish Women's & Children's hospitals.

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Department of Human Services, Victoria (2002a). *VEMD & VAED Extract 1999-2002 (YTD)*. (CD prepared for CEH by the Information Analysis Unit).
 Totikidis, V. (2003). *Centre for Culture, Ethnicity and Health: An Overview of Data Related to Cultural and Linguistic Diversity in Victoria and the Acute Hospital System* (Unpublished Report).
 Australian Bureau of Statistics (2002). *Basic Community Profile Series*. Drawn from the Australian Bureau of Statistics 2001 Census of Population and Housing. Melbourne: Commonwealth of Australia.
 Department of Human Services, Victoria (2002b). *Victorian Hospital Information Services. The 1997/98 Victorian Hospital Comparative Data Report: Key Comparative Measures*. Retrieved 23.06.03: http://aimsinfo.health.vic.gov.au/VHCD/VHCD199798/key_comparative_measures.asp

Defining Health

Health as a Human Right

The Declaration of Alma Ata defines health as

...a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal where realisation requires the action of many other social and economic sectors in addition to healthcare.¹

Policy development in health care occurs within the context of international organisations such as the United Nations (UN) and the World Health Organisation (WHO). These bodies provide policy direction to the international community and domestic governments with Australia's Federal and State health policies being developed under these common international frameworks and standards. Definitions of health derived from these bodies² are also relevant to local hospital-level policy development when responding to the needs of patient/client groups from non-English speaking backgrounds.

Health is considered a human right. One major international goal concerning health is the promotion and realisation of health equity for all people.³ As such, a broad definition of health has been adopted by both the World Health Organisation and the United Nations.

The right to health is understood as:

The right to an enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.⁴

Inequalities in health are based on structural and social inequities informed by discrimination. In response, an international human rights framework has been adopted to identify, analyse and respond to such inequities.⁵

This framework includes a list of essential prerequisites to achieve the highest possible level of health as outlined in the Ottawa Charter for Health Promotion.⁶ These include:

- Peace
- Shelter
- Education
- Food
- Income
- A stable eco-system
- Sustainable resources
- Social justice and equity

The prerequisites for optimal health involve a number of common challenges internationally that impact on national and local health care, including at the level of hospital policy development. These include:⁷

- Equitable resource distribution
- Achieving healthy working/living situations
- Collaboration across different levels of government

- The use of health care technology advances that help populations and do not hinder the equitable attainment of optimum health for all members of a population

Health service provision needs to be available, accessible, acceptable, of high quality, non-discriminatory and equitable.⁸ These considerations inform both Federal and State government policy stances and are of ongoing relevance to hospitals and the communities they work with.

¹ International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978: *Declaration of Alma-Ata*.

² *Mexico Ministerial Statement on Health Promotion: Framework for Countrywide Plans of Action for Health Promotion*.

³ United Nations Economic and Social Council (2000) Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights: General Comment # 14 (2002): The right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights).

⁴ World Health Organisation (2001) *WHO's Contribution to the World Conference Against Racism, Facial discrimination, Xenophobia and Related Intolerance: Health and freedom from discrimination*.

⁵ First International Conference on Health Promotion, Ottawa, 21.11.86: *Ottawa Charter for Health Promotion*.

⁶ Conference Statement of the 2nd International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988: *The Adelaide Recommendations*.

⁷ United Nations Economic and Social Council (2000) Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights: General Comment No. 14 (2002): the right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights).

Responding to Language Needs

1 When is an interpreter needed?¹

A hospital environment can be very stressful for patients, and much of the language used is specific to healthcare. If a person is experiencing stress or is faced with unfamiliar language, their capacity to communicate in a second language is greatly diminished.

An interpreter may be needed in the following situations:

- The patient exhibits no understanding or effective use of English.
- The patient is able to communicate in English but in a limited capacity.
- Where the patient is able to communicate in English but is more comfortable with her/his own language.
- The patient is under stress, which may hinder her/his ability to communicate adequately in English.
- When undertaking any health assessment.
- When communicating any information affecting the patient (e.g. information about the health of the patient, information about prescribed drugs, consent to treatment or hospital admission).
- When providing patients/client groups with information about entitlements rights and responsibilities.
- When conducting any formal interview.

2 How can you tell if a person's English is adequate for the situation?²

Ask the person if they require an interpreter. If the person declines but you remain uncertain whether their competency in English is adequate for the situation, try the following approaches. Remember that the interpreter is available for your benefit as much as the other person:

- Ask questions that require the person to answer in a sentence rather than with a "Yes" or a "No" response.
- Ask the person to repeat in their own words what you have said to them.
- If you feel that an interpreter is needed, suggest that you would like to arrange an interpreter, if only to assist you with your own understanding.

