Bridging the Health Gap:

Improving access to culturally safe primary health care services during the after hours period for culturally and linguistically diverse communities

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The Voice of Multicultural Victoria

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Ethnic Communities' Council of Victoria Inc. (ECCV) is the voice of multicultural Victoria. As the peak policy advocacy body for ethnic and multicultural organisations in Victoria, we are proud to have been the key advocate for culturally diverse communities in Victoria. Since 1974 we have been the link between multicultural communities, government and the wider community.

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1. Executive summary

This Final Report contains the Findings and Recommendations of the "Improving access to culturally safe primary health care services during the after hours period for culturally and linguistically diverse communities" project commissioned in June 2020 by North Western Melbourne Primary Health Network (NWMPHN) and undertaken by Ethnic Communities' Council of Victoria (ECCV) in partnership with Community-Owned Primary Health Enterprises (COPHE). The key objective of this project was to identify solutions to improve cultural responsiveness of primary health care providers and thus improve access to primary care services for culturally and linguistically diverse (CALD) communities living within the NWMPHN catchment.

The project partners undertook a review of the available literature on usage of primary health care by people from CALD backgrounds in the NWMPHN catchment, best practice for cultural responsiveness in primary care, and the systemic challenges faced by people from CALD backgrounds in accessing and using primary care. The results of the literature review suggested that despite the NWMPHN catchment having one of the most culturally and linguistically diverse communities in Victoria, many CALD community members were not receiving adequate culturally responsive primary care that was able to meet their specific health needs as consumers from CALD backgrounds.

Following the completion of the literature review a Project Advisory Group (PAG) was convened comprising representatives from primary health care providers, CALD health consumers, ECCV, COPHE and NWMPHN. The PAG met on a monthly basis and provided feedback and guidance to inform the development of the project and deliverables.

In addition to the literature review, a series of consultations were conducted with CALD community members, primary health care providers, general practitioners, community health organisations and multicultural organisations located within the NWMPHN catchment to identify the existing enablers and barriers in the primary care system to providing culturally responsive services, and to understand where improvements are required to deliver culturally responsive primary care. Based on the results of these consultations and the literature review, the following key Findings and Recommendations were determined:

Findings	Recommendations
1) The primary health system provides good quality services, but can be difficult to access and navigate for consumers from CALD communities.	**Improve the access and usability of the primary care system for CALD consumers.** This recommendation proposes targeted changes to be made in telehealth, digital access, after hours services and consumer feedback mechanisms.
2) Cultural responsiveness in service design and delivery is inconsistent across the primary care sector.	**Improve the cultural responsiveness of primary care service design and delivery.** Our findings suggested that the cultural responsiveness of primary care services could be improved if consumers from CALD backgrounds had more say in how services were designed and delivered. Consequently, this recommendation focussed on coproduction of primary care services with CALD communities and increasing the workforce mutuality of the sector i.e. increasing the participation of CALD people in the primary care workforce so that the sector becomes more representative of the communities it serves.

Findings	Recommendations
3) The general practice sector (GP) needs to build its cultural responsiveness.	**Improve the cultural responsiveness of the general practice sector.** The cultural responsiveness of the GP sector was found to be less consistent than other primary health care providers. This could be rectified with a greater emphasis on cultural competence and responsiveness in GP training and accreditation in conjunction with GPs collaborating more regularly with cultural connectors and ethno-specific bodies.
4) CALD data is not used sufficiently in planning and commissioning processes.	**Collect and use CALD data to inform culturally responsive policy and practice.** Though data for CALD groups is already being collected, it can be better used for planning and implementation of culturally responsive primary care service provision. The data sets collected also need to be comprehensively overhauled.
5) The Western medical model is not culturally responsive to the primary care needs of a diverse community.	**A new model for culturally responsive mental health and AOD primary care is needed.** Many people from CALD backgrounds find mainstream mental health and AOD primary care service models to be culturally unsafe. Foundational work needs to be done in collaboration with CALD communities and researchers to develop new models of service provision fit for the diversity of the community.
6) The use of interpreters is inconsistent and underutilised.	**Promote more consistent use of interpreters in primary care.** Greater awareness and understanding of how to engage with interpreters is needed among primary health care providers, so that engaging an interpreter when one is needed becomes an everyday part of the service.

The final deliverable of the project was to develop a tool for assessing the cultural responsiveness of primary care service providers. ECCV and COPHE developed a Culturally Responsive Assessment Tool (the Tool or CRAT) to help commissioned primary health care providers to assess their current level of cultural responsiveness and identify quality improvement activities that will help improve their cultural responsiveness. Based on the project's findings and recommendations and supported by an environmental scan of best practice diversity and inclusion frameworks and assessment processes, the project partners designed a suite of resources for use by primary care service providers commissioned by NWMPHN, including the Tool, Implementation Guide, Cultural Responsiveness Action Plan template, Cultural Responsiveness Review template, as well as tools to identify priority actions and examples of best practice. The Tool and its supporting documents were delivered to NWMPHN as a separate suite of resources.

The Tool is the key resource developed for this project, while its accompanying resources are designed to help implement quality improvement activities and record progress. When put to use these resources will help NWMPHN meet its commitment to supporting the continuous quality improvement of its commissioned services.

2. Project background

2.1 Introduction

In June 2020, the North Western Melbourne Primary Health Network (NWMPHN) commissioned the Ethnic Communities' Council of Victoria (ECCV) in partnership with Community-Owned Primary Health Enterprises (COPHE) to identify ways that primary health care providers can build upon their cultural responsiveness and thus improve access to primary care services for culturally and linguistically diverse (CALD) communities living within the NWMPHN catchment.

Through its Commonwealth funding NWMPHN has a commitment to improve primary health services for the general community as well as a range of specific target groups including CALD communities, thus aligning with the PHN goal of "the right care in the right place at the right time."[1] Previous reports commissioned by NWMPHN have indicated an adequate level of primary care for the general community, including after-hours primary care, mental health services and alcohol and other drug (AOD) services.[2]

The NWMPHN catchment is served by a complex and large primary care system that includes 13 hospitals, 11 community health services, more than 540 general practice medical centres and over 120 mental health and AOD service providers.[3] For CALD communities, however, only 33 providers in the catchment indicated that their primary service was to provide culturally and linguistically responsive primary care. Moreover, of these service providers only two were open in the after-hours period, and both were located in the inner-city local government area of Moreland.[4]

Although insufficient data from the catchment exists to show conclusively that people from CALD communities are under-utilising so-called "mainstream" primary care, a growing body of literature and anecdotal evidence from NWMPHN commissioned service providers and CALD consumers appears to indicate this is the case.[5] It is in the absence of a clear understanding of how well the primary care system is serving the needs of CALD communities, that this project has been commissioned. It will be our aim to address this gap in the knowledge, and in doing so to provide recommendations for how services can become more culturally responsive to the needs of all people living within the NWMPHN catchment.

2.2 Project partners

About ECCV

The Ethnic Communities' Council of Victoria (ECCV) is the peak advocacy body in Victoria for multicultural communities and people from culturally and linguistically diverse backgrounds. ECCV has over 220 member organisations, including ethnic associations, multicultural service providers, and eight regional ethnic communities' councils across the state. ECCV has been advocating for human rights, freedom, respect, equality and dignity for migrant and refugee communities, and for a socially cohesive and inclusive Victorian community since 1974. ECCV has a long history in advocating for the rights of multicultural communities, informing industry practice and influencing governments on a range of issues including disability, aged care, health, employment, culturally responsive services and equitable access. ECCV has a strong commitment to advocating for the health and wellbeing of migrant and refugee communities. This project builds on previous work that ECCV has done in cultural responsiveness in health care, including health literacy, mental health, primary health, chronic disease management and health promotion.

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[1] Department of Health website, "PHN Background": https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background, accessed 6/1/21.

[2] See the two reports, North Western Melbourne Primary Health Network (NWMPHN), "Needs Assessment Reporting, 2019," Melbourne: 2019; Impact Co., "After Hours Primary Care: Gap Analysis and Recommendations," Melbourne: 2018.

[3] NWMPHN, "Health Needs Reporting, 2019," p. 11

[4] Impact Co., p.57

[5] See for example the Impact Co. report.

About COPHE

Community Owned Primary Health Enterprises (COPHE) is an expert and experienced team working to grow community influence in primary health care. COPHE believes that many groups within the community do not have adequate access to primary health care services. These include communities with low numbers of health care professionals as well as some specific population groups who find it hard to get the kind of care they need. COPHE aims to increase the access of affordable and appropriate primary health care to poorly-served communities or client groups by supporting local organisations to develop such services. COPHE works with organisations to increase understanding of how the primary health care system works while exploring innovative alternative models of primary health care delivery and funding. COPHE also works with organisations to develop sustainable service and funding models for primary health care services.

2.3 Project aim and objectives

The project objectives were to:

- Understand and define key considerations in the delivery of culturally responsive primary health care.
- Identify solutions to improve cultural responsiveness of primary health care providers.
- Develop or refine existing tools and resources to support health providers to undertake activities to improve cultural responsiveness within services.

The aims of this project were twofold. Firstly, it was investigative: gathering primary evidence to understand key considerations in the delivery of culturally responsive primary health care will help to identify where the primary care system is meeting the needs of CALD communities and where it is not.

And secondly, it was prescriptive: the findings will inform recommendations and resources to build capacity of primary care service providers to be more culturally responsive to the needs of a highly diverse community.

To achieve these aims and objectives, the project undertook the following activities:

- Conduct a review of the available literature, alongside consultation with primary health care providers and CALD community members, to identify the existing enablers and barriers in the primary care system to providing culturally responsive services.
- Develop a set of recommendations for NWMPHN that will improve cultural responsiveness of primary health care providers.
- Develop an assessment tool that can support primary health providers commissioned by NWMPHN to undertake activities to improve the level of cultural responsiveness within their services.

3. Project context

3.1 Scope of the project

This project assessed the cultural responsiveness of primary care services operating within the NWMPHN catchment. Primary care can be defined as the first point of contact that people have with the health system and can include general practice, general practice nursing and allied health services such as maternal and child health, social work, counselling, physiotherapy and community health.[6] A broader definition of primary care also includes visits to emergency departments (EDs), but admission to hospitals or referrals to specialists are not considered primary care,[7] and are therefore outside the scope of this project.

Within the broader scope of primary health this project also focused on specific services including:

- Mental health services
- Alcohol and other drug (AOD) services
- ED usage
- After hours care, which is defined as:
    - 6pm to 8am Monday to Friday
    - 12pm Saturday to 6am on Monday
    - All hours on public holidays

There is a further refinement in the after hours definition between sociable and unsociable hours. Unsociable hours are generally agreed to be the overnight period from 11pm to 7am for all nights of the week.[8]

It should be noted that the original scope of the project was intended to focus on after hours primary care services, as reflected in the project title. However, a broader learning from the project was that improving the overall cultural responsiveness of primary care services would enhance services in business hours as well as after-hours services. Consequently, the final report of the project looks at the cultural responsiveness of all primary health services within the NWMPHN catchment.

3.2 Geographic and demographic context

3.2.1 The NWMPHN catchment

The NWMPHN catchment includes some of the fastest growing and most culturally diverse local government areas (LGAs) within Victoria. Covering 13 LGAs, the catchment has an area of 3,212 km^2 and a total population of over 1,640,000, approximately one third of the Greater Melbourne metro area. The catchment is demographically diverse and includes rapidly expanding growth corridors in Wyndham, Melton and Hume; more densely populated inner-suburban LGAs including Brimbank, Maribyrnong, Moonee Valley, Hobsons Bay, Moreland, Darebin and Yarra; the mixed residential and commercial zone of the Melbourne CBD; and the rural and semi-rural LGAs of Moorabool and Macedon Ranges.

