

Culturally and Linguistically Diverse Children and their families

Implications for paediatric and child development services in Queensland



Culturally and Linguistically Diverse Children and their families – Implications for paediatric and child development services in Queensland.

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Australia's Aboriginal and Torres Strait Islander culture, Australia's First Nation's people, are the original cultural groups of Australia and have been for thousands of years.

While some of the considerations outlined in the following document are relevant for all culturally responsive practice, Aboriginal and Torres Strait Islander culture is not specifically covered in this paper.

Understanding the unique experience of Aboriginal and Torres Strait Islander culture and history and recommendations for culturally responsive practice are covered in other relevant documents compiled by Aboriginal and Torres Strait Islander authors including; 'Working together: Aboriginal and Torres Strait Islander Mental health and Wellbeing' and 'Cultural Responsiveness in Action: An IAHA Framework'. <http://iaha.com.au/policy/cultural-responsiveness/>



Summary

The term “Culturally and Linguistically Diverse (CALD)” refers to **Australia’s non-indigenous groups** that have a cultural heritage different from the dominant Anglo-Australian culture¹. Health, illness and disability are all concepts shaped by cultural values and beliefs. Our culture will influence how we perceive, experience and manage health and illness. Multicultural diversity is increasing throughout Queensland due to increased migration and refugee intake.

The *Multicultural Recognition Act 2016* sets the vision for an inclusive, harmonious and united Queensland through the multicultural charter, multicultural policy and the action plan (2016-17 to 2018-19)². This paper supports a whole of Queensland Government approach to being committed to building cultural capability throughout the workforce with reference to child health and development.

Being “CALD” in and of itself does not necessarily increase the risk of developmental vulnerability. However, there are some culturally and linguistically diverse groups who experience additional vulnerability that may require prioritisation or modification of usual practice to ensure equitable and timely access to services.

Children from Non-english speaking backgrounds who begin school not proficient in English are also more likely to experience vulnerability in other domains of development. To improve access and ongoing engagement by children and their families from CALD backgrounds, specialist child development services need to be aware of cultural considerations during diagnostic assessment and service provision.

All health services need to be aware of the cultural profile of their local community. This includes an awareness of other multicultural community agencies in which they can partner to deliver culturally appropriate services.

Culture is a dynamic yet stable set of beliefs and attitudes shared by a group of people³. This frames our worldview and helps us to make sense of what we know. Culture involves more than conforming to external patterns of behaviour, but rather colours how we view our world. Culture is learned rather than an instinctive behaviour. It is something inherited from as well as taught by the surrounding community and passed on from one generation to the next. Health, illness and disability are all concepts shaped by cultural values and beliefs. Our culture will influence how we perceive, experience and manage health and illness⁴.

The purpose of this document is to:

- Build a common understanding around cultural considerations for health practitioners in child development and other paediatric teams throughout Queensland Health;
- Outline the whole-of-Queensland government commitment to ensure a culturally capable workforce;
- Summarise some core cultural considerations for child development and other paediatric health services when delivering services to children and families from CALD backgrounds to optimise equity of access and engagement;
- Provide links to further information and resources to support culturally sensitive practice in paediatric and child development services.

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Introduction

What do we mean by “Culturally and Linguistically diverse” (CALD)

Cultural diversity has evolved as a result of the increased movement of people and communication throughout the world. Queensland is an increasingly multicultural society and home to people who speak more than 220 languages, who hold more than 100 religious beliefs and come from more than 220 countries. The term “Culturally and Linguistically Diverse” (**CALD**) became the term used by policy makers from about 1996 to incorporate Australia’s non-indigenous groups that have a cultural heritage different from the dominant Anglo-Australian culture.

People from CALD backgrounds can be first, second or third generation. The first generation is defined as those born overseas and now residing in Australia. The second and third generations being children and grandchildren of the first generation.