3 Interpreter Booking Checklist³

When booking an interpreter the following information will assist in identifying the most effective interpreter for the situation:

- The language or dialect required.
- The gender of the interpreter. (This is applicable in gender sensitive cases. You may also need to consider the ethnic or religious background of the interpreter).
- The name of the patient requiring an interpreter.
- The date, time and anticipated duration of the interview.
- The name of the person that the interpreter is to report to upon arrival.
- The correct address for the assignment, including specific instructions if the address or location is unusual or complex.
- The type of assignment, focusing on the areas of specialisation (e.g. particular medical diagnosis, type of clinical assessment and any other relevant contextual information to assist in effective interpreting).
- Always stipulate to the agency that you expect an accredited professional interpreter in languages tested by NAATI with the level of expertise in the area required (e.g. specialist training in health interpreting).

- Reiterate the time you expect the interpreter to arrive.
- Always allow adequate time to brief the interpreter. If you are not able to brief the interpreter directly before the interview, offer your telephone number and have the interpreter contact you prior to the interview for a telephone briefing.
- As a courtesy, provide information on parking availability and other organisational information and restrictions to facilitate easy access for the interpreter.

4. Working with an Interpreter Onsite

An interview with an interpreter present consists of a three-way interaction between the interviewer, the interpreter and the interviewee. The following recommendations have been developed to assist you in working more effectively with an interpreter:

- Introduce yourself and the interpreter to your patient.
- Explain what the interview is about and what you hope to achieve.
- Explain to the patient the interpreter's role within the interview. Inform the person that the interpreter's role is to assist communication by interpreting everything said by all parties.
- Maintain control of the interview. You must ask the questions and hear the replies fully. The interpreter's task is to assist in communication, not to conduct the interview.
- Position yourself in a way that permits you to speak directly with the patient and allows you to have maximum eye contact with them.
- When speaking to your patient use the first person (e.g. 'I' instead of 'Ask him/her'). Talking directly to the patient will allow for more effective communication and enable the use of other communication strategies including eye contact and body language.
- Keep your questions, statements and comments short and deliver them in segments, allowing the interpreter to relay the information in stages. Some interpreters may have excellent memory retention, while others prefer to receive the information in shorter segments, thereby ensuring accurate interpretation. Take note of the interpreter's method of signaling to you when your comments or questions are too long and allow the interpreter to do the same with the patient.
- Never assume that interpreting is a simple mechanical task of matching the non-English word or expression with the English equivalent (if indeed such an equivalent exists).
- It is unreasonable to expect the interpreter to be a 'walking dictionary'. There will be times when they will need to consult a reference or ask for clarification of terms or concepts used.
- Do not assume that just because a person appears to have a basic understanding of English, they will then be able to comprehend all that is said, especially in relation to terms, expressions and jargon common to medical and other specialist contexts. A patient's understanding may be further impeded if they feel under any stress.
- Do not isolate the patient by engaging the interpreter in discussion without explanation. If you need to clarify or discuss something with the interpreter, request that this be explained to the patient first.
- Allow the patient to raise any questions or issues of concern.
- Before the end of the interview, summarise key points for the patient. Make sure that they understand the information given and any follow-up actions required of them. For example, they may need to complete and return documents or written forms.

¹ Adapted from the Victorian Interpreting and Translating Service (undated), *We speak your language: A Guide to Cross-Cultural Communication*, VITS, Melbourne

² Guide for the use of professional interpreters in health services, Multicultural Mental Health Australia, www.mmha.org.au/research/guidelines/interpreters

³ Adapted from the Victorian Interpreting and Translating Service (undated), *We speak your language: A Guide to Cross-Cultural Communication*, VITS, Melbourne

