Making a difference through learning

Waitemata District Health Board

Toolkit
For Staff Working In A Culturally And Linguistically Diverse Health Environment

He aha te mea nui o te ao
Maku e ki atu
He tangata, he tangata, he tangata

I ask you, what is the greatest thing in the world? It is people, it is people, it is people

No Te Tai Tokerau

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Terms Used In This Toolkit

ASIAN
People originating from the Asian continent, east of and including Afghanistan, and south of and including China[1]. It includes Asian people born overseas and born in New Zealand.

CALD
Culturally and Linguistically Diverse people, whose main language(s) and/or cultural identity is different from both *Maori tangata whenua* o Aotearoa and the mainstream New Zealand society.

KIWI
Kiwi is a colloquial term used nationally and internationally for people from New Zealand. The name derives from the kiwi, a flightless bird which is native to, and the national symbol of, New Zealand.

MAORI
Maori are the indigenous people of Aotearoa (New Zealand) and are a signatory to Te Tiriti o Waitangi. Maori are also known as tangata whenua.

MIGRANT / IMMIGRANT
People of any nationality who were born overseas and come to settle in New Zealand.

PACIFIC / PASIFIKA
People originating from the Pacific Islands.

PAKEHA
A colloquial term, used in reference to non-Maori (especially European) New Zealanders by Maori and Polynesian people.

PALAGI / PALANGI
A colloquial term, used in reference to New Zealand Europeans by Pacific / Pasifika people.

REFUGEE
Refers to a person that "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality, and is unable, or owing to such fear is unwilling to avail himself / herself of the protection of that country" (United Nations High Commissioner for Refugees [UNHCR], 1951, p.16).

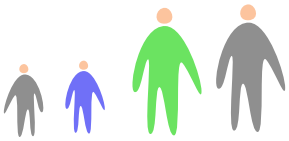
TAUIWI
Is a colloquial term, used in reference to NZ Europeans by Maori people.

1 Rasanathan, K., Craig, D., & Perkins, R. (2006). The novel use of "Asian" as an ethnic category in the New Zealand health sector. Ethnicity and Health, 11, 211–27.

About This Toolkit

A **Guide For All Staff** P. 6 - 34

B **Guide For All CALD Staff** P. 35 - 42



C **Guide For All Managers**
(Including CALD Managers) P. 43 - 52

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E **Appendices** P. 55 - 69

You can view and print this toolkit from WDHB Intranet under Corporate/Learning & Development page as well as under www.caldresources.org.nz under CALD Resources/Waitemata DHB/CALD Resources page under Cross Cultural Toolkits

How To Use This Toolkit

This toolkit offers some guidance for staff and managers who work in primary and secondary care in a CALD health environment in New Zealand's Waitemata DHB.

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

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

C — **Section C** is for managers who lead multicultural teams. This section should be read by ALL MANAGERS including CALD managers.

D — **Section D** lists Training, Resources and Supports for staff working in Waitemata DHB. This section is for ALL STAFF.

E — **Section E** contains appendices, which include information on: Cultural Competence Standards, Policies, Legislation, and acronyms and idioms that are commonly used in New Zealand. References for the toolkit are included. This section is for ALL STAFF.

The toolkit is not intended as a definitive guide, but as a quick reference tool only. It is designed to supplement training and is NOT adequate for, nor intended as a substitute for, appropriate training.

PLEASE NOTE: A training module which complements this toolkit will be available to staff. Managers who manage CALD teams will also be supported with a training module.

ICON KEYS

Manager

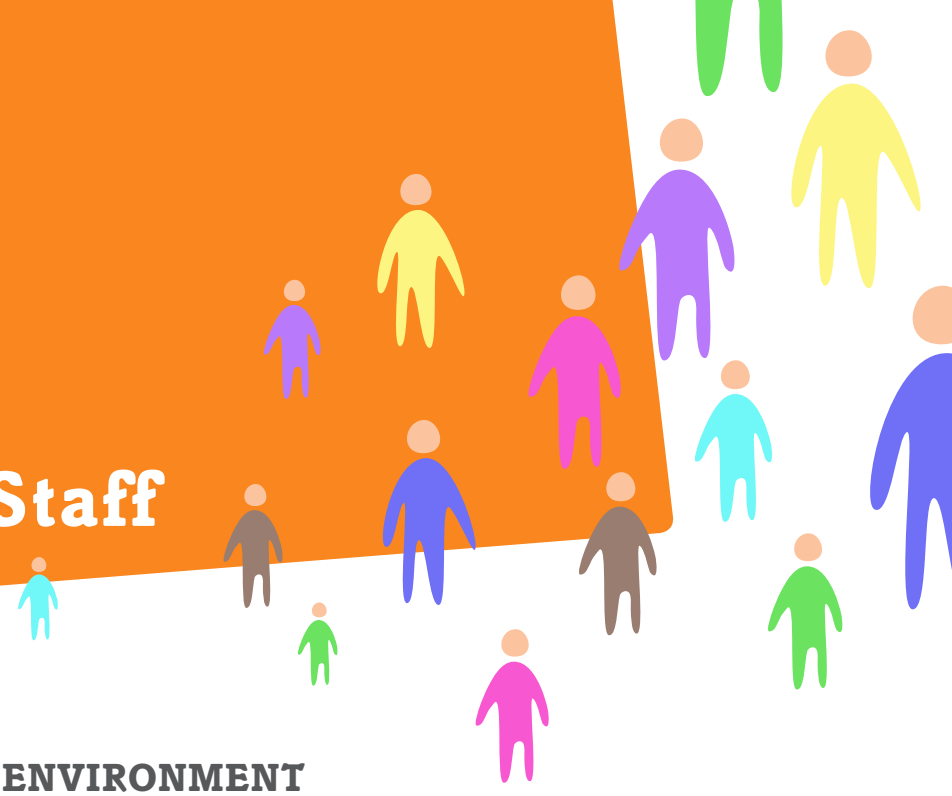
Self-reflective questions for your own workbook

New Zealanders

CALD Immigrants

Section A

Guide For All Staff



A1
MULTICULTURAL ENVIRONMENT

New Zealand is becoming an increasingly multicultural environment. Within the health system this presents challenges not only to health professionals offering services to patients and to the patients who receive these services, but also to staff in their collegial relationships with each other.

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

- Team member relationships (this includes all staff working within a CALD team, i.e. immigrant staff relating to Kiwi staff, and between immigrant staff themselves)
- Manager-staff relationships and the ability to facilitate a multicultural team
- Staff-patient (including clinician-patient) relationships.

Significant variations in communication occur across cultures in

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

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

- More awareness about the issues that affect communication
- Better understanding of the challenges that arise
- Tolerance and acceptance between colleagues in meeting these challenges.

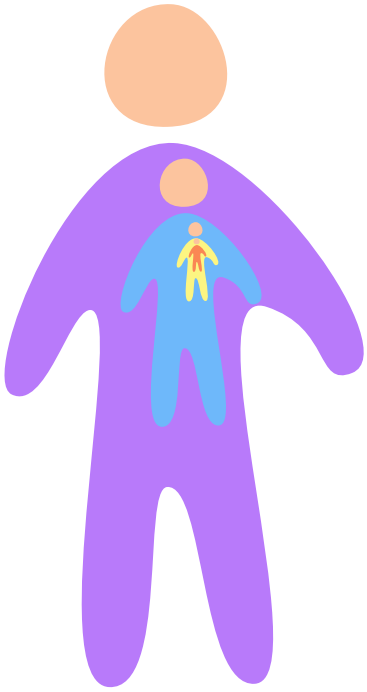
A2

CULTURAL COMPETENCE

Why the need for cultural competence?

When working in a culturally and linguistically diverse team, cultural competence is essential in developing an effective and harmonious working environment. The quality of the working environment not only affects the wellbeing of staff, but impacts on their ability to provide the best possible healthcare services.

Cultural competence requires an awareness of cultural diversity as well as the ability to function effectively, and respectfully, when working with people of different cultural backgrounds than one's own. This requires appropriate attitudes, skills and knowledge, and an acknowledgement that a person's culture and belief systems influence his or her interactions with others. Good working relationships need mutual respect and understanding.



Tolerance and understanding is not restricted to ethnicity, but also to gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status or perceived economic worth.

It is not sufficient to be sensitive in cultural interactions only. Expectations and requirements are that all health care providers possess the skills to be considered culturally competent, not only within a clinical context but also within the collegial environment.

CULTURAL SAFETY

'Cultural Safety' is a further aspect of Cultural Competence that applies directly to the recipients of health services and to the providers of the services. It refers to service delivery and provides consumers of services with an opportunity, and power, to comment on practice and influence the quality of service toward successful outcomes for CALD users. It requires that the providers of services are competent to work with CALD users and that they understand and recognise the limitations of some health practices when applied within some cultural contexts. It ensures the respect, enhancement and empowerment of the cultural identity and wellbeing of individual service users, families and groups from diverse cultures. Unsafe clinical practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual.

(Adapted from the Nursing Council of New Zealand 2005).

A2 continued

ELEMENTS OF CULTURAL COMPETENCE

1. Awareness

Having the capacity for cultural self-assessment

Cultural awareness requires firstly the recognition that our culture and belief systems influence our interactions with others. It involves an awareness of our own beliefs, values, expectations and cultural practices, and the understanding that these may differ from the beliefs, values, expectations and cultural practices of people from other cultures.

2. Sensitivity

Becoming conscious of the microdynamics inherent in cultural interactions

Sensitivity in our interactions is necessary to enable us to recognise and evaluate how our own culture impacts on people from other cultures, and on how they influence our own way of relating. Being sensitive in our relating facilitates mutual respect and understanding.

3. Knowledge

Developing a knowledge base about other cultures

Being culturally competent requires that we have some knowledge of other cultures, and how their practices and expectations differ from our own. Whilst we are not able (or expected) to become experts on every cultural group with whom we interact, having some knowledge of how the culture differs on common dimensions can help us avoid many of the potential misunderstandings and aversions that can develop. Becoming knowledgeable is an ongoing endeavour and there are many ways of acquiring information in as culturally diverse an environment as New Zealand. Knowing whether someone belongs to an Individualistic or Collective culture is helpful although we need to be careful of stereotyping, generalising or being ethnocentric.

4. Skills

Reflecting competence in relationship

Knowledge about other cultures is not sufficient for cultural competence. We need to be able to adapt our knowledge in practice. This necessitates that we are congruent in behaviour and attitudes in our interactions. It helps to be receptive and able to learn from the members of other cultures. To achieve this we need to develop sensitivity, awareness, flexibility, non-judgmental thinking, knowledge, and an inquiring attitude. Skills are needed to demonstrate these qualities in interactions between health care workers and clients and in the workplace.

Cultural competence is not necessarily

- Changing your culture or your values
- Liking another culture or person's values
- Agreeing with other cultures' values
- Knowing everything about another culture.

MYTH
That cultural competence is something that grows over time and can be 'picked up' by interacting with members of other cultures. NOT TRUE. It is a skill that requires focus, effort, and practice.

A3
UNDERSTANDING CULTURE

What is culture?

We can think of culture as a 'lens' through which we see the world. It shapes what and how we see, it provides a reference through which to understand our experiences, and it determines to some degree the opportunities and possibilities open to us. Understanding and experiencing the world through the lens of another culture provides us with unexpected opportunities to broaden and deepen our experiences of living.

Marsella (2005) defines cultures as having shared, learned behaviours and meanings that are socially transferred in life-activity settings. They shape and construct our realities.

These can be

- Transitory or enduring
- Dynamic
- Internally or externally represented
- Oriented towards a healthy lifestyle and coping with stressors, or less so.

Culture is expressed throughout most aspects of living, the most easily recognised being

- Food
- Clothing
- Language
- Values, moral codes, religion
- Rituals e.g., marriage rituals
- Relationship
- Song and dance
- Framing methods
- Buildings
- History of peoples.

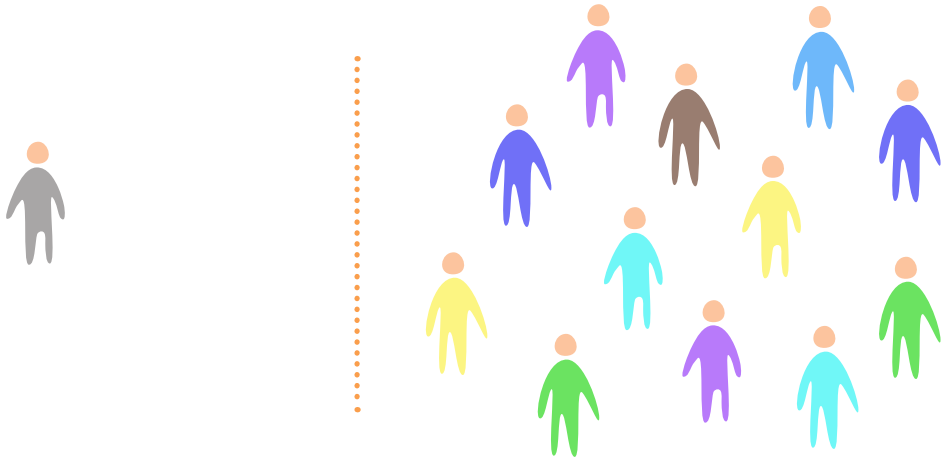
Most of what we learn to value is embedded in our sub-consciousness in such a way that we remain largely unaware of our values and how they affect our behaviours and expectations of others.

A3 continued

UNDERSTANDING CULTURE

Cultural dimensions

Before we understand how our culture impacts on others, we need first to understand the dynamics of our own culture. Following are four dimensions on which we can identify how cultures differ (Hofstede, 1980).



1. Individualism versus Collectivism (individual vs. group)

Individualism is a common pattern among cultures of Western Europe and new world countries settled by people originally from Europe. They include the USA, Canada, Australia and the majority culture of New Zealand. Individualistic cultures make up only about 20% of the people in the world.

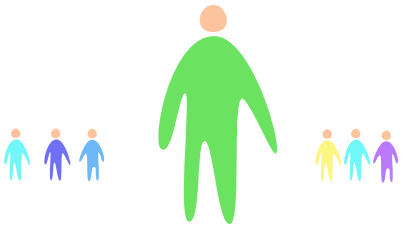
In **Individualistic cultures** a well-adjusted person

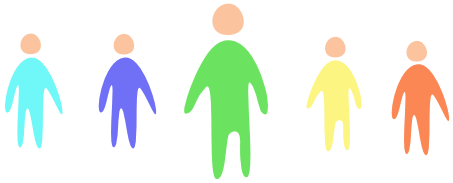
- Is independent
- Makes decisions without reference to others
- Moves freely from one group to another
- Communicates in a direct and open manner
- Values assertiveness.

Collectivism is the common pattern amongst about 80% of the world's cultures. These include all of Asia and Africa, indigenous cultures of Australia, USA, Canada, New Zealand, the Pacific Nations and South America, and most of the cultures of Mediterranean Europe.

