RESEARCH TO ACTION

>> Bridging the gap between what we know and what we do

Culturally Proficient Service Delivery

A Rapid Review of the Literature

Centre for Applied Disability Research

An Initiative of National Disability Services

NDS National Disability Services

THE CENTRE FOR APPLIED DISABILITY RESEARCH

The Centre for Applied Disability Research (CADR) is an initiative of National Disability Services (NDS). CADR aims to improve the wellbeing of people living with disability by gathering insights, building understanding, and sharing knowledge. CADR's applied research agenda is helping to build the evidence base and support stakeholders to better understand what works, for whom, under what circumstances and at what cost.

RESEARCH TO ACTION GUIDES

Bridging the gap between what we know and what we do. Our objective is to build a comprehensive online collection of disability research and translational resources for the Australian context. Our Research to Action Guides are based on the best available local and international evidence and put together by subject matter experts to support research end users to engage with the evidence. We gather and analyse evidence about what works, and package that information into efficient and practical resources.

ACKNOWLEDGEMENTS

This Guide was authored by Maria Katrivesis, Consultant and Trainer and Hamish Robertson, Consultant and Researcher.

This resource was developed with support of Australian governments through the Research and Data Working Group. NDS Gratefully acknowledges the support of the NSW Government in establishing the NDS Centre for Applied Disability Research.

SUGGESTED CITATION

Katrivesis, M. & Robertson, H. (2018) 'Culturally Proficient Service Delivery. A rapid review of the literature', Research to Action Guide. NDS Centre for Applied Disability Research

ABOUT THIS RESEARCH TO ACTION GUIDE

This Rapid Review forms part of the Research Action Guide on cultural proficiency, a suite of resources produced for CADR on this topic. A complimentary Guide, based on the findings of this review, has been developed to support staff working alongside people from culturally and linguistically diverse (CALD) backgrounds with disability build their individual cultural proficiency. A second guide provides practice leaders and managers in disability services with a practical pathway to cultural proficiency.

The entire Research to Action Guide suite is available at the CADR Clearing House, www.cadr.org.au.

FEEDBACK

Do you have feedback, or a suggestion for a Research to Action Guide? We welcome your thoughts and ideas. Please contact info@cadr.org.au.

CONTENTS

1. EXECUTIVE SUMMARY

This report presents a rapid review of the literature on cultural proficiency, cultural competence and related terms. The focus is on disability in Culturally and Linguistically Diverse Communities (CALD) across Australia. The aim of this is to inform disability sector organisations in their work with diversity issues as they interact with a changing disability population and service environment. This rapid review is part of a Research to Action Guide, which also includes good practice guides, informed by the evidence. The 2014 Audit of Disability Research and a later update in 2018 confirm there are substantial knowledge gaps in our understanding of the intersection between disability and diversity.[143] A growing expertise and knowledge base is clearly required if equity is to be achieved in this area, as past and present research confirms the lack of a high quality CALD disability research base.

2. RAPID REVIEW

INTRODUCTION

The Culturally Proficient Service Delivery Research to Action Guide has been developed to assist in the provision of accessible, appropriate and effective disability (and related) services. The Guide comprises the rapid review and a number of supporting pieces, all designed to inform thegood practice. The aim of this rapid review is to provide a current understanding of the intersection of disability issues with cultural diversity issues in the research literature. The purpose in doing this is to support people in the disability sector in developing their own research-informed strategies and practices for working in the increasingly diverse and dynamic disability environment. The need for better understanding of the intersection of diversity and disability issues can only grow in coming years as the social and scientific understanding of disability as an intersectional field of experience and practice expands and develops.

The rapid review summarises the evidence on the provision of culturally proficient services in the disability, and related sectors. The review included both peer reviewed and relevant grey literature, including previous work undertaken by the authors. Full details of the methodology are presented in Appendix 1. It was developed in response to two key research questions: What are the key aspects of a culturally proficient workforce's practice; and how do you provide culturally proficient services and supports?

The review provides an overview of what is known about disability and culturally and linguistically diverse (CALD) communities in Australia. It then briefly reviews the terminology and underpinning philosophies relating to the provision of services to members of CALD communities, followed by a discussion of relevant models and approaches, including their limitations. The report concludes with the Good Practice Summary, which incorporates the core elements of culturally proficient service provision. Issues associated with disability in Aboriginal and Torres Strait Islander communities are not addressed in this rapid review but are part of the NDS and Centre for Applied Disability Research program of work and dealt with in other resources.