3.2.2 Country of birth

Around 44% of residents in the catchment were born in a country other than Australia,[9] considerably higher than the state average of 28.4%.[10]

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[6] Department of Health website, "Primary Care": https://www1.health.gov.au/internet/main/publishing.nsf/Content/primarycare, accessed 6/1/21.
[7] Department of Health website, "Fact Sheet: Primary Health Care": https://www1.health.gov.au/internet/main/publishing.nsf/Content/Fact-Sheet-Primary-Health-Care, accessed 6/1/21.
[8] Impact Co., p. 14
[9] *Ibid*., p. 32
[10] Victorian State Government, "Victoria's Diverse Population: 2016 Census." Melbourne: Department of State and Premier, 2017.

There are also clear patterns of settlement among different LGAs within the catchment. Maribyrnong and Yarra, for example, both have large and established Vietnamese communities that moved into the area in the 1970s and '80s, while Moreland and Darebin have sizeable ageing Italian communities who migrated after the Second World War. The tables below indicate the range of countries of birth in the catchment.[11]

LGA	India		China		Vietnam		Italy		Philippines		Greece	
	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population
Brimbank	4.78%	0.64%	1.23%	0.17%	11.17%	1.50%	1.64%	0.22%	2.96%	0.40%	1.14%	0.15%
Darebin	3.11%	0.32%	3.29%	0.33%	1.91%	0.19%	4.18%	0.42%	0.63%	0.06%	3.10%	0.31%
Hobsons Bay	2.89%	0.18%	1.20%	0.07%	1.60%	0.10%	1.67%	0.10%	1.15%	0.07%	1.20%	0.07%
Hume	4.37%	0.60%	0.41%	0.06%	0.67%	0.09%	1.63%	0.22%	1.33%	0.18%	0.55%	0.08%
Macedon Ranges	0.26%	0.01%	0.20%	0.01%	0.05%	0.00%	0.50%	0.02%	0.23%	0.01%	0.11%	0.00%
Maribyrnong	4.00%	0.23%	2.82%	0.16%	9.33%	0.53%	1.12%	0.06%	1.30%	0.07%	1.02%	0.06%
Melbourne	4.47%	0.42%	15.75%	1.48%	0.00%	0.00%	0.92%	0.09%	0.00%	0.00%	0.17%	0.02%
Melton	3.78%	0.35%	0.59%	0.06%	1.38%	0.13%	0.72%	0.07%	2.91%	0.27%	0.29%	0.03%
Moonee Valley	2.36%	0.19%	1.58%	0.13%	1.99%	0.16%	4.14%	0.33%	0.59%	0.05%	1.22%	0.10%
Moorabool	0.58%	0.01%	0.11%	0.00%	0.13%	0.00%	0.33%	0.01%	0.21%	0.00%	0.12%	0.00%
Moreland	2.52%	0.28%	1.64%	0.18%	0.72%	0.08%	4.85%	0.55%	0.70%	0.08%	2.09%	0.23%
Wyndham	10.31%	1.55%	2.54%	0.38%	0.75%	0.11%	0.80%	0.12%	2.64%	0.40%	0.25%	0.04%
Yarra	0.74%	0.04%	1.81%	0.11%	3.02%	0.18%	0.99%	0.06%	0.36%	0.02%	1.31%	0.08%
% of PHN Catchment		**4.81%**		**3.13%**		**3.08%**		**2.27%**		**1.61%**		**1.17%**

LGA	Malaysia		Iraq		Malta		Sri Lanka		Pakistan		Lebanon		Turkey	
	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population	% of LGA population	% of PHN Catchment population
Brimbank	0.47%	0.06%	0.24%	0.03%	2.33%	0.31%	0.98%	0.13%	0.94%	0.13%	0.41%	0.05%	0.34%	0.05%
Darebin	0.62%	0.06%	0.22%	0.02%	0.24%	0.02%	0.57%	0.06%	0.37%	0.04%	0.80%	0.08%	0.17%	0.02%
Hobsons Bay	0.43%	0.03%	0.08%	0.00%	1.31%	0.08%	0.25%	0.02%	0.31%	0.02%	1.13%	0.07%	0.06%	0.00%
Hume	0.22%	0.03%	5.39%	0.73%	0.59%	0.08%	1.57%	0.21%	1.05%	0.14%	1.76%	0.24%	3.14%	0.43%
Macedon Ranges	0.10%	0.00%	0.00%	0.00%	0.36%	0.01%	0.11%	0.00%	0.00%	0.00%	0.03%	0.00%	0.02%	0.00%
Maribyrnong	1.00%	0.06%	0.11%	0.01%	0.22%	0.01%	0.50%	0.03%	0.49%	0.03%	0.12%	0.01%	0.20%	0.01%
Melbourne	4.87%	0.46%	0.05%	0.00%	0.08%	0.01%	0.00%	0.00%	0.00%	0.00%	0.07%	0.01%	0.00%	0.00%
Melton	0.38%	0.04%	0.26%	0.02%	1.45%	0.14%	0.89%	0.08%	0.53%	0.05%	0.26%	0.02%	0.18%	0.02%
Moonee Valley	0.57%	0.05%	0.09%	0.01%	0.56%	0.05%	0.46%	0.04%	0.17%	0.01%	0.27%	0.02%	0.26%	0.02%
Moorabool	0.10%	0.00%	0.00%	0.00%	0.55%	0.01%	0.11%	0.00%	0.03%	0.00%	0.00%	0.00%	0.00%	0.00%
Moreland	0.58%	0.06%	0.45%	0.05%	0.51%	0.06%	0.61%	0.07%	1.89%	0.21%	1.63%	0.18%	1.03%	0.12%
Wyndham	0.95%	0.14%	0.13%	0.02%	0.51%	0.08%	0.94%	0.14%	0.95%	0.14%	0.41%	0.06%	0.08%	0.01%
Yarra	0.86%	0.05%	0.03%	0.00%	0.08%	0.00%	0.23%	0.01%	0.08%	0.00%	0.06%	0.00%	0.18%	0.01%
% of PHN Catchment		**1.04%**		**0.91%**		**0.86%**		**0.80%**		**0.78%**		**0.75%**		**0.68%**

3.2.3 Humanitarian visa arrivals

The NWMPHN catchment is also home to many residents who have arrived in Australia on a humanitarian visa. In 2017, 3,202 humanitarian arrivals settled in the catchment, representing 19% of all humanitarian arrivals in Australia for that year.[12] In 2019-20 Victoria had a total of 75,964 people settle across the migration streams, as outlined in the table below.[13] Of those settling in Victoria, 60% of those on humanitarian visas settled in northwest Melbourne, compared to 36% on a family visa and 39% on a skilled visa.

	Migration Stream 2019-20		
Local Government Area	**Humanitarian**	**Family**	**Skilled**
Hume	1,233	958	1,370
Brimbank	342	990	1,383
Wyndham	336	1,629	3,246
Melton	289	855	945
Maribyrnong	136	498	978
Darebin	49	681	1,334

[11] All figures taken from Australian Bureau of Statistics Census Data 2016

[12] Impact Co., p. 34

[13] All following settlement data taken from *Settlement Data Reports Financial Year 2019-20*. (2020, August). Department of Home Affairs. https://www.data.gov.au/dataset/ds-dga-8d1b90a9-a4d7-4b10-ad6a-8273722c8628/details.

Moreland	43	863	2,072
Hobsons Bay	39	325	521
Moonee Valley	36	501	834
Melbourne	35	1,070	4,668
Yarra	31	556	703
Macedon Ranges	0	53	33
Moorabool	0	34	50
TOTAL NWMPHN catchment	2,569	9, 013	18,137
TOTAL VICTORIA	4,261	24,924	46,779

The number of humanitarian visas granted by the Australian government had been on the rise until the outbreak of the COVID-19 pandemic. For 2019-20 Australia's Humanitarian Program was set at 18,700 places; however, after the program was suspended on 19 March 2020 due to the COVID-19 pandemic, a final total of 13,171 visas were granted.

Within the catchment the settlement of humanitarian arrivals is distributed unevenly, with over half of humanitarian arrivals concentrated in the City of Hume. In contrast, the LGAs of Melton, Moorabool and Macedon Ranges recorded no humanitarian arrivals as of 2018.[14] Settlement details such as this will have a direct bearing on the accessibility and appropriateness of primary care services, as different CALD communities will have different primary care needs. Hume, for example, will have greater need for refugee primary health services than other regions within the NWMPHN catchment.

3.2.4 Languages spoken

There is very high linguistic diversity among the languages spoken by community members across the NWMPHN catchment. The tables below show some of the main languages spoken at home across the region.[15]

LGA	Vietnamese	Mandarin	Italian	Arabic	Greek	Punjabi	Turkish
	% of LGA population	% of LGA population	% of LGA population	% of LGA population	% of LGA population	% of LGA population	% of LGA population
Brimbank	16.19%	1.49%	2.52%	2.21%	2.72%	2.90%	1.20%
Darebin	2.32%	3.64%	6.62%	3.03%	6.34%	0.89%	0.25%
Hobsons Bay	2.00%	1.45%	2.68%	3.43%	2.65%	0.96%	0.11%
Hume	1.00%	0.53%	2.89%	8.26%	1.42%	2.56%	6.83%
Macedon Ranges	0.05%	0.34%	0.75%	0.07%	0.27%	0.06%	0.07%
Maribyrnong	11.87%	3.19%	1.78%	0.97%	2.17%	0.46%	0.42%
Melbourne	1.49%	18.69%	1.26%	1.28%	0.48%	0.13%	0.23%
Melton	2.02%	0.87%	1.47%	1.83%	1.14%	1.93%	0.83%
Moonee Valley	2.34%	1.78%	6.78%	1.48%	3.12%	0.34%	0.54%
Moorabool	0.14%	0.18%	0.47%	0.15%	0.27%	0.32%	0.02%
Moreland	0.90%	1.95%	7.87%	4.87%	4.57%	0.58%	1.83%
Wyndham	1.00%	3.38%	1.35%	1.93%	0.64%	3.62%	0.17%
Yarra	3.89%	2.20%	1.81%	0.80%	2.63%	0.06%	0.27%
% of PHN Catchment	4.35%	3.76%	3.70%	3.30%	2.67%	1.75%	1.54%

[14] Impact Co., p. 34

[15] All figures in these tables were compiled by the authors from Australian Bureau of Statistics Census Data, 2016.

LGA	Cantonese	Filipino/Tagalog	Spainish	Urdu	Macedonian	Assyrian/Aramaic
	% of LGA population	% of LGA population	% of LGA population	% of LGA population	% of LGA population	% of LGA population
Brimbank	2.15%	2.74%	1.46%	0.74%	2.38%	0.21%
Darebin	1.21%	0.49%	0.80%	0.50%	1.48%	0.09%
Hobsons Bay	1.02%	0.91%	0.70%	0.33%	1.21%	0.02%
Hume	0.28%	1.14%	0.57%	1.33%	0.34%	6.04%
Macedon Ranges	0.06%	0.12%	0.21%	0.02%	0.07%	0.01%
Maribyrnong	2.98%	0.99%	1.29%	0.72%	0.87%	0.03%
Melbourne	3.89%	0.27%	1.69%	0.20%	0.11%	0.00%
Melton	0.57%	2.63%	1.36%	0.70%	1.71%	0.21%
Moonee Valley	1.56%	0.43%	1.03%	0.20%	0.41%	0.13%
Moorabool	0.03%	0.17%	0.25%	0.04%	0.08%	0.00%
Moreland	0.64%	0.54%	0.96%	2.36%	0.16%	0.44%
Wyndham	1.03%	2.26%	0.87%	1.71%	0.56%	0.02%
Yarra	1.36%	0.21%	1.02%	0.09%	0.19%	0.00%
% of PHN Catchment	1.54%	1.41%	1.15%	1.02%	0.96%	0.95%

The level of proficiency in English also varies throughout the catchment. For instance, in Brimbank 13.37 % of the population speaks English "not well or not at all," compared to 9.21% in Maribyrnong, 7.34% in Darebin and 4.88% in Hobsons Bay. Patterns of English proficiency such as this will have bearing on the accessibility of primary health information, and may also affect CALD community members' choices of services, e.g. choosing to use services where their community language is spoken over solely English-speaking services.