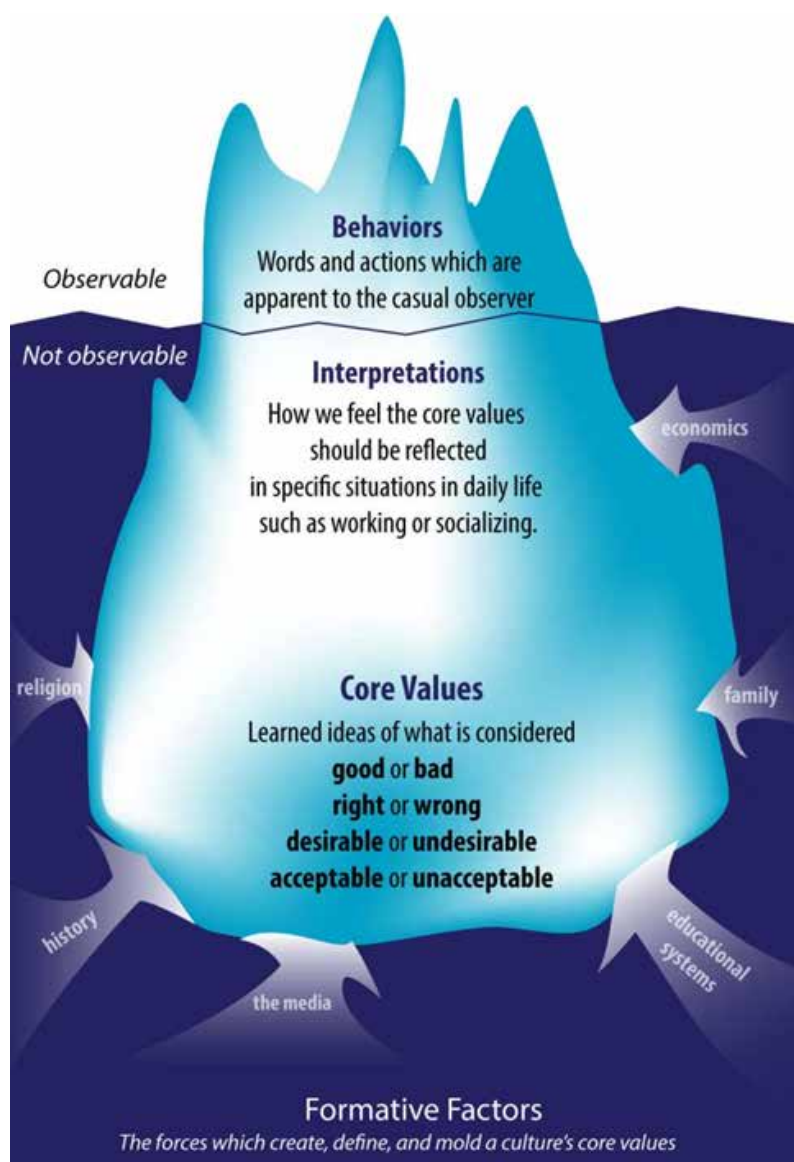


Figure 1: The Cultural Iceberg⁵

Who are Culturally and linguistically diverse groups?

Culturally and linguistically diverse groups include;

- migrants
- temporary residents
- humanitarian entrants.

Migrants

Migrants are defined as any person who was born overseas whose usual residence is Australia. People who arrive in Australia under the Migration program (as opposed to the Refugee and Humanitarian program) have usually chosen to enter Australia under skilled, business or family streams.

Temporary residents

Temporary residents are people living and working in Australia on temporary visas including work, student, prospective partner (fiancé) and provisional partner (spouse) visas. Temporary residents normally require private health cover and are not eligible for Medicare services. Some countries with reciprocal health arrangements (see Appendix 1) can access emergency and Pharmaceutical Benefits Scheme (PBS) services but are not eligible for other public health services. This category excludes clients who hold bridging visas and are applying for asylum (see below).

Humanitarian entrants

People who come to Australia under a humanitarian visa class have been deemed to require resettlement because of significant humanitarian concerns. The main groups of humanitarian entrants include:

1. *Refugees and humanitarian entrants who have been accepted for permanent resettlement in Australia.*

People who come to Australia as refugees under the Humanitarian Settlement Program have met the United Nations High Commissioner for Refugees (UNHCR) definition of “Any person who, 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/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country”⁶.

2. *Asylum seekers*

An asylum seeker is someone applying for protection whose request for sanctuary has yet to be processed. They may be residing in Australia under several different visa types however, unlike refugees they have the added insecurity of being unsure if they can remain permanently in Australia and varying levels of eligibility to Medicare services.

Asylum seekers may be;

- People on any class of Bridging Visa who are applying for refugee status;
- People at any stage of the onshore refugee decision making process who may be awaiting a primary decision, or at any stage of review of their primary decision.

3. Temporary Humanitarian Visa Holders (THV)

THV holders are people who have a temporary protection visa to remain temporarily in Australia and include:

- Humanitarian Stay (Temporary) visa (HSTV) (visa subclass 449)
- Temporary Protection visa (TPV) (visa subclass 785)
- Temporary Humanitarian Concern visa (THCV) (visa subclass 786).

Additional Terminology

Ethnicity

An ethnic group is a social group that shares a common and distinctive culture, religion and language. A country of origin or an identified nationality can include multiple ethnic groups. For example; Chin, Karen Cochin and Rohingya are some of the different ethnic groups from the country of Myanmar. An enquiry about the family’s “preferred language” can be more important than nationality in determining appropriate interpreter services.

Acculturation

CALD groups are sensitive to the dynamic process of “acculturation”. Acculturation refers to the extent to which adaptations are made to cultural values as influenced by the dominant culture such as speaking English or choosing to wear more western attire.