Countries and Languages Spoken¹

Country	Languages/Dialects Spoken
Afghanistan	Pushtu, Dari
Albania	Albanian, Greek
Algeria	Arabic, French, Berber dialects
Angola	Bantu, Portuguese
Argentina	Spanish, Italian, German, French
Armenia	Armenian
Austria	German, Slovene, Croatian, Hungarian
Azerbaijan	Azerbaijani, Russian, Armenian
Bahrain	Arabic, Farsi, Urdu
Bangladesh	Bangla
Belarus	Belorussian, Russian
Belgium	French, Dutch, German, Flemish
Bolivia	Spanish, Quechua, Aymara, Guarani
Bosnia and Herzegovina	Bosnian, Serbian, Croatian
Brazil	Portuguese
Brunei	Malay, Cantonese
Bulgaria	Bulgarian
Burundi	French, Swahili, Kirundi
Cambodia	Khmer, French
Chile	Spanish
China	Mandarin, Hakka, Cantonese, Hokkien, Toishan, Teo Chiew, Shanghainese plus others
Colombia	Spanish
Costa Rica	Spanish
Croatia	Croatian, Serbian, Bosnian
Cuba	Spanish
Cyprus	Greek, Turkish
Czech Republic	Czech, Slovak
Denmark	Danish, Faeroese, Greenlandic
Djibouti	Arabic, French, Afar, Somali
Dominican Republic	Spanish
East Timor	Tetum, Portuguese, Hakka, Indonesian
Ecuador	Spanish, Quechua
Egypt	Arabic (Egyptian)
El Salvador	Spanish
Eritrea	Afar, Bilen, Kuname, Nara, Arabic, Tobedawi, Saho, Tigre, Tigrinya
Estonia	Estonian, Russian, Finnish
Ethiopia	Amharic, Oraminga, Tigrinya plus others
Fiji	Fijian, Hindi
Finland	Finnish, Swedish
Fyr of Macedonia	Macedonian, Albanian, Serbian
France	French
Georgia	Georgian, Russian, Armenian, Azerbaijani
Germany	German
Greece	Greek
Haiti	Creole, French
Honduras	Spanish
Hungary	Hungarian
India	Hindi, Bengali, Gujarati, Kashmiri, Malayalam, Marathi, Oriya, Punjabi, Tamil, Telugu, Urdu, Kannada, Assamese, Sanskrit, Sindhi
Indonesia	Bahasa Indonesian plus others
Iran	Farsi (Persian), Azari, Kurdish, Arabic
Iraq	Arabic, Kurdish

Israel	Hebrew, Yiddish, Arabic, Russian
Italy	Italian
Japan	Japanese
Jordan	Arabic
Kazakhstan	Kazak, Russian
Korea South	Korean
Kuwait	Arabic
Laos	Lao, Hmong, French
Latvia	Latvian
Lebanon	Arabic
Libya	Arabic, Italian
Lithuania	Lithuanian, Polish, Russian
Malaysia	Malay, Chinese languages, Tamil
Malta	Maltese
Mauritius	French, Creole, Hindi, Urdu, Hakka
Mexico	Spanish, Indian languages
Monaco	French, Italian, Monegasque
Morocco	Arabic, French, Berber dialects, Spanish
Nauru	Nauruan
Nepal	Nepali
The Netherlands	Dutch, Frisian
Nicaragua	Spanish
Norway	Norwegian
Pakistan	Punjabi, Pushtu, Urdu, Balochi, Sindhi
Peru	Spanish, Quechua
The Philippines	Filipino (Tagalog)
Poland	Polish
Portugal	Portuguese
Romania	Romanian
Russia	Russian
Samoa	Samoan
Saudi Arabia	Arabic
Slovakia	Slovak, Hungarian
Slovenia	Slovene
Somalia	Somali, Arabic
Spain	Spanish
Sri Lanka	Sinhalese, Tamil
Sudan	Arabic
Sweden	Swedish
Switzerland	German, French, Italian
Syria	Arabic, Armenian, Assyrian
Taiwan	Mandarin, Taiwanese, Hakka
Thailand	Thai, Hokkien, other Chinese dialects, Lao, Malay
Tonga	Tongan, English
Tunisia	Arabic, French
Turkey	Turkish
Uganda	Swahili, Luganda, Ateso, Luo
Ukraine	Ukrainian
United Arab Emirates	Arabic
Uruguay	Spanish
Uzbekistan	Uzbek, Russian, Tajik
Vanuatu	Bismala, French
Venezuela	Spanish
Vietnam	Vietnamese, French, Khmer, Cantonese, Teo Chiew
Yemen	Arabic
Yugoslavia	Serbian, Croatian

¹ Adapted from Central Health Interpreting Service Inc (undated), A Guide to Countries & Languages Spoken, CHIS, Melbourne. [Information Brochure]

Cultural Competency Checklist⁵

Below is a checklist of skills and approaches for working in a cross-cultural context:

- Understand the concept of culture and how it can influence
 - Human behaviour
 - Interpretation of that behaviour
 - Evaluation of that behaviour
- Demonstrate an openness and willingness to explore the same things from the perspective of people from diverse cultural backgrounds
- Demonstrate an openness and willingness to identify and explore one's own cultural base (e.g. values, beliefs and attitudes) emotions and thoughts generated by intercultural interactions
- Demonstrate the ability to identify useful and culturally appropriate strategies for working with people from diverse cultural backgrounds

Cultural competency is an evolving process that involves exposure to information on culture, communication and interpersonal interactions and involvement in intercultural interactions.