In comparing the country of birth and languages spoken at home data sets, it is evident that there are significant numbers of second-generation migrants who speak a language other than English at home. Some of these community members may also have varying levels of proficiency in English. Conversely, it is also probable that many second- or third-generation migrants may be more proficient in English than their parents' or grandparents' first languages. However, second- and third-generation migrants may also have culturally specific primary health needs, although they do not have the same language needs as migrants who are not as proficient in English.

3.3 After hours primary care

Improving the cultural responsiveness of after hours primary care is a key consideration of this project. The *After Hours Primary Health Care: Gap Analysis and Recommendations* report commissioned by NWMPHN in 2018 suggests that there is high variation between the availability of after hours primary care throughout the NWMPHN catchment. Out of 2,659 primary health services reported to be open during the after hours period across the catchment, 1,448 or 54% are located in the five inner-suburban LGAs of Melbourne, Moreland, Yarra, Moonee Valley and Maribyrnong. The outer growth corridors of Hume and Melton only have 179 and 121 after hours services respectively, while the rural LGAs of Macedon Ranges and Moorabool are serviced by only 48 and 21 after hours providers respectively. [16]

3.3.1 Reasons for presenting to EDs

While there is a wealth of information about issues of access to after hours primary healthcare and avoidable attendance at EDs, less work has been done to investigate the access to and usage of after-hours primary health care by people from CALD communities. The *Gap Analysis* report identified the following reasons why consumers in general will attend EDs for non-urgent care[17]:

[16] Impact Co., p. 50
[17] *Ibid*., p. 7

- Perceived seriousness: the need for immediate attention and a perceived urgency or seriousness of the condition.
- Capacity of primary care: this particularly relates to children's health needs, where there is significant evidence that parents attend ED due to perceived or actual limited capacity of GPs.
- Advantages of accessing care at an ED: public funding means there are no out of pocket costs associated with attendance.

The *Gap Analysis* report also identified a number of key characteristics of ED usage that have a bearing to CALD communities:

- Nationally, 50% of ED visits are triaged as non-urgent (Category 5) and semi-urgent (Category 4), and 31% of all ED presentations occurred after-hours.[18]
- Between 2014 and 2016, 2,269 residents from the NWMPHN catchment attended an emergency department during the after hours period for a mental health related problem assessed as non-urgent or semi-urgent.[19]
- Between 2014 and 2016, 12,546 ED presentations in the after hours periods required an interpreter across the NWMPHN catchment,[20] a little under 4.8% of all after hours ED presentations in the catchment for the same period.[21] However, the usage of interpreters varied greatly across the different LGAs in the catchment, from over 7% for Brimbank (7.8%), Melbourne and Yarra (both 7.3%), to 2% or lower for Melton (2.0%), Wydham (1.6%), Macedon Ranges (0.2%) and Moorabool (0.1%).[22]

In the context of the use of EDs by CALD communities, Mahmoud *et. al.* (2015) have shown that people from CALD backgrounds are less likely than the general population to consider contacting a GP before attending an ED. Reasons for not attending a GP included that they did not have a regular GP, or it could take a long time to get an appointment. The research also suggests that patients who had been in Australia for a shorter period were less likely to contact a GP before attending an ED. There is also an over representation of CALD consumers presenting to EDs for semi-urgent and non-urgent services. International research supports these observations, whereby CALD consumers are more likely to seek care at an ED for less urgent health issues.[23]

[18] *Ibid*., p. 14; this is referring to the 2016-17 period.
[19] *Ibid*., p. 40
[20] *Ibid*., p. 44
[21] *Ibid*., p. 39
[22] *Ibid*., p. 44
[23] Mahmoud, I., Eley, R., & Hou, X.-Y. (2015). "Subjective reasons why immigrant patients attend the emergency department." *BMC Emergency Medicine*, 15 (1), pp. 1–6.

4. Activities undertaken

4.1 Literature review

Primary health needs of CALD communities

Throughout the scoping and research undertaken for this project, we were fortunate to be able to draw upon the wealth of data and reporting that NWMPHN releases on a regular basis. NWMPHN's annual Health Needs Reporting documents (2018 and 2019 editions) were particularly useful in gaining a detailed overview of the differences in primary care needs across the 13 LGAs that make up the NWMPHN catchment. Though not a key focus of these documents, the Health Needs Reporting provide summaries of identified CALD primary health access and equity issues, which proved useful for our project in identifying a baseline of community needs from which we could design our consultation process.

The 2018 report *After Hours Primary Health Care: Gap Analysis and Recommendations* commissioned by NWMPHN and prepared by Impact Co. was instrumental for our project in providing the quantitative data and evidence for after hours usage in the NWMPHN catchment. This report was particularly useful for understanding the most common reasons for after hours ED visits, and moreover the authors had undertaken an audit of CALD-centric after hours service providers in the catchment. However, as with the Health Needs Reporting, the *Gap Analysis* did not focus primarily on CALD usage of after hours services.

Data or literature on CALD usage of after hours primary care and emergency departments was much less readily available. One of the few papers we found that looked specifically at the reasons why CALD consumers attend EDs was "Subjective reasons why immigrant patients attend the emergency department," authored by Queensland-based Ibrahim Mahmoud, Rob Eley and Xiang-Yu Hou (2015).

Language services and interpreters

Interpreter services were the one exception to this rule, with considerable evidence available specifically about the Australian context. "Patient length of stay, patient readmission rates and the provision of professional interpreting services in healthcare in Australia" by Beagley *et. al*. (2020) uses the results of a 10-year longitudinal study of interpreter usage at a large hospital in northern Melbourne to provide an evidence-based argument for the health benefits of CALD consumers having access to interpreters, such as reduced lengths of stay and readmissions.[24] Hlavac et. al. in "Applications of policy and the advancement of patients' health outcomes through interpreting services: data and viewpoints from a major public healthcare provider" (2018) was useful for us in demonstrating how interpreting services can be integrated into policy and hence operationalised at the level of organisational practices and programmes.[25] A number of papers we reviewed on interpreter usage in Australia, such as the ECCV policy paper *Our Stories Our Voices*: *Culturally diverse consumer perspectives on the role of accredited interpreters in Victoria's health services* (2017), highlighted the continuing issues that impact equitable access to interpreters by CALD consumers, such as lack of time during medical bookings, lack of knowledge of medical terminology and inconsistent standards of professionalism reported by consumers.[26]

Mental health needs

Regarding the mental health primary care needs of CALD communities, the Final Report of the Royal Commission into the Victorian Mental Health System provided insights into the long-standing issues surrounding access and equity within the mental health system, as well as providing some initial

[24] Beagley, J. Hlavac, J. Zucchi, E. "Patient length of stay, patient readmission rates and the provision of professional interpreting services in healthcare in Australia." *Health and Social Care in the Community*. John Wiley & Sons, 2020, p. 7

[25] See also another paper co-authored by Hlavac *et. al*., "Translation as a sub-set of public and social policy and a consequence of multiculturalism: the provision of translation and interpreting services in Australia." which looked at policy settings for interpreting services at a national level.

[26] ECCV, *Our Stories Our Voices*: *Culturally diverse consumer perspectives on the role of accredited interpreters in Victoria's health services.* Melbourne: 2017, pp.16-17

recommendations for reform. The Interim Report acknowledges that Victorians from CALD backgrounds "face a range of barriers when seeking treatment, care and support" for mental health issues.[27] It also describes the mental health system in Victoria as broken[28] and outdated,[29] concluding that "[t]he system has simply not kept up with the changes in the diversity and extent of the demands now placed on it. At one level, this means many people cannot get the services they seek; at the extreme, it places some at risk of a variety of harmful, even fatal, consequences."[30]

The ECCV Issue Brief*: Mental health and well being for Victoria's multicultural communities under COVID-19* and the Issues Paper *Responding together: Multicultural young people and their mental health* (2020) released by the Centre for Multicultural Youth were also useful in identifying the more recent mental health impacts of COVID-19 among CALD communities.

In looking for examples of best practice for culturally responsive mental health primary care, we found the concept of "targeted universalism" to be useful for imagining a mental health system that was not monolithic and monocultural, but could rather operate in parallel modalities so as to provide culturally responsive support that was tailored to the specific needs of CALD communities. As Powell *et. al*. explain in "Targeted Universalism: Policy and Practice" (2019), "Targeted universalism means setting universal goals pursued by targeted processes to achieve those goals. Within a targeted universalism framework, universal goals are established for all groups concerned. The strategies developed to achieve those goals are targeted, based upon how different groups are situated within structures, culture, and across geographies to obtain the universal goal."[31]

Frameworks for cultural responsiveness

Finally, in terms of identifying examples of systems level approaches to culturally responsive primary care, the Department of Health and Human Services *Delivering for Diversity - Cultural Diversity Plan 2016-2019* and the Royal Australian College of General Practice's "Standards for General Practice" provided useful baselines against which our recommendations for culturally responsive primary care could be compared, while the *HealthWest Partnership Standards for Workforce Mutuality* (2019) gave an example of a targeted framework for supporting health and community organisations to build workforces that are more reflective of the diversity of the communities they serve.[32]

The ECCV report *Falling through the Cracks* (2018) identified a number of key areas for improving access to primary health for migrant and refugee communities, such as building the cultural responsiveness of frontline community and health workers, supporting multicultural community organisations and networks to work with communities, and advocating for the adequate provision of interpreters and bilingual workers.

Two documents by Victorian Transcultural Mental Health, *Cultural Responsiveness Principles & Practices* (2020) and *Frameworks that inform cultural responsiveness principles & practices* (2020) were also useful for informing the analysis and recommendations from an intersectional lens. This project took a broad view to identifying the social, economic, geographic and other factors relevant to access to primary health care for migrant and refugee communities, in addition to identifying systemic barriers and gaps in the primary health system. The cultural and language factors for communities are not solely the focus of the findings and recommendations. Rather, the findings also reflect on the culture, process, workforce, and practices of primary care services. The recommendations thus identify opportunities to address and change these systemic barriers.

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[27] State of Victoria, "Royal Commission into Victoria's Mental Health System – Interim Report." Melbourne: Victorian Government Printer, November 2019, p.10.
[28] *Ibid*., p. 5.
[29] *Ibid*., p. 8.
[30] *Ibid*., p. 7.
[31] Powell, J. Menendian, S. Ake, W. "Targeted Universalism: Policy & Practice." Berkeley, California: Haas Institute for a Fair and Inclusive Society, University of California, Berkeley, 2019, p. 5
[32] Note that the HealthWest Partnership catchment is almost coterminous with the NWMPHN catchment.