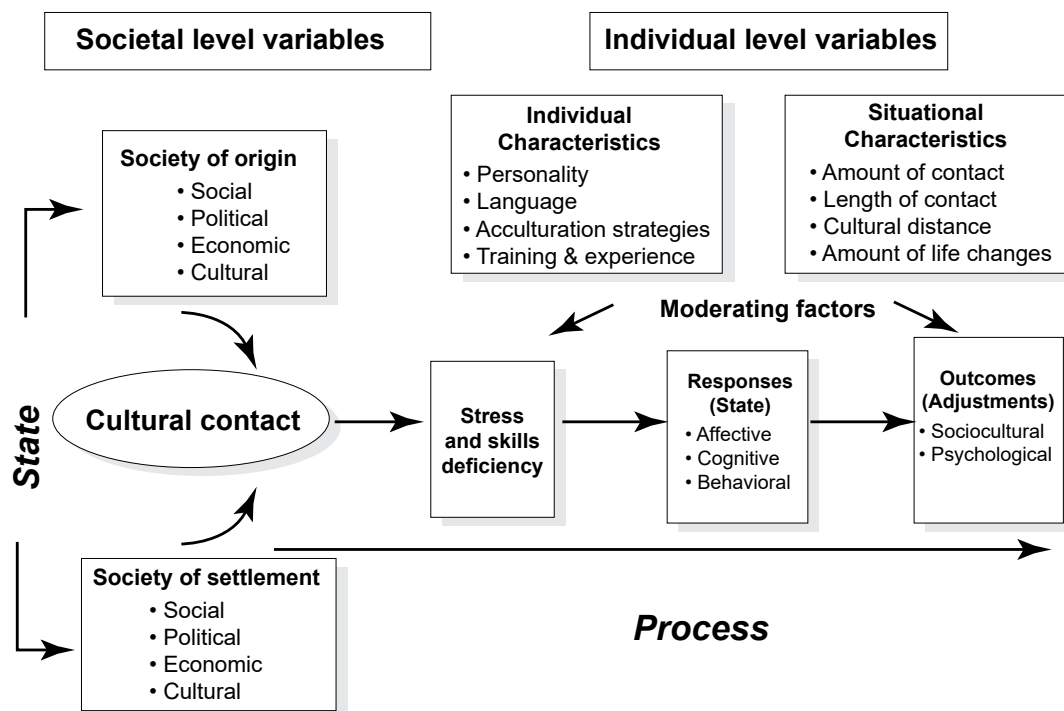


Figure 2. Process of Acculturation⁷

Acculturation cannot be assumed to correlate with length of experience with the dominant culture but rather is influenced by the interplay of factors 8 outlined in figure 2. The process of acculturation can be associated with additional stress experienced in different ways by different family members. Examples of this include; marital conflict due to differences in acculturation of male/female roles within the community, pressure for children to keep certain cultural roles and values when trying to align with the dominant culture.

A Queensland perspective on CALD communities

Queensland has a relatively small proportion of CALD communities compared to New South Wales and Victoria. Australian Bureau of Statistics data from 2016 identified that over one million people in Queensland were born overseas. This represented approximately 21 per cent of the state's population with the greatest proportion living within the Brisbane region. This was a substantial increase from the 1.1 per cent identified in the 2011 census (see Appendix 29 which provides details of 2016 census data on languages by region).

The top three languages spoken other than English are;

- Mandarin – 69,474 (1.5 per cent)
- Vietnamese – 25,914 (0.6 per cent)
- Cantonese – 24,900 (0.5 per cent)

In the top ten culturally diverse suburbs in south east Queensland, 50 per cent of the community speak a language other than English, while in Brisbane this is only 20 per cent⁹.

There has also been an increase in refugees and humanitarian entrants to Queensland with approximately 1800 refugees settling in Queensland each year. This is continuing to increase with an additional 1400 Syrian and Iraqi refugees settled in Queensland in 2017. The main areas of settlement include Brisbane, Logan, Toowoomba, Gold Coast and Ipswich with a plan for more regional settlement occurring in the future. The Refugee Health Network publishes annual snapshots of refugee health and settlement activity across Queensland. More information can be found at the link below.

<http://www.refugeehealthnetworkqld.org.au/publications/>

Refugees have often experienced extensive trauma and loss. This can have a profound impact on their capacity to trust and therefore access health and social supports. Health services in their country of origin may be very different and are often limited due to war and unrest. Refugees come from very diverse backgrounds and may have very different levels of health literacy. Immediate stressors of housing, finance and separation from their family may be prioritised over immediate health needs. More information can be found at the link below.

<http://www.refugeehealthnetworkqld.org.au/>

The Refugee Health Network provides extensive resources to support improved co-ordination of health care for this population such as comprehensive primary care services that gathers background health and family information and checks health literacy. The Refugee Health Network also provides multicultural resources, links and cultural training for health practitioners.

Refugees also have access to post settlement services in the first six to twelve months delivered by various non-government organisations. These services focus on welcoming families, housing assistance, life skills, Australian cultural orientation and social supports. Additional foundational settlement up to five years is available for families who may have more complex settlement support needs.

There are approximately 3000 asylum seekers currently residing in Queensland under a variety of visa classes from countries including Iran, Sri Lanka, Afghanistan, Bangladesh and Pakistan. This group experience the same health and wellbeing challenges as refugees with the additional insecurity of being unsure of permanent settlement. Historically asylum seekers were not eligible for health services through Medicare, however, there has been a recent change in policy from July 2017 enabling vulnerable asylum seekers approved access to public health services at no charge.



Key documents and CALD policies

The increasing number of migrants and humanitarian entrants from diverse cultural backgrounds has been acknowledged by the Queensland Government. A whole of government response has been recommended to increase cultural awareness and social inclusion with policies including;

- The **Queensland Multicultural Recognition Act** (Section 20) - in recognition of a commitment to embrace multiculturalism
- The **Multicultural Action Plan** - a whole of Queensland Government response devised in line with the act
- **Refugee Health and Wellbeing: A Policy and Action Plan for Queensland 2017–2020**
- **Queensland Language Services Policy** - Queensland Government agencies set the expectation that all Government departments will use best practice by engaging qualified interpreters when it is evident that a consumer cannot effectively communicate in English.

Cultural differences and Health Service engagement

Culture is an important factor in the development of one's sense of identity.

Cultural differences can impact on what value or priority any group or individual places in its use of resources. There are several dimensions to consider when understanding how cultural systems interact. Differences include: views on individual versus group importance, outlook on time and space, the roles of men and women, class and status systems, core values, language, rituals, work ethic and beliefs about health¹⁰.

As an example, “collectivist” cultures (including many Eastern, Middle Eastern, African, South American and some Mediterranean cultures) tend to define themselves in terms of their relationships rather than individual characteristics. Identity is based on the social network and social harmony is highly valued. In collectivist societies, greater importance is placed on the needs of the community over the needs and aspirations of the individual.

CALD families from collectivist cultures may be operating from different values and beliefs. They may be reluctant to seek services outside of the family and may also be reluctant to discuss parenting or other family concerns to a public service due to perceived shame. This is considered as one of the reasons that some ethnic groups are less likely to access and engage in mainstream health and support services.

A reluctance to offend may also impact whether families seek clarification or give honest feedback if the service is not meeting their needs.