The culturally competent person is willing to explore other cultures and to explore and challenge one's own beliefs by:

- Evaluating and exploring alternative explanations
- Identifying and exploring personal cultural attitudes and biases

Cultural competency also implies the person:

- Sends, receives and understands verbal and non-verbal messages accurately, appropriately and in a meaningful way using a variety of communication skills and strategy
- Has an understanding of the concept of culture
- Recognises that culture affects all human behaviour, but that is only one of many factors involved
- Recognises that culture influences both one's own behaviour and that of others
- Respects the culture of others and demonstrates this respect in socially appropriate ways
- Acknowledges and values cultural diversity, including the language values and customs of people from other cultures
- Recognises limitations in cultural knowledge, both one's own and that of others
- Can obtain and recognise culturally valid and appropriate information in one's own culture and that of others
- Uses cultural information in a responsible way
- Recognises that all personal and professional values have a cultural basis
- Recognises that culture influences the environment in which services are provided, what services will be available, and how those services will be provided
- Avoids applying 'cultural cookbook' approaches to intercultural interactions and the delivery of services
- Is comfortable working with people from diverse cultures
- Demonstrates skill in selecting and using culturally sensitive intervention strategies
- Demonstrates knowledge of when and how to obtain assistance or access resources in order to enhance intercultural interactions
- Can recognise individual and institutional barriers to the provision of culturally appropriate services
- Understands that socio-economic, political, institutional and individual factors have a significant impact on people's lives and that these impacts may be greater for people from certain cultural groups
- Understands that professional values and codes of conduct have an effect on intercultural interactions and the provision of services

⁵ Adapted From: Transcultural Mental Health Centre 1996, *Enhancing Cultural Competency: Video and Manual Training Package*, Transcultural Mental Health Centre, North Parramatta, NSW.

Migrant Resource Centres

Migrant Resource Centres provide a range of settlement services to newly arrived individuals and families including accommodation, employment and education, such as English language classes. They also provide information on a range of health and welfare services.

Funded by the Federal Department of Immigration & Multicultural & Indigenous Affairs, Migrant Resource Centres are key ethnic community stakeholders operating on a regional basis and have experience in working with newly arrived and emerging ethnic communities. Importantly, that can assist in providing hospitals with information, contacts and expertise regarding the regional communities that they work with.

Geelong MRC

153 Pakington St, Geelong West 3218
Ph: 03 5221 6044
Fax: 03 5223 2848

Gippsland MRC

Morwell Head Office
100-102 Buckley St, Morwell 3840
Ph: 03 5133 7072
Fax: 03 5134 1031

Sale Office

c/- Central Gippsland Health Services
Cnr Cunningham & Palmeston Sts, Sale 3850
Ph: 03 5143 8800
Fax: 03 5143 8890

MRC North East

251 High St, Preston 3072
Ph: 03 9484 7944
Fax: 03 9484 7942

MRC North East Moreland

278 Sydney Rd, Coburg 3058
Ph: 03 9383 6233
Fax: 03 9383 6299

North West Region MRC

45 Main Rd West, St. Albans 3020
Ph: 03 9367 6044
Fax: 03 9367 4344

North West MRC Hume Office

Cnr Blair & Belfast Sts, Broadmeadows 3047
Ph: 03 9351 1278
Fax: 03 9351 1210

Northern Mallee Migrant Services Group Inc

255 Eleventh St, Mildura 3500
Ph: 03 5023 7885/5022 1006
Fax: 03 5021 2450

Multicultural Health Resource Centre

175 Glenroy Rd, Glenroy 3046
Ph: 03 9306 5611
Fax: 03 9306 5644

South Central Region MRC

40 Grattan St, Prahran 3181
Ph: 03 9510 5877
Fax: 03 9510 8971

Oakleigh Branch

18a Chester St, Oakleigh 3166
Ph: 03 9563 4130
Fax: 03 9563 4131

South Eastern Region MRC

Level 1, 314 Thomas St, Dandenong 3175
Ph: 03 9706 8933
Fax: 03 9706 8830

Westgate Region MRC

78-82 Second Ave, North Altona 3022
Ph: 03 9391 3355
Fax: 03 9399 1796

Westgate Region MRC Werribee Office

17 Watton St, Werribee 3030
Ph: 03 9742 3900

Regional Ethnic /Migrant Communities' Councils

Ethnic/Migrant Communities' Councils are voluntary community organisations that represent ethnic communities within their region or state. The role of Ethnic/Migrant Communities' Councils is to advise all levels of government, develop policy and contribute to community debates regarding issues relevant to ethnic communities. They also advocate on behalf of ethnic communities.