Additionally, the Embrace Multicultural Mental Health Framework (2020) was extensively consulted, as it provided an evidence-based framework for culturally responsive mental health service delivery specific to the Australian context,[33] while the Migrant & Refugee Women's Health Partnership's *Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds* (2019) helped to identify best practice cultural responsiveness benchmarks for clinicians working in primary care settings.[34]

4.2 Project Advisory Group

A Project Advisory Group (PAG) was recruited and convened at the beginning of the project. The PAG's role was to provide guidance to inform the development of the project. Members of the PAG included representatives from primary health care providers, health consumers, the project-lead organisations and NWMPHN (see the PAG membership list below).

PAG meetings were held on a monthly basis throughout the duration of the project. Due to COVID-19 health guidelines in place in Victoria during 2020-21, all PAG meetings at the time of writing were conducted online using the Zoom platform. Meetings were chaired by the ECCV Executive Officer (when available), and secretariat support was provided by the ECCV project co-lead.

Members of the Project Advisory Group (PAG)

Name	Organisation	Role*
Linda Holdsworth	cohealth	Practice Manager
Lis de Vries	COPHE	Consultant (project co-lead)
Rod Wilson	COPHE	Director
Chris Christoforou	ECCV	Executive Officer (PAG chair)
Rashmi Kumar	ECCV	Policy & Advocacy Manager
Martin Plowman	ECCV	Project Lead, Culturally Safe Practice (project co-lead, PAG secretariat)
Argireta Ateva	ECCV	CALD Health Consumer Representative
Lamija Cancar	ECCV	CALD Health Consumer Representative
Katia Kaloustian	ECCV	CALD Health Consumer Representative
Kasey Elmore	North Richmond Community Health	AOD Counsellor / Outreach Worker
Emiliano Zucchi	Northern Health	Director, Transcultural and Language Services
Ash Badhan	NWMPHN	Program Officer, Integration
Agnieszka Kleparska	NWMPHN	Project Officer, Priority Operations
Francis Acquah	Positive Mental Health Program	Clinical Director
Silvana Izzo	Victorian Transcultural Mental Health	Service Development Consultant

* Note: Role held at the time of the project.

4.2.1 CALD Health Consumer Representatives

In accordance with best practice ECCV developed the specific project role of CALD Health Consumer Representatives to be part of the PAG, with the purpose of providing advice and feedback on the project

[33] Embrace Multicultural Mental Health (2020), "Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery." The Embrace Project website, https://embracementalhealth.org.au/service-providers/framework, accessed 30/3/21.

[34] Migrant & Refugee Women's Health Partnership (2019), *Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds*. Migrant & Refugee Women's Health Partnership website, https://culturaldiversityhealth.org.au/competency-standards-framework/ accessed 30/3/21.

development and deliverables from the perspective of users of the primary health system. Three CALD Health Consumer Representatives were ultimately recruited, based on the following selection criteria:

- Resident within the NWMPHN catchment
- Having a CALD background
- Recent experience using primary health services in the NWMPHN catchment (i.e. within the past 6 months)
- Experience working in the primary health, community development or multicultural sectors.

4.3 Community consultations

4.3.1 Methodology

Recruitment of community participants

Community participants were recruited via the following methods:

- A promotional flyer asking for expressions of interest to take part in the community consultations was developed by ECCV and circulated in the ECCV monthly members' newsletter and via ECCV and COPHE's community contacts.
- ECCV members and affiliated organisations promoted directly to community members.
- The ECCV CALD Health Consumer Representatives promoted the focus groups directly to their community contacts.

Forty-eight expressions of interest from community members were received. From these, the final 25 participants were selected according to the following criteria (in descending order of importance):

- Resident within the NWMPHN catchment
- Representative of the CALD communities living within the NWMPHN catchment
- Recent usage (i.e. within the past 6 months) of primary health services in the NWMPHN catchment
- Gender representation
- Age representation

Focus groups

Six focus groups were conducted between 28 October 2020 and 25 November 2020, with the number of participants ranging from two to six. A set of standardised consultation questions was developed, which were used for each focus group (see Appendix 1). Each focus group session ran for approximately 1.5 hours, and was facilitated by two or three members of the ECCV-COPHE project team with one team member taking notes while the others took turns facilitating. Interpreters were offered to all participants, with one focus group conducted with the assistance of a Vietnamese interpreter and a Vietnamese-speaking Bilingual Health Educator from the Multicultural Centre for Women's Health.

The focus groups were conducted online using the Zoom remote meeting platform. Two community participants in two different focus groups were unable to access a digital device to enter the virtual meeting room. In one case this was because the participant did not own or have access to a digital device with the capacity to join the Zoom meeting; in the other case the participant experienced technical difficulties with their device on the day of the focus group. In both cases, one of the facilitators called the participant on their mobile phone and put them on loudspeaker. This allowed the participant on the phone to hear and be heard by the other participants in the Zoom meeting room, and thus still be able to take part in the focus group.

Two of the focus groups were made up of participants from a single cultural and language background. This occurred because these focus groups were made up of pre-existing community support groups. The other four focus groups included participants from a mix of CALD backgrounds, and were selected by the facilitators.

One focus group was conducted primarily in Vietnamese with the aid of a Vietnamese interpreter who translated between the mainly Vietnamese speaking participants and the English-speaking facilitators. Two out of the six participants spoke English but preferred to use Vietnamese, while the other four participants spoke only Vietnamese. The other focus groups were conducted in English.

All 25 participants in the community consultations received a $50 Coles gift voucher to acknowledge their contribution to the project. All but one of the participants received their vouchers electronically; one participant requested to have a physical gift voucher mailed to their postal address.

4.3.2 Results of community consultations

Summary of community participants

	Suburb	LGA (Local government area)	Migrant or refugee community	Languages spoken	Age	Gender
1	Glenroy	Moreland	Pakistani	Urdu, English, Punjabi, Hindi	40	Female
2	Fawkner	Moreland	Lebanese	Arabic, English	47	Female
3	Essendon West	Moonee Valley	Syrian	Syriac, Arabic, English	39	Female
4	Brunswick	Moreland	South Sudanese	Arabic, Nuer, English	62	Male
5	Deer Park	Brimbank	Indian	English, Hindi, Gujarati (fully fluent), Marathi, Arabic (partial)	28	Female
6	Carlton North	Yarra	Indian	Hindi, English	47	Female
7	Fawkner	Moreland	Pakistani	Urdu, English	37	Male
8	Fitzroy	Yarra	Somali	Somali, English	31	Male
9	Craigieburn	Hume	Iraqi	Arabic, Syriac, English	24	Female
10	Fawkner	Moreland	Pakistani	Urdu, English	35	Female
11	Fawkner	Moreland	Nepalese	Nepali, English	37	Female
12	Melbourne	Melbourne	Chinese	Mandarin, English	33	Female
13	Craigieburn	Hume	Syrian	Arabic, English	48	Female
14	Fawkner	Moreland	Pakistani	Urdu, English	30	Female
15	Derrimut	Brimbank	Indian	Hindi, Marathi, Gujarati, English	26	Female
16	Delahey	Brimbank	Vietnamese	Vietnamese	75	Male
17	St Albans	Brimbank	Vietnamese	Vietnamese, English	57	Female
18	Albanvale	Brimbank	Vietnamese	Vietnamese	79	Male
19	Albanvale	Brimbank	Vietnamese	Vietnamese	70	Female
20	St Albans	Brimbank	Vietnamese	Vietnamese, English	71	Female
21	Delahey	Brimbank	Vietnamese	Vietnamese	72	Female
22	Hoppers Crossing	Wyndham	Chinese	Mandarin, Cantonese, English	65	Female
23*	Viewbank	Banyule	Chinese	Mandarin, Cantonese, English	58	Female
24*	Viewbank	Banyule	Chinese	Mandarin, Cantonese, English	54	Female
25*	Balwyn North	Boroondara	Chinese	Mandarin, English	59	Female

*Note: These participants did not live within the NWMPHN catchment.

Gender representation

Number of female participants: 20 (80%)
Number of male participants: 5 (20%)

Age representation

Age range of participants: 24 – 79 years
Average age of participants: 48.9 years
Median age of participants: 47 years

Geographic representation

Participants per LGA

LGA	Number of participants	Percentage of participants (%)
Brimbank	8	32
Moreland	7	28
Hume	2	8
Yarra	2	8
Melbourne	1	4
Wyndham	1	4
Moonee Valley	1	4
Banyule*	2	8
Boroondara*	1	4
Total	**25**	**100**

*Note: These LGAs are not within the NWMPHN catchment

Number of suburbs represented: 16 (14 inside NWMPHN catchment)
Number of LGAs represented: 9 (7 inside NWMPHN)

Representation from CALD communities

Participants by cultural background

Migrant or refugee community	Number of participants	Percentage of participants (%)
Vietnamese	6	24
Chinese	5	20
Pakistani	4	16
Indian	3	12
Syrian	2	8
South Sudanese	1	4
Somali	1	4
Iraqi	1	4
Nepalese	1	4
Lebanese	1	4
Total	**25**	**100**

Number of CALD communities represented: 10

Languages spoken by participants

Participants per language spoken

Language	Number of speakers*
English	21
Arabic	6

Vietnamese	6
Mandarin	5
Hindi	4
Urdu	4
Cantonese	3
Gujarati	2
Marathi	2
Syriac	2
Nepali	1
Nuer	1
Punjabi	1
Somali	1

* Note: The total number of speakers of all languages listed exceeds 25 participants because the majority of participants could speak more than one language.

Number of languages spoken by participants: 14
Number of participants who used an interpreter: 6 (all Vietnamese)
Number of interpreters used: 1 (for the Vietnamese focus group)

4.3.3 Discussion

Gender disparity

Among the group of 25 community participants, more women than men participated. Out of a total of 25 participants, 20, or 80% of the group, were women, and just 5 or 20% were men. No participants identified as any gender other than male or female (Note: the section for "Gender" in the personal information survey that was sent to interested community members was an open text field in which applicants were free to identify or not identify their gender according to their own self-expression).

Geographic representation

Out of the 13 LGAs that make up the NWMPHN catchment, 7 were represented among the community consultation participants. Overall, there was more representation from CALD communities living in suburbs closer to the city where there is a greater range of primary health services available. We didn't hear from community members living in the outer metro and rural parts of the NWMPHN catchment, and there was also lower representation from the growth corridors in Wyndham and Melton. Three of the participants lived in LGAs that lie outside of the NWMPHN catchment. It was a pragmatic decision to include these participants as they were part of an existing Chinese community group.

CALD community representation

Overall we achieved a broad representation of the migrant and refugee communities living within the NWMPHN catchment, with good representation from the East Asian (Vietnamese and Chinese), South Asian (Pakistani and Indian) and Arabic-speaking communities (Syrian, Iraqi and Lebanese). Within these larger cultural and geographic communities we also returned a good representation from refugee and recently arrived communities such as the Syrian, Iraqi, Pakistani and Chinese communities. Against this, we had low or no participation from a number of migrant communities living in the NWMPHN catchment. African communities were under-represented given their relative size within the catchment, and despite targeting these communities in our promotion for the consultations there was no representation from the larger and more established European migrant communities such as the Italian or Greek communities.

Digital accessibility

Following the COVID-19 public health guidelines from the Victorian Government Department of Health and Human Services that precluded in-person meetings, we held the focus groups online using the Zoom online meeting platform. There were some advantages to doing this: participants did not need to travel, meaning that people who had limited transport options were able to take part in the project. The capacity of Zoom for participants to turn off their video cameras while still taking part in a meeting also gave a greater sense

of privacy to some participants. However, alongside these benefits there were also barriers to participation posed by online meetings. Chief among these was that it was a hard prerequisite that participants had access to a digital device that was capable of supporting a Zoom meeting. This excluded community members who did not own or were not able to access a suitable digital device – and with public libraries closed during lockdown and restrictions on visiting other households, the options for borrowing or using public access digital devices were severely curtailed. The second potential barrier was the assumption that even if community members could access a digital device, they would be required to have the digital literacy and digital skills to use them for this purpose.