In **Collectivist cultures** a well-adjusted person

- Is interdependent
- Takes account of the well-being of others in the group when making decisions
- Has strong connections to one group
- Communicates in a more indirect manner
- Is concerned for the maintenance of the group, avoids open conflict and disagreement.





2. Power distance (status and authority difference)

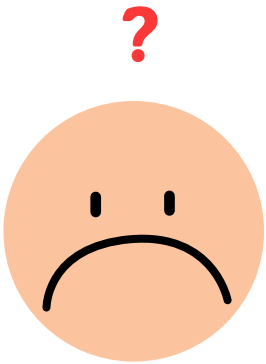
Power distance refers to the distance in status between those of high status and those of lower status in an organisation or culture. It reflects the extent to which a culture expects and accepts hierarchical differences.

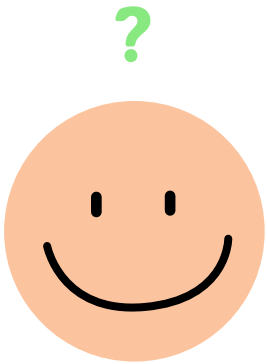
High power distance cultures include

- A large gap in status between powerful and less powerful
- Arrogance expressed by authority figures
- Humility expressed by subordinates
- An association with collectivism.

Low power distance cultures include

- Less status gap
- More egalitarianism
- An association with individualism.





3. Uncertainty avoidance (tolerance of uncertainty and ambiguity)

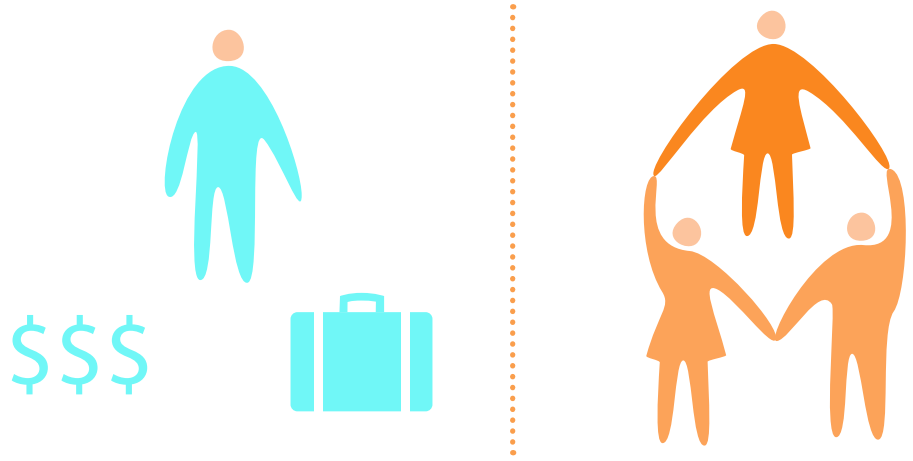
This refers to the extent to which members of a culture feel threatened by uncertainty, ambiguity and the unknown. It is a cultural measure of the degree to which people tolerate risk.

In **High uncertainty avoidance** cultures

- People are uncomfortable if rules are unclear
- Job stability is valued
- Individuals often experience higher stress
- Collectivism is usually more closely associated.

In **Low uncertainty avoidance** cultures

- People are more relaxed when rules are unclear
- People are more able to move from one job to another
- Individualism is usually more closely associated.



4. Masculinity versus Femininity (fixed or more flexible roles)

Masculinity versus femininity (within a cultural context) refers to the degree to which a culture values and reinforces traditional roles, and the degree to which a culture is task or relationship oriented.

Masculinity in culture is associated with

- Material success, money, being strong, competitive and assertive (valued by both the men and women as important)
- Greater differentiation and discrimination between genders
- Boys and girls study different subjects, boys don't cry, girls do.

Femininity in culture is associated with

- 'Feminine' societies are opposite. They are more relationship focused (valued by both the men and women)
- Less differentiation and discrimination between genders.

Identifying your own cultural values

Cultural values can be dynamic and lie on a continuum. Where would you sit on the continua below, and which pattern of valuing does your culture tend toward?

Individualism ..... Collectivism

Low power distance ..... High power distance

Low uncertainty ..... High uncertainty

Masculine ..... Feminine

The dimensions on the left reflect values that are more Individualistic and those on the right more Collectivist ones. The cultures of English speaking and European immigrants differ in small ways from New Zealand majority culture. These subtle differences are sometimes surprising and can cause their own stress. For example, small language differences such as the Kiwi reference to "jandals" when English speaking immigrants call this kind of footwear "thongs" produce confusion, as can the request to "bring a plate".

The cultures of people from Africa, the Middle East and Asia differ much more markedly along a number of dimensions, and these differences have implications for relationship and understanding in the work place, as well as for patients in healthcare.

SCENARIO

Collective culture family obligations

Fetu was an inpatient on the diabetes ward at his local hospital. During visiting hours he constantly received numerous visitors, so many that they would sometimes spill out into the corridor or into the neighbouring patient's area. This was not an uncommon scenario for many of the Pacific Island patients. Nursing staff became exasperated and would complain amongst themselves about what they perceived as inconsiderate behaviour by many of their Pacific Island patients and their families. They thought that it seemed an obvious solution for immediate family members to visit and send news to extended family members, so as not to overcrowd the wards.

Solution / Possible Approach

One evening Elena, one of the nurses on duty, consulted a Pacific Island colleague on her shift, nurse Ailini. She mentioned the problem and asked why it seemed such a common occurrence. Ailini explained that Pacific Island culture placed great value on the nuclear and extended family since the collective unit is seen as more important than the individual. It is customary and expected that family members visit any of their relatives who are in hospital and that each person's sense of self-worth is determined by their interdependence and reciprocity within the unit. Not to visit would be disrespectful and unloving, and not maintaining family ties. She also explained how the support of the family members was integral to the healing of the patient.

Elena realised that she (and some of her colleagues) had not fully understood the cultural values of Pacific Islanders and at the next meeting she relayed her story to the charge nurse manager on the ward. The team then explored ways to meet the needs of this group and it was decided to offer the visiting family members the Maori hui room (meeting room) for waiting so that all the members could sit together and take turns in visiting the patient without disturbing others in the same ward.

SCENARIO
Power Distance

An Eastern European psychiatrist was consulting with a patient in a multicultural team. The social worker was Japanese with good English proficiency, and the client and interpreter were Korean. During the interchange between psychiatrist and patient it became clear to the Japanese social worker that the interpreter and patient were being misunderstood by the psychiatrist.

It created some confusion and the social worker felt distressed at what she witnessed. However, out of respect for the doctor she felt unable to say anything since in her culture bringing the situation to his attention might imply incompetence on his part. Such a situation would cause him to 'lose face' and be embarrassed, and in Asian cultures this is to be avoided at all costs. So she remained silent. The Korean interpreter apparently found it difficult to understand the doctor (and vice versa) although they were both able to speak English. English was the second language for both of them.

Solution / Possible Approach
In such a situation it would be best practice for the staff member to consult a clinical supervisor, manager or professional coach and seek assistance in handling the issue.

Cultural perspective
New Zealand culture in general (kiwi culture)

There can be marked differences between Maori and NZ European societies and culture. This is particularly apparent when moving in tribal (Iwi) circles. Due to impact of colonisation and tribal differences, there can also be subtle but important variations in protocols. The following are common ideas about New Zealanders. However they are generalisations and may not apply to all individuals.

- New Zealanders are friendly, outgoing, somewhat reserved initially yet polite, and enjoy extending hospitality
- They are quite easy to get to know as they say hello to strangers and will usually offer assistance without being asked
- They do not value overly forward or excessively friendly behaviours
- They do not value aggressiveness or overly assertive behaviour
- There is a common 'tall poppy' syndrome. This means that Kiwis may not value people who push ahead or stand out too much in the crowd
- They respect people who are honest, direct, and demonstrate a sense of humour (note that humour is culturally determined!)
- They are trusting people until they are given a reason not to be
- Low power distance and egalitarian values allow them to move to a first name basis quickly and drop the use of titles. This is different for Maori on the marae where ritanga (protocol) is important
- Some Maori do not see themselves as Maori and use the term Tangata Whenua (people of the land)

- Kiwis take pride in their individual achievements and believe that opportunities are available to all
- Wealth and social status are not as important to Kiwis as to many other cultures. New Zealanders in general, and Maori in particular are more relationship focused
- Maori are more communal and some tribes are more hierarchical, especially in formal situations e.g. the elder (male or female) is seated in a specific area and will be asked to open or close a meeting.

HOW CULTURE IMPACTS ON RELATIONSHIPS

How 'normal' do you consider your culture to be?

There is a danger in assuming that our own culture is normal and that others' are odd. Working within a culturally diverse environment requires that we are able to recognise differences as equally valuable (although it doesn't require that we necessarily agree with or like the differences).

Below are ways in which different cultures can be approached. Stereotyping and ethnocentrism are more likely to result in offence and clashes than careful generalisations and an appropriate cultural attitude.

Stereotyping

This is the belief that a statement is true of all individuals from a particular group. Stereotyping tends to dehumanise people, boxing all members of a group into one unrealistic category. Stereotyping is one of the most common causes of offence in culturally diverse interactions.

Ethnocentrism

The view that our own culture's way of doing things is the right and natural way, and that all other ways are inferior, unnatural, perhaps even barbaric. This prevents us from meeting people on their own cultural ground. Instead there is often an implicit goal to try to get people to conform to host culture values and traditions. This has direct implications for staff relationships, both colleague to colleague, as well as between managers and staff.

Generalisation

Indicates common trends, but further information is needed to ascertain appropriateness of a statement to a particular individual.

The 'rule' may be inaccurate when applied to an individual or group.

Cultural Relativism

The attitude that others' ways of doing things are different but equally valid. There is an attempt to understand the behaviour in its cultural context and NO JUDGEMENT is made.

SCENARIO
Ethnocentrism

Mark:
"We've got quite a multicultural workforce now. It's amazing how many different cultures we have ..... at least 5 just in our team....."

Sally:
"Yeah, we do. But you know it annoys me how so many of these people act so polite on the one hand and then on the other they seem to think they can do what they like – come late, never bother to look at you when they talk, say yes when they mean no, never answer you directly. It makes things complicated".

Mark:
"Well that's the difference in values isn't it?"

Sally:
"Values? What do you mean? Values are values, we all know what's right and wrong. They just don't seem to bother".

Mark:
"I think you're being a bit ethnocentric Sally".

Sally:
"What's that?"

Solution / Possible Approach
Explain the meaning of 'ethnocentrism' to Sally, alert her to the requirement for cultural competence within the health environment and refer her to the toolkit and to CALD training available for Waitemata DHB staff. If you are not aware of the specific training available, a manager or team leader can be consulted.

Use the following checklist to assess your own cultural competence.

Checklist for ongoing Cultural Competence development

1. How self-reflective are you about your interactions with colleagues from other cultures or minority ethnic groups? (Rate yourself on a scale of 1–5)

2. Do you recognise prejudices you may hold about certain ethnic groups, or their practices and beliefs?

3. Can you identify how ethnocentric you might be in your interactions with colleagues from different cultures?

- Can you greet colleagues or clients from any other culture in their own language (verbal or non-verbal)?
- Do you assume that they need to understand how your health system works?
- Do you know anything about where they come from and the circumstances under which they might have migrated?
- Do you know anything about their traditional practices and expectations?
- Are you able to accommodate any of the diversity in your interactions?

4. How does your ethnic identity affect your decisions when working with members of other cultures?

5. How often do you attend functions or take part in any activities with colleagues from minority ethnic groups?

6. Have you read any books / articles or seen any films recently about people from other cultures, particularly minority ethnic cultures?

7. Do you respect colleagues' religious or spiritual beliefs that are different from your own? Are you able to incorporate these comfortably in interactions when appropriate?

8. Have you discussed any cross-cultural issues that might have arisen in your work, with a colleague or supervisor?

9. Have you attended any training or sought education on cross-cultural issues?

10. Have you ever challenged a racist attitude by someone, or realised you might have made / thought one?

11. How much do you value the metaskills of 'compassion', 'neutrality', 'nonjudgement', 'acceptance' and 'listening' in your interactions?

Adapted from Jackson and Camplin-Welch (2007).

MYTH
One of the myths about cultural diversity is that difference is best understood through lifestyle, language, foods and other visible aspects of culture. NOT TRUE. It is the invisible and unstated differences that present the most challenges and violations of trust and respect. These are held largely in the VALUES, and in the expectations, goals and styles of communications. In fact, many cultures have values and styles that are almost opposite to each other. If we assess meaning based on patterns in our own culture, we are likely to misinterpret, misunderstand and be confused.

A4

CULTURES IN COMMUNICATION

1. Effective cross-cultural communication

"Because cultures differ widely in body language, how to show (dis)respect, modesty and privacy concerns, expressions of (dis)agreement, and what constitutes courtesy, varies considerably across cultures. It is easy when dealing with someone from another culture to unwittingly give offence or to unintentionally make someone feel awkward, uncomfortable, or confused"
Bacal, Jansen and Smith (2006), (p.306)

The following scenario shows how easily this happens.

SCENARIO
Different Values

A group of work colleagues meet for the first time at a member's home for a social occasion. The hosts are a Maori couple, and some of the guests are male and female Kiwis, some are of other European descent, a Burundian female and a Japanese female. One of the hosts greets each person as they come through the door with a hongi (touching noses). Migang, the Japanese woman stands back just out of reach as her host begins to move toward her, she greets him with 'hello' and hurriedly follows her colleagues down the passage.

How does Hane (host) respond to Migang's avoidance of his greeting?

Hane:
"Well, it was rude, she was not accepting my hospitality and my welcome. It looks like she thinks she is better than I am. I feel offended. When she comes to my home, she should do things the way we do here".

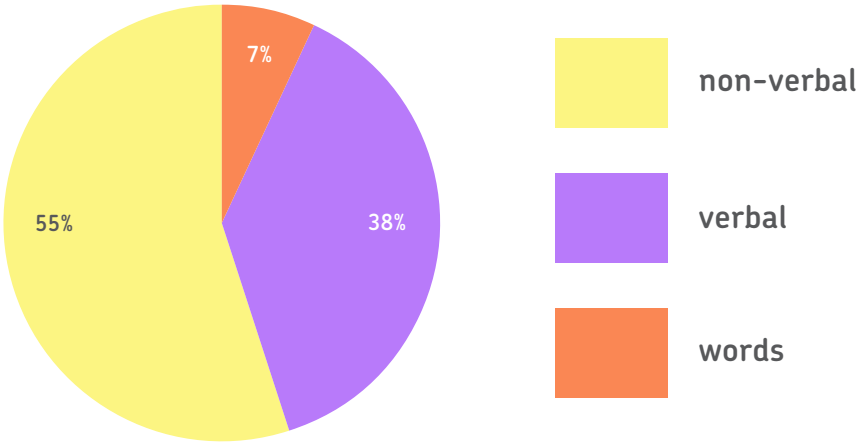
Migang:
"I felt a panic, I did not know what to do. I was afraid for a moment because it was such a strange thing to do. In our culture we do not greet each other by touching, it is not acceptable to show affection in public, and especially so close. We do not often touch each other, especially the elders, even at home. I knew he was welcoming me, but I did not feel able to respond. I feel very uncomfortable now as I see that I have offended him."