Many immigrants to Australia come from what can be described as “high power” cultures where there is greater acceptance of power differentials. This can contrast with the egalitarian emphasis in Australian society which is situated towards the low power end of the continuum. This may influence how services are perceived and the expectations that families have of health service providers. For example, the expectation of health practitioner as the “expert” and therefore an avoidance of questioning or disagreement with the practitioner.

Refugees and other migrant groups can also have high expectations of Australian health services expecting that chronic conditions can be cured. This can lead to disillusionment and disengagement when this does not occur.

The level at which these values are held on to will vary related to individuals' and family's cultural identity, and their level of acculturation.

Differences in parenting practices

A family's culture may affect attitudes, values, beliefs and capacities across many areas. These areas include: child-rearing practices, health practices, meanings of disability, perceptions of education, and perceptions of early childhood intervention⁴.



Parents interact with their children by encouraging and discouraging certain behaviours based on what is deemed appropriate or valued by the culture¹¹. For example, notions of politeness and obedience are culturally determined and will be reflected in child rearing practices.

Culture and Attachment

Attachment is a universal concept but can be context dependant. In collectivist cultures there tends to be a greater number of parental and other family figures available for any infant as opposed to 1 or 2 primary caregiver roles in individualist cultural groups.

In keeping with Bronfenbrenner's bioecological model of development, figure 3 outlines the differing values that impact on parents' priorities and exposure to experiences subsequently influence children's development.

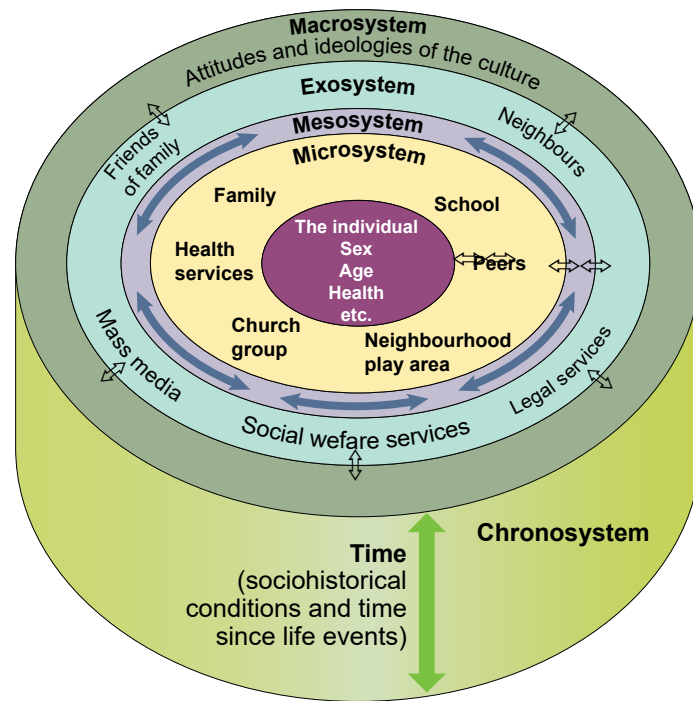


Figure 3. Bronfenbrenner bioecological model of development¹²

Culture and beliefs about cause and treatments of health and disability

Cultural and individual beliefs about the causes and meaning of disability will impact on ideas about the worth of a person with a disability and their subsequent acceptance of the term or the person. A family's beliefs may affect the resources they spend, expectations and opportunities for participation. Some cultures may consider a disability as "Gods will" or that the disability is a form of punishment for wrongdoing. Differing values and beliefs about development can impact on **when** parents present with concerns. For example, a limited number of studies have shown that children from African American, Hispanic and Asian families are less likely to receive early diagnosis of autism than those from caucasian families^{13, 14}.

Cultural beliefs and values can also impact **how** families engage in intervention and their level of understanding and acceptance of diagnoses.

- In some cultures, there is no direct translation for "intellectual disability".
- Some cultural groups will have more concrete interpretations of terms such as "Mental illness" or "Disability" and may refuse to acknowledge such diagnoses.
- Concepts of confidentiality can differ in other countries so can affect some cultural groups belief that their health information is secure and will not be shared resulting in concerns about accepting the use of interpreters.
- Differing views of causes of illness and disability impact on the types of treatment sought. For example, in China, two distinct causal interpretations of autism exist¹⁵. The western understanding of autism as a neurodevelopmental disorder. The Traditional Chinese Medicine (TCM) interpretation that all mental illness, including autistic disorder, is related to vital and spiritual forces and to healthy life practices in the social, cultural, and political realm. Chinese parents' treatment choices can therefore vary from applied behaviour analysis to acupuncture and herbal medicine.

CALD and Developmental Vulnerability

A CALD family background in and of itself does not imply developmental vulnerability or assume disadvantage.