CONTEXT

The estimates of people with disabilities within CALD communities vary according both to the definition used and the types of disabilities included. The 2016 Census revealed that 67 per cent of the Australian population were born in Australia. 49 percent of Australians had either been born overseas (first generation Australian) or one or both parents had been born overseas (second generation Australian).[1] The 2015 Survey of Disability, Ageing and Carers showed that a disability rate of 15.8% amongst people born in non-English speaking countries, and 21.0% amongst those born overseas in other English speaking countries. The rate was 13.6% for people whose main language spoken at home was other than English compared to 18.6% for the mainly English speaking population.[2]

It is important to note that due to linguistic and methodological limitations, these figures might be an under-representation, not least of all because language spoken is not an indication of either cultural or religious diversity. In addition, a recent review of the disability and CALD data argues that CALD people with disability are: significantly underrepresented (still rarely above 13% of users) in their use of specialist disability services; have comparable disability rates (given data limitations) with the Australian-born community; have higher rates of profound and severe disability; and have a higher need for assistance than those who speak English at home.[3]

TERMINOLOGY AND APPROACH

This Research to Action Guide uses 'cultural proficiency' as a way of describing appropriate service provision to CALD communities. This term is the latest in a number of attempts to encapsulate the competencies required by providers, including both organisations and individuals in order to achieve this aim. The brevity of this review does not allow for full discussion of the terms, but it is important to note that in both the literature and in practice there are variations. Appendix 2 provides a brief outline of the differences and their origins. The notion of cultural competency has evolved over time[4] and this is reflected in the range of terms used including: cultural competence,[5] cross-cultural competency,[6] cultural appropriateness,[7] cultural safety,[8] cultural sensitivity,[9] cultural humility,[10] and cultural proficiency[11] amongst others. A relatively recent meta-review indicates that that are over 30 models of intercultural competence and over 300 related constructs.[12]

Each definition has a different, although often overlapping, focus. A similar issue arises with the focus of research, with much of the work in this field occurring within the context of healthcare and in relation to disability services in areas such as psychology,[13 14] mental health [15-17] and rehabilitation [18-20 21] which span both fields. Cultural proficiency as a term is still most understood and operationalised within the context of education.

Approaches to service delivery for people with disability have changed significantly over the last decades as the medical model of care gave way to a social model of disability, supported by human rights enshrined in national and international policies and strategies.[22 23] There is also an argument for understanding disability and cultural diversity from an intersectional approach, that is to say from the perspective where vulnerabilities and experiences are both cumulative and interactive[24] (and therefore cannot be 'teased out individually' [25 26]) and for engaging with the 'culture of disability' framework as a way of addressing the inequities experienced across both fields.[27 28]

WHAT ARE THE KEY ASPECTS OF A CULTURALLY PROFICIENT WORKFORCE'S PRACTICE?

Cultural proficiency can be understood and applied at different levels: systems; organisations or services; teams or units; and individual professional, staff, managers and volunteers. [29] Different elements and factors shape the ability to provide culturally proficient or competent practice at each of these levels. In order to attract and meet the needs of people from CALD backgrounds with disability, a disability service requires culturally proficient professionals, staff, managers and volunteers associated with disability services. However, what cultural proficiency actually means in a disability service provider organisation may vary within the context of specific services and client groups.

A service providing care, for example, for members of largely second or third generation immigrants (as is the case for many descendants of post-World War II immigrants) will need to be culturally aware, but may not necessarily require additional language support. Those providing care for individuals who developed disabilities because of torture and/or trauma in their country of origin, or in transit to Australia, including refugees and displaced persons, may require more specialised knowledge about interacting with their clients.[30]

The literature identifies two intersecting elements that form the basis of this skill mix. These are the organisation or services' ability to identify, attract and retain workers with the required cultural/linguistic skills[31–34] and/or the services ability to support workers to develop and enhance those competencies.[35]

Current research evidence on the contributions of CALD workers in the disability sector itself falls into four key categories:

1. "mere" labour (a preparedness to work for a low wage, including readiness to work in undesired jobs);
2. those competences which are not related to ethnicity (professional knowledge, skills, abilities, work experience);
3. those competences directly related to ethnicity (language, cultural skills and knowledge, networks and contacts, new approaches to work tasks); and
4. the worker's ethnicity itself (as a symbol for cultural accessibility, authenticity, and equity).[36]

With regards to specific workforce competencies, cultural competence, like all competence, can be broken down into the knowledge, skills and attitudes (the 'three legged stool'[40]) required for culturally proficient practice.[41] A list of key competencies is presented in Table 1, below.