Solution / Possible Approach

It would be helpful for both parties to be aware that there are differences in protocol for greeting people from other cultures. Hane may have realised that Migang has different practices to his own, and whilst being disappointed may not have felt personally offended. If Migang were aware of the protocol of her hosts before visiting, she may have either been prepared to engage in the greeting, or have had a different way of managing the situation e.g. to bow as is customary in her culture, demonstrating respect to her host. Alternatively she may have bowed and expressed hope to her host that he did not find her greeting offensive but that in her culture it was not customary to greet people in a physical way.

Did you know?

In communicating, our message is conveyed through:



7% words
38% verbally, through volume, pitch and rhythm
55% non-verbally through facial expressions and other body language and gestures

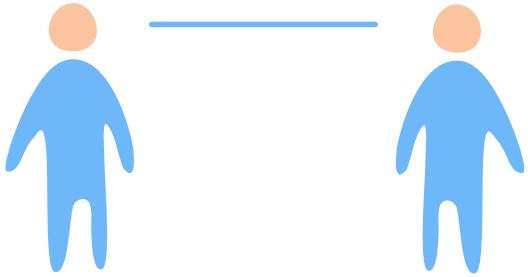
(Barbour 1976)

2. Values and communication styles

Values are the norms within a culture that are considered acceptable or unacceptable. They are usually unspoken, hidden and integral to most of our actions. Because they are hidden, they commonly cause misunderstanding and offence between people of different cultures and traditions. Many cultural values around relating are expressed through the way that we communicate. Below are some aspects of communication styles that differ across cultures.

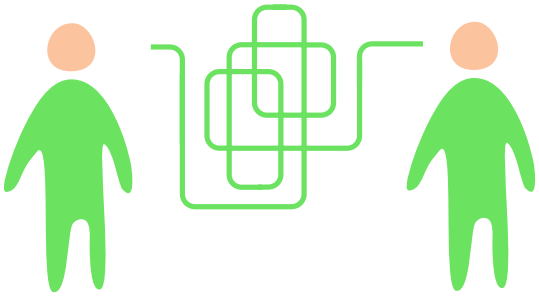
Note that these are generalised. Individuals may combine aspects of different styles.

2.1. Direct vs. Indirect



DIRECT

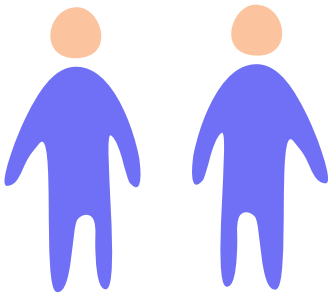
- Asserts self
- Responds with ‘no’ readily
- Uses ‘I’ more often
- Values being proactive
- Uses linear thought processes
- Directness in stating the point or conclusions is the norm
- Listener focuses on what is said
- Disagreement is not personalised
- Can address and confront those with higher status directly.



INDIRECT

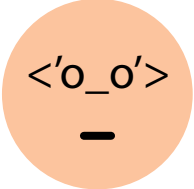
- Does not assert self
- ‘No’ responses may not be permissible, especially with those in authority
- Uses ‘we’ more often
- Values following established practices
- Uses ‘circuitous’ thought processes
- Directness in stating the point or conclusions can be considered inappropriate
- Listener focuses on what is implied
- Disagreement is personalised
- Does not confront authority, or must go through an appropriate channel.

2.1. Formal vs. Informal



FORMAL

- Values formality
- Uses titles and / or surnames (family names)
- Values time as cyclical and relationship takes precedence over task or appointment
- Values silence to process information
- Tolerates physical proximity more easily (e.g. in queues)
- Touch is generally reserved for family and close friends, or not permissible in public at all
- Values soft or no eye contact, or of short duration
- Values control of emotional display, to varying degrees
- Controls body language
- Less or no facial expression.



INFORMAL

- Values informality
- Uses first names
- Values time as linear and values punctuality
- Avoids silences / is very verbal
- Values physical distance / space
- Tolerates touch more readily (e.g. handshake)
- Values direct eye contact
- Values expression of emotion (including anger)
- Readily animates body language
- Uses more facial expressions.

IDENTIFYING ONE'S OWN PREFFERED STYLE OF COMMUNICATION

Identify your own values and styles along the following continua.

1 Formal	◂·····▸	Informal
2 Listening	◂·····▸	Talking
3 Structured	◂·····▸	Flexible
4 Tradition	◂·····▸	Change
5 Collaboration	◂·····▸	Competition
6 What you know	◂·····▸	Who you know
7 Task	◂·····▸	Relationship
8 Fixed rules	◂·····▸	No rules
9 Indirect communication	◂·····▸	Direct communication
10 Team	◂·····▸	Individual
11 Security	◂·····▸	Risk
12 Hierarchy	◂·····▸	Equality
13 Harmony (by avoiding)	◂·····▸	Harmony (by confronting)
14 Time (value punctuality)	◂·····▸	Time (value relationship over schedules)
15 Limited eye contact	◂·····▸	Eye contact

What aspects of the opposite style do you find difficult to accept or understand?

Can you find out more from members of other cultures what the opposite forms of communication may mean, or why they are used?

2.3. Different non-verbal Greeting Styles across cultures

- Smile or inclination of head
- Handshake, using one or both hands together
- Hongi (touching noses)
- Kiss on cheek, or both cheeks
- Bow, slight inclination of body, or deep bow
- Raising hat
- Hug
- Salute or wave
- Namaste (hands together in prayer position).

Note: In some cultures, the order in which individuals, members of a group or family are greeted will depend on their seniority or status.

EYE CONTACT

Scenario 1

An immigrant German midwife was teaching Lu, a young Burmese girl (16 years) who had approached the clinic for help, about contraception. However Lu did not interact much, never asked questions and averted her eyes from the midwife whenever she spoke. The midwife interpreted this as a lack of interest and had concerns about her involvement in her own care.

In reality, Lu was showing respect to the midwife by avoiding eye contact and not questioning, and by giving very brief answers. If she were to ask questions this might imply that the midwife was not doing a good enough job in her explanations, and too much talking would also seem disrespectful. Burmese culture, like most Asian cultures is hierarchical and the midwife misinterpreted Lu's responses according to her own cultural values.

Scenario 2

A recently immigrated Middle Eastern patient was becoming overly familiar with a young Kiwi nurse, during the course of his hospital stay. The nurse became increasingly uncomfortable and finally spoke with her supervisor. It turned out that her direct and continued eye contact had been interpreted as an encouragement by the patient. In his culture direct eye contact from a woman is understood as a sexual invitation. He had become confused by her growing abruptness with him, and also by her continued eye contact.

Adapted from Galanti (2008)

Solution / Possible Approach

In both cases the cultural values of the patient were not understood. Training in cultural diversity for the midwife and nurse would probably have allayed both their concerns, and influenced the way they related to the patients. Consulting the supervisor in Scenario 2 also proved helpful.

2.4. Other cultural expressions that may need clarifying

Whilst these aspects below do not reflect communication styles *per se*, they may be an important part of communication. For example, food in some cultures embodies implicit messages. What is brought, how much, variety, and its context, may communicate more than the obvious. These aspects are areas of richness but are also potential ground for confusion or misunderstanding. Enquiry can reveal layers of meaning.

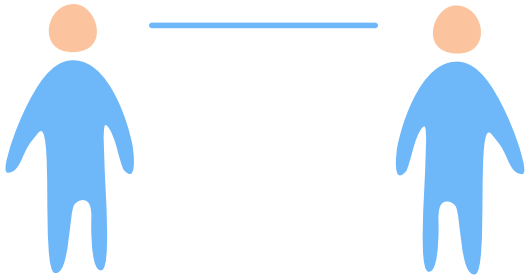
- Food (e.g. what is eaten when, how a refusal may be interpreted, what to offer so as not to cause embarrassment, fasting etc.)
- Clothing (e.g. head dress and other traditional dress, what is informal dress)
- Language (e.g. use of slang and profanities and how these are interpreted)
- Humour (includes idioms and quotes, facial expressions and gestures)
- Moral codes (e.g. hierarchy and status, permissible behaviours and differences amongst generations and between genders)
- Religious practice and gestures (e.g. taking time out for ritual prayer or celebrations, time taken off for family illness and bereavement)
- Song and dance (e.g. symbolic meaning of song and dance)
- Rituals (e.g. marriage or initiation rituals, or health practice rituals)
- Relationships and the forms they take (e.g. how friendship is expressed between genders and inter-generationally, what behaviour is expected between people of differing status).

NOTE:

Be aware of generalising across members of a culture. Identifying a group's style of communication alerts us to potential areas of difference. Every individual needs to be assessed along each continuum of values to see where they lie in relation to other members of their group. Many immigrants have spent time in different countries integrating values from host cultures, some live in multicultural families, others may be long standing residents of New Zealand and have assimilated many Kiwi values. Pre-judging people based on visible difference can result in stereotyping. Listening, communication and observing are key to developing genuine relationship.

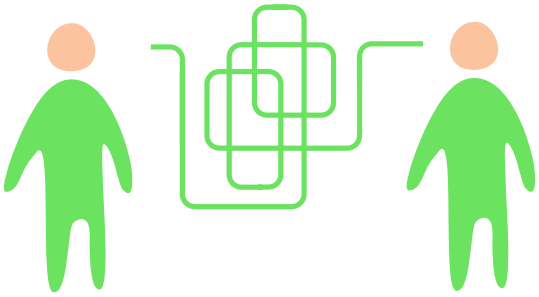
Are there other expressions of culture you have encountered that you would like to ask colleagues from different cultures about?

3. How typical responses of people whose styles are opposite, can be misunderstood



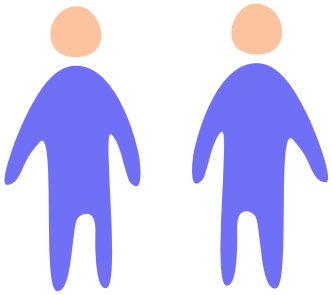
DIRECT STYLE
common misunderstandings

- Assertiveness is perceived as aggressiveness
- Responding with 'no' can be perceived as disrespectful or rude
- Using 'I' is perceived as self-importance at the expense of the team
- Being proactive can be perceived as surpassing authority or team collaboration
- Linear thought processing can be perceived as simplistic or superficial
- Listening to what is said, and not to what is implied can be perceived as lacking in perceptiveness
- Disagreeing can be perceived as conflictual and / or disrespectful, as compromising team harmony
- Addressing authority figures directly is perceived as disrespectful or not knowing 'one's place'.



INDIRECT STYLE
common misunderstandings

- By not responding with 'no', answers can be misunderstood or perceived to be evasive
- Using 'we' can be perceived as lacking self-confidence or assertiveness
- Following established practices can be perceived as diffident and lacking in ability to take authoritative roles
- 'Stepping stone' processing can be seen as slowness or lack of understanding
- Listening to what is implied, and not to what is said can be perceived as not having listened or understood
- Person is perceived as unwilling to seek resolutions
- Person is perceived as ineffective
- Personalising disagreement can be seen as an inability to maintain objectivity, or as oversensitivity
- Not addressing authority directly can be seen as passive, lacking initiative, diffidence or ineffectiveness.



FORMAL STYLE
common misunderstandings

- Formality can be perceived as unfriendly
- Use of titles can be perceived as coldness or unwillingness to develop relationship
- Silence can be perceived as disinterest or a lack of willingness to engage, or lacking initiative
- Physical proximity can be seen as intrusive or inappropriate
- Refusal to touch (e.g. handshake) can be experienced as personal rejection
- Soft or no eye contact can be seen as evasive, not to be trusted, disinterested
- Lack of emotion can be seen as coldness
- Controlled body language can be seen as distance, lack of engagement, inhibiting relationship
- Little or no facial expression can be seen as neutrality or dislike.

INFORMAL STYLE
common misunderstandings

- Informality can be perceived as 'forward' or insensitive
- First names can be perceived as rude or disrespectful
- Expressiveness or wordiness can be seen as ungracious / lacking wisdom
- Maintaining physical 'space' can be personalised
- Touching can be seen as intrusive or threatening
- Direct eye contact can be seen as disrespectful or threatening
- Expression of emotion can be seen as lacking self-respect, letting the team or family down
- Animated body language can be seen as indiscreet
- Facial expressions can be misinterpreted.

SCENARIO
Non-Assertiveness misunderstood

Maria Park was a Korean charge nurse in a delivery ward. She was a highly proficient nurse both technically and with her patients; however, on the ward she was not given the respect accorded to her role. She seemed unable to lead her team, give instructions, or address performance issues. She seemed indecisive and was apologetic when anything went wrong.

This was all consistent with a traditional role of a Korean woman where the culture is hierarchical and the ideal woman is subservient and passive. Avoiding conflict and maintaining harmony was the sign of a capable worker. Her co-workers liked her personality but did not respect her leadership. She soon became aware of the problems and sought counselling after which things began to improve. However, it took some time for her to realise the problem and during this period she was extremely stressed.

Adapted from Galanti 2008

4. Tips for communicating with people from different cultures

Verbal communication and language

- Speak slowly and clearly
- Avoid slang (its meaning may not be understood, or may be offensive)
- Avoid humour (it is culture specific as it relies on proficient use of language and on shared knowledge and practices)
- Separate questions (e.g. not 'would you like to'..... or.....?)
- Avoid negative questions (e.g. 'are you not coming?' as a 'yes' might mean 'yes, you are right, I am not coming' or may indicate an affirmative)
- Avoid interrupting (take turns in speaking as some cultures do not value assertiveness and may not speak unless left the space to do so, or invited)
- Check if your message has been understood
- Summarise discussions or instructions
- If there is uncertainty, write the instruction / message down (note: written information is not valued equally across cultures. For some people, the written word is less credible than the spoken word).

Written communication and language

- Write clearly and legibly
- Use plain English
- Avoid long, complicated sentences
- Get someone to read what you have written and check that the intended message is clear
- Apply these principles to all written documentation.

Other aspects of communication and interaction

- Be supportive (communicating in another language is challenging)
- Follow etiquette (it is necessary to find out about etiquette of other cultures in your team)
- Show respect
- Be aware of cultural assumptions
- ASK! (enquire about practices, expectations and needs as this will usually be understood as interest)
- Incorporate different practices (e.g. into greetings, into providing opportunities for members to speak during meetings. For example, some cultures use some version of a 'talking stick' to designate the speaker where the person holding the stick or object is given the space and authority to speak without interruption.)
- Collaborate in understanding each other (i.e. it is a two-way process).