Due to their pivotal role in the ethnic services sector, Ethnic/Migrant Communities' Councils can provide information regarding key stakeholders in the various ethnic communities, information on ethnic services networks and activities that are relevant to health planning.

Federal Peak Body: Federation of Ethnic Communities' Councils of Australia

FECCA House
1/4 Phipps Close, Deakin ACT 2600
PO Box 344, Curtin, ACT 2605

Ph: 02 6282 5755
Fax: 02 6282 5734
Email: admin@fecca.org.au
Web: www.fecca.org.au

State Peak Body: Ethnic Communities Council of Victoria

150 Palmerston St, Carlton, Vic 3053

Ph: 03 9349 4122
Fax: 03 9349 4967
Email: eccv@eccv.org.au
Web: www.eccv.org.au

Victorian Regional Ethnic/ Migrant Communities' Councils

Albury/Wodonga Ethnic Communities' Council

PO Box 918, Albury NSW 2640
Contact: Sinthong Toumngoun (President)
Ph: 02 6021 1844
Fax: 02 6043 2239

Ballarat Regional Multicultural Council

PO Box 1814, Bakery Hill, Vic 3354
Contact: Sulaika Dhanapala (Chairperson)
Ph: 03 5339 9817
Fax: 03 5339 9844

Ethnic Council of Shepparton and District

PO Box 585, Shepparton, Vic 3632

Contact: Vicki Mitsos (President)
Doris Nilsen
Ph: 03 5831 2395
Fax: 03 5833 2551

Geelong Ethnic Communities' Council

153 Pakington St, Geelong West, Vic 3218

Contact: Jordan Mavros (CEO)
Ph: 03 5221 6044
Fax: 03 5223 2848

Gippsland Ethnic Communities' Council

RMB 4289A, Hazelwood North Vic 3840

Contact: George Venturini (Chairperson)
Ph: 03 5166 1502
Fax: 03 5166 1888

Bendigo Regional Ethnic Communities' Council

PO Box 2323, Bendigo Mail Centre, Vic 3552

Contact: Chandalala Mambwe (Chairperson)
Maria di Cicco (Secretary)
Ph: 03 5441 6644
Fax: 03 5441 6644

Sunraysia Ethnic Communities' Council

PO Box 1213, Mildura Vic 3502

Contact: Victor Matotek (President)
Nick Forsberg
Ph: 03 5022 1006
Fax: 03 5022 2601

Data Resources

<p>Australian Bureau of Statistics (ABS)</p> <p>Ph: 1300 135 0 70 Web: www.abs.gov.au Email: client.services@abs.gov.au</p>	<p>The ABS advises people to initially telephone for queries regarding statistics.</p>
<p>Department of Sustainability and Environment Urban and Regional Research</p> <p>Ph: 03 9655 8814 Web: www.doi.vic.gov.au/research Address: Level 20, 80 Collins St, Melbourne, Vic 3000</p>	<p>This resource contains information on urban and regional change, urban, regional and population research, populations projections, demographic information and data. Additional research links are also available from this website.</p>
<p>Centre for Culture Ethnicity and Health</p> <p>Contact: Tanja Bahro Ph: 03 9427 8766 Web: www.ceh.org.au Email: enquiries@ceh.org.au Address: 23 Lennox St, Richmond, Vic 3121</p>	<p>The Acute Care Diversity Collaboration project has developed statistical analyses of Victorian Admitted Episodes Dataset, Victorian Emergency Minimum Dataset and ABS 2001 statistics for Victorian public hospitals.</p>
<p>Victorian Office of Multicultural Affairs (VOMA)</p> <p>Ph: 03 9651 1270 Web: www.voma.vic.gov.au Email: multicultural.affairs@dpc.vic.gov.au</p>	<p>The VOMA website has current Victorian statistics based on migration data and ABS Census data.</p>
<p>Department of Immigration and Multicultural and Indigenous Affairs</p> <p>Ph: 131 881 Fax: 03 9235 3300 Web: www.dimia.gov.au Address: Ground Floor, Casselden Place 2 Lonsdale St, Melbourne, Vic 3000</p>	<p>Provides information and statistics on immigration demographics.</p>
<p>Victorian Department of Human Services</p> <p>Public Health www.dhs.vic.gov.au/phd Burden of Disease www.dhs.vic.gov.au/phd/bod Public Hospital's www.health.vic.gov.au/publichospitals/index</p>	<p>Contact details for staff from various DHS areas can be located from the 'Contact Us' sections relating to specific sites.</p>

Resource Documents

General

Charter of Public Service in a Culturally Diverse Society

Department of Immigration and Multicultural Affairs, Commonwealth of Australia, 1998.