4.4 Primary care service provider consultations

4.4.1 Methodology

Alongside the community consultations, we conducted consultation interviews with a range of primary care service providers operating within the NWMPHN catchment. In total 16 primary care service providers were interviewed, according to the following schedule identified in the project objectives by NWMPHN:

Mental health service providers:	5
Alcohol and other drug (AOD) service providers:	5
Community health organisations:	4
Multicultural organisations:	3
Total:	17

The final 16 service providers were selected according to the following criteria (in descending order of importance):

- The service was located within the NWMPHN catchment.
- The service had a strong focus on working with CALD communities – this was in order to identify best practice examples for the latter phase of this project.
- The delegates from each service provider whom we interviewed represented a range of roles within the primary health sector.

Each primary care service provider interviewee was asked a standardised set of questions developed by the ECCV-COPHE project team (see Appendix 2). The 16 interviews were conducted between 16 September 2020 and 15 December 2020, with each interview taking approximately 1.5 hours to complete.

All interviews were held remotely using the Zoom online meeting platform, and were facilitated by one of the project leads from either COPHE or ECCV. Interpreters were made available for the service provider interviews but ultimately were not needed, with all the interviews being conducted in English.

4.4.2 Results

Summary of primary care service provider interviews

Service provider type	Organisation	Interviewee	Interviewee position
Mental health services	CAREinMIND private provider	Alison Mynard	Managing Director and practicing psychologist, Next Door Psychology
	Jesuit Social Services	Louise Flynn	Manager, Support After Suicide
	Victorian Transcultural Mental Health	Silvana Izzo	Education and Service Development Consultant

Service provider type	Organisation	Interviewee	Interviewee position
	Victorian Counselling and Psychological Services	Harry Bryce	Services Director
	IPC Health Dual Diagnosis Program*	Sylvia Grant	Manager, Counselling and Well-Being Services
Alcohol and other drugs (AOD)	Odyssey House	Bryan Ambrosius	Manager, Catchment Melbourne N&W Metro AOD Service (North, West)
	IPC Health Dual Diagnosis Program*	Sylvia Grant	Manager, Counselling and Well-Being Services
	Uniting Care Regen	Marilyn Gavaghan	Senior Manager, Clinical Services
	North Richmond Community Health	Kasey Elmore	Operations Manager Medically Supervised Injecting Room (MSIR), Acting Program Manager AOD team
	Mycentre Support Services	Ulukile Masi Masiyane	Program Manager
Community health	Cohealth	Linda Holdsworth	Practice Manager
	Women's Health West	Susan Timmins	Team Leader, Action for Equity
	DPV Health	Don Tidbury	Chief Executive Officer
	Your Community Health	Jamuna Parajuli	Refugee Health Nurse
Multicultural organisation	Migrant Resource Centre North West	Christian Astourian	Manager Diversity 'n' Disability
	Foundation House	Mardi Stowe	General manager, community capacity program
	Multicultural Centre for Women's Health	Joyce Jiang	Health Promotion Manager

*Note: IPC Health's Dual Diagnosis Program is a dual mental health and AOD service, and was thus consulted in both of these service provider categories.

4.4.3 Discussion

Within the parameters of service provider consultations set by the project brief, we felt that we were able to interview a broadly representative range of organisations working within primary health and community development across the NWMPHN catchment. In achieving this, we drew upon ECCV's member networks and COPHE's extensive contacts within the primary care sector.

All the organisations we consulted were generous with their time and were forthcoming in providing information and insights into their work practices and the challenges faced by CALD community members using the primary health system. We believe the goodwill shown towards this project is indicative of the

recognition by organisations and practitioners across the sector of the need for change in culturally responsive primary care.

4.5 General practice consultations

4.5.1 Methodology

The project objectives required consultations with 5 medical practices located within the NWMPHN catchment. It was a secondary requirement that these medical practices also work with culturally and linguistically diverse consumers.

Initially, our plan was to conduct individual interviews with general practitioners (GPs) working at the selected medical practices. A set of standardised interview questions were developed for this cohort of interviewees, with a projected completion time of approximately 1 hour (see Appendix 3). It was planned that the interviews would be conducted remotely via the online meeting platform Zoom and would be facilitated primarily by the project lead from COPHE.

One interview with a GP was completed in this manner. However, subsequently we found it very difficult to recruit GPs to participate in the interviews. Most GPs who responded cited a chronic lack of time. GPs working in medical practices usually see patients in a standard 15-minute appointment; an approximately 1-hour long interview would therefore prevent them from seeing at least four patients. On top of this, the greater volume of health appointments created by the COVID-19 pandemic, combined with GPs having to work with patients remotely due to lockdown restrictions, meant that most GPs we approached did not have the capacity to take part in individual interviews.

To address this, we decided to gather responses from GPs via an online survey instead. We adapted the original survey questions into an online survey format, which was uploaded to the survey platform SurveyMonkey (see Appendix 3). Using our collective contacts in the general practice sector, we emailed the survey link to a number of medical practices located within the NWMPHN catchment. GPs completed the survey online, following which we collated and analysed the responses returned.

4.5.2 Results

The medical practice survey was kept active from 26 October 2020 until 20 November 2020. In that time 11 survey responses were returned from GPs working in medical practices located throughout the NWMPHN catchment. Taken together with the single individual interview completed, we consulted with a total of 12 GPs.

Summary of GP interviews and surveys

	Suburb	LGA	CALD communities using this medical practice (as reported in GP survey)
1	Fitzroy	Yarra	Sudanese, Somalian
2	Not given	Not given	Not given
3	Footscray	Maribyrnong	Tibetan, Sudanese, Ethiopian, Eritrean, Somali, Chin, Vietnamese, Iraqi (Arabic speaking), Kurdish, Chinese
4	Collingwood	Yarra	Tigrinya, Oromo, Amharic, Dinka, Nuer, Tibetan, Farsi, Arabic-speaking, Vietnamese, Mandarin- and Cantonese-speaking, Urdu, Dari-speaking, Swahili, Assyrian-Chaldean
5	Footscray	Maribyrnong	Chin, Burmese, Sudanese, Eritrean, Ethiopian, Pakistani, Italian, Greek
6	Hoppers Crossing	Wyndham	Karen, Karenni, Ethiopian, Tibetan, Syrian
7	Footscray	Maribyrnong	Dinka, Amharic, Tigrinyan, Ethiopian, Iraqi, Hazaragi, Vietnamese, Indian, Pakistani, Chin, Hakka, Karen,

	Suburb	LGA	CALD communities using this medical practice (as reported in GP survey)
			Congolese, Eritrean, Greek, Italian, South American, Liberian, Iranian, Afghan
8	Epping*	Whittlesea*	Arabic, African, Italian, Persian, Thai
9	Footscray	Maribyrnong	Arabic, Asian, South Asians, Colombians, Serbian, Croatian
10	Broadmeadows	Hume	Turkish, Arabic-speaking
11	Fitzroy	Yarra	Horn of Africa
12	Coolaroo	Hume	Somali, Turkish, Syrian, Aboriginal

*Note: Not within the NWMPHN catchment.

Geographic representation of medical practices

LGA	Number of medical practices	Percentage of practices consulted (%)
Maribyrnong	4	33.3
Yarra	3	25.0
Hume	2	16.7
Wyndham	1	8.3
Whittlesea*	1	8.3
No response	1	8.3
Total	12	100

*Note: Not within the NWMPHN catchment

Number of suburbs represented: 7 (6 inside NWMPHN catchment)
Number of LGAs represented: 5 (4 inside NWMPHN)

4.5.3 Discussion

We feel that the decision to consult with medical practices via an online survey rather than individual interviews helped extend our reach, returning a total 12 responses or just over twice as many as were required in the project brief. Moving our consultations to an online survey allowed GPs to complete the questions in their own time, with the result that more surveys were completed. Though an unintended consequence, this meant that the information returned from the medical centre consultations was richer, and we were more confident of being able to identify the themes emerging from the responses.

Although we promoted the survey extensively across the NWMPHN catchment, the geographic representation of participating medical centres was concentrated in LGAs closer to the city, with the Cities of Maribyrnong and Yarra constituting over half (7) of the surveys returned. There was lower representation from the outer suburban growth corridors of Wyndham and Hume, and no representation from the more rural LGAs of Moorabool and Macedon Ranges. This observed pattern broadly mirrors the distribution of medical centres across the NWMPHN catchment, which shows a higher concentration of medical centres in LGAs closer to the city compared to the outer suburban and rural LGAs.[35]

One medical centre was located outside of the NWMPHN catchment in Epping, which lies inside the City of Whittlesea and near the border with the City of Hume, which is part of the NWMPHN catchment. We chose to include this medical centre as it was often used by consumers who lived within the NWMPHN catchment.

[35] Impact Co., pp. 51-52; although referring to after hours general practices, this data gives a good indication of the distribution of medical centres across the NWMPHN catchment.

5. Findings and Recommendations

5.1 Introduction

In the following section we will present our findings and recommendations based upon the consultations and research undertaken for this project. It should be noted that the intended audience for these recommendations is primarily NWMPHN, as this project was commissioned by NWMPHN to identify areas for improvement in culturally responsive primary care within their catchment.

This report was undertaken in the context of primary health care in Victoria. Although there are modes of primary care provision addressed in this report which are fairly uniform at a national level in Australia, such as general practice and emergency departments, some of the primary care services we consulted with and have examined are more properly unique to the Victorian health system. Community health centres, for instance, though widespread and widely used within Victoria, are rarely seen in other states. Capacity building networks such as the Primary Care Partnership (PCP) platform, which can be powerful drivers for the development and implementation of new primary care initiatives, are also absent in other parts of Australia. As such, the findings and recommendations are very much tied to the local needs and issues experienced by CALD communities living within the north-western region of Greater Melbourne. On balance, these findings are also more relevant to publicly funded or not-for-profit primary care.

Having said this, we expect that these findings and recommendations are relevant to regions outside the NWMPHN catchment. It is likely that this report anticipates primary care access and equity issues identified by other PHNs across Australia with highly diverse communities, such as the South Eastern Melbourne PHN or the WentWest PHN in western Sydney. These findings and recommendations could therefore be adapted to the needs of PHNs in other parts of Australia.

Beyond the sphere of PHN commissioned activity are the experiences of CALD users of primary care. While we acknowledge that these experiences can and do vary according to a great many factors – cultural and linguistic differences between different CALD communities, socioeconomic status, time since arrival in Australia, migration pathways and visa status, geographic location, state and regional differences in primary care systems and so on – throughout our consultations we also observed certain commonalities of experience in using the primary care system. Through judicious and strategic application of the learnings from this report, we believe that other sectors of the health system, including secondary, tertiary and private health care, could also take significant steps towards building their capacity to be more culturally responsive to the needs of Australia's diverse society.

5.2 Summary of findings

Overall, CALD consumers consulted for this project indicated a high level of satisfaction with the standard of care and the quality of practitioners working in the sector. In particular, CALD community participants expressed trust in receiving good quality care from emergency departments, ambulance services and community health centres. They were more ambivalent about the quality of service received from general practice, stating that there were very good GPs working in the sector but that consumers would often have to "shop around" until they found one that was satisfactory for their needs.