Think of 3 occasions where you might have misunderstand opposite styles of communication?

Are there ways in which you can adjust your own communication style to accommodate others in your team and to facilitate better understanding between you?

A5

CREATING GOOD WORKPLACE RELATIONSHIPS

1. Building trust

Building trust requires a multi-ethnic mindset (flexibility) and the ability to recognise, understand, respect and negotiate cultural differences.

Build trust between team members by

- Knowing yourself and being self-reflective in your interactions
- Extending trust
- Exercising cultural curiosity (don't be afraid to ask questions)
- Exercising cultural sensitivity
- Being consistent
- Being honest
- Knowing your job
- Listening, observing and talking to be understood.

2. Understanding the workplace context

In different contexts, different rules can apply when relating. **'High context'** groups are those in which people have close connections over a long period of time. Many aspects of cultural behaviour are not made explicit because most members know what to do and how to behave from years of interaction with each other. Family is an example of a high context environment.

'Low context' places or groups are those in which people tend to have many connections but of shorter duration. In these groups, cultural behaviour and beliefs may need to be spelled out explicitly so that those coming into the cultural environment know how to behave. Workplaces can be low context places, especially for people coming from cultures that differ from the host or dominant culture in the working environment.

High context communication

- Less verbally explicit communication, less written / formal information
- More internalised understandings of what is communicated
- Value long term relationships
- Strong boundaries - who belongs versus who is an "outsider"
- Communication is indirect

Low context communication

- Rule oriented, people play by external rules
- More knowledge is codified, public, external, and accessible
- Separation of time, of space, of activities, of relationships
- More interpersonal connections but of shorter duration
- Communication is direct
- Task-centered where decisions and activities focus around what needs to be done
- More division of responsibilities.

It is helpful to be aware of the implicit as well as formalised and written rules of the workplace, and to make sure that all members of the team are privy to the same information. This would apply particularly to new members joining teams.

3. Understanding how cultural dimensions can be expressed in working relationships

For people from **Collective Cultures** who enter a workplace where Individualist Culture values dominate, the following may be helpful:

Individualist working environments

- As an individual you are expected to work on your own and use your initiative. Remember that you can't depend on the group for answers, you need to come up with your own and make suggestions
- Prepare yourself for a working environment that may be less reliant on relationships and personal contacts
- Work and personal life are likely to be kept separate
- Employees or subordinates will expect the chance to work on projects or solve issues independently. Being too intrusive into their work may be interpreted negatively
- It is not uncommon for people to try and stand out from the rest.

Lower Power Distance working environments

- Don't expect to be treated with the usual respect or deference you may be used to (especially if you hold what you consider to be an authoritative position)
- Colleagues will want to get to know you in an informal manner with little protocol or etiquette
- Involve others in decision making
- Do not base judgments of people on appearance, demeanor, privileges or status symbols.

For people from **Individualist Cultures**, the following may be helpful in understanding possible expectations and practices from colleagues who come from Collective Cultures:

Collective working environments

- Individuals will have a strong sense of responsibility for their family which can mean they take precedence over business
- Praise should always be directed to a team rather than individuals as other wise this may cause people embarrassment
- Reward teams as well as people
- Promotions usually depend upon seniority and experience, not performance and achievement
- Decision making may be a slow process, as many individuals across the hierarchy will need to be consulted.

Higher Power Distance working environments

- Clear and explicit directions are expected
- Deadlines should be highlighted and stressed
- Subordinates will not expect to take initiative
- Management style is more authoritarian and relationships with staff may be more distant
- Respect and deference are expected to be shown to those higher up the ladder. This is usually reflected through language, behaviour and protocol.

High Uncertainty Avoidance working environments

- Don't expect new ideas, ways or methods to be readily embraced
- You need to allow time to help develop an understanding of an initiative to help foster confidence in it
- Involve local counterparts in projects to allow them a sense of understanding. This then decreases the element of the unknown
- Decision making is more difficult when the environment is unfamiliar.

Feminine culture working environments

- Recognise that people value their personal time. They prioritise family and take longer holidays. Working overtime is not the norm
- Small talk at social (or business) functions will focus on an individual's life and interests rather than just business
- Personal questions are normal rather than intrusive
- Nepotism is seen as a positive and people openly show favouritism to close relations.

CREATING GOOD WORKPLACE RELATIONSHIPS

1. Are there ways in which you can enhance trust in your working relationships? This might be with particular individuals, or within your teams in general.

2. In the Low Context environment of the New Zealand workplace, what sets of rules may be unclear or misunderstood by team members? List any that could be brought to the attention of the team?

4. Respecting and accommodating differences

We can be respectful by

- Listening
- Engaging curiosity - show interest and ask questions (as appropriate)
- Communicating about cultural differences
- Acknowledging people (through greeting, inclusion and consultation)
- Valuing diversity and celebrating the opportunities it brings
- Acknowledging that different practices can broaden our world view
- Avoiding stereotyping, generalising or being ethnocentric
- Meeting people with open-mindedness.

We can accommodate differences by

- Empathising with difficulties in adapting
- Being flexible when instituting 'rules' and procedures
- Developing structures and process that accommodate different needs and strengths
- Making changes that can be easily accommodated
- Collaborate with others about what they need
- Making implicit 'rules' explicit
- Building a strong sense of teamwork and mission.

The three R's

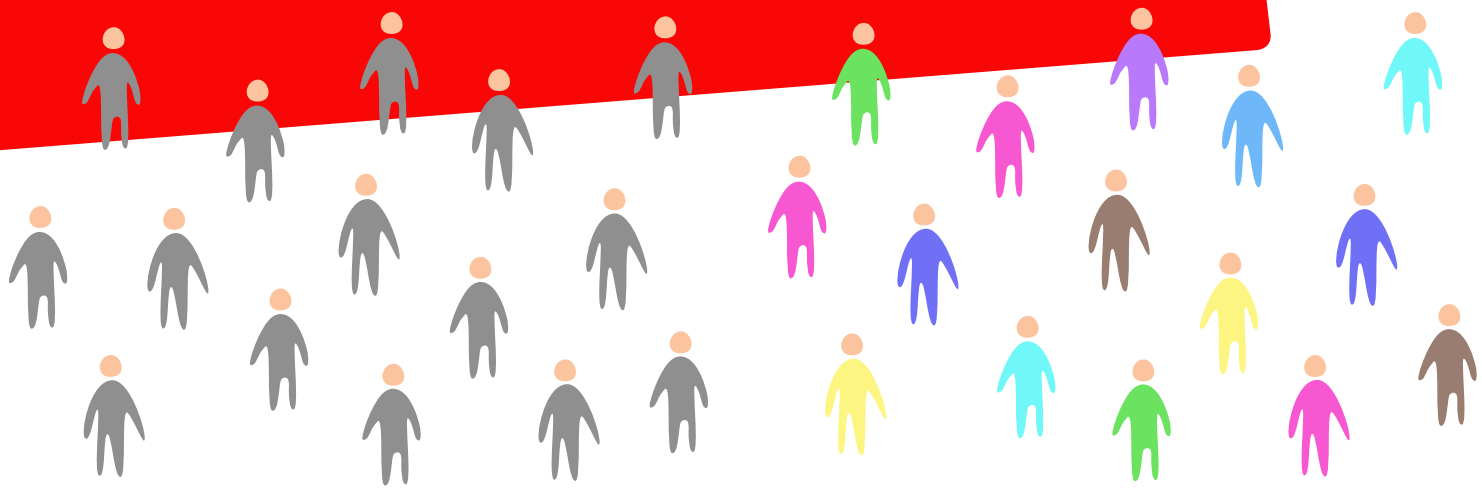
- **Recognise** cultural differences
- **Respect** cultural differences
- **Reconcile** cultural differences.

Are there ways in which you can adjust your communication style to accommodate differences?

Are there any ways that you could assist someone in your team to adapt to the multi-cultural working environment?

Section B

Guide For CALD Staff
(INCLUDING CALD MANAGERS)



B1
EXPECTATIONS AT WORK

1. Understanding New Zealand Culture In General

Note: There can be marked differences between Maori and NZ European societies and culture. This is particularly apparent when moving in tribal (Iwi) circles. Due to colonisation and tribal differences, there can also be subtle but important variations in protocols across tribes.

The following are common ideas about New Zealanders. However they are generalisations and may not apply to all individuals.

- New Zealanders are friendly, outgoing, somewhat reserved initially yet polite, and enjoy extending hospitality
- They are quite easy to get to know as they say hello to strangers and will usually offer assistance without being asked
- They do not value overly forward or excessively friendly behaviours, in spite of informal greetings and interactions
- They do not value aggressiveness or overly assertive behaviour
- There is a common 'tall poppy' syndrome. This means that Kiwis may not value people who push ahead or stand out too much in the crowd
- They respect people who are honest, direct, and demonstrate a sense of humour (note that humour is culturally determined!)

- They are trusting people until they are given a reason not to be
- Low power distance and egalitarian values allow them to move to a first name basis quickly and drop the use of titles. This is different for Maori on the Marae where protocol and status is important
- Kiwis take pride in individual achievements and believe that opportunities are available to all
- Wealth and social status are not as important to Kiwis as in many other cultures
- Maori are more hierarchical, especially in formal situations (e.g. the elder (male or female) is seated in a specific area and will be asked to open or close a meeting.

2. Understanding New Zealand Culture in the Workplace

Kiwi Cultural Values

New Zealanders with European heritage (often referred to as 'Pakeha' by Maori) tend towards

- Individualism
- Low power distance
- Low uncertainty
- Masculinity and Femininity.

New Zealanders who are from Maori tribes tend towards

- Collectivism
- High power distance
- High uncertainty
- Femininity.

NOTE:
It can be problematic to generalise values. Many Maori and New Zealand 'Pakeha' have found ways to accommodate each other's culture and many have assimilated values from the other. Some people have ancestry from both culture groups. The workplace will follow protocol from both sets of cultures. There is specific protocol followed in accordance with the Treaty of Waitangi. Be sure to familiarise yourself with these protocols and assess each person's cultural preferences individually.

3. New Zealand Values

Individualist Values

When working within the New Zealand Health System generally, you will be working within an Individualistic environment. Be reminded that

- You will be expected to work on your own and use your initiative
- You won't be able to depend on the group for answers
- The working environment may be less reliant on relationships and personal contacts than in other cultures
- Work and personal life are likely to be kept separate
- It is not uncommon for some people to try and stand out from the rest.

Low Power Distance

The New Zealand Health System is generally a Low Power Distance environment. Be reminded that

- You may not be treated with the usual respect or deference you may be used to
- Colleagues will want to get to know you in an informal manner with less protocol or etiquette than is usual in some other cultures
- Team members will expect collaboration in decision making.

SCENARIO
Low Power Distance

A Kiwi nurse Leigh, worked well with her colleague, an Indian physician Dr. Akram until she was transferred to the Diabetes clinic. At the clinic, protocol allowed her to adjust medications, order lab work and new medications as long as she got the doctor to sign the orders. Dr. Akram always questioned her rudely about her decisions asking what her rationale was and on occasion refused to sign the orders. After taking a cultural competence course Leigh realised that the doctor, being Asian, probably saw her approach as disrespectful. After this she decided to ask his opinion, express her concern about the patient and ask what he would like to have done. He seemed much more receptive to this approach and their relationship improved. Dr. Akram had practised for most of his life in India and was not used to nurses 'overriding' or 'interfering' in his decisions. Indian hospitals have a much stronger hierarchical system than in New Zealand.

(Adapted from Galanti 2008).

Solution / Possible Approach
Cultural Competence training for both staff would be of benefit in such a scenario. Knowing that there was a Lower Power Distance value in New Zealand than in the country of origin of the doctor may have helped the nurse understand the situation from the beginning. The doctor, alternatively, may not have perceived the nurse's communications as disrespectful. Even one party having competence in cross-cultural interactions would have been helpful in this situation.

Etiquette of New Zealanders

Most Kiwis

- Use first names amongst colleagues, although doctors are often addressed as 'Dr.' and second name (surname)

- Write their names using the given name first, followed by their family name or surname (e.g. Mary Macintosh)

- Address each other with informal gestures, e.g. a wave, a smile or a verbal greeting. Handshakes and bowing are not usual amongst New Zealanders, although they might be with other members of the team

- Verbal greetings include:
    - > Hi
    - > Hi there
    - > Kia Ora
    - > Gidday' (Australian influence)
    - > Good morning / afternoon / evening
    - > Hello

- Ask 'how are you?', or ask if you are having a good day. It is a form of friendliness and they do not necessarily expect long explanations

- Expect punctuality. They value and expect staff to observe formal work hours (unless other arrangements are made) and to be punctual to meetings

- Feel able to take initiative at work and make suggestions for the team without being invited to do so

- Will speak up at meetings in an informal way; this is not seen as disrespectful to managers and team leaders.

Some Maori terminology frequently used in the workplace

People and Groups

Ariki	person of high inherited rank (male or female)
Hapu	sub-tribe, clan
Iwi	tribe
Kaumatua	elder, senior people in the kin group
Whakapapa	genealogy, kin connections
Whanau	extended or non-nuclear family
Whanaunga	kin, relatives

Meeting related

Haere mai!	Welcome! Enter!
Hui	a meeting, gathering, conference
Koha	gifts (monetary or food)
Marae	an area for formal gathering, usually a designated building
Waiata	song or chant which follows a speech

Concepts

Aroha	compassion / love
Kai	food (common usage)
Mana	authority; secondary meaning – reputation, influence
Taonga	treasured possessions or cultural items
Tapu	sacred, not to be touched, taboo (because of sacred nature)

Greetings

Kia Ora	Hi! Goodday! (informal)
Morena	Good morning (more formal)
Tena koe	formal greeting to one person
Tena korua	formal greeting to two people
Tena koutou	formal greeting to many people (used to address groups)
Tena koutou katoa	formal greeting to everybody present, including oneself

More terminology and audio with the correct pronunciation of the above can be found at www.nzhistory.net.nz/culture/tereo

4. Work Ethics and Protocol

Ethics in the workplace involve a set of values, attitudes and skills. The following principles are taken from Ministry of Health's 'Let's Get Real' project. Although these arose within the mental health sector, the principles provide useful guidelines for all staff within the health system.

Values

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

Attitudes

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

How would you have to adjust your practice to operationalise the above 'Attitudes' in your multicultural team?

Skills

- Ability to work with service users
- Ability to work with Maori and Kiwis
- Ability to work with families / whanau of colleagues and service users (recognition of family as part of wider community)
- Ability and willingness to challenge stigma and discrimination
- Ability to implement legislation, regulations, standards, codes and policies relevant to role
- Ability to actively reflect on work and practice in ways that enhance collaboration and support service users, and to engage in professional and personal development.