Available online and in PDF or HTML formats at:

www.immi.gov.au/multicultural/_inc/publications/charter/charter

Cultural Diversity Framework: A Guide to the Planning and Delivery of Culturally Appropriate Human Services

Multicultural Strategy Unit, Department of Human Services, Melbourne, 2003, [Consultation Draft].

Available online in PDF format at:

www.dhs.vic.gov.au/multicultural/cdf

Valuing Cultural Diversity Policy Statement

Victorian Office of Multicultural Affairs, Department of Premier and Cabinet, 2002.

Available in PDF formats for screen and hardcopy use from the Publication's Section at:

www.voma.vic.gov.au/domino/web_notes/voma/vomasite.nsf/Frameset/VOMA

Language

Model for Assessing Translating and interpreting Requirements

Victorian Settlement Planning Committee, Melbourne, [date unknown].

Available in PDF format at:

www.immi.gov.au/tis/model.pdf

The Language Services Guidelines: A Toolkit for Commonwealth Agencies

Department of Immigration & Multicultural Affairs & Indigenous Affairs, Citizenship and Language Services Branch, 2002.

Available in PDF format at:

www.immi.gov.au/tis/tis_review/index

Improving the Use of Translating and Interpreting Services: A Guide to Victorian Government Policy and Procedures

Victorian Office of Multicultural Affairs. 2003.

Available in PDF format from the Publications Section at:

www.voma.vic.gov.au/domino/web_notes/voma/vomasite.nsf/Frameset/VOMA

Data Collection

Standards for Statistics on Cultural and Language Diversity

Australian Bureau of Statistics, Commonwealth of Australia. 1999.

Available in PDF format at:

www.abs.gov.au/ausstats/abs@.nsf/o/79FAB04272992D54CA25697E0018FEBD

The Guide: Implementing the Standards for Statistics on Cultural and Language Diversity

Commonwealth Interdepartmental Committee on Multicultural Affairs, Commonwealth of Australia, 2001.

Available online and in PDF format at:

www.immi.gov.au/multicultural/_inc/publications/statistics_guide/index

Services

Multicultural Resources Directory 2002-03

Victorian Office of Multicultural Affairs, 2002.

Available in PDF formats for screen and hardcopy use from the Publications Section at:

www.voma.vic.gov.au/domino/web_notes/voma/vomasite.nsf/Frameset/VOMA

Specific Groups

Access to Information About Government Services Among CALD Audiences

Department of Premier and Cabinet, Worthington Di Marzo, Cultural Partners Australia, 2001.

Available in PDF format or hard copy from Information Victoria at:

www.information.vic.gov.au/resources/cald_report

Framework for Responding to the Needs of Refugees and Asylum Seekers Within Primary Care Partnerships

Centre for Culture Ethnicity and Health/Ethnic Communities' Council of Victoria, 2002.

Available in hardcopy from the Centre for Culture Ethnicity and Health; telephone: 03 9427 8766 or in PDF format under the Publications listing at:

www.ceh.org.au/frame1

Multicultural Aged Care Services Directory

Ethnic Communities' Council of Victoria, 2002, (2nd Edition).

Copies can be obtained from ECCV by telephoning 9349 4122 or specific resources can be located by searching via the Multicultural Services Directory online at:

www.eccv.org.au/db

Better Ethnic Access to Services Kit: A Resource for Primary Care Partnerships

Action on Disabilities in Ethnic Communities, 2001.

Available in Microsoft Word format (some sections in PDF) from:

www.adec.org.au

Internet Resources

Consumer Resources

Consumers' Health Forum of Australia	www.chf.org.au
National Resource Centre for Consumer Participation in Health	www.participateinhealth.org.au
Victorian Hospital Patient Charter	http://patientcharter.health.vic.gov.au

Health Accreditation and Quality Resources

Agency for Healthcare Research and Quality	www.ahrq.gov
Australian Centre for Effective Healthcare	www.eha.usyd.edu.au
Australian Centre for Health Promotion	www.achp.health.usyd.edu.au
Clinical Risk Management, Victorian Department of Human Services	http://clinicalrisk.health.vic.gov.au
Joint Commission on Accreditation of Healthcare Organisations	www.jcaho.org
National Centre for Classification in Health	www2.fhs.usyd.edu.au/ncch
The Australian Council on Healthcare Standards	www.achs.org.au
The International Society for Quality in Health Care Inc	www.isqua.org.au
Victorian Quality Council	http://qualitycouncil.health.vic.gov.au

Health Information Resources

HealthInsite Health Information, Commonwealth Government of Australia	www.healthinsite.gov.au
Infoxchange Australia Service Seeker	www.vic.serviceseeker.com.au
New South Wales Multicultural Health Communication Service	www.health.nsw.gov.au/health-publicaffairs/mhcs
Royal Women's Hospital, Well Women's Site	www.rwh.org.au/wellwomens
Victorian Government Health Information	www.health.vic.gov.au