- There is evidence that exposure to multiple languages does not hinder, and can support cognitive and linguistic development, when both languages are considered and when controlling for socioeconomic influences¹⁵.
- Data from National Assessment Program Literacy and Numeracy (NAPLAN) and Australian Early Development Census (AEDC) indicates that when controlling for language difference, developmental outcomes are commensurate or better for children with CALD than non CALD backgrounds.
- Longitudinal studies in the UK demonstrate that children from Indian cultural backgrounds, score consistently higher on all developmental measures¹⁷.
- In large population studies¹⁸, children from immigrant families have been noted to lag behind their native-born peers mainly on language measures which does not necessarily lead to long term impacts. Relatively better developmental outcomes for migrants in countries such as Canada and Australia are attributed to the larger proportion of skilled migration programmes.
- The AEDC data shows that from 2015, children with a language background other than English (LBOTE) identified as not proficient in English, were more likely than other children to experience vulnerability on one or more (27.8 and 20.4 per cent) and two or more developmental domains (14.2 and 10.2 per cent). This gap between LBOTE and Non LBOTE has been closing steadily since 2009. For children experiencing developmental vulnerability on one or more domain(s), the gap between LBOTE children and those who only spoke English was 10.6 per cent in 2009, 9.2 per cent in 2012 and 7.4 per cent in 2015¹⁹.
- AEDC data continues to show that a lack of language proficiency in English can be a marker of developmental vulnerability. Some 94 per cent of children who were reported as not proficient in English from both LBOTE and English-speaking backgrounds, were reported to experience developmental vulnerability on one or more domain(s). Almost all these children were reported as being developmentally vulnerable on the communication skills and general knowledge domain. These children are more likely to be developmentally vulnerable or at risk on all the AEDC domains.
- There are certain populations of migrants in Australia with identified additional risk factors. For example, Pacific Islander populations are a group with identified increased health risks. However developmental vulnerability in this population and other cultural groups is explained by known risk factors including poverty, trauma, poor parental mental health and low parental education.
- Refugees and asylum seekers have often fled from adverse living conditions, including exposure to violence torture and undernutrition. These are identified factors that negatively impact child development and health more broadly. Lack of financial security, intergenerational trauma, other stressors and even torture also impact on parental mental health. This can in turn affect parents' capacity to prioritise seeking health care.
- Isolation from extended family hence differing level of child development knowledge also impacts on timing of seeking health and developmental services in the early years.
- Migrants, refugees and asylum seekers all have increased risks for exposure to trauma and family violence where isolation from extended family and acculturation places additional stresses on families. Women may remain in abusive relationships due to risks to their residency.
- There are now fewer entrance restrictions for refugees and asylum seekers than in other migrant programmes. Refugee families can include children, young people and parents with complex,

diagnosed and undiagnosed developmental disabilities. The additional challenges for young people can be in transitioning to Australian society while negotiating complex family relationships and their developing independence, their own cultural identity and the developmental tasks of adolescence.

- In the long term, children and young people from CALD backgrounds, particularly those from a refugee background, have been shown to experience; poorer social development outcomes, lower engagement in the workforce, higher risk of homelessness, mental health problems and lower health service utilisation.
- The age and developmental state of a child, length of experienced trauma and amount of parental/carer support is related to the development and severity of post traumatic symptoms. Furthermore, this impacts upon the complexity of cognitive and physical impairment, developmental delay and the treatment outcomes²⁰.
- For refugee and humanitarian entrants showing signs of Post-Traumatic Stress Disorder (PTSD), developmental delays and speech and language problems, there is evidence they respond best to intervention when these health issues are addressed early in the settlement period²¹.
- Timely access to appropriate early intervention for this population group will reduce the frequency of recurrent presentations for acute care and ensure long term health and wellbeing²².



Implications for Child Development Practice and Service delivery

The lack of workforce cultural competency is a significant barrier to working with culturally and linguistically diverse families^{23, 24}.

‘Culturally responsive practice’ and family-centred practice are deeply linked because culture profoundly shapes both human development and family structures, whatever a family’s culture. Children’s personal, family and cultural histories shape their learning and development²⁵.

Culturally responsive practice requires professionals and organisations to respond respectfully and skilfully to the needs of diverse communities. Seen as part of a broader concept of cultural competence, ‘culturally responsive practice’ is described as a set of ‘congruent behaviours, attitudes and policies that come together in a system or agency or among professionals’ that enable effective work in cross-cultural situations²⁶.

Culturally competent practice requires:

- personal maturity and thoughtfulness in outlook and practice,
- effective funding and work with interpreters,
- building relationships with community leaders/educators
- using translated resources effectively

Prioritisation

Some specific populations of CALD families with identified risk factors as outlined above may require prioritisation or flexibility with referral criteria by specialist Child Development Services. This ensures care is timely and integrated with the services and supports available through specialist refugee and resettlement services.

Service provision

Providing effective diagnostic services that support families’ understanding requires integration of biological, psychological, family and cultural considerations.

The “Act Now for a better tomorrow”

https://www.health.qld.gov.au/_data/assets/pdf_file/0024/438036/scycn-child-development.pdf resource document has established principles of practice to guide child development within Queensland Health.

Children and families with CALD backgrounds need to be considered in the context of these principles. The cultural differences in child rearing and interpretation of health and development as described previously are general and may be encountered to a greater or lesser extent when working with CALD children and families. Every family has a unique context shaped by their experiences, ethnicity, biology, history and level of acculturation and it is therefore important to resist generalisations.

Awareness of one's own "cultural perspective" and ongoing self-reflection around the cultural lenses through which the individual and the service view children, families and development, will contribute to individual and families' perspectives being understood.

Preparation to promote access

An awareness of the local communities' cultural demographic can assist Child Development Services in engaging and providing easier access for CALD children and families. Partnerships with multicultural services and primary care providers who can support access and engagement is crucial. Ongoing partnerships with these groups throughout the child and families' journey with the service supports clinicians' understanding of the child and family's culture within their community context. These groups can further support families' engagement and identify and facilitate appropriate community transitions (see Appendix 1).

Support understanding of the health system in Australia

Culturally sensitive services explore what the consumers are expecting from the service. This includes what they understand about health services in Australia and how they are different from services in their country of origin.

People from "high power" distance or "collectivists" cultures may feel uncomfortable with collaborative approaches to the provision of health care and being involved in a decision-making process can be a source of significant stress or confusion. Innovative ways of managing this cross-cultural conflict when delivering health services are required. Engagement of bicultural workers (individuals specifically employed by services to support cultural understanding and engagement) can support this collaboration.