The Skills above can be seen as performance indicators and staff can assess themselves against these to establish their skill level. Three different levels of performance indicators would be expected for:

- Staff
- Practitioners
- Managers / Team Leaders.

(the above are adapted from www.tepou.co.nz/page/752-Values-attitudesand-the-seven-Real-Skills)

(Refer to Appendices for Competence Standards for the varying professions)

QUICK GUIDE TO NZ HEALTHCARE SYSTEM

ONLY IF YOU ARE VERY ILL OR IF YOUR CONDITION IS VERY SERIOUS THAT YOU CANNOT WALK OR DRIVE, OR WHEN YOU HAVE A SERIOUS ACCIDENT
Go to the nearest local Accident & Medical Centre or a public hospital emergency department OR Call an ambulance if it is an emergency (e.g when you have a heart attack) – **Dial 111.**

Where do I go if I am very unwell or have an accident?

Where do I go if I'm sick?

IF YOU ARE NOT SERIOUSLY ILL go to a GP or a primary health service provider

IF YOU ARE UNSURE of whether you need to see a GP or **go to hospital** or **need other health advice**, phone healthline

Primary Healthcare Services

The way into Primary Health Services is generally through doctors and community health centres. All people should register with a general practice or other primary health care service provider.

Most of these services are subsidised by the local District Health Board (DHB)

HEALTHLINE
Provides free 24 hour health advice on
0800 611 116

Do I need to pay to see my family doctor/ nurse?

YES – you do pay a consultation fee but the government provides funding so that GP visits are cheaper.

For most people, pharmaceutical prescriptions have a relatively low charge per item.

It is important to register with a general practice or health centre who will enrol you in a Primary Health Organisation (PHO) so that you get access to cheaper GP visits and pharmaceuticals.

Otherwise if you are not registered with a general practice or health centre belonging to a PHO, you will pay more as a "casual patient".

It may also cost more for consultations after hours.

A small surcharge may apply for accident related GP visit. (Refer to ACC website www.acc.co.nz)

SPECIALIST ASSESSMENTS

Go to a GP for advice. Your GP will refer you to a public hospital or private specialist if further diagnosis or treatment is required.

Note:
You **don't** have to pay for **public hospital services** if you are a New Zealand citizen / resident or if you meet the criteria for funded hospital services (see eligibility criteria later on). Ask your doctor or health centre if you have any questions.

You **DO HAVE** to pay for **private specialist or private hospital care.**

Specialist Services

Public Hospitals

Public hospitals offer emergency services, medical and surgical, maternity, operating room, elderly care, mental health service, community health services such as district nursing and diagnostic services such as Xrays, scans. Not all services are provided by public hospitals

Private Hospitals

Compiled by Sue Lim, Asian Health Support Services, Waitemata DHB
Updated: February 2009

EXPECTATIONS AT WORK

1. In what ways is your culture different from New Zealand culture?

2. What functions / meetings use Maori protocol and structure in your team or organisation?

3. What do YOU need to do to participate appropriately in these functions?

4. Are there any words or gestures (that are different from your culture) that you can use when greeting New Zealanders at work?

5. What aspects of the New Zealand culture are the most challenging for you to adjust to?

6. What Kiwi values, attitudes and skills that are expected at work are different from those of your own culture?

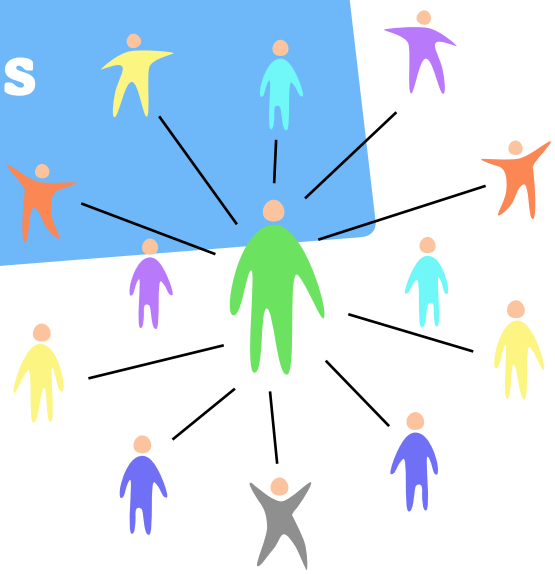
7. In what ways is the New Zealand health system different, and in what ways similar to the health system in your own country?

8. Is there anything about your culture that you would like your Kiwi colleagues to understand? Can you find a way to communicate this, perhaps to your Manager, or during team meetings, or informally?

Section C

Guide For All Managers

(Including CALD Managers)



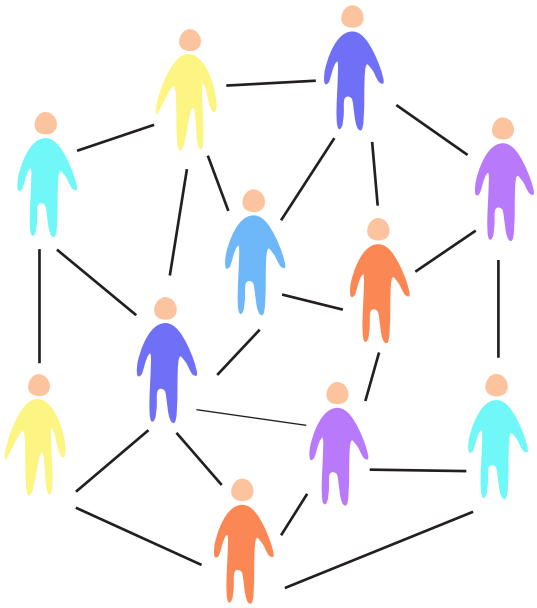
It is essential that all managers leading a culturally and linguistically diverse team are trained in cultural competence. What follows highlights some of the complexities of working in a CALD team, and offers some pointers as a guide, but this is in no way a substitute for training in cross-cultural management. Team leaders and managers also need to be proficient in conflict mediation.

C1
MANAGING A CULTURALLY DIVERSE TEAM

In order to understand the micro dynamics of the team, it will be necessary to understand something about the values, practices and communication styles of the cultures to which the different members belong, and also to ensure that all members of the team understand each other.

In New Zealand, and in the Health System, teams are more egalitarian and management and leadership follow a style of facilitation, or mentoring. This differs from environments with a High Power Distance value where the managers are seen as authority figures at the top of a hierarchy. In these cultures managers are regarded as experts, expected to have all the answers and have a team of varying levels of subordinates below them.

As a team leader in New Zealand you are expected to be able to join the team members as an equal, but also to know when to step back and provide guidance, direction and reward. Your role needs to be clarified so that all staff understand their relationship with you and your responsibilities.



1. Build an Effective Team

- Create a context for team work by holding a focus on the bigger picture – do members see how their team contributes to creating the best service for service users?
- Develop a common team identity
- Create clarity about the team's common goals and purpose (create a vision and mission statement with your team)
- Engage commitment to the team's success through motivation and appropriate feedback (receptivity to style of feedback will be culture specific)
- Ensure that members understand the team structure, and team processes
- Ensure that all team members know their roles, as well as the roles of others, and the role of the manager
- Communicate your expectations clearly about team goals, individual responsibilities, and deadlines
- Clearly explain about protocol and etiquette
- Ensure that individuals feel empowered and are sufficiently supported to accomplish their own goals
- Not all members may know how to work interpersonally in the New Zealand work context. Provide enough information
- Ensure that work activities are well coordinated
- Encourage flexibility
- Encourage relationship
- Find ways to engender trust. Trust is one of the most essential qualities of good relationship, and developing trust takes time. Organising group social activities can help create this, as well as consistent team building and supportive facilitation.

What cultural factors will you have to negotiate in order to build a team identity and vision in your team?

2. Integrate Cultural Differences

- Create awareness of difference. Meet regularly, acknowledge difference and encourage discussion about difference (unfamiliar behaviour and interaction is often interpreted as 'abnormal' or wrong')
- Be explicit about difference in expectations
- Collaborate in the team, on ways to accommodate people's varying styles of communicating and interacting (e.g. direct vs. indirect)
- Allow the expression of diversity (as appropriate) in the work team
- Model acceptance and interest in diversity as a team leader
- Be willing to make mistakes around cultural understanding and model how to manage these
- Use Hofstede's Cultural Dimensions to identify and acknowledge differences amongst team members. Have members find their positions along the continuum either on paper, or in exercises requiring interaction and movement (attend the Managing Cultural Diversity training programme offered by Waitemata DHB).

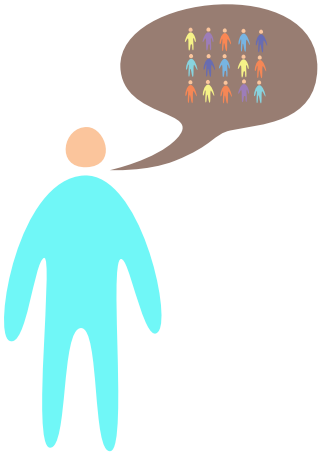
Individualism	Collectivism
Low power distance	High power distance
Low uncertainty	High uncertainty
Masculine	Feminine

- Bring awareness to variations in verbal and non-verbal greetings. Avoid applying your own culture's non-verbal gestures to other cultures
- Be aware of and highlight differences for your team on how people communicate, especially using facial expressions and what these might convey, and what might be expected
- Be aware of current power imbalances and encourage staff to discuss these and find ways to accommodate or address the structure, as appropriate
- Encourage staff to discuss cultural aspects of their cases at case management meetings.

How many different cultures are represented in your team?

What percentage follow more Collectivist culture styles and what percentage Individualistic styles?

What do you need to do to integrate the team members around these differences?



3. Assist members to overcome language difficulties

- Have members share their traditional verbal and non-verbal greetings and encourage members to greet people in different ways
- Ensure that important directives are understood. Check for understanding, summarise, ask for feedback and provide written documentation for reference. When communicating in writing, make sure you get feedback before assuming the message has been understood
- Make team members aware of different levels of language (English) proficiency so that they can support each other
- Be careful of assuming that language proficiency reflects competence. People's strengths may not be reflected in language, but lie in some other area. Get to know your team members' strengths
- Use pictorial information and diagrams where possible if there are team members who have low English proficiency. Engage the team in creating the diagrams or flowcharts
- When there is breakdown in communication, find ways to work through this rather than attributing blame to one party for the misunderstanding.

4. Give everyone an opportunity to voice his or her opinions

- Cultures with High Power Distance may be more reticent to contribute. Find ways to include people, invite them to speak
- Establish an environment in which people are comfortable to speak out when in groups
- Some cultures have specific protocol about speaking with 'superiors' and in meetings. Be sure what these expectations are and assist people to understand the expectations of their current workplace
- Team members from a culture valuing Low Power Distance environment will not expect to be invited to speak and are likely to regard managers as equals. CALD managers may not receive the expected deference and this should not be mistaken for disrespect.

SCENARIO
Cultural difference in expectations

Kim is a Japanese nurse in a clinical team. She seldom spoke in meetings, volunteered to take on tasks, or helped others with their work. Her colleagues regarded her as unfriendly and stuck up. They started to avoid her, not include her in team decisions and the team leader Mary noticed that she was becoming increasingly isolated.

During an individual interview with Kim, Mary discovered that Kim believed that contributing during the team meetings would be disrespectful unless someone invited her to do so. She also did not volunteer to assist colleague nurses with their work since in her culture this would imply that they were not able to manage the tasks themselves. When she was told that Kiwi nurses customarily help each other out with tasks she was surprised. Mary decided to hold regular team meetings about differences in culture and values. These greatly improved collegial relationships and she was warmed to find that once some of the misperceptions were out in the open, people were supportive of each other and able to joke about the differences. One of the best outcomes she reported was improved attitudes towards patients.

(Adapted from Galanti 2008)

SCENARIO
Integrating cultural differences

Mr Koloi, a Tongan patient was suffering from unremitting pleurisy and was hospitalised by his GP because it was thought that he was not receiving adequate medical care at home. The family and Mr Koloi in particular, were very unhappy about the hospitalisation. Inspite of appropriate interventions Mr Koloi's condition deteriorated in hospital with him constantly requesting to be sent home. His immediate and extended family unfortunately lived too far from the hospital to visit regularly and his daughter who took care of him was a working single mother with three small children. Although members of the church visited him and were able to offer support, he missed his family and felt very lonely. He became depressed and the daughter requested discharge.

Solution / Possible Approach

On one of the ward meetings the charge nurse manager asked Sela, a Samoan nurse if she had any suggestions about the patient from a cultural perspective. Sela consulted one of her Tongan colleagues and reported back to the team. She suggested that the significantly differing cultural environment and approach to healthcare might be contributing to Mr Koloi's deterioration. She detailed the importance of family participation and presence in healthcare, and how the holistic approach was vital in recovery. When asked what she meant by this Sela explained that spiritual and emotional balance was as important to the wellbeing of the patient as the physical, and that since he was not able to talk to his family or participate in any of his usual spiritual practices or rituals, he was deprived of the essentials of his life.

Arrangements were subsequently made for him to return home. He was to receive visits from the nurse at the local clinic and went home with specific instructions to his family for his care. In addition, a fakataha fakafamili (a specific family meeting) was arranged to address unresolved emotional issues that might have been contributing to his ongoing ill health (his son had returned to Tonga about which he was heart sore). In a short period there was noticeable improvement in his condition and his daughter expressed gratitude that the nursing staff had re-considered the situation. She had resigned herself to the situation believing that the hospital system was simply different and would not be able to accommodate 'our ways'.

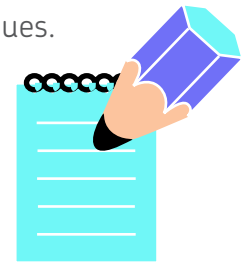
5. Set some team ground rules

Respect

- Hold zero tolerance for discrimination and stereotyping
- Do not allow people to be interrupted, over-ridden or ignored during discussions and meetings
- Team members need to address one another respectfully.

Conflict Management

- Conflicts and misunderstandings need to be addressed as they arise
- If members are unable to resolve conflict or misunderstanding amongst themselves, the team leader needs to mediate. Conflict can be a creative force bringing change and deepening relationship if well handled. Remember to allow each person's viewpoint to be heard, and look for the underlying cultural values that might be at the core of issues. Coaching from managers may be needed.



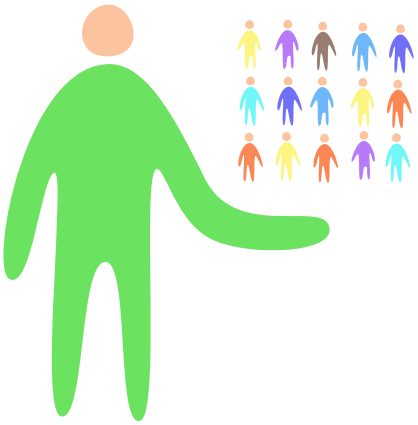
Are there any potentially conflictual issues that your team faces at present? Do cultural issues underlie the difficulties?