International Health and Human Rights Resources

Office of the High Commissioner for Human Rights (OHCHR)	www.unhchr.ch
United Nations Educational, Scientific & Cultural Organization (UNESCO)	www.unesco.org
United Nations (UN) (English)	www.un.org.english
World Health Organization (WHO) (English)	www.who.int/en

Language and Translation Resources

Australian Institute of Interpreters & Translators Inc	www.ausit.org
Central Health Interpreter Service	www.chis.org.au
Health Translations Directory	www.healthtranslations.vic.gov.au
National Accreditation Authority for Translators & Interpreters Inc	www.naati.com.au
Translating & Interpreting Service	www.immi.gov.au/tis
Victorian Translating & Interpreting Service	www.vits.com.au

Legislative Resources

Australian Human Rights and
Equal Opportunity Commission

www.eoc.vic.gov.au/responsibilities/employers

Equal Opportunity Commission Victoria

www.eoc.vic.gov.au/responsibilities/employers

Privacy Victoria, Office of the
Privacy Commissioner

www.privacy.vic.gov.au/dir100/priweb.nsf

Victorian Health Legislation,
Department of Human Services

www.health.vic.gov.au/legislation/index

Mental Health Resources

Multicultural Mental Health Australia

www.mmha.org.au/library/services/information

Victorian Transcultural Psychiatry Unit

www.vtpu.org.au

Multicultural Resources

Action on Disabilities in
Ethnic Communities

www.adec.org.au

Centre for Culture Ethnicity and Health

www.ceh.org.au

Ethnic Communities' Council of Victoria

www.eccv.org.au

Victorian Multicultural Commission

www.multicultural.vic.gov.au/index

Multicultural Services Database

www.eccv.org.au/db

Policy Resources

Australian Policy Online, The Institute
for Social Research, Swinburne
University of Technology

www.apo.org.au

Centre for Culture Ethnicity & Health

www.ceh.org.au

Health Issues Centre Inc

http://home.vicnet.net.au/~hissues/aboutus

Ministerial Advisory Council for
Cultural & Linguistic Diversity
Department of Human Services

www.dhs.vic.gov.au/multicultural

Multicultural Access Unit,
Department of Health, WA

www.health.wa.gov.au/mau

Population and Statistical Resources

Australian Broadcasting Commission
Australian Health Map

www.abc.net.au/health/healthmap/default

Australian Bureau of Statistics

www.abs.gov.au

Australian Institute of Health & Welfare

www.aihw.gov.au/index

Department of Immigration,
Multicultural & Indigenous Affairs

www.dimia.gov.au

National Library of Australia,
Australian Statistical Internet Sites

www.nla.gov.au/oz/stats

Victorian Burden of Diseases Report
Site, Department of Human Services

www.dhs.vic.gov.au/phd/bod/index

Victorian Office of Multicultural Affairs

www.voma.vic.gov.au/domino/web_notes/voma_vomasite.nsf/FramesetVOMA

Options for Consulting with Members of Ethnic Communities

Before You Start:

- Find out how the target group receives information and work within that framework
- Sometimes meanings get lost in translation, test all translated material to ensure the intent remains the same
- Before embarking on a strategy make sure that the participants understand the process and what is expected of them during the consultations