Table 1: Summary of key cultural competencies

Attributes	Competencies (numbers indicate references)
Knowledge	• Cultural knowledge (including both ethnicity/religion and disability) [20 42 27 42–44] • Ethno-specific, multicultural and general support services[42–45] • Cultural politics and power relations, including oppression, healthcare disparities and social justice[28 46–50] • Client (person and family) centred practice[46 51–53] • Strengths-based approaches [54 55 56]
Skills	• Listening skills[57 21 46] • Interpersonal and rapport building skills [57 58] • Communication skills [27 43 57 59 60] • Use of interpreters[21 61–63] • Interdisciplinary and inter-professional collaboration[45 60 64 65] • Adaptation of professional skills[59]
Attitudes/awareness	• Compassion and emotional support[66 67] • Honesty and trust building [66 58 68] • Respect [66 69 70] • Self-awareness, including to bias[27 71–73] • Humility[74–76]

Employment of bi- or multi- lingual staff or cultural brokers can improve access to services, open up new client groups, improve the quality of service provision, and in a small number of cases has been shown to improve outcomes for CALD communities.[37–39]

The implications of these competencies can be summarised in the definition of cultural competence provided by Suarez-Balcazar et al. (2009).[77] Based on early work by Campinha-Bacote (1999)[78] they argue that cultural competence is "... demonstrated when the practitioner understands and appreciates differences in health beliefs and behaviors, recognises and respects variations that occur within cultural groups, and is able to adjust his or her practice to provide effective interventions for people from various cultures".[77: 499] As well as the competencies identified above, Campinha-Bacote (2001) includes cultural encounters as essential (direct engagement in cross cultural activities) to the cultural competence process,[70] an approach supported by other research.[79–82]

Cultural proficiency or competence is a set of skills, attitudes and behaviours required for the effective and appropriate delivery of services. One of the seminal articles in this field is by Cross et al (1989)[83] who describe the six stages of cultural competence, running from cultural destructiveness, through cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and finally cultural proficiency (which is described as an organisational rather than individual attribute and will be taken up in the next section). While other authors provide different models[78 84–86] of staging or development, the core concept is that the development of cultural competence needs to be undertaken over a period of time and within a

supportive organisational environment.[5 87]

At present, good quality research-based evidence on the effectiveness of different cultural competency training approaches and methods is limited due to significant differences in definitions, approaches and evaluations of outcomes.[88] Support for developmental approaches continues nonetheless and cannot simply be discounted due to a lack of generalised evidence.[5 89 90] More emphasis needs to be placed, however, on programs which can support intersectional[91 92], multifaceted[93] and reflexive,[5 94-97] rather than simplistic cultural information, approaches.[98-100] Risks in simplistic cultural competence training approaches include: essentialising the different 'other'; creating an inflated sense of competence; and creating resistance against incompetence.[101]

New approaches to the development of cultural competencies, including simulation,[102-104] consultations and coaching,[105 106] need to be undertaken within enabling organisational environments which support the changes the training intends to effect.[107] If staff, after having undergone such training return to a workplace environment where it is not valued and supported any learning acquired is extinguished.[108 109] The inclusion of community representatives as participants as well as presenters in cultural competency training is also effective.[110-112] The involvement of community and advocacy groups in all aspects of disability services strengthens the links, knowledge and trust between them.[113 114]

HOW DO YOU PROVIDE CULTURALLY PROFICIENT SERVICES AND SUPPORTS?