Co-operation

- Provide a forum for members to ask for, and offer assistance
- Encourage tolerance, acceptance and compassion of differences
- Co-operation over competition
- Engage the team in creating the ground rules. It is your task to help members adhere to them.

Decision-making

- Establish protocol for making decisions so team members have a common understanding and expectations on how this is done. Cultures with High Power Distance traditions with 'ascribed-status' will expect leaders to make decisions, and know all the answers. Others will expect to be part of the decision-making.



6. Helping Staff Adjust

- Create a 'buddy' or mentor system to assist new members to integrate. Have people from different cultures support each other
- If there are misunderstandings between staff (or between staff and service users) explore how much of these may be due to cultural differences
- Encourage people to consult their clinical coach, professional supervisor or team leader for further assistance
- Create a regular forum for people to explore differences so that misunderstandings, or potential misunderstandings can be worked through, or averted. Make this regular and explicit. Creating a warm and supportive environment in which to do this will encourage participation
- Ensure that all staff have access to appropriate protocols and legislation. These may differ significantly across cultures and countries (e.g. around death and dying, religious needs, gender expectations, births and pregnancy)
- Ensure that people have access to appropriate training. Cultural competence training is essential for all team members who work in culturally diverse environments.

SCENARIO

New Zealand legislation around disclosing terminal illness

A Kiwi patient was diagnosed with cancer and the doctor, who is Iraqi, fed back test results to her family first. They were surprised, and the patient was angry and upset when she discovered about her condition through her family. She felt that her rights to know about her own health and to make decisions for herself were violated.

Problem:
In Iraq the doctor is believed to be the authority in a hierarchical system, and patients are rarely informed about terminal illness since it is believed that the doctor would know best about what treatment they should have. It is also believed the patient's condition would deteriorate with knowledge about their terminal illness since the patient would likely lose hope. The family is usually informed instead. The doctor followed what he believed was a respectful and thoughtful practice.

Solution / Possible Approach:
The doctor needs access to New Zealand legislation around patient rights. In addition, cultural differences need to be highlighted since differences may be overlooked as etiquette, and not noted as required practice. Cultural competence training is necessary.

C2

MOTIVATING A CULTURALLY DIVERSE TEAM

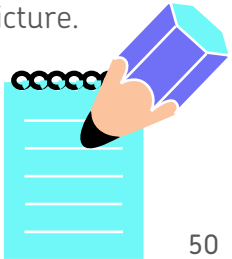
1. What motivates you doesn't motivate me

Motivating a culturally diverse team can be a challenging task. Individuals are motivated differently depending not only on personal goals and needs, but on cultural beliefs and values. People from task-oriented cultures are more likely to be motivated by task achievement, reward and recognition.

Relationship oriented cultures will more likely be motivated by establishing successful relationship and following etiquette.

- Find out what motivates each member of your team. ASK if it isn't obvious. Be aware of underlying cultural values
- Encourage members to discuss their differences in motivation
- Assign roles depending on individual's motivations as well as strengths
- Support team members to be successful in their roles
- Acknowledge and reward achievement – both achievements that support the team's goals and those that support the individual's (e.g. someone may do well in networking, and whilst this may not be an explicit goal of the team, it is a valuable resource in the bigger picture. Acknowledge their strength)

Do you know what motivates each member of your team?



2. Getting the best from diversity

- Find commonalities within the diversity. These can be found not only in work objectives and interests, but in shared values, importance of family, or in recreational activities. Help members to find something that they share

- Celebrate and value the richness of diversity. A culturally diverse team has the potential of great creativity, innovation and meaningful relationship given their multi-faceted perspectives and range of experiences. Reinforce these aspects

- Promote your team's diversity. Research tells us that well managed, diverse teams outperform homogenous teams

- Get your teams to explore aspects of different cultural practices and values that could be used with patients, to enhance the standard of care (whilst maintaining compliance with NZ health policies and practice)

- Create a new culture!

What is the potential that your particular team composition offers? Can you find a way to get this from your team, and identify its value? This could assist with a team identity or vision.

SCENARIO

Finding the best in diversity: 'Relationship' AND 'Task'

A young Chinese nurse Ling, took great care of her elderly Maori patient, Ahu. She completed all her tasks efficiently, took detailed notes, checked issues with her supervisor and expressed concern to her colleagues. However, on a patient satisfaction survey the patient complained of having an uncaring and unfriendly nurse and expressed dissatisfaction with the care. On further exploration of the situation it became apparent that Ling did not communicate much with her patient, avoided eye contact, did not ask questions, and seemed always in a hurry.

In Ling's culture (as in most Asian cultures) it would be considered rude to initiate conversation with a patient, to ask questions unless necessary, or to have eye contact, particularly with an elder. Ling's reticence was due largely to her respect for her patient and her hurried demeanour was in service of efficiency. Ahu, on the other hand valued relationship over task and was wanting warmth, eye contact and touch. Maori culture generally orients time around relationship rather than around schedule. It is no wonder that misunderstanding occurred.

Solution / Possible Approach

Have staff discuss these differences and find ways to incorporate the values from different orientations. How can efficiency AND nurturing be communicated to patients in ways that they will be receptive to, or how can concern be communicated while still offering a highly efficient service? It is vital that the issues are brought to the table and solutions found through team collaboration. It is imperative that the differences are seen as difference in cultural values, and NOT as personal incompetence. For clinical safety some coaching from the nurse educator is required.

SCENARIO
Culturally Competent System Response

The following situation occurred in an Emergency Care Department regarding an orthopaedic patient who required complex nursing care. His needs were particularly unusual and these had not been experienced previously in the particular hospital.

The patient was Mr S, an 85-year-old Indian male who had fallen in the shower at 4 o'clock in the morning and fractured the left neck of his femur. His followers (of whom about 20 were with him in Emergency Care) considered him a "living saint". The charge nurse manger was told that he must not 'behold the form of a woman'. Fortunately she had been able to roster a male registered nurse overnight, however there were no male nurses on the morning shift, hence she had not been able to ascertain the patient's current condition. The patient had been reviewed by the orthopaedic team and would be going to the operating room sometime during the day. He would require an orthopaedic bed.

Fortunately there were two empty male beds and patients were moved around to make a double room close to the charge nurse manager's office. The service manager and the charge nurse manager consulted the spokesperson for Mr. S to clarify the patient's cultural and religious needs so that they could find ways to accommodate these on the ward.

The spokesperson was a prominent General Practitioner (GP) from the area and was familiar with the systems, policies and procedures of the hospital. He explained that the patient was considered by the Hindu community to be their spiritual leader. They thought of him as a "living saint" due to the harsh self-discipline he followed for his spirituality and religious beliefs. Mr S had taken strict vows of celibacy which prohibited association, communication or viewing of a female person.

Mr S had over 200,000 followers and disciples around the world and had travelled from India to give spiritual leadership lectures to his followers at a local temple. Mr S had three disciples present with him who would undertake all his personal care, as there were particular rituals required around bodily wastes. His spokesperson asked that the patient be nursed by male nurses only, and that if that were not possible either a colleague GP or he would stay with the patient overnight to continue IV therapy and medications.

The orthopaedic service manager and charge nurse manager assured the spokesperson that they would do everything possible to meet their specific requests. Mr. S was to be allocated a double side room and have the other bed closed off but it was explained that in the event of a hospital bed crisis that the bed would need to be opened for another male patient. In regards to the male nurse the charge nurse manager negotiated with other surgical wards to swap nursing staff to cover those shifts where there was no male nurse allocated. The spokesperson was informed that there were ethical and legal requirements concerning nursing care and documentation which would need to be addressed. They needed to ensure that nurses were following safe practice regarding IV medications and to monitor what the GP was administering to the patient. (Mr S would not take any oral medications that hadn't been prepared by his disciples in his own country in case the hospital medications contained alcohol).

Mr S underwent surgery in the afternoon accompanied by the GP and his male nurse.

During the period Mr S was in the operating room the charge nurse manager researched the legality regarding the issue of a GP administering IV medications to an inpatient at the hospital. It was ascertained that a General Medical Practitioner who held a valid and current license to practice medicine and who adhered to the DHB policies and procedures was able to administer IV medications when checked by a registered nurse. It was required that procedures be recorded in the drug register and documented in the patient's notes.

Ethically it was extremely difficult for any staff member to write documentation regarding the patient when only having had verbal discussion with disciples or the GP and not being able to assess the patient holistically themselves. One of the main concerns was the pressure area care and skin integrity as the department prided themselves on a very low rate of pressure areas in their elderly patients. Nutrition and fluid intake was also a concern as Mr S, through his disciples, refused all hospital meals and fluids. These were brought in by his attendants to ensure that possible additives in the hospital food would not contravene his strict Hindu diet.

The situation was extremely challenging for the charge nurse manager of the ward. It was her usual practice to visually and (where necessary) physically assess all patients on a daily basis to ensure they were receiving the most appropriate care or treatment. In Mr S's case she was having to rely entirely on male nursing staff and in some instances very junior nurses, plus GPs with whom she had not worked previously and so had not built a trusting working relationship. However, over the five days Mr S was in the ward she came to trust her medical colleagues in unexpected ways. She reported that they were open communicators, held respect for ward nurses and the charge nurse manager herself, and never caused any concerns or demanded any particular care or treatment that they knew the staff would not be able to provide in the public hospital system.

After 30 + years in nursing and in varying positions in many hospitals in New Zealand and in the UK, the charge nurse manager found that the situation challenged her beliefs around ethical and cultural awareness to the extreme. She expressed that it had been a very insightful journey for her nursing staff and herself and that the sincere gratitude and thanks they received from Mr S and his followers left them with a warm feeling that they had met the challenge and passed the test.

This is an example of a culturally competent and flexible system response to a challenging situation.

Section D

Training, Resources Support

a. Training available for CALD immigrant staff

Training available to develop skills and strategies to enable effective working relationship between CALD staff and Kiwi staff, and to improve literacy, numeracy and communication / English language skills

- Being Kiwi Competent [Refer Waitemata DHB Organisational Learning and Development intranet for details about when this course is available]
- English language support [Refer Waitemata DHB Organisational Learning and Development intranet for details of English language courses available].

b. Training available for ALL STAFF (including managers)

Training to develop skills and strategies to enable effective working relationships between staff

- Working in Culturally Diverse Team [Refer Waitemata DHB Organisational Learning and Development intranet for details about when this course is available].

c. Training available for MANAGERS managing culturally diverse teams

Training to develop skills and strategies to enable effective management of culturally diverse teams

- Managing Culturally Diverse Teams [Refer Waitemata DHB Organisational Learning and Development intranet for details about when this course is available].

d. Training for ALL STAFF working with CALD clients

Cultural Competence training for working effectively with CALD patients / clients / service users

- CALD Module 1: Culture & Cultural Competence
- CALD Module 2: Working with Migrants (Asians)
- CALD Module 3: Working with Refugees
- CALD Module 4: Working with Interpreters
- CALD Module 5: Specialist Training - Working with Asian mental health clients (for mental health practitioners only)
- CALD Module 6: Specialist Training - Working with Refugee mental health clients (for mental health practitioners only).

e. Resources available for ALL STAFF working with CALD clients

The following are services and resources to support Waitemata DHB staff working with CALD clients as listed on the website www.CALD resources.org.nz

- Cultural support for Asian health patients
- Cultural support for Asian mental health clients
- Culture-specific Asian smokefree service
- Culture-specific Asian CADS counselling service
- Culture-specific Asian Problem Gambling service
- Culture-specific Refugee mental health services
- Translated resources
  (Ward communication tools; brochures, patient information)
- Online Cross-Cultural Resources including a booklet detailing 7 Asian, 3 Eastern Mediterranean, and 4 African cultures
  (with practical tips for health practitioners).

f. Support available for CALD Staff

Please contact the Human Resource Manager / Advisor of your service for the following:

- Issues relating to harassment and bullying
- Kiwi buddy to continue learning about Kiwi values / communication style
- Issues relating to discrimination
- Clinical / professional supervision.

Please contact the Waitemata DHB Occupational Health Personnel for information and access to an Employee Assistance Programme.

For any other matters pertaining to training and support for cross cultural issues, please discuss with your team leader and manager of your service to identify your needs and ascertain what support is available at Waitemata DHB.

Section E

Appendices

E1
GLOSSARY OF HEALTH SECTOR ACRONYMS

For acronyms used in Waitemata DHB refer to Waitemata DHB Policy "Abbreviations Approved for Use" in the Clinical Practices Manual.

COMMONLY USED IDIOMS IN NEW ZEALAND

IDIOM / SAYING	WHAT IT MEANS
About face	When something is turned around the opposite way, or when someone changes their mind (e.g. a government or organisation changes their position on an issue)
Across the ditch	On the other side of the Tasman Sea – this is used to refer to Australia or New Zealand depending on the speaker's location
All over the place / show	Something is disorganised / confused
A OK	Things are OK, absolutely fine
A redneck	A racist person who is narrow-minded. This term originates from the Southern States of America
Arvo	Afternoon
A smoothie	A handsome man who is very good at meeting and talking to women
A steal	It's a good deal, it costs less than it is worth
At a loss	Unable to understand / comply
At odds	Cannot agree with someone / arguing
At your wit's end	No idea what to do next, very frustrated
Away laughing	Indicating something successfully completed
A wolf in sheep's clothing	A dangerous person who pretends to be harmless
At the end of the day	Finally, when all is said and done, in conclusion
Back burner	Low priority
(On the) Back foot	At a disadvantage, forced to take a defensive position
Back in two ticks	Will be back in a moment

IDIOM / SAYING	WHAT IT MEANS
Beside the point	Not relevant to the matter being discussed or considered
Big bikkies	Large amounts of money
Bot (to catch the bot)	To get a germ or bug
Box of birds	Ok, easy, going well
Bullshit (considered impolite)	You're telling lies / fibs'
By the book	Do something exactly as you are supposed to
Change of heart	Change the way you think and feel about something
Change your tune	Change your ideas or way you talk about them
Cheers	Thank you
Clear as mud	Very confusing / unclear
Copycat	A person who imitates other people
Cramp my style	To restrict me, compromise me
Crook	Sick, ill, or go awry or a bad person or someone who rips others off
Daylight robbery	High or exorbitant prices or charging
Deal to	Beat up, thrash
Face value	Accept the appearance rather than look deeper into the matter
Fall flat on your face	To be completely unsuccessful usually because of a bad attitude
Feel free	There is no problem
Flat out	Working as hard and fast as you can