The CALD community participants also identified a number of significant barriers to accessing and receiving culturally responsive services. These included:

- Language barriers, both in terms of translated materials and the low numbers of primary care practitioners who spoke community languages.
- Issues with using interpreters, including lack of choice of interpreters and issues with interpreter accuracy with regards to health and medical terminology.
- Uncertain or incomplete knowledge of the complexity of the primary care health system, including not knowing where to find this information in the first place.

- Uncertain understanding of the role of GPs, with many of the community participants stating that they came from countries that did not have the equivalent of General Practitioner.
- Long waiting times for bookings, coupled with too-short times for appointments.

The primary health care providers we consulted with largely concurred, while also identifying other systemic barriers to access and equity within the primary care system. These included:

- The inflexibility of the Western medical model as a "one size fits all" approach to meet the needs of communities with different models of health and wellbeing, particularly with regards to mental health and AOD services.
- An ongoing lack of professional development and support for interpreters despite abundant training and resources about engaging interpreters.
- A scarcity of funding for culturally responsive capacity building in the primary care sector.
- The challenges in the profit-driven general practice business model to accommodate the requirements of culturally responsive care, such as longer appointment times, provision of interpreters etc.

We will discuss these findings and the recommendations that follow from them in more detail in the section below, under the following headings:

Finding 1: The primary health system provides good quality services, but can be difficult to access and navigate for consumers from CALD communities.

Finding 2: Cultural responsiveness in service design and delivery is inconsistent across the primary care sector.

Finding 3: The general practice sector needs to build its cultural responsiveness.

Finding 4: CALD data is not used sufficiently in planning and commissioning processes.

Finding 5: The Western medical model is not culturally responsive to the primary care needs of a diverse community.

Finding 6: The use of interpreters is inconsistent and underutilised.

5.3 Findings and Recommendations

Finding 1: The primary health system provides good quality services, but can be difficult to access and navigate for consumers from CALD communities.

Trust in primary care services

The consumers consulted in this project praised the quality of the primary health system and primary health practitioners in the NWMPHN catchment. Consumers indicated that the services they rated most highly were those they had the most trust in – these included emergency departments, particularly those located in the "Royal Three" major hospitals of Royal Melbourne Hospital, Royal Women's Hospital and Royal Children's Hospital, ambulance services and community health centres. Trust in general practice was more variable, with the community participants indicating they trusted GPs on a case-by-case basis. Trust and reputation of particular services were communicated among communities via word of mouth, family connections and social media.

A number of community participants, particularly those from Chinese backgrounds, also told us that they trusted complementary primary care (such as Chinese traditional medicine) over in-sector primary care for less serious health issues. Some participants also indicated that they trusted practitioners who shared their cultural and/or language background more than those who did not, although this was not universally the case. For example, some participants also said that they would rather see a good "Australian" GP (by which

we took to mean an English-speaking Anglo-Australian) than a less-skilled GP who spoke their own language.

The service providers we consulted also indicated that proving their trustworthiness to consumers was a key step in providing culturally responsive care. If consumers did not trust a service, we were told, they simply would not return to it. Medical credentials on their own were not sufficient to promote trust. Trust had to be earned with the consumers through empathy and inter-relational means, and there was not one single way to do this. Although it was beyond the scope of this project to examine more closely the question of how trust of primary care might differ between the experiences of CALD consumers and consumers from non-CALD backgrounds, both the service providers and community participants we consulted indicated that overcoming barriers to trusting primary care services was more difficult for consumers from CALD backgrounds.

Key barriers to access

The consumers and service providers we consulted discussed a range of barriers experienced by people from CALD backgrounds to accessing the primary care system. The key barriers identified were:

- **English language proficiency is a requirement to access and use the system:** All respondents told us that having either low or no English language proficiency was a major barrier to accessing and using primary care. Translated resources and interpreters helped, but were not always available. Some of the consumers relied on family members or friends who had higher English language proficiency, while others told us they had to learn English for themselves before they were able to access and use the primary care system.
- **Unfamiliarity with the primary care system:** Many of the consumers and service providers told us that CALD consumers were often unfamiliar with the primary care system, or that it took them some time to understand how to access and use it. Some of the consumers indicated that they received fragmentary or no information on primary care upon their arrival in Victoria, and had to rely for information on the support of family or community members, or had to work it out for themselves. Other consumers told us that for minor health issues they would seek in-culture support first, as they were more familiar with and trusted these supports within their community. This might include using traditional medicine or consulting with a faith leader, for example. These respondents said they would only visit GPs or EDs for more serious illnesses or conditions. However, as we could not find any baseline data comparing the usage rates of “mainstream” alternative primary care against that of CALD communities, it was beyond the scope of this project to determine whether this practice is more prevalent within CALD communities than the general population.
- **Cultural differences between service providers and consumers:** Most (but not all; see below) of the consumers we talked with said they were generally more comfortable with and had more trust in seeing practitioners from a shared cultural and language background. This was particularly the case for newly arrived migrants and refugees who had low English language proficiency or were completely unfamiliar with the primary care system.
- **Lack of public or private transport:** A number of the consumers said that lack of public or private transport options, combined with services being located at a distance from their homes, meant that they did not often access primary care unless they were “desperate” or had an emergency.
- **Type of employment and variable working hours:** Some of the consumers and service providers said that the type of employment and working hours had an impact on accessing primary care in a timely manner. Many new migrants and refugees are engaged in casual or insecure work, where taking time off to attend medical appointments would result in loss of pay or could impact on their job security. Conversely, consumers who did not have regular employment but had parenting or caring responsibilities also found it difficult to find time to attend primary care services. The result in both cases was consumers putting off primary care visits until the health issue either resolved itself or had reached a crisis, or going directly to an emergency department or after hours service when it became apparent primary care was needed.

A number of other themes around access and usage of the primary care system emerged from the consultations, which are covered in more detail below.

Use of ambulances and emergency departments

A number of consumers, in particular those whose English proficiency was low, said they relied primarily upon ambulance services for their after hours primary health needs even after having lived in Victoria for many years. These consumers indicated that they trusted the ambulance service, and always received good information and support when they arrived at the hospital. When asked if they would use other after hours services, they indicated that they would still go to an ambulance service first. The community participants who said they relied most on ambulance services for primary care were either over 65 years of age or were the parents of young children.

The consumers we talked with held in particular high regard the EDs of the "Royal Three" public hospitals clustered in the inner suburb of Parkville i.e. the Royal Melbourne Hospital, Royal Women's Hospital and Royal Children's Hospital. Although some of the consumers said that in an emergency they would visit the hospital closest to them, all said that the hospitals in Parkville provided the best services. Some of the consumers indicated that they would travel to one of these three hospitals even if there were another hospital or an after hours clinic closer to them.

A number of service providers suggested that co-locating a primary health hub adjacent to a hospital would be a way to reduce low level ED visits, and would also open up access to primary care for consumers who were unfamiliar with the system. The proposed co-located primary health hubs were modelled on community health centres – i.e. a one-stop hub for GPs, dental services, mental health services and specialist services. The idea proposed was that consumers presenting at a hospital emergency department with a low-level health issue could be referred directly to the adjacent health hub, where they could access both primary care and the health information that suited their needs.

Use of telehealth

The increase in telehealth bookings during the COVID-19 lockdowns has had a mixed impact for CALD communities. On the positive side, some consumers found it easier to use telehealth than to present in person to bookings, especially if they had work or caring duties that restricted their personal time. Others indicated that telehealth bookings reduced the stigma and shame of being seen to access a mental health or AOD service in person, as there was lower risk of being seen onsite by other members of their community. The service providers we talked with also observed these themes. A number of respondents said that text-based telehealth communications were also used extensively to communicate with service providers and other community members, in particular WhatsApp and Facebook.

However, a number of both CALD community participants and service providers also identified challenges to access and equity relating to telehealth. Some of the consumers indicated that telehealth bookings were more difficult than in-person appointments if an interpreter was required, as this added a layer of complexity to the interaction. We were also told that equity in digital access and literacy should not be taken for granted among the many diverse cohorts of people within CALD communities. Many CALD consumers either lacked access to appropriate digital devices or did not have the technological skills to navigate virtual platforms. This was borne out during the community consultations for this project, where two of the participants did not have computers or smartphones to access the virtual focus group meetings, and instead communicated via a phone call on loudspeaker.

Finally, the lack of privacy that some consumers experienced when trying to connect to telehealth appointments in a home setting could also be a barrier to access. This was especially the case in situations of domestic violence, where consumers could not talk with service providers from within their homes for fear that the perpetrators of domestic violence with whom they lived would overhear sensitive conversations.

Recommendations: Improve the access and usability of the primary care system for CALD consumers

1. Review and update guidelines for the use of telehealth within general practice to include culturally responsive measures such as access to free interpreters, health literacy etc.
2. Commission a project to develop guidelines for culturally responsive and accessible use of emerging digital platforms.
3. Promote after hours primary care services including doctor on call and nurse on call apps through ethnic media outlets.
4. Commission a study to identify what particular service provider skills, practice approach and communication methods tend to foster trust in primary care among CALD communities, as compared to the general community.
5. Review existing NWMPHN consumer and service provider feedback platforms to identify where information about cultural responsiveness can be collected.
6. Co-design a "culturally responsive star" rating system with CALD consumer representatives.
7. Commission community awareness campaigns that promote after hours services and provide culturally accessible information for CALD communities.

Finding 2: Cultural responsiveness in service design and delivery is inconsistent across the primary care sector.

Many primary care organisations in the NWMPHN catchment provide culturally responsive programs. Organisations that are performing well in the provision of culturally responsive service and programs tend to share the following characteristics:

- Consumers from CALD backgrounds are involved in the consultation, collaboration or co-production of programs and services.
- The organisation has to some level made cultural responsiveness a whole of business approach or a core part of their business.
- Interpreters are provided for consumers whenever they are needed.
- There is a high degree of cultural and linguistic mutuality between the workforce of the organisation and the diversity of the community.
- Health literacy practices and guidelines are used throughout the organisation. (However, a number of respondents pointed out that health literacy was most effective when it was a two-way process: i.e. where the goal of health literacy initiatives is not only to raise the health literacy of consumers, but also to reframe primary health messaging to be more culturally relevant.)
- The organisation employs or collaborates with "cultural connectors" who play an intermediary or liaison role between CALD consumers and health professionals.

However, there is still much work to be done for the primary care sector to become more culturally responsive, especially in "mainstream" service providers that do not have a CALD focus to their work. From our consultations, it seems apparent that very few primary care service providers have achieved a satisfactory level of competence in all of the cultural responsiveness characteristics described above.

Recommendations: Improve the cultural responsiveness of primary care service design and delivery

1. Review and update the minimum requirements for community co-production, consultation and engagement criteria in in the tender brief when commissioning services.
2. CALD representation based on considerations of mutuality with the NWMPHN catchment is made part of the selection process for NWMPHN consultative bodies such as the CALD Reference Group, People Bank, Clinical Council and tender assessment panels.
3. Develop guidelines and a funding model for NWMPHN commissioned primary health care providers to introduce and support "community connectors" roles in primary care organisations.

4. Use the Cultural Responsiveness Assessment Tool developed in this project to identify minimum level cultural responsiveness of organisations as a part of NWMPHN's eligibility criteria for commissioning.
5. Review the referral linkages between in-hours and after hours primary health care providers to ensure that these processes are culturally responsive to the needs of CALD communities.

Finding 3: The general practice sector needs to build its cultural responsiveness.

GPs remain a cornerstone of the primary care sector in NWMPHN. Given that Australians on average see a GP 5.6 times per year, a population of 1.64 million people in the NWMPHN catchment suggests approximately 9.4 million visits to GPs annually.[36] We heard from many of our community participants that a GP would be their first point of contact in seeking primary care for most health issues except for emergencies; this also included seeking help for mental health and AOD issues.