	STRATEGY	STRENGTHS	WEAKNESSES	ACTIONS FOR SUCCESS
Questionnaire	<p>Questionnaire in Print: <i>A list of questions the participant receives in print and is expected to complete and then send or hand back</i></p> <p>A Quantitative Research Method</p>	<ul style="list-style-type: none"> ▪ Allows for anonymity, important within small communities ▪ Able to collate responses and transfer them easily into data ▪ Able to consult with large samples ▪ Can access participants off site 	<ul style="list-style-type: none"> ▪ Written communication may not be an appropriate form of consultation ▪ Hard to identify language preferences ▪ Assumes a level of literacy and understanding of questionnaire processes ▪ Questions open to misinterpretation ▪ Average response rate 25% 	<ul style="list-style-type: none"> ▪ Ask the participants how they would best like to answer the questions – in written form, in a face-to-face interview or on the telephone ▪ Focus test questions to ensure they will generate the responses you need (may be able to focus test with bi-lingual workers who will understand from both perspectives) ▪ Offer the interviewee the opportunity of using an interpreter ▪ Discuss with the participant the process to ensure an understanding of what is expected of them ▪ Ask participants if they would prefer a male or female interviewer or if this is not relevant for them ▪ Develop open-ended or probing questions to ensure the responses are not what the participant thinks the interviewer wants to hear ▪ Select venues that participants are familiar with
	<p>Questionnaire in Person: <i>A face-to-face interaction between a participant and interviewer where a pre-determined set of questions are asked and answered</i></p> <p>A Quantitative Research Method</p>	<ul style="list-style-type: none"> ▪ Able to utilise bi-lingual workers or interpreters ▪ Allows for responses based on a strong understanding of the questions and the context of the questionnaire ▪ Able to collate responses and transfer them easily into data 	<ul style="list-style-type: none"> ▪ Some participants may have gender preferences ▪ Time and resource consuming process ▪ Responses may be based on what the participant thinks the interviewer wants to hear 	
	<p>Questionnaire by Phone: <i>A telephone interaction between a participant and interviewer where a pre-determined set of questions are asked and answered</i></p> <p>A Quantitative Research Method</p>	<ul style="list-style-type: none"> ▪ Can use telephone interpreters ▪ Allows for response clarification ▪ Able to collate responses and transfer them easily into data 	<ul style="list-style-type: none"> ▪ Difficult to obtain target audience's telephone numbers ▪ Time consuming, particularly if using a telephone interpreter ▪ Relies on a high understanding of the process 	
Focus Group	<p>Focus Groups <i>An organised discussion with invited individuals to gain information about their views and experiences relating to a topic</i></p> <p>A Qualitative Research Method</p>	<ul style="list-style-type: none"> ▪ Allows for specific cultural and linguistic requirements to be met ▪ Better able to target marginalised or smaller communities ▪ Able to explore the topic in depth ▪ Able to cater to sensitive topics 	<ul style="list-style-type: none"> ▪ Leaves community members out of the process ▪ Moderator has limited capacity to control interaction ▪ Difficult to find appropriate sample group to ensure the correct information is attained 	<ul style="list-style-type: none"> ▪ Develop a recruitment strategy to ensure as representative a group as possible ▪ Liaise with specialist services to ensure effective recruitment and cultural and linguistic appropriateness

	STRATEGY	STRENGTHS	WEAKNESSES	ACTIONS FOR SUCCESS
Forum	<p>Location based Community Forums</p> <p><i>A participatory event where invitees are asked to contribute comments and questions concerning a specific issue. The participants are invited based on regional proximity and association with the issue to be consulted on</i></p> <p>A Qualitative Research Method</p>	<ul style="list-style-type: none"> Can enable similar groups to come together to participate Allows for targeted, specific feedback in an identified framework Can work through community organisations, targeting existing structures Provides a sense of real participation by invitees 	<ul style="list-style-type: none"> May be hard to organise translators as people may attend without requesting it May not be culturally appropriate to criticise or comment in public Participants may not be comfortable with venue Participation may not be representative 	<ul style="list-style-type: none"> Prominently advertise 'interpreters available on request' Develop a range of forums ensuring appropriate targeting of participants (eg. women and youth) Negotiate with community organisations to identify the most effective individuals for participation Conduct forums at both day and night to ensure participants who have prior commitments have an opportunity to participate Negotiate with target audience to ensure participants are comfortable with process
	<p>Language/Ethnic Community Specific Forums</p> <p><i>A participatory event where invitees are asked to contribute comments and questions concerning a specific issue. The participants are invited based on shared language/ethnicity and association with the issue to be consulted on</i></p> <p>A Qualitative Research Method</p>	<ul style="list-style-type: none"> Allows for specific cultural and linguistic requirements to be met Allows for a real dialogue between participants and organisers Allows for targeted, specific feedback in an identified framework Provides a sense of real participation by invitees 	<ul style="list-style-type: none"> The targeted community may be factional and bringing the groups together difficult Group context can reduce expression of dissenting views Participation may not be representative May not be culturally appropriate to criticise or comment in public 	
Consultation with representatives	<p>Consultation with Organisational Representatives</p> <p><i>A series of interviews or focus groups with individuals who have a specialist knowledge of the areas of interest</i></p> <p>A Qualitative Research Method</p>	<ul style="list-style-type: none"> Participants will have a strong understanding of both cultural sensitivities and program policies 	<ul style="list-style-type: none"> Community workers and leaders may not be aware of all the issues you wish to explore The information is second hand and is subject to interpretation 	<ul style="list-style-type: none"> Identify organisational representatives who have first hand experience of the issue Prioritise case study or procedural information to better conceptualise the information Negotiate to ensure that you are talking with the most appropriate person Ask participants if they require an interpreter

Don't Forget:

- Be wary of consultation overload
- Reimburse participants for their time and costs to participate
- Ensure each person understands what is expected of them during the consultations