As noted previously, the first definition of cultural proficiency was as the last stage of Cross et al's (1989)[83] model of cultural competence. Culturally proficient agencies were distinguished by '... seek[ing] to add to the knowledge base of culturally competent practice by conducting research, developing new therapeutic approaches based on culture, and publishing and disseminating the results of demonstration projects ... [and by] hir[ing] staff who are specialists in culturally competent practice. Such agencies [are said to] advocate for cultural competence throughout the system and for improved relations between cultures throughout society." Burcham (2002) includes cultural proficiency in her model of cultural competence, and drawing on Cross et al[83] and Villarruel[115] locates it at the last and highest level of development,[86] and combines those characteristics with 'an evidence of commitment to change'.[116] Wells (2000) argues that cultural proficiency is actually a higher order concept than cultural competence, and as such overcomes the limitations of competency models that focus on awareness, sensitivity or even competence.[117]

In short, culturally proficient services recognise the specific factors affecting CALD individuals and groups access and use of services[118-121] and develop strategies to remove barriers and supporting and facilitating culturally proficient care both within individual services and organisations, and across the sector as a whole. One definition of a culturally competent or proficient organisation which has been forwarded is "... one which recognises, respects and responds to diversity in order to achieve the best possible outcomes for all its clients."[122]

The use of services by people from CALD backgrounds with disability are affected by a range of experiential, local or community and systems factors, the development of responses to meet those need to be both evidence based and context sensitive.[118-121] There is no 'one size fits all' approach in responding to CALD communities, but as in the case of practice competencies, there

is a strong synergy between culturally proficient practice in disability organisations and human rights approaches to service provision.

These barriers could be addressed in a number of ways. The Acheson Inquiry into health inequalities provided a set of useful principles around which equitable and appropriate service delivery should operate.[123] The inquiry argued that services serving disadvantaged populations are not of poorer quality or less accessible; that the allocation and application of resources are in relation to need and; positive efforts are made to ensure greater uptake and use of effective services, with extra efforts made to reach those who [are in greater need of such services].[123] In brief, this means that in providing culturally proficient services and supports, disability services need to address (and evaluate) four components: access, utilisation, quality and safety, and outcomes.

Access factors include (amongst others) individual, family and community differences in understanding and responding to disabilities;[62 124] knowledge of available services;[119] isolation;[125] language and literacy barriers;[73 126] concerns about the cost of care;[125] and concerns about the delivery of care.[69] Utilisation of all care services by vulnerable groups is affected by factors including those just listed, but also provider characteristics such as generalisations and stereotyping, bias, prejudice and discrimination, staff anxiety and uncertainty; and organisational factors including the availability and type of services, including community services, and language barriers.[127]

Some specific approaches include removing language barriers by employing bilingual staff, training staff in languages, supporting the use of interpreters;[62] skills development through training and methodologically and conceptually sophisticated development approaches (as discussed previously);[62 77] recognising that culturally competent practice may take additional time and effort on the part of individual staff and therefore the organisation; [71] allocating adequate resources for the use of resources including interpreters, bilingual workers and the development of appropriate materials; [62 128] and utilising strengths and community-based approaches in order to value and capitalise on the strengths within families and communities.[43 62]

The quality, safety and client outcomes of disability services provided are arguably the least researched areas of the field. Several reviews of cultural competency in health care have resulted in similar findings of methodological weakness. While evidence shows that culturally competent services can improve access, quality and utilisation of care, there is little evidence of improvements in outcomes for clients. [129 130 131 132] Several organisational characteristics are required if culturally proficient approaches are to be developed. These include: a clear organisational vision for cultural proficiency; a public commitment to that vision by executive, leaders and champions across the organisation; executive sponsorship of and responsibility for the plan; the use of cultural proficiency audits; a commitment of resources; and a set key performance indicators and metrics (individual and organisational).[133 134 122]

The Victorian Health Promotion Foundation produced a critical review of various audit processes in the diversity practice which still provides a baseline for cultural competency approaches and provides suitable metrics.[135] Multicultural Mental Health Australia (MMHA) has produced a national cultural competency tool specifically for mental health service providers136. Robertson and Travaglia [122] developed a comprehensive model for the delivery

of culturally proficient disability services in Australia based on the issues and principles outlined in the previous sections of this report. Their argument is that in order to deliver culturally competent services, a set of inter-related organisational dynamics need to be addressed. A number of organisational characteristics are required if culturally proficient approaches are to be undertaken. These include: structural and system supports (legislation, policies and procedures, planning and resource management); frameworks (access, equity, anti-discrimination and human rights); environment (physical, cultural, safety, forecasting); resources (including financial, all staff, material, relational, relationships with communities and other organisations); information (including data collection, consultation processes, communication and education); people (including planning, competence, development and leadership); activities (including services, provider and staff responsibilities, program and service development); quality (including monitoring, evaluation, improvement and research) and metrics.