Communicating about culture

The **explanatory model** of illness is a way for consumers and health practitioners to explain or better understand some, or all of the aspects of an illness or problem to promote engagement²⁶⁻²⁸.

Inquiring about a family's explanatory model works best in the context of a meaningful relationship. The inquiry is best initiated with a statement of respect such as, "*I know different people have very different ways of understanding illness... Please help me understand how you see things.*"

This can include questions like:

- *What do you think caused the problem?*
- *What do you think your illness does to you (child)?*
- *What do you think the natural course of the illness is? What do you fear? Why do you think this illness or problem has occurred? How do you think the problem should be treated?*
- *How do want us to help you? Who do you turn to for help?*
- *Who should be involved in decision making?*

Such conversations provide a space to negotiate between the families' explanatory model and that of the health provider. To do this successfully the health practitioner needs to:

- Approach this with an open mind
- Explore the families understanding of the problem
- Explain the background to the Health Professional's understanding of the problem
- Acknowledge the parent / families model as an important source of understanding
- Work together to identify areas of agreement and to stress the strengths in the families' situation
- Further discuss where discrepancies remain.

Another simple strategy to support cross cultural communication is **L.E.A.R.N**²⁹.

Listen – ask open ended questions to understand the person's perception of the situation

Explain – your perception of the situation

Acknowledge – and discuss the differences and similarities

Recommend – a plan that is mutually acceptable

Negotiate – agreement and action plan (win/win)

The Diagnostic Statistical Manual Fifth Edition (DSM 5) acknowledges the impact of culture on diagnosis of neurodevelopmental and mental health disorders and provides a cultural formulation interview using the explanatory model³⁰.

The cultural explanatory model can also be used as a framework for reflective practice on culture for individual health practitioners and teams to consider their own views on health disability and illness based on our personal / cultural background.

Cultural and linguistic factors – Use of interpreters

There is a Queensland Government expectation that all Government Departments engage qualified interpreters when it is evident that a consumer cannot effectively communicate in English. Qualified interpreters are recommended as they meet the required standard of skill and quality and maintain confidentiality, impartiality and accuracy as part of the Australian Institute of Interpreters and Translators (AUSIT) codes of ethics.

Interpreting is available on site (interpreter visit the home or clinic setting) or via telephone.

Telephone interpreting connects across the country and may have greater range of languages and availability.

Acceptance to use professional interpreters

- Families can be reluctant to use interpreters for the following reasons
 - They consider that their language competency in English is adequate.

- There is concern about the confidentiality of the interpreter.
- Small ethnic groups can be concerned when many community members are known.
- Just because a parent can speak some English, does not mean they will have adequate English competency to understand or explain difficult concepts.
- Use of interpreter can be justified by explaining the purpose being to increase the Health practitioners understanding of the families’ situation.
- See Appendix 4; developing competency working with interpreters.



Cultural considerations for developmental assessment

Developmental assessment for migrants, refugee and asylum seeker children can be complex and require an understanding of multiple languages acquisition and language transitions as well as the impact of migration, trauma, settlement and previous access to support services.

“Being aware of and responding appropriately to cultural and linguistic diversity are fundamental to ethical assessment practices” ³¹,

Developmental assessments will require:

- Close liaison with families, primary care providers, migrant and refugee agencies and interpreter services.

- Family history including family structures identification of important family members, parent educational background and work history in their home country, previous health and hospitalisations, language history and amount and timing of exposure to languages
- Consideration of the validity of Diagnostic tests that have been developed for mainstream western cultural populations which can contain both linguistic and cultural bias.³²
- For communication assessment, inclusion of a comprehensive language history including the timing and exposure to different languages, the typical languages spoken by caregivers and percentage of each language spoken in different contexts.
- Consideration of the cultural background, language loading and composition of the normative group on which the assessment was constructed and evaluated for any formal assessment of communication or social skills, cognition or executive function.
- If English is a second language avoidance of standardised verbal IQ testing is recommended. If assessment of cognition is requested, the purpose should be clarified and other means of gathering this information considered. Nonverbal cognitive assessment may be indicated.
- Consideration of whether the individual being assessed has had access to the same environment as that of the population on which the test is standardised. Clinical judgement, as to the applicability of providing standardised scores can then be determined.
- If assessment is requested for academic purposes then an achievement measures can be used as a baseline to dynamically assess progress.
- Exploration of opportunities, experience and exposure when assessing play, social, motor, adaptive function.

Diagnosis, feedback and transition to support services

As previously mentioned there can be differing explanatory models for disease and disability. For example, in some cultures there is the fatalistic view that the child's difficulties are a form of punishment for previous sins and this belief can disempower families in implementing strategies for change.

Exploration of a family's explanatory model requires a trusting and open dialogue throughout diagnostic process.

A history of 'trauma' can impact directly on the child's developmental presentation but also on the families' ability to process health messages and information. Additional consideration in messaging may be required including visual supports, translated material and frequent checking for how messages are being received.

In some cultures, diagnostic labels can be a source of intense shame and guilt for the families. Cultural beliefs may result in the parents feeling culpable for the child's difficulties. In this case it is important to adapt feedback to families and focus on a profile of strengths and difficulties without placing significant emphasis on diagnostic labels. Engagement with bicultural health workers may be required to increase the effectiveness of these clinical encounters.

Recommendations

1. That services engage with local community networks to understand the cultural groups that live in their communities and consider accessing bicultural workers.
2. That consideration is given to “modifying usual practice” to ensure equitable and timely access to services particularly for more vulnerable children, young people and families (i.e. refugees and humanitarian entrants).
3. That child developmental and paediatric health services have specific and ongoing training in working with interpreters and CALD children and families and that this is embedded into service orientation and professional development.
4. That cultural beliefs and values around the concerns or problems presenting are routinely explored with families as part of any diagnostic process.
5. That cultural considerations are included in a biopsychosocial diagnostic formulation.