However, our consultations with both community participants and GPs indicated that the cultural responsiveness of general practice was overall lower than that of community health centres or EDs. The main challenges we identified are described below:

Unfamiliarity with the role of GPs

All the consumers and service providers we consulted with indicated that people from CALD communities experience a range of barriers to accessing and using general practice. We were told that newly arrived migrants or refugees were often completely unfamiliar with the role of GPs in the health system, because there was no equivalent for general practice in their countries of origin. Some consumers said that until they had understood the role of GPs as a first point of contact, they relied on EDs or ambulances for their primary health needs.

Trust is a critical factor for people from CALD backgrounds attending a GP

This mirrors the point made in Finding 1 above. Community participants told us that trust in GPs was related to not just the GP's clinical capacity, but their ability to understand the specific health needs of the CALD consumer. This ability was often but not always related to a shared cultural or language background, as some community participants also told us they would rather see a GP from a different cultural background as long as they trusted that particular GP. Consequently, community participants told us they would "shop around" until they found a GP they trusted.

While it seems likely that questions of trust would inform the choice of GPs among consumers across the wider community, it is also possible that the criteria for trustworthiness might vary from community to community. For instance, the trust factors that matter for a newly arrived refugee family may be significantly different to the trust factors for a settled Anglo-Australian family. However, it is beyond the scope of the current project to identify these factors.

Use of interpreters in general practice

There were two major barriers to working with interpreters reported by GPs working in clinics or private practice (but not in community health settings), both of which relate to a lack of capacity in profit-driven business models to budget for interpreters as a standard part of service delivery:

The standard 15-minute GP appointment does not provide sufficient time to organise a phone interpreter on the spot or to accommodate the extra time needed for the back-and-forth communication between the GP, interpreter and consumer.
The costs to use interpreters are too expensive for providers that are ineligible for funding.

The result was that many of the GPs we consulted said they did not use interpreters on a regular basis. Some GPs said they relied on family members of the patients who could speak English to provide

[36] Based on data taken from National Health Performance Authority (2015), "Healthy Communities: Frequent GP attenders and their use of health services in 2012–13," p. 9.

interpreting, which was backed up by the accounts of several of the community participants. One GP said that they encouraged patients who had trouble understanding English to record the appointment on their phone and refer to the video recording later.

Standard 15-minute GP appointments are not long enough

The standard GP appointment time of 15 minutes is not long enough to meet the specific needs of CALD consumers. As mentioned above, 15 minutes is often not long enough to book or work effectively with an interpreter. Moreover, people from CALD backgrounds often have more complex primary health issues and require longer appointments. This is especially the case with people who have arrived in Australia as refugees.

Cultural and linguistic mutuality with GPs

Being able to speak with a GP or another health worker in their own language helped CALD consumers to understand health instructions and to orient themselves in the primary care system. Some of the consumers said that they continued to return to GPs who had the same cultural or language background even after the consumers had moved to different suburbs and lived at some distance from the health service. However, a number of consumers also told us that after they had settled in Victoria, they would prefer to work with an English-speaking-only GP who was good at their job, rather than a GP from the same cultural or language background who was of lesser quality.

Recommendations: Improve the cultural responsiveness of the general practice sector.

1. Work in partnership with settlement services to provide newly arrived refugees with culturally responsive information on the primary care system and to connect with GPs in their area of settlement.
2. Liaise with the National Health Services Directory to add a filter to search for GPs via languages spoken.
3. Develop and incorporate "Community health profiles" based on CALD data into the NWMPHN's annual Health Needs Reporting and promote these profiles to GPs and other primary care providers as briefing information for working culturally responsively.
4. Work with the Royal Australian College of General Practitioners (RACGP) to review existing GP training resources and courses and, where possible, develop and incorporate new content relating to best practice in culturally responsive primary care. Key topics to include in this new material include:
    - Working with CALD communities and using interpreters.
    - Culturally responsive AOD practice (see also Recommendation 6 below).
    - Culturally responsive mental health practice.
5. Work with other PHNs to advocate for the Standards for General Practices (5th edition) to include indicators that better reflect the needs of CALD communities.
6. Develop guidelines and a funding model for general practices to introduce and support "community connectors" roles (the role of "community connectors" will be discussed more in the Best Practice section of the Final Report).

Finding 4: CALD data is not used sufficiently in planning and commissioning processes.

CALD usage data

NWMPHN collects detailed and useful data from a number of its commissioned services that indicate usage rates by people from CALD backgrounds. However, that data is not readily accessible by other sub-units within NWMPHN, nor is it made publicly available through the annual Health Needs Reporting or other publications. There is limited capacity, therefore, to analyse CALD usage data and use it to inform NWMPHN's planning and commissioning processes. This in turn makes it difficult to identify service delivery and accessibility gaps, or to conduct other health needs analyses relating specifically to CALD communities.

Workforce diversity data

Currently there is no workforce diversity data collected consistently across the primary care bodies commissioned by NWMPHN. If this data were collected safely and made available for planning it could be used to inform a workforce mutuality analysis, by which the diversity of the commissioned bodies' workforces can be compared against the diversity of the NWMPHN's catchment. Based on these results, initiatives and objectives could be put in place to raise the mutuality of the commissioned bodies' workforce with respect to the diversity of the community.

Recommendations: Collect and use CALD data to inform culturally responsive policy and practice.

1. Review the minimum data set so that the data collected is consistent and relevant to the needs of CALD communities. Using the revised minimum data set, develop protocols on the collection, analysis, dissemination and usage of CALD data.
2. Include analysis of CALD usage data in the NWMPHN's annual Health Needs Reporting.
3. Conduct or commission the analysis of CALD usage data from other sources, such as hospitals, emergency departments, community health centres and general practice.
4. Design and implement a culturally safe collection of internal NWMPHN workforce diversity data on a regular basis e.g. every 2 years, to be used in planning for internal workforce mutuality objectives.

Finding 5: The Western medical model is not culturally responsive to the primary care needs of a diverse community.

Many of the service providers we consulted told us that the Western medical model does not have the flexibility or capacity to be culturally responsive to the needs of CALD communities, who often have different models of health, caring and wellbeing. This was particularly the case for mental health and AOD services, where we heard from all the mental health service providers consulted and a number of the community participants that the concept of "mental health" did not exist in some cultures in the way it does in mainstream primary care discourse. This inability of the Western model to be articulable with other models of health meant that many people from CALD communities were either receiving primary care of a lower standard than other consumers, or were choosing not to seek in-sector primary care at all.

This argument was posed most urgently by mental health and AOD providers. The theme that emerged was that the Western medical model used in most "mainstream" (i.e. non-CALD specific) mental health and AOD services was unable to differentiate the culture-specific forms of stigma relating to mental health and AOD issues across different communities. Mainstream services were therefore unable to address or manage the effects of culture-specific stigma in service or program delivery.

Stigma is culture-dependent, and thus the form and experience of stigma relating to mental health and AOD issues can vary between different communities. Conceptualisations of mental health and wellbeing also vary considerably. Not all cultures pathologise mental health issues, nor do all cultures conceptualise mental health issues as health conditions, but may have other models and understandings of mental wellbeing.

Subsequently, when many people from CALD backgrounds encounter the Western-centric clinical-counselling model used by many mental health and AOD primary health care providers, they can experience a profoundly culturally "other" object that shares little common ground with their models of mental wellbeing. This can result in "mainstream" mental health and AOD programs failing to meet the needs of migrant and refugee communities.

This alienating experience can also easily become traumatic when more coercive mental health and AOD referral pathways are forced upon consumers from CALD backgrounds. Police intervention, for instance, is sometimes the first point of contact for mental health and AOD primary care. For many consumers this

encounter can be disempowering and can result in referral pathways that lead into the criminal justice system rather than the primary care system.

Much work needs to be done to reconceptualise and destigmatise mental health and AOD primary care for CALD communities. However, we have identified a number of indicators from our consultations that point the way towards more culturally responsive mental health and AOD primary care:

- The programs are co-produced with community.
- The service delivery model includes a "community connector" to liaise between consumers and service providers.
- Where it is safe and appropriate to do so, mental health and AOD counselling services provide the option to include the family members or other significant people in the life of the consumer.
- When interpreters are used, they are not personally known to the consumer or their direct circle of family and community.
- Complementary counselling and therapy based on community-specific practices are incorporated into the program.

Recommendations: A new model for culturally responsive mental health and AOD primary care is needed.

1. Commission a piece of work to collaborate with community leaders and specialists in culturally responsive mental health to understand the different forms of stigma towards mental health and AOD issues among CALD communities. This work should also develop guidelines for mental health and AOD service providers on how to respond to stigma in culturally responsive ways. This could result in a program that could then be piloted in collaboration with a particular community.
2. Commission a project to identify guidelines for the safe and appropriate inclusion of family members and other significant people in mental health and AOD services.
3. Commission a project to identify guidelines for conceptualising, translating and communicating culturally safe mental health and AOD information for CALD communities.
4. Form a research partnership with a university to identify how alternative models for clinical psychology and mental health that are more culturally responsive can be incorporated into existing tertiary courses for general practice and primary health.

Finding 6: The use of interpreters is inconsistent and underutilised.

Inconsistent use of interpreters

Both the service provider and community consultations agreed that consumers from CALD backgrounds will choose to use interpreters when they are needed and made available.

However, the use of interpreters is inconsistent and interpreters are often underutilised across the range of primary health settings. Interpreters were most often used in community health settings, where many community health organisations either employ bicultural workers who are proficient in community languages, employ interpreters as members of integrated health teams, or utilise interpreting agencies such as Translating and Interpreting Services (TIS) or LanguageLoop (formerly Victorian Interpreting and Translating Services (VITS)).

Interpreters were less often used in general practice and private provider settings, as described in more detail in Finding 3 above.

Mode of delivery

Face-to-face and in-person interpreters were identified as best practice, as this mode of delivery is better at conveying nuances of meaning, body language and cultural understandings. When in-person interpreting is not available, video interpreting is preferable to telephone interpreting for the same reasons that video is better able to capture physical cues of body language and facial expressions.

Telephone interpreting was identified by both service providers and consumers as the most difficult mode of delivery to work with effectively. The lack of visual cues through body language meant that nuance and tone could be lost, while some consumers indicated that it was harder to form a rapport with an interpreter whose face they could not see. Both service providers and consumers reported that the necessity of using phone interpreters during COVID-19 lockdowns, when consumers were unable to attend medical appointments in person, had increased many of the respondents' confidence and capacity in working with phone interpreters.

Working in integrated health teams

Interpreters were found to be most effective when working as part of an integrated health team, such as in community health settings where interpreters (or bicultural workers who could speak community languages) would work alongside GPs, refugee health nurses, counsellors and other allied health practitioners or specialists. In these settings, interpreters were not simply an "add-on" or an optional extra; they became part of "business as usual," and would accompany consumers at each step of referral within the community health setting. Working with the same interpreter increased the level of trust between consumer and service provider, with the result that consumers would return more regularly to the service, rather than put off seeking medical support until their condition(s) had worsened into a crisis. It was also found that making interpreters part of an integrated health team served to increase their professional capacity, as working consistently in these settings allowed interpreters to familiarise themselves with medical terminology and processes. Where in-house interpreters were not available, some service providers issued GPs and other practitioners with individual access codes to interpreting services, as a way to encourage staff to use interpreters as often as required by consumer needs.

Some responses from general practice indicated that it would not be practical to have an in-house team of interpreters attached to GP clinics. The reasons cited for this were related to the general practice business model. The costs of employing a team of interpreters were prohibitive, and as mentioned earlier the standard 15-minute GP appointment time was not long enough to accommodate the extra time needed to work with an interpreter.