GAPS IN THE EVIDENCE

In assessing the evidence for this rapid review what was sought was examples of strategies or interactions to support culturally proficient practice. In closing, two issues need to be addressed. The first is that cultural competency (and most of its derivations) are not without critics. These often relate to the lack of socio-political engagement of some of the models, which are a result, it is argued, of a focus on 'culture' to the detriment of understanding of inequality [137] [138] social justice[139] and of more complex nuanced and dynamic notions of individual and collective identity. [140] [141] Bhui et al (2007) argue that while cultural competence is relevant as a goal, its implementation is highly variable and largely untested using reliable research methods.[142]

The Report of Audit of Disability Research in Australia[143] canvassed the disability research environment, including the scholarly and grey literature, for the years 2000 to 2013. The researchers reviewed over 2000 research reports and found significant gaps in the available evidence on disability services, as well as an overall lack of strategic thinking and funding in the research current disability research environment. It found that current research does not address in any substantial way the National Disability Research and Development Agenda's four key target groups: Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds (CALD); women with disability; and people in regional, rural and remote areas.

These findings support those of this review process. With notable exceptions, in comparison to healthcare, there is limited international research that directly addresses the needs of people from CALD backgrounds with disability, and what is available is often produced as a result of an overlap between the two fields (as in the case of mental health or rehabilitation services). Once the search is directed to the Australian context, the evidence base becomes even more scant. As a result, much of what is known comes from practice-based knowledge. This makes the directive to culturally proficient services to conduct their own research and advocate for their field, even more important.

APPENDIX 1: METHODS

This project followed a documented, repeatable rapid literature review process which is based on a modified version of the PRISMA method. All details of the processes used in the searches are provided. The purpose in doing so is to make this search process repeatable by subsequent researchers or practitioners and to support the transparency of the research process. In addition, for those new to research processes, this can support their early development of skills and capacities in the research process. These rapid review searches were conducted during the timeframe of 1 March to 14 March 2017.

The timeframe for the literature search itself was the period 2000 to 2017 and five main databases were utilised. We should point out that this is not a comprehensive history of the terminology but a rapid update of its development in the 21st century. As discussed below, cultural competency language and work goes back to the late 1980s. The databases explored were Web of Science (WOS), Medline, Ovid, PsychINFO and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Some other databases were reviewed for their potential utility and while the authors found a high level of duplication of results, this does not suggest this present selection covers all of the potentially available resources, as many other databases exist. In addition to this, we have supplemented this resource with books, articles and reports from other sources to extend the scope and history of the issues covered and to provide a more rounded resource for researchers and practitioners working in the disability sector.

The main search terms used in the first stage were: cultural competence, cultural competency, cultural safety and cultural proficiency. The terms 'competence' and 'competency' were used because sometimes different researchers, researchers in different academic disciplines or even different countries may emphasise slightly different terminologies, or publishers would index the articles slightly differently by their use of keyword selections. Overlaps were very common and when we merged the grid of downloads from all 25 individual searches and their resulting EndNote files, we reduced the total number of references by almost half. Within these we then searched for four main disability-related terms: disability; disabled; impairment and handicap. Each sub-search was done individually and then the four remaining files were merged and de-duplicated in EndNoteTM,a popular bibliographic software package (one of several available). The result was a file of 209 unique outputs, mostly journal articles but also including one thesis.

RESULTS

The tables below shows the individual searches conducted and the results for each individual search. Each search was saved as a separate EndNote database file and these are available in EndNote or plain text formats. The two numbers in each are firstly the total results for each search term by each database, and secondly (in parentheses) the number of results for an initial Quick Search, an Endnote command option, on the term 'disability'. This gave a basic count of the preliminary results and an indicator that the term 'disability' also occurred in journal titles and the like, meaning that it did not necessarily point specifically to an article, report or thesis on that topic. This was achieved by doing a more explicit search within the final consolidated Endnote file including the abstracts for all 209 publications (see Table 2 below)