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Appendix 1: Resources

Explanatory Model

https://www.youtube.com/watch?v=f1dA_oorQPo

Community Linkages, Services and Supports

Qld Health Cross Cultural Learning and Development Training Resources

<https://qheps.health.qld.gov.au/multicultural/training/training>

Multicultural Diversity figures

<https://www.dlgrma.qld.gov.au/multicultural-affairs/multicultural-communities/multicultural-diversity-figures.html>

Cultural competency training

<https://www.culturalcompetencetraining.com.au/>

Multicultural health

<http://qheps.health.qld.gov.au/multicultural/>

https://www.health.qld.gov.au/multicultural/health_workers/for_hlth_workers

https://ausit.org/AUSIT/Documents/Code_Of_Ethics_Full.pdf

Queensland Health Mental Health services identify the importance of cultural interpretation and have established a state-wide service “**Qld Transcultural Mental Health Centre**” which includes the services of bicultural workers

<https://metrosouth.health.qld.gov.au/qtmhc>.

Amparo – disability support service for families from CALD backgrounds

<http://www.amparo.org.au/factsheets/>

Asylum seeker definitions and legislation

http://www.rch.org.au/Asylum_seekers.aspx

Refugee health network

<http://www.refugeehealthnetworkqld.org.au/>

Reciprocal health arrangements for Temporary Visa holders

<https://www.humanservices.gov.au/individuals/enablers/rhca-medical-care-visitors-australia>

Resources :-

Cultural Atlas- Interactive guide to cultural groups who are living in Australia.

<https://culturalatlas.sbs.com.au/>

Qld health translation

<https://www.health.qld.gov.au/multicultural/interpreters/translation>

Language services guidelines

<http://www.dlgrma.qld.gov.au/resources/multicultural/policy-governance/lsp-guidelines.pdf>

Appendix 2: Languages spoken in Queensland

Language spoken at home (a) by statistical area level 4 (SA4) (b), Queensland, 2016

Statistical area level 4 (SA4)	Language spoken at home										Total (d)	
	English	Mandarin	Vietnamese	Cantonese	Spanish	Italian	Korean	Hindi	Punjabi	Tagalog		Other languages (c)
Brisbane - East	195,482	1,334	485	558	924	757	280	707	539	654	11,372	223,095
Brisbane - North	164,256	2,286	528	1,573	1,157	2,164	719	2,014	2,764	1,698	17,099	206,522
Brisbane - South	212,811	29,686	4,753	10,218	3,087	1,838	6,348	3,967	4,968	1,659	44,486	340,569
Brisbane - West	141,560	5,979	1,698	1,857	1,570	629	1,095	1,081	414	345	15,663	178,991
Brisbane Inner City	184,859	7,023	1,187	2,609	3,518	2,447	2,432	1,533	889	627	23,503	250,207
Cairns	190,417	1,419	331	585	507	2,597	1,086	300	1,546	962	18,284	240,190
Darling Downs - Maranoa	110,994	303	57	78	130	410	111	99	174	532	2,722	126,289
Central Queensland	191,286	558	607	194	271	195	170	323	348	1,036	7,774	220,912
Gold Coast	459,299	9,300	948	2,996	3,148	2,406	3,480	1,362	1,454	1,581	42,146	569,997
Ipswich	247,560	2,049	12,066	746	1,784	472	591	1,753	1,176	1,339	28,173	323,069
Logan - Beaudesert	248,473	3,176	1,369	1,380	1,481	520	1,103	2,034	1,475	1,255	34,912	317,296
Mackay - Isaac - Whitsunday	143,999	630	172	150	232	336	191	239	209	1,093	6,099	169,688
Moreton Bay - North	206,017	1,007	320	332	474	546	443	442	134	878	8,984	236,091
Moreton Bay - South	170,090	955	181	346	808	645	200	1,027	622	837	10,630	194,969
Queensland - Outback	56,253	90	133	43	69	294	18	114	64	257	13,531	79,700
Sunshine Coast	308,716	870	259	344	817	979	398	306	410	474	12,617	346,522
Toowoomba	128,349	1,272	140	262	271	195	323	296	369	362	7,827	149,512
Townsville	195,766	614	396	390	464	1,872	334	324	286	851	10,180	229,031
Wide Bay	255,645	707	271	204	221	633	266	202	143	545	6,820	287,883
Queensland (e)	3,820,632	69,474	25,914	24,900	21,006	20,009	19,620	18,163	17,991	16,999	323,599	4,703,193

(a) Based on the top 10 languages spoken at home by Queensland usual residents.

(b) Data are at ASGS 2016.

(c) Includes languages not identified individually, 'Inadequately described' and 'Non-verbal, so described'.

(d) Includes language not stated.

(e) Queensland includes Migratory - Offshore - Shipping and No usual address (Old).

Source: ABS, Census of Population and Housing, 2016, General Community Profile - G13.

Appendix 3: Queensland Government Legislation and Policies

In 2016 the **Queensland Multicultural Recognition Act** (Section 20) was passed in recognition of a commitment to embrace multiculturalism. The Act;

- promotes Queensland as a united, harmonious and inclusive community and will foster opportunities for people from culturally and linguistically diverse backgrounds to participate in all aspects of life in our prosperous state
- acknowledges that a diverse, dynamic and cohesive society will deliver important benefits for all Queenslanders, including the community, government and business sectors
- recognises our diverse cultural heritage and aims to ensure that government services are responsive to the needs of our multicultural communities.