IDIOM / SAYING	WHAT IT MEANS
Gear	Clothing, equipment for sports, generally belongings that you carry around
Get it off your chest	To confess something that has been troubling you
Get the ball rolling / Get the show on the road / Get off the ground / Set the wheels in motion	To get something started / put a plan into action
Get the picture	To understand something fully
Get your head around something	To understand something even though it's hard to comprehend
Get up my nose	Annoy someone
Give it heaps	Make a really big effort
Go hand in hand	Things that go together, are associated
Gone pear-shaped / Gone to pot	Something has gone wrong or produced an unexpected result
Good as gold	Every thing is OK / in order
Good on you / ya!	Congratulations! Well done – said to encourage
Gossip Chatterbox	Someone who talks about other people
Graft	Hard work
Hands are tied	Unable to act for some reason
Happy as Larry	Very happy
Hard to handle / Hard to take	A person who is unpleasant Or a difficult person who makes other people angry
He can't take a hint	He does not respond to subtle cues
He's full of himself / He's up himself	He is very arrogant and snobbish He is very opinionated and egotistical

IDIOM / SAYING	WHAT IT MEANS
Hit the hay / Hit the sack	Go to bed
Hold the fort	To look after something or assume someone's responsibilities while they are away
Hot chick / Hot babe	An attractive woman (offensive to many women)
Hunk	An attractive and handsome man
I can read you like a book	I can predict your behaviour I have an insight into how you behave
I can take it or leave it	I don't really mind I don't particularly like something but I don't hate it either
I can't get my head around it	I don't quite understand
In the long run	Over a long period of time In the end In the final result
In the nick	Naked, without clothes on In prison
In two minds	Can't decide what to do about something
In your dreams!	You are being unrealistic
It's no big deal	It is not important
It's not the end of the world	It is not that important to worry about
Jack-of-all-trades	Someone that can do many different jobs / tasks
Keep in touch	Stay in communication
Keep me posted	Keep me up-to-date with information / developments
Let's call it a day	Take a break from doing something
Littlie	A little one, a young child
Lolly	Sweetie, or sometimes money

IDIOM / SAYING	WHAT IT MEANS
Look on the bright side	To see things in an optimistic way
Lose the plot	When someone has stopped being rational about something
Macho-man	A strong masculine man, usually quite self-assured
Mate / matey	Friend
Mates rates	Reduced rates for friends
Narked	Annoyed, cross
New kid on the block	A person who has recently joined a company, team, etc. and does not know how things work yet
No flies on you	Smart, shrewd (no flies on her)
Nothing to write home about	It's nothing important or worthy of mention Something which you have seen which is not very impressive
Not to know someone 'from a bar of soap'	Don't recognise them at all
Off the cuff	To do something without preparation
Offsider	Assistant of another (often of a cook)
Off the planet / Way-out / Off the wall	Something strange or weird
Off with the fairies / Away with the fairies / Head in the clouds	Daydreaming, or having unrealistic ideas about things
On the same page / wavelength	Thinking the same way / Have the same ideas
Piece of piss / (considered impolite) Piece of cake	Something easy to do

IDIOM / SAYING	WHAT IT MEANS
Pull your weight	Not making enough effort, especially in group work
Put on a pedestal	To make somebody seem important, have unrealistic expectations of them
Quack	A medical doctor who isn't considered to know what he's doing, or practitioners who people think are fakes (sometimes suggests that the doctor is not certified) Slang for a medical doctor
Rapt / Chuffed	Extremely pleased
Scarce as hens' teeth	Very scarce, unusual
See eye-to-eye	To agree about something
Set / written in stone	Cannot be changed
Shark	A greedy and unscrupulous person who often gambles, or makes money at other's expense A person who makes their living by gambling
Shout	To treat / pay for a round (often drinks but can be food or entertainment)
Sickie	Sick-leave – 'take a sickie' (often on Mondays i.e. not genuinely sick)
She'll be right	Everything will turn out OK
Skite	To boast
Streetwise	Astute
Sweet as.....	No worries, everything is good, OK
Switched-on Up with the play Fingers on the pulse	A person who is up to date with what is happening
Tall poppy	To stand out, above the rest
Tell me about it Join the club	I have had the same bad experience that you have had

IDIOM / SAYING	WHAT IT MEANS
That's a tough call	That is a hard decision to make
The wop wops	Rural areas where very few people live
There are no flies on me	To be worldly
Think outside the box	To think in an imaginative and creative way
Till the cows come home	After a long time...indicating it might not ever happen
To be in hot water	To be in trouble
To be on the same wavelength To have rapport with	To have something in common with somebody To have the same way of thinking
To be out of your depth	To do something that you can't really do, or work in an area you don't feel familiar in
To be up yourself	To be proud or conceited
To be up the creek without a paddle	To be in a hopeless situation without any chance of solving it
To call the shots	To make the decisions
To cut corners	To try to do something as cheaply or as quickly as possible, often sacrificing quality
To give a hand	To help someone
To have nothing in common	Not to have the same interests or the same way of thinking
To lose the plot	To lose control, get really confused, or go mad
To pay through the nose	To pay a high price for something
To throw a wobbly	To shout, have a temper fit
Up in the air	When there is uncertainty about a decision or situation

IDIOM / SAYING	WHAT IT MEANS
Up market	Anything associated with people who have surplus money (e.g. a house, suburb, clothing)
Up the duff	Pregnant
Water off a duck's back	Something is not heard or taken on board by the listener (like water rolling off without sinking in)
Water under the bridge	Past experiences which you should not dwell on
Were you born in a tent?	You've left the door open
What are ya?	Is that all you've got?
What's up?	What's wrong? How are you?
What's your take on that?	Asking someone for their opinion and ideas about something
White Elephant	An expensive enterprise which becomes redundant after initial use (e.g a stadium built for the Olympics, which is not used thereafter)
Whole shooting box / Whole box of tricks	Everything, everyone, the 'whole box of tricks'
(That) Will never fly	An idea or project that has no chance of succeeding
You can say that again / There's no two ways about it / You'd better believe it	That is definitely true, without a doubt
(It's) Your call	It is up to you to make a decision on the matter
You're full of crap (considered impolite)	You're telling lies

More Idioms can be found at http://www.usingenglish.com/reference/idioms/

E2

LEGISLATION, STANDARDS, STRATEGIES AND POLICY

1. COMPETENCE STANDARDS FOR STAFF WORKING IN CALD ENVIRONMENT

Kiwi Competence

To work successfully with staff from Kiwi cultural backgrounds, CALD staff need to demonstrate appropriate attitudes, awareness, knowledge and skills and have the ability to:

- Understand how their own cultural values impact on relationships with colleagues who are from Kiwi cultural backgrounds
- Gain insight into Kiwi values and norms
- Be able to converse effectively with Kiwis using English language
- Establish relationships and rapport with Kiwi colleagues.

Competence Standards For Staff Working In Cultural Diversity

To work successfully in diversity, staff need to demonstrate the appropriate attitudes, awareness, knowledge and skills and have the ability to:

- Understand core intercultural competencies (cultural self-awareness, culture-specific awareness and knowledge, building bridges)
- Apply these competencies in the workplace
- Understand and apply a framework for understanding culture
- Distinguish and understand how descriptions and interpretations of behaviour differ
- Demonstrate how personal experiences and cultural values influence interpretations and evaluations of others
- Explain how cultural values translate into culture-specific behaviours
- Identify ways in which communication can be enhanced, by recognising common language and accent challenges
- Prepare intercultural learning goals for inclusion in performance objectives and personal goal setting
- Have and be able to articulate a framework for developing intercultural relationships
- Recognise when one's own communication style and norms are inappropriate and be able to adjust these appropriately
- Seek explanations for behaviour and communication that are different from one's own.

Competence Standards For Managers Managing Culturally Diverse Teams

To work successfully and effectively as a manager leading a culturally diverse team, a manager needs to demonstrate the appropriate attitudes, awareness, knowledge and skills and have the ability to:

- Understand and apply intercultural competencies (cultural self-awareness, culture-specific awareness and knowledge, building bridges)
- Apply these competencies in workplace settings
- Describe briefly ethnic diversity in New Zealand and the implications for government service delivery, policy development and human resources practices
- Explain and be able to apply a framework for understanding culture
- Distinguish and understand how descriptions and interpretations of behaviour differ
- Demonstrate how personal experiences and cultural values influence our interpretations and evaluations of others
- Explain how cultural values translate into culture-specific behaviours
- Identify and demonstrate tools for overcoming stumbling blocks to effective intercultural communication (e.g. language and accents)
- Prepare intercultural learning goals for inclusion in performance objective and personal goal setting
- Have and be able to articulate a framework for developing intercultural relationships
- Be able to assist staff to adjust to working in a multicultural team
- Understand the influence of cultural differences in the workplace and society.

Cultural Competence for Health Practitioners

One of the additional provisions for health regulatory authorities introduced under the Health Practitioners Competence Assurance Act 2003 (HPCAA) www.moh.govt.nz/hpca is that of setting the standards of cultural competence to be observed by health practitioners. This is included under section 118(i) of the Act.

The concept of 'cultural competence' was developed in health care to better meet the needs of increasingly culturally diverse populations, and in response to the growing evidence of disparities in the health of ethnic minority groups (Betancourt et al., 2003; Brach & Fraser, 2002). In New Zealand, the interpretation of the meaning of 'cultural competence' is complicated by the fact that the Health Practitioner's Competence Assurance Act does not give a clear definition of the term. Professional registration bodies for the health and disability workforce in New Zealand have each defined cultural competence in different ways. Some examples of the definitions that are being used in New Zealand are listed here:

2. STRATEGIES

Waitemata DHB's Health Gain and Service Improvement Priorities, 2005 considered addressing health inequalities as a priority area. It stated that in order to achieve this, health services should be accessible, culturally appropriate and safe to meet the healthcare needs of the population, including Asian people, migrants and refugees. Ministry of Health DHB Operations Policy Framework 2006-2007 requires all DHBs to consider ethnic peoples:

- In the policy framework for consultation
- In contribution to strategic development for ethnic peoples' health improvement
- In workforce development: capacity building in health and disability sector, contribution to ethnic specific provider and workforce development
- In the reducing inequalities framework
- In service provision process: to acknowledge and ensure integrity of consumer's culture
- In service satisfaction process: to include significant local ethnic groups to assess services.

National, Regional and Local Mental Health Strategies: The following strategic documents have included the need for DHB consideration to ensure responsiveness of mental health and addiction services for people from diverse culture and ethnic groups

- Te Tahuhu: Improving Mental Health 2005-2015: The Second NZ Mental Health & Addiction Plan
- Te Kokiri: The Mental Health & Addiction Action Plan 2006-2015
- Northern Regional Mental Health & Addictions Services Strategic Direction 2005-2010
- Mental Health Commission's Recovery Competencies of Mental Health Workers 2001
- Auckland Regional Mental Health & Addictions Implementation Plan 2006-2010: Improving mental health services responsiveness to Asian communities
- Improving mental health services responsiveness to Asian communities in Waitemata District: Implementation Plan 2006-2010.

The Auckland Regional Settlement Strategy 2006 concluded the need for health providers to consider responsiveness for migrant and refugee populations in funding, planning, service delivery and workforce development areas.

3. LEGISLATION AND ACTS

Legislation and Acts: the following are some of the legislation requiring health practitioners and service providers to ensure the provision of culturally responsive and competent services to consumers from culturally and linguistically diverse backgrounds.

- The Health and Disability Commissioner Act 1995 and the Health and Disability Code of Rights 1996 give consumers the right to be provided with services that take into account the needs, values and beliefs or different cultural, religious, social and ethnic groups. The Code gives consumers the right to freedom from discrimination, coercion, harassment and exploitation.

- Right 5 of the Code of Health and Disability Services Consumers' Rights gives clients the right to communication.

- The Mental Health (Compulsory Assessment and Treatment) Act 1992 and the 1999 amendments promote a culturally sensitive approach.

- The Health Professional Competence Assurance Act (2003) incorporates the basic principles of ongoing competence, requiring the Medical Council to ensure the cultural competence of medical practitioners.

4. POLICY AND GUIDELINES

For Waitemata DHB staff, please refer to the following through the Waitemata DHB intranet:

- Maori Health Service Access
- Pacific Health Service Access
- Asian Health Service Access
- Interpreting and Translation Services.

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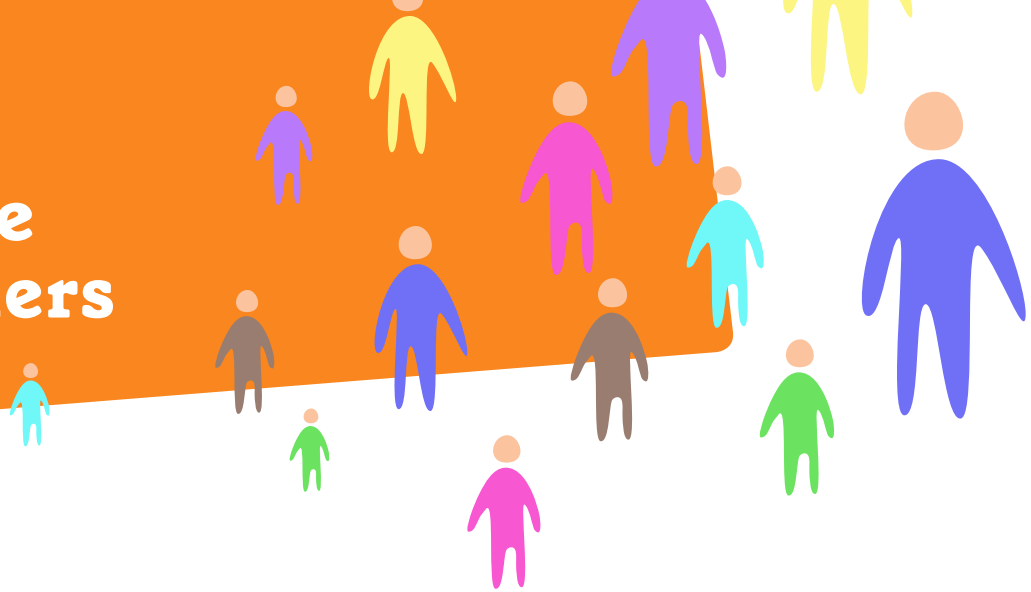
Cultural Competence for Health Practitioners



One of the provisions for health regulatory authorities introduced under the Health Practitioners Competence Assurance Act 2003 (HPCAA) www.moh.govt.nz/hpca is to set the standards of cultural competence to be observed by health practitioners. This is included under section 118(i) of the Act.