Table 2. Search Strategy and Results Summary

Search No.	Search Terms	Database				
		Web of Science	Ovid	Medline	CINAHL	PsycINFO
1	Cultural competence	2851 (47)	1251 (30)	1451 (23)	5824 (111)	2608 (54)
2	Cultural competency	1104 (20)	730 (21)	4059 (77)	725 (18)	1065 (36)
3	Cultural safety	243 (1)	15 (0)	181 (3)	456 (3)	106 (2)
4	Cultural proficiency	30 (0)	14 (0)	19 (0)	54 (1)	104 (1)
5	Culturally and Linguistically Diverse	831 (22)	139 (0)	259 (1)	226 (15)	842 (13)

Table 3. Disability Search Terms Results in Consolidated EndNote Search

Term Used	Results
Disability	169
Disabled	28
Impairment	33
Handicap	3
Sub-Total	233
De-duplicated Total	**209**

Table 3 above shows that by far the most commonly indexed of the search terms was 'disability' itself. 'Disabled' came third suggesting that this literature focuses more on the issue of disability itself rather than people with disability as groups or individuals, but more on this below. Lastly, 'impairment' was the second most common of the four terms which given the health and medical nature of several of the databases should be no great surprise. Perhaps more surprising is that the term 'handicap' was so rarely counted with only three mentions in total. This may be a result of positive changes in the prevailing disability discourse, including the health and medical literature, at least during the period since 2000 when this search starts.

APPENDIX 2: TERMINOLOGY

One of the issues with the terminology associated with both disability and diversity is that there are ongoing changes, reinterpretations and even new language entering these discussions at semi-regular intervals. The term 'cultural competence' originated with Cross's work in bilingual education and child therapy in the United States back in the late 1980s.[83] Cultural safety emerged from work on Maori health inequalities by nursing theorist and practitioner Irihapeti Ramsden in New Zealand.[144] Cultural proficiency re-emerged (see Cross et al, 1989) in 2000 from another nursing practitioner, Marsha Wells, whose intention was to go beyond the prevailing cultural competence paradigm, one which "extends cultural competence into nursing practice, administration, education, and research".[117] Wells also refers us to the transcultural nursing theorist Leininger's principles for cross-cultural work including (a) keeping a very open-ended view of diversity and differences, and (b) to avoid seeing people as being all alike (stereotyping) on the basis of some shared, but possibly arbitrary, characteristic (language, culture, religion etc.).[145] [146] Here too we need to consider of this extensive set of developments from the nursing and psychological/therapeutic domains are appropriate to or even sufficient for a broader disability-oriented environment.

Cultural proficiency had the lowest number of outputs overall, suggesting that there is some way to go if this modified concept from nursing theory is to have a significant impact. The data in theses searches indicate that it has had much of its impact to date in the health professions including nursing, medicine and allied health. Leavitt's[147] book on cultural competence uses the term 'cultural proficiency' in relation to disability work but the contents of the book emphasise the more conventional 'cultural competence' terminology. The difference in emphasis appears to position cultural competence as an achievable outcome (progressing from incompetence through to eventual competence) while the smaller 'cultural proficiency' literature suggests an ongoing developmental process with which organisations and practitioners are engaged.

It must be noted that much, even most, of this literature and the concepts it contains is derived from the United States. Some caution is required in borrowing and then applying ideas, concepts and practices that have a very specific cultural and historical context. It is acceptable, even advisable, to ensure that we are not simply replicating American approaches but, instead, adapting them to local situations and contexts. The emphasis on 'race relations,' for example, in American literature (different again in the United Kingdom or New Zealand contexts) often leads to a conflation of terms such as 'race/ethnicity' as though the history and meaning of these terms is either approximately the same or even that they are necessarily connected. The assumption can emerge that using the same language or terminology means we really are all talking about exactly the same things and this is an issue that needs to be clarified. It is important, we suggest, to unpack and think through such terms and their application before rushing to add these concepts and practices to Australian disability environments.

The literature identifies several major concepts that have emerged since the late 1980s, which we briefly describe here to help inform your exploration of your service's starting point and intended direction in terms of developing capacity in this area. These concepts include cultural competence; cultural proficiency; and cultural safety. There is very limited research evidence supporting any of these approaches in terms of their implementation or evaluation with diverse

communities. Most are conceptual devices established by people working directly in those spaces who saw a lack of participation in service use by diverse groups proportional to their representation in the population. This is a key starting point for disability organisations to consider having accepted the need for greater engagement with diverse communities, and this in turn, as identified by the NDIA and others, reinforces the developmental need for better data collection, analysis and use in the sector.