As part of the Act, a Multicultural Queensland charter and advisory council was established.

The Multicultural action plan is a whole of Government response devised in line with the act. <https://www.dlgrma.qld.gov.au/multicultural-affairs/policy-and-governance/multicultural-policy-and-action-plan.html>

This plan outlines 3 priority areas: -

1. Culturally responsive Government.

- Improved knowledge about customers' diversity
- Culturally capable services and programs
- A productive, culturally capable and diverse workforce

2. Inclusive harmonious and united communities

- Recognition and respect for Aboriginal and Torres Strait Islander heritage and culture
- Queenslanders celebrate our multicultural identity
- Connected and resilient communities
- A respectful and inclusive narrative about diversity

3. Economic opportunities

- Queensland gets the most benefit from our diversity and global connections
- Individuals supported to participate in the economy

In response to the action plan **Queensland Health** has committed to meet the following outcomes: -

1. Develop agency implementation plans outlining the steps needed for the government agency to collect and report on the minimum mandatory indicators for culturally diverse customers.
2. Ensure relevant staff are aware of the minimum mandatory indicators for culturally diverse customers and of the importance of capturing this information.
3. Develop a plan to ensure that the improved data regarding culturally diverse customers is aggregated and published on a regular basis, subject to all privacy requirements being met.
4. Investigate the feasibility of a dedicated patient experience survey and developing tailored

engagement strategies for patients from diverse backgrounds and their carers and families.

5. Improve collaboration across health portfolio agencies to deliver better health services and support for patients from diverse backgrounds and their carers and families.
6. Increase participation by people from diverse cultural backgrounds in health promotion, prevention and early intervention programs.
7. Use the Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery within Queensland Health.
8. Redevelop the department's multicultural health web content to support better access to services and health literacy for people from diverse cultural backgrounds.
9. Develop and implement a refugee health and wellbeing policy and action plan under the Refugee Health and Wellbeing: A Strategic Framework for Queensland 2016.

Refugee Health and Wellbeing: A Policy and Action Plan for Queensland 2017–2020 priority areas for action

1. Communicate and collaborate with colleagues
2. Establish the state-wide refugee health and wellbeing network
3. Modify usual practices to meet the health and wellbeing needs of refugees
4. Use professional interpreter services
5. Engage with the community
6. Measure, collect, collate, monitor and innovate
7. Deliver evidence based quality healthcare to people from refugee backgrounds

This link provides general information on the responsibilities of Hospital and Health Services (HHSs) in the provision of healthcare to refugees, asylum seekers and detainees, including information on Medicare eligibility and revenue.

https://www.health.qld.gov.au/_data/assets/pdf_file/0033/676518/refugees-asylumseekers-infosheet.pdf

Appendix 4: Developing competency in working with interpreters

Queensland Language Services Policy

<https://www.dlgrma.qld.gov.au/multicultural-affairs/policy-and-governance/language-services-policy.html>

Queensland Government agencies set the expectation that all Government departments will use best practice engaging qualified interpreters when it is evident that a consumer cannot effectively communicate in English.

Qualified interpreters are recommended as they meet the required standard of skill and quality and also maintain confidentiality impartiality and accuracy as part of the AUSIT codes of ethics.

Qld health language services policy recommends the following order of preference if an emergency arises and an accredited interpreter cannot be accessed.

1. Accredited interpreter
2. Health professional fluent in the language
3. Other health employees who can speak the language
4. Relatives or friends.

The accuracy of language and dialect can be checked using the following language identification card.
http://qheps.health.qld.gov.au/multicultural/interpreting/language_ID_crd.pdf

More time is required when working with interpreters as each message needs to be repeated.

The following provide basic information on working with interpreters: -

- Talk to the interpreter immediately prior to the session to outline the purpose and goals of the session.
- Seating - (triad)
- Speak directly (using eye contact) to the consumer (interpreter should translate each sentence as stated unless there is no direct translation of the target)
- Speak in short phrases and pause to allow the interpreter to relay the message.
- The interpreter should give a translation the consumers reply directly.
- You can check in with the interpreter at the end of the session
- Interpreters will translate the language – however they may not necessarily interpret cultural differences unless specifically asked. It is therefore OK to ask for feedback for some cultural interpretation.
- While interpreters may write some basic notes for families, interpreters will not do translation.
- In keeping with service equity, every effort should be made to ensure important information and resources are available in the family's language. (see appendix for link to translated developmental information.
- Translated information should always be back translated to ensure that the concepts have been accurately interpreted in the translated material.

- Translated material should also be translated back into the English to ensure that the meaning is accurately maintained in the target language.
- While linguistic interpretation is required to ensure accurate communication with non-English speaking consumers, clinicians also need to consider cultural interpretation. This can occur through the help of interpreters both with the interpreter in preparation for clinical contact and also with families using the explanatory model.

For further training in working with interpreters

<https://www.dlgrma.qld.gov.au/resources/multicultural/policy-governance/lsp-guidelines.pdf>

http://qheps.health.qld.gov.au/multicultural/interpreting/int_resources.htm

The following provides a guide to developing material for translation.

http://qheps.health.qld.gov.au/multicultural/support_tools/9MCSR_trnsltn_gde2.pdf

Translated resources

The following are links to material relevant to child health and development that has been translated into multiple languages

<http://www.mhcs.health.nsw.gov.au/publicationsandresources/resources-by-language>

<https://raisingchildren.net.au/for-professionals/working-with-parents/cultural-diversity/different-cultures-videos>

<http://www.healthtranslations.vic.gov.au/bhcv2/bhcht.nsf>



Queensland
Government