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CULTURAL COMPETENCE DEFINITION AND STANDARDS

The Medical Council of New Zealand and the Royal New Zealand College of General Practitioners www.mcnz.org.nz / www.rnzcgp.org.nz	**Nursing Council of New Zealand** www.nursingcouncil.org.nz	**Social Workers Registration Board** www.swrb.org.nz
"Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge: • That New Zealand has a culturally diverse population • That a doctor's culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship • That a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding." (2006)	**The Nursing Council of New Zealand, (2002) Guidelines for cultural safety, the Treaty of Waitangi, and Maori health in nursing and midwifery education and practice serve as the basis for the indicators of competence related to the practice of cultural safety for all ethnic groups in New Zealand.** The 2007 Competencies for registered nurses provide the indicators that nurses are expected to demonstrate when practising "in a manner that the client determines as being culturally safe" (NZNC, 2007, p. 9).	**The Social Workers Registration Board (SWRB) has developed the SWRB Core Competence Standards for social workers. (The SWRB recognises core competences that reflect practice standards accepted in social work in New Zealand (Section 42 [3]). The core competence standards apply to all competence processes that are set and approved by the SWRB. The requirements of the Act, the International Federation of Social Workers definition of social work and the ANZASW standards of practice have informed the SWRB in determining these standards).**
To work successfully with patients of different cultural backgrounds, a doctor needs to demonstrate the appropriate attitudes, awareness, knowledge and skills: **Attitudes** • A willingness to understand your own cultural values and the influence these have on your interactions with patients • A commitment to the ongoing development of your own cultural awareness and practices and those of your colleagues and staff • A preparedness not to impose your own values on patients	**The competencies include the nurse's ability to:** • Apply the principles of cultural safety to nursing practice • Recognise the impact of the culture of nursing on client care and endeavour to protect the client's wellbeing within this culture • Practise in a way that respects each client's identity and right to hold personal beliefs, values and goals • Assist the client to gain appropriate support and representation from those who understand the client's culture, needs and preferences	**A competent social worker's practice must demonstrate the following:** **1. Competence to practise social work with Maori:** • The social worker is competent to practise social work with Maori • Able to engage with Maori in culturally appropriate ways and in an inclusive manner • Can articulate how the wider context of Aotearoa New Zealand both historically and currently can impact on practice content

The Medical Council of New Zealand and the Royal New Zealand College of General Practitioners www.mcnz.org.nz / www.rnzcgp.org.nz	Nursing Council of New Zealand www.nursingcouncil.org.nz	Social Workers Registration Board www.swrb.org.nz
• A willingness to appropriately challenge the cultural bias of individual colleagues or systemic bias within health care services where this will have a negative impact on patients **Awareness and knowledge** • An awareness of the limitations of your knowledge and openness to ongoing learning and development in partnership with patients • An awareness that general cultural information may not apply to specific patients and that individual patients should not be thought of as stereotypes • An awareness that cultural factors influence health and illness, including disease prevalence and response to treatment • A respect for your patients and an understanding of their cultural beliefs, values and practices • An understanding that patients' cultural beliefs, values and practices influence their perceptions of health, illness and disease; their health care practices; their interactions with medical professionals and the health care system; and treatment preferences • An understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings • An awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the clinical situation	• Consult with members of cultural and other groups as requested and approved by the client • Reflect on his/her own practice and values that impact on nursing care in relation to the client's ethnicity, culture and beliefs • Avoid imposing prejudice on others and provide advocacy when prejudice is apparent	• Offers practical support to Tangata Whenua for their initiatives • Have knowledge of the Treaty of Waitangi, te reo Maori and tikanga Maori • Supports Mana Whenua and Maori services in their area **2. Competence to practise social work with different ethnic and cultural groups in Aotearoa New Zealand:** • The social worker is competent to practise social work with different ethnic and cultural groups in Aotearoa New Zealand • Creates an environment of respect and understanding • Able to engage with a range of people in culturally appropriate ways and in an inclusive manner • Recognises and supports diversity among groups and individuals • Can articulate how the wider context of Aotearoa New Zealand both historically and currently can impact on practice content • Displays ethical behaviour and responsibility **3. Competence to promote social change:** • Promotes and advocates the needs of social change to provide fairness for all • Respects the worth and dignity of clients and does not associate with any form of discrimination • Reflects on social work practice with a view to enhance principles of human rights, social justice and social change

The Medical Council of New Zealand and the Royal New Zealand College of General Practitioners www.mcnz.org.nz / www.rnzcgp.org.nz	Nursing Council of New Zealand www.nursingcouncil.org.nz	Social Workers Registration Board www.swrb.org.nz
Skills • The ability to establish a rapport with patients of other cultures • The ability to elicit a patient's cultural issues which might impact on the doctor-patient relationship • The ability to recognise when your actions might not be acceptable or might be offensive to patients • The ability to use cultural information when making a diagnosis • The ability to work with the patient's cultural beliefs, values and practices in developing a relevant management plan • The ability to include the patient's family in their health care when appropriate • The ability to work cooperatively with others in a patient's culture (both professionals and other community resource people) where this is desired by the patient and does not conflict with other clinical or ethical requirements • The ability to communicate effectively cross culturally and: › Recognise that the verbal and nonverbal communication styles of patients may differ from your own and adapt as required › Work effectively with interpreters when required › Seek assistance when necessary to better understand the patient's cultural needs		**4. Competence to promote problem-solving in human relationships:** • Assists and advocates clients to gain control over their own circumstances • Maintains confidentiality, trust and respect • Communicates with the client's community, their families, whanau and caregivers • Demonstrates flexibility and adaptability • The social worker is aware of their own bias and values **5. Competence to promote empowerment and liberation of people:** • Upholds and promotes the civil and legal rights of the client where possible • Works with conflict to generate positive outcomes and displays leadership qualities • The social worker secures the client's participation in a working relationship • Facilitates problem-solving and development opportunities with clients • Is supportive to other social workers **6. Competence to utilise theories of human behaviour and social systems:** • Has an understanding of social work theories and the approach of these theories into practice • Utilises appropriate theories of human behaviour and social cultural systems

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		• Utilises a range of social work practices • Discharges statutory functions according to the Aotearoa New Zealand law and meets their obligations to clients **7. Competence to utilise social work practice approaches:** • Can demonstrate an ethical base for their practice which informs personal and professional boundaries • Uses their personal attributes appropriately • Engages and utilises supervision • Keeps accurate and current casework records • Engages in continuing professional development **8. Competence to promote the principles of human rights and social justice:** • Respects the client's right to privacy and confidentiality of any information provided in the course of the professional relationship • Promotes a commitment to higher global values, such as human rights, self-determination and social change • Seeks to understand others first, works cooperatively and indentifies strengths, opportunities and responsibilities when working with others **9. Competence to use systems of accountability in place for their work:** • Practises only within the boundaries set by their skills, experience and knowledge levels • Is aware of, and responds appropriately to, actual or potential conflicts of interest

The Medical Council of New Zealand and the Royal New Zealand College of General Practitioners www.mcnz.org.nz / www.rnzcgp.org.nz	**Nursing Council of New Zealand** www.nursingcouncil.org.nz	**Social Workers Registration Board** www.swrb.org.nz
		• Communicates clearly and accurately • Manages resources safely and effectively • Establishes and actively participates in systems of accountability in accordance with social work ethics and standards for professional practice • Engages with and utilises social work supervision • Develops professional networks to enhance accountability **10. Adhere to professional social work ethics:** • Maintains professional integrity • Upholds high standards of personal conduct, ethics and acts with integrity • Establishes high expectations which value and promote social work practices • Encourages others and participates in professional development • Adheres to the SWRB Code of Conduct http://www.swrb.org.nz/CodeOfConduct.html • Meets their obligations to their client within the content of those functions and adherence to the SWRB Code of Conduct guidelines

Auckland Region
Allied/Public Health/Technical MECA
Cultural Responsiveness

This practice domain advances the competencies for practitioners regarding cultural competence for Pacific cultures or for people from other cultures that you interact with in your clinical/ professional practice. Cultural responsiveness requires an awareness of cultural diversity and the ability to function effectively and respectfully when working with people from different cultural backgrounds. It also requires awareness of the practitioner's own identity and values, as well as an understanding of how these relate to practice. Cultural customs are not restricted to ethnicity but also include (and are not limited to) those related to gender, spiritual beliefs, sexual orientation, abilities, lifestyle, beliefs, age, social status, or perceived economic worth. The development of objectives based on the themes identified below relies on maintaining key relationships to ensure oversight, direction, leadership and guidance from the appropriate people within local organisations and the community.

Theme	Example of Activities
Demonstrates alignment of clinical/ professional practice and appropriateness with policies related to other cultural population groups represented in your DHB	• Develops and maintains relationships with groups representing an identified culture • Demonstrates a working relationship with relevant community resources • Demonstrates an understanding and analysis of current issues in specific client groups • Links DHB Strategic plan with clinical practice in key target areas
Develops an in-depth understanding of an identified cultural group within your DHB	• Researches into an identified culture, its wider environmental context, leadership structure and its interplay with clinical practice • Researches DHB vision and values and that culture's population principles of health, linking this to own role and responsibilities • Researches disparities in the DHB population and links this to own service
Developing a culture of cultural competence	• Demonstrates leadership and role modelling in both clinical and professional practice and service delivery • Challenges culturally inappropriate practices and supports staff to make changes • Is actively involved in developing cultural policies within own service • Develops needs assessment of cultural requirements for staff • Cultural knowledge and appropriateness is applied to clinical and professional practice • Demonstrates an understanding of own issues regarding cultural intervention • Demonstrates a working relationship with relevant community groups • Develops understanding and analysis of current issues in specific client groups • Leads the DHB Strategic Plan with clinical practice in key target areas

CULTURAL COMPETENCE DEFINITION AND STANDARDS

Occupational Therapy Board of New Zealand www.otboard.org.nz	**Physiotherapy Board of New Zealand** www.physioboard.org.nz	**New Zealand Psychologists Board** www.psychologistsboard.org.nz
To provide a service that takes into account the socio-cultural values of the client/tangata whaiora, family/ whanau and significant others and the experience of trauma as dimensions of culture.	**The Physiotherapy Board of New Zealand (2009) Physiotherapy competencies for physiotherapy practice in New Zealand include cultural competency in Competency 1: "Analyse and discuss the biomedical, behavioural and social science bases of physiotherapy and integrate bases into physiotherapy practice".** (Note: This is not a standard but an explanation)	**Cultural competence is defined by the NZ Psychologists Board as having the awareness, knowledge and skill necessary to perform a myriad of psychological tasks that recognise the diverse worldviews and practices of oneself and of clients from different ethnic/cultural backgrounds. Competence is focussed on the understanding of self as a cultural-bearer; and wellbeing whether pertaining to individuals, peoples, organisations or communities and the development of relationships that engender trust and respect. Cultural competence includes an informed appreciation of the cultural basis of psychological theories, models and practices and a commitment to modify practice accordingly.**
1. Demonstrate understanding of the complexity of culture **2.** Recognise the multiple realities and identities that people bring to the practice context e.g. gender, ethnicity, religious belief, sexual orientation, ability, life stage. **3.** Demonstrate understanding of power dynamics in therapeutic contexts, and foster opportunities for clients/ tangata whaiora to maximise self advocacy skills **4.** Demonstrate awareness of the cultures of occupational therapy and their potential impact on the person **5.** Identify personal significant cultural values, beliefs, attitudes, and prejudices, and understand their potential impact. **6.** Recognise own level of cultural safety, consult, and refer on where indicated	**Section 1.9 requires the physiotherapist to:** • Explain the principles of the Treaty of Waitangi from an historical perspective. • Explain the relevance of the Treaty of Waitangi to a physiotherapist. • Describe the cultural differences of the current population in New Zealand in relation to health. Understand the complexities of giving and receiving a therapeutic intervention such as cultures, beliefs, behaviours, age, gender and social structure.	**1. Awareness** (a) Awareness of how one's own and the client's cultural heritage, gender, class, ethnic-racial identity, sexual orientation, institutional or organisational affiliation, practice orientation, disability and age-cohort help shape personal values, assumptions, judgements and biases related to identified groups. **2. Knowledge** (b) Knowledge of how psychological theory, methods of inquiry, research paradigms and professional practices are historically and culturally embedded and how they have changed over time as society values and politically priorities shift (c) Knowledge of the history and manifestation of oppression, prejudice and discrimination in home country, and that of the client and their psychological sequelae.

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7. Identify and safely respond to client/tangata whaiora values, beliefs, attitudes and practices 8. Recognise and respect the uniqueness of the individual in the context of their community 9. In consultation with the client/tangata whaiora, identify and work in partnership with resources of family/whanau, community and significant others. 10. Ensure intervention is guided by reflective practice 11. Action treaty of waitangi partnership responsibilities, liaising and developing relationships with local iwi and maaori health, welfare and education workers 12. Respond appropriately where cultural difference may be an issue.		(d) Knowledge of socio-political influences (e.g. poverty, stereotyping, stigmatisation, land and language loss, and marginalisation) that impinge on the lives of identified groups (e.g. identify information, development outcomes, and manifestations of mental illness) (e) Knowledge of cultural-specific diagnostic categories, and the dangers of using psychometric tests on populations that differ from the normative group. (f) Knowledge of such issues as normative values and about illness, help-seeking behaviour, interactional styles, community orientation, and worldview of the main groups that the psychologist is likely to encounter professionally (g) Knowledge of culture-specific assessment procedures tools and their empirical (or lack of) background. (h) Knowledge of family structures, iwi, hapu and other inter-tribal relations, gender roles, values, educational systems (kura kaupapa, kohanga reo) beliefs and worldviews and how they differ across identified groups along with their impact on identity formation, development outcomes and manifestations of mental illness. (i) Knowledge of the NZ/Aotearoa Code of Ethics (2002), knowledge of the Treaty of Waitangi and its application to psychological practice and knowledge of legislation governing psychologists in NZ. **3. Skills** (j) Ability to accurately evaluate emic (culture-specific) and etic (universal) hypotheses related to clients from identified groups and to develop accurate research findings and/or clinical conceptualisations, including awareness of when issues involve cultural dimensions and when theoretical orientation needs to be adapted for more effective work with members of identified groups.

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		(k) Ability to accurately assess one's own cultural competence, including knowing when circumstances (e.g. personal biases; stage of ethnicity identify; lack of requisite knowledge, skills, or language fluency; socio-political influences) are negatively influencing professional activities and adapting accordingly (e.g. professional development, supervision, obtaining required information, or referring to a more qualified provider – emphasis there is on professional development). (l) Ability to modify (where appropriate) assessment tools; or to forego assessment tools and quality conclusions appropriately (including empirical support where available) for use with identified groups (culture-specific models) (m) Ability to design and implement non-biased, effective treatment plans and interventions for clients from identified groups, including the following: • Ability to assess such issues as clients' level of acculturation, ethnic-identity status, acculturative stress, gay and lesbian issues, (see point 1) (whanau groups) • Ability to ascertain effects of therapist-client language difference (including use of translations or cultural advisors) on psychological assessment and intervention; • Ability to establish rapport and convey emphathy in culturally sensitive ways (e.g. taking into account culture-bound interpretations of verbal and non-verbal cues, personal space, eye-contact, communication style); • Ability to initiate and explore issues of difference between the psychologist and the client, when appropriate and to incorporate these issues into effective treatment planning. (n) Ability to conduct supervision in a culturally competent manner (for the benefit of the client and the supervisee, and supervisor) taking into account the factors above.