One point should be made very clear before engaging with these concepts and that is the approach utilised towards the very concept of culture itself. 'Culture' is not a simple construct and it can be seen as one of the most complicated conceptual devices in the English language, prone to misuse and oversimplification – especially when applied to others.[148] The American use of terms such as 'race/ethnicity' should also be seen as non-transferable constructs in that this construction is very specific to the American social and historical context. Assuming an understanding of cultures and/or languages based on, for example, commonly held ideas or generalised notions drawn from the social sciences are a risk in this type of work. It is perhaps fortunate that some understanding of this complexity already exists in the disability sector as can be seen in the concept of Deaf community language and culture. Some writers have suggested that disability itself can be seen as a form of or intersectional with diversity itself, implying a significant cultural dimension to the disability experience.[27] While others have even suggested that culture can be seen as disability in that 'disability' status is attributed in particular cultural contexts, that are culturally constructed, rather than existing as an intrinsic property of the individual.[149] In this context, and highly relevant to the terminology discussed here, the very concept of 'diversity' can be viewed as a specifically American cultural construction.[150]

Keep in mind also, as noted above, that there is an existing and continuing critique of 'cultural competency' and related ideas in the literature.[151] [152] A common concern is that rather than changing systems to be fundamentally more inclusive, cultural competency strategies may simply work to smooth out the rough edges of established organisations, their services and practices – without necessarily ensuring systemic change or building a sustainable knowledge base. Thus, for example, while we would see interpreters as being essential in complex healthcare environments, and Australia has healthcare interpreter services available, it is still very common for all manner of communication failures to occur in healthcare, to do so regularly and with important consequences for patients and their families.[153]

CULTURAL COMPETENCE

The term cultural competence emerged from the work done by Terry Cross and colleagues in the late 1980s in counselling children with learning difficulties from diverse backgrounds and in bilingual contexts.[83] This remains a major field for cultural competency development – bilingual childhood education and language training. The concept is specifically American in its origin but has spread, in one form or another, to many other countries often through professional education and training formats. [154] The basic premise of 'cultural competence' is that organisations and individuals can work effectively with people from other cultural backgrounds by improving their knowledge of and skills in cross-cultural encounters. Note also that the concept is essentially an equity based construct (i.e. values based) but not one arising from or

supported by research evidence on the efficacy of applied cultural competencies.

In addition, a number of variations on the theme, including several different models, have emerged as different professionals and theorists engage with the idea of enabling 'competence' in cross-cultural encounters.155 We note that an explicitly principled approach is clearly important in both disability and cross-cultural/diversity work. In the disability context, the UN Convention on the Rights of Persons with Disabilities (2006) and a more generalised human rights position should also possess the capacity to inform work with CALD communities (in a developmental fashion and not assuming equivalence across communities). In the diversity context, often a social justice approach is simply the best available ethical foundation given past failures in service delivery and client representation.

CULTURAL PROFICIENCY

As noted in the body of the review, the term cultural proficiency was coined back in the early days of cultural competence theorising by Cross and colleagues, making it more foundation al than more recent authors suggest. Wells has argued that 'cultural proficiency' as a practical and philosophical approach to diversity that overcomes the limitations of previous models, including cultural awareness, cultural sensitivity, cultural humility and cultural competence.[117] Her premise for this was that 'proficiency' is a higher order concept than 'competence' and thus provides a more overarching construct. Here too, her original article is not evidence-based or supported by research but proposes instead as it's theoretical rationale, an extension of the received cultural competence concept. We note also that even in the literature search we conducted that the terms 'cultural competence' and 'cultural proficiency' were often used as though they were completely equivalent terms indicating that this distinction is not well understood.

CULTURAL SAFETY

The cultural safety concept emerged from the field of New Zealand Maori nursing activism and healthcare provision 144 and it has since become popular in some other Indigenous communities and contexts. In Australia, it is mainly utilised in healthcare work with Aboriginal and Torres Strait Islander communities to emphasise the importance of a person's whole identity being recognised and accepted in the service encounter.[156] Even here, the term 'cultural competency' is often as likely to be applied to work with Aboriginal and Torres Strait Islander communities as it is with CALD or other forms of diversity.[157] This mixed usage confirms a key issue identified in this rapid review which is that there is a marked variability in how these each of terms are understood, used and applied even within the healthcare systems within which their usage is most marked.