Consumer choice of interpreters

Both service providers and consumers told us that consumers want to have more control in choosing the interpreter assigned them. Consumers indicated that establishing a culturally safe and appropriate working relationship with an interpreter was based on more than just sharing the same language. Other factors that consumers said were important to consider when assigning an interpreter were:

- **Gender:** A number of consumers said that they were more comfortable talking with an interpreter of the same gender. This was especially the case for female consumers in situations where women's health or reproductive health was being discussed. The preference for gender matching was expressed more by respondents from East African, Middle Eastern and Muslim communities. However, it was noted that there was a chronic shortage of female interpreters for some languages; a South Sudanese respondent and a Somali respondent both said that there were "no female interpreters" for Dinka and Somali working in Melbourne as far as they knew.
- **Dialect:** Dialectal differences in spoken languages, especially languages with a broad geographic spread such as Arabic, could result in consumers working with interpreters they had trouble understanding, despite speaking the same parent language. Respondents indicated it would be helpful for consumers to be able to nominate their preferred dialect as part of the interpreter booking process.
- **Proximity to community and privacy:** Some consumers expressed a concern about privacy and confidentiality in situations where they worked with an interpreter who was part of their immediate community. Respondents said they would feel more comfortable taking about health and personal matters if they had the option to choose interpreters who lived in a different city or state.
- **Knowledge of health terms and health system:** Both service providers and consumers highlighted the issues of working with interpreters who were not familiar with health language and

terminology, with the result that vital information would be omitted and appointment times would be taken up with extra explanation.

Recommendations: Promote more consistent use of interpreters in primary care

1. Develop and implement an education campaign promoting the role of interpreters in primary health settings with two main objectives:
    - To educate primary health providers and especially GPs on the purpose and benefits of using interpreters in primary care settings.
    - To raise awareness among CALD communities that using an interpreter when needed is a human right.

    The education program should also include information on how to book and work with interpreters, and should be deployed on media and communications platforms that use health literacy principles and are accessible to CALD consumers.
2. Add reporting requirements for NWMPHN commissioned services to demonstrate engagement with interpreters at levels that reflect community need based upon relevant demographic data such as English-language proficiency.

6. Outline of Cultural Responsiveness Assessment Tool and supporting resources

The final deliverable of the project was to develop a tool for assessing the cultural responsiveness of primary care service providers commissioned by NWMPHN. Based on the project's findings and recommendations and supported by an environmental scan of best practice diversity and inclusion frameworks and assessment processes, ECCV and COPHE developed the following suite of resources, which were provided to NWMPHN as separate documents for ease of access and use by commissioned services:

1. Cultural Responsiveness Assessment Tool

The Cultural Responsiveness Assessment Tool (the Tool) was designed to help commissioned primary health care providers to assess their current level of cultural responsiveness and hence to identify quality improvement activities that will help improve their cultural responsiveness. Users of the Tool will assess their levels of cultural responsiveness across 10 best practice Indicators and to identify Actions which will help to improve their service's overall cultural responsiveness. The Indicators are organised into three broad Activity Areas, as described in the table below:

Activity Area	Indicator
1. Participation and engagement	**1. Co-production with community** It is important that health services are designed and delivered in collaboration with members of the communities that they are intended for. This is called the principle of co-production. We provide the opportunity for co-production with consumers from migrant and refugee backgrounds to ensure that our services are culturally responsive. Co-production when done right includes the full cycle starting with co-design of the service, co-decision making in the allocation of resources, co-delivery of the service and co-evaluation of the service going forwards.
	2. Workforce mutuality Our staff members reflect the diversity of the community we work within and provide services for. Our staff is culturally and linguistically diverse at all levels, including volunteers, practice staff, clinicians, managers and Board members. This kind of diversity is called "workforce mutuality," which goes beyond tokenistic inclusion of a workforce made up of "diverse" individuals to instead build services and workplaces that represent the community of people who use them. In building our workforce mutuality, we seek to address avoidable inequities relating to disadvantage, discrimination and under-representation.
	3. Consumer feedback We need to know if our service is providing the same level of health outcomes for everyone in the community. To make sure that people from migrant and refugee backgrounds are not being inequitably disadvantaged, we collect consumer feedback on our service's cultural responsiveness in a culturally safe and participatory manner for use in our service planning, implementation and evaluation processes.
2. Access and equity	**4. Culturally responsive digital access** Culturally responsive digital access to telehealth, online booking, referral options and other service information is a key component in making sure that everyone in the community can access our service when they need it. Our goal is to make sure that all avoidable barriers to digital access that may impact consumers from migrant and refugee backgrounds have been removed.
	5. Interpreter Engagement

Activity Area	Indicator
	All people in the community have the right to access professional interpreters so that they may communicate freely with primary health care providers in the language of their choice. Having access to and being able to engage interpreters is a normal and everyday part of our service.
	6. Culturally responsive communications Our service is skilled in the use of culturally responsive communications so that we can reach people from all backgrounds in the community. We use health literacy, translated materials and culturally relevant media platforms to make sure people from migrant and refugee backgrounds know what our service has to offer and that it is available to everyone.
	7. Culturally responsive referrals and partnerships We recognise that one service cannot meet all the complex needs of consumers. We therefore provide consumers with referral pathways to a diverse range of services, and explore opportunities to work in partnership with ethno-specific and multicultural organisations.
3. Culture and capacity	**8. Culturally responsive leadership and organisational culture** Having the support of leadership is crucial to embedding cultural responsiveness as part of "business as usual" across all aspects of our service and programs. It is equally important that our service's commitment to cultural responsiveness is embedded in the way we work and behave in our organisation. We demonstrate this commitment in many ways.
	9. Culturally responsive data To understand the needs of our consumers and improve the quality of our service, we collect and/or access culturally responsive data and research in a culturally safe and appropriate way for use in our planning and implementation processes.
	10. Cultural responsiveness training Our people are the core of our service. We support their capacity to provide the same level of primary care to all members of the community by providing our people with cultural responsiveness training and professional development.

2. Cultural Responsiveness Action Plan template

The Cultural Responsiveness Action Plan provides commissioned services with a basic template for developing a 6-18 month workplan to implement the culturally responsive Actions identified after having used the Tool. The Action Plan template supports users in identifying Actions, assigning responsibilities and priorities, and developing a timeline for implementation.

3. Cultural Responsiveness Review template

The Review template is intended to support commissioned services in tracking their progress between successive iterations of Action Plans, in alignment with NWMPHN's commitment to supporting the quality improvement process for commissioned services.

4. Implementation Guide

The Implementation Guide provides a comprehensive step-by-step how-to guide on using the Tool, Action Plan and Review templates. It also includes a set of Practice Examples and links to resources to support commissioned service providers in developing and implementing their Cultural Responsiveness Action Plans.

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Appendix 1: Questions for community focus group consultations

Key domains of engagement
Based on the scoping and research for this project in conjunction with the themes emerging from the primary service consultations, we have identified three key domains of CALD community members' engagement with the primary health system that we want to know more about. These domains include:

1) **Knowledge of the primary care system**
   What awareness do CALD community members have of the primary care system, where do they get their information and what barriers to knowledge do they face?

2) **Practices employed to use the primary care system**
   How do CALD community members use the primary care system? When and where do they go for specific health needs such as after hours care, mental health care and alcohol and other drugs services?

3) **Experience of using the primary care system**
   What aspects of the primary care system work well for CALD communities? What doesn't? What would improve the primary care system for CALD community members?

Consultation questions
Domain 1: Knowledge

1) Where do you find out information about health services and how to use them?
2) What are some of the challenges you have experienced finding out about the health system?

Domain 2: Practices

3) If you or a family member had a mild health problem or illness, where would you go first?
4) If you or a family member had a more serious health problem or an emergency, where would you go?
5) What would you do if you had to see a health service after hours?
6) What if it was a mental health problem, or an alcohol and drugs-related problem?

Domain 3: Experience

7) Can you tell us about a good experience that you had with a health service? Why was it good?
8) Can you tell us about what are some of the barriers or problems you have faced when using health services?
9) Have you booked interpreters when you go to a health service? If so, what has been your experience with interpreters?
10) What are some things that health services can do to do a better job for people from multicultural backgrounds?

Is there anything else that you would like us to know about your experiences using the health system?

Appendix 2: Consultation questions for Primary Health Care Providers

Date of interview:
Name of service:
Name and position of interviewee:
Type of primary health services provided:

1. Are there any particular CALD communities that use your service regularly?
2. Are these consumers from particular locations?
3. Why do you think these particular cultural groups visit your service?
4. Is there a difference between the reasons particular groups present in hours or after hours?
5. What are the key health issues you have identified in the CALD communities presenting to your service?
6. Would you say that the cultural backgrounds of the staff at your service reflect the cultural backgrounds of your consumers?
7. Is your service targeting any specific CALD communities?
8. What are the key things your service has done to be culturally responsive to the needs of CALD consumers?
9. What are the barriers for the use of your service by CALD communities?
   E.g. cost, opening hours, language, distance to travel etc.
10. Do you regularly use interpreters for health services? If so, what works, what doesn't?
11. Do any of the staff at your service speak a language other than English when working with consumers?
12. What is the service model/resourcing you need to provide your services to CALD communities?
13. Do you think that some CALD community groups access specific primary health services in your area, if so why?
14. Are CALD communities using telehealth at the level you would expect given their relative representation in this community?
15. Given that children in 0-4 age group and over 65 are over-represented in ED presentations, does your practice have confidence and mechanisms in place to treat these groups?
16. Where do these patients go when your service is closed?
17. Do you receive feedback in relation to patients who attended a hospital ED?
18. Do you think or have evidence of your patients using ED for primary health services?
19. What improvements do you think could be made for the provision of AH primary health services?

Do you have any other comments which may assist in improving after hours services for CALD communities?

Appendix 3: GP survey questions

GP Survey
The Ethnic Communities Council of Victoria (ECCV) is working in partnership with Community Owned Primary Health Enterprises (COPHE) to lead research and consultations to understand how primary health care providers, including general practices and commissioned service providers, can improve their services' cultural responsiveness. The findings from this project will support the implementation of culturally responsive care and inform and guide future commissioning activities of NWMPHN.

This survey will help us identify:

- what general practices are currently doing that is supporting culturally responsive care;
- what improvements are required; and
- what the barriers and enablers are to deliver culturally responsive care.

In addition to that, this survey will help us better understand the challenges that culturally and linguistically diverse (CALD) communities face in accessing GP services.

Who we want to hear from?
We want to hear from GPs who provide primary care in central, northern or western Melbourne.

You can get involved by completing this online survey. The survey should take around 10 minutes to complete and your answers will remain anonymous. Responses are required by 29 November.

What happens next?
The feedback from the survey will be used to inform and guide our project and recommendations for improving cultural responsiveness.

Survey Monkey Link
www.surveymonkey.com/r/V5MZZWX

Survey questions

1. The postcode of my principle place of practice is:
2. Are there any particular CALD groups that use your Medical Practice? If yes, please state which communities.
3. Why do you think these CALD groups access your service in preference to others?
4. What are the key things your practice has done or is currently doing to be culturally responsive to CALD communities?
5. What barriers does your medical practice have to delivering culturally responsive care?
6. What would help your service be more able to meet the health care needs of the CALD community?
7. We understand that very few medical practices use an interpreting service, why is this so?
8. Do you think lack of English language skills creates problems for CALD communities when accessing medical services?
9. What would assist you to make better use of an interpreter?
10. Any other comments:

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