While there is a strong indigenous emphasis in the use of 'cultural safety', an area which is dealt with separately by the NDS, NDIA and others, we note that the focus on safety (including individual, collective, organisational and environmental safety) is clearly one which resonates in disability work generally and has direct relevance also to the intersection of disability and cross-cultural or, more broadly conceived, diversity work.[158] Here also the premise is primarily a philosophical position rather than an understanding emerging directly from the research evidence. Clearly if operating from a human rights perspective the safety of the individual with disability is paramount and, also, a failure to address language needs and

cultural factors can put clients and carers at risk of negative outcomes across multiple systems (disability services, healthcare, education, justice etc.). The concept of safety can also apply equally to service providers, especially frontline staff, in what is a complex and rapidly changing sector.

In summary, many of the prevalent concepts in this area originated in the broader healthcare sector and disciplines including nursing, medicine, counselling, mental health and social work. While health itself is very important in disability work, this also means that concepts drawn from healthcare should be assessed against the principles and values of disability work, including the social model of disability. Adapting these types of diversity constructs to disability work is an essential process in ensuring that they reflect the existing and emergent values of disability work, in order that CALD people with disability not be framed simply as patients or clients. Lastly, it is only through this process that a consistent approach to and strategies for cultural competency, or its adapted Australian equivalent, in the disability sector can be fully realised. The alternative is, as in healthcare, a sporadic and poorly-defined approach to cultural competency development, implementation and outcomes.

APPENDIX 3. POPULATION DIVERSITY AND DISABILITY IN AUSTRALIA

POPULATION DIVERSITY AND DISABILITY IN AUSTRALIA

This section briefly describes the complexity of Australia's population and its relationship to disability. Cultural and language differences need to be better understood in order to inform disability communication and service delivery strategies. As we note elsewhere in this resource, the research base on the intersection diversity and disability in Australian is poorly understood and a great deal more research and information is needed to fill in the gaps in our current knowledge. As the NDIS rolls out, it is becoming evident that the level of CALD community participation in the NDIS rollout is well below their proportion of the population.[159] If the NDIS and the disability sector generally is to develop competence in this area, then an understanding of the demography of the CALD communities is a minimum starting point.

It is recognised that CALD data is insufficient and using country of birth as an indicator of CALD is inadequate to the task.[160] As at March 2018, the NDIA are developing a CALD Strategy to support people from culturally and linguistically diverse backgrounds in accessing the services of the NDIS.[161]

CENSUS DATA

Country of Birth Data

The table below shows the top five countries of birth, other than Australia, from the 2016 Census. The traditional English-speaking countries remain dominant for country of birth, including England and New Zealand. In 2016, there were over 300 separately identified languages spoken in Australian homes, with 21% of Australians who spoke a language other than English.[162] However, the reader can see also how the rapid shift in migration from Asia, with Mandarin, Cantonese and Vietnamese all in the top 5 Languages spoken by a person at home.

The number of people identifying as being of Aboriginal or Torres Strait Islander origin is on the increase. In the 2011 Census, 2.5% of the population identified as being Aboriginal or Torres Strait Islander. This has increased to 2.6% of the Australian population in 2016 (650,000). In 2016, 6.7% of Aboriginal or Torres Strait Islander people reported in the Census that they had need for assistance with a core activity. This has increased from 5.4% in 2011.[163]

The following tables from the 2011 and 2016 Census data highlight our culturally diverse nation.

Language spoken by a person at home (Top 5)[162]

Language	2011		Language	2016	
English only	76.8%	16,509,291	English only	72.7%	17,020,417
Mandarin	1.6%	336,410	Mandarin	2.5%	596,711
Italian	1.4%	299,833	Arabic	1.4%	321,728
Arabic	1.3%	287,174	Cantonese	1.2%	280,943
Cantonese	1.2%	263,673	Vietnamese	1.2%	277,400

Country of Birth (Top 5)[162]

Country of Birth	2011		Country of Birth	2016	
Australia	69.8%	15,017,846	Australia	66.7%	15,614,825
England	4.2%	911,593	England	3.9%	907,570
New Zealand	2.2%	483,398	New Zealand	2.2%	518,466
China	1.5%	318,969	China	2.2%	509,555
India	1.4%	295,362	India	1.9%	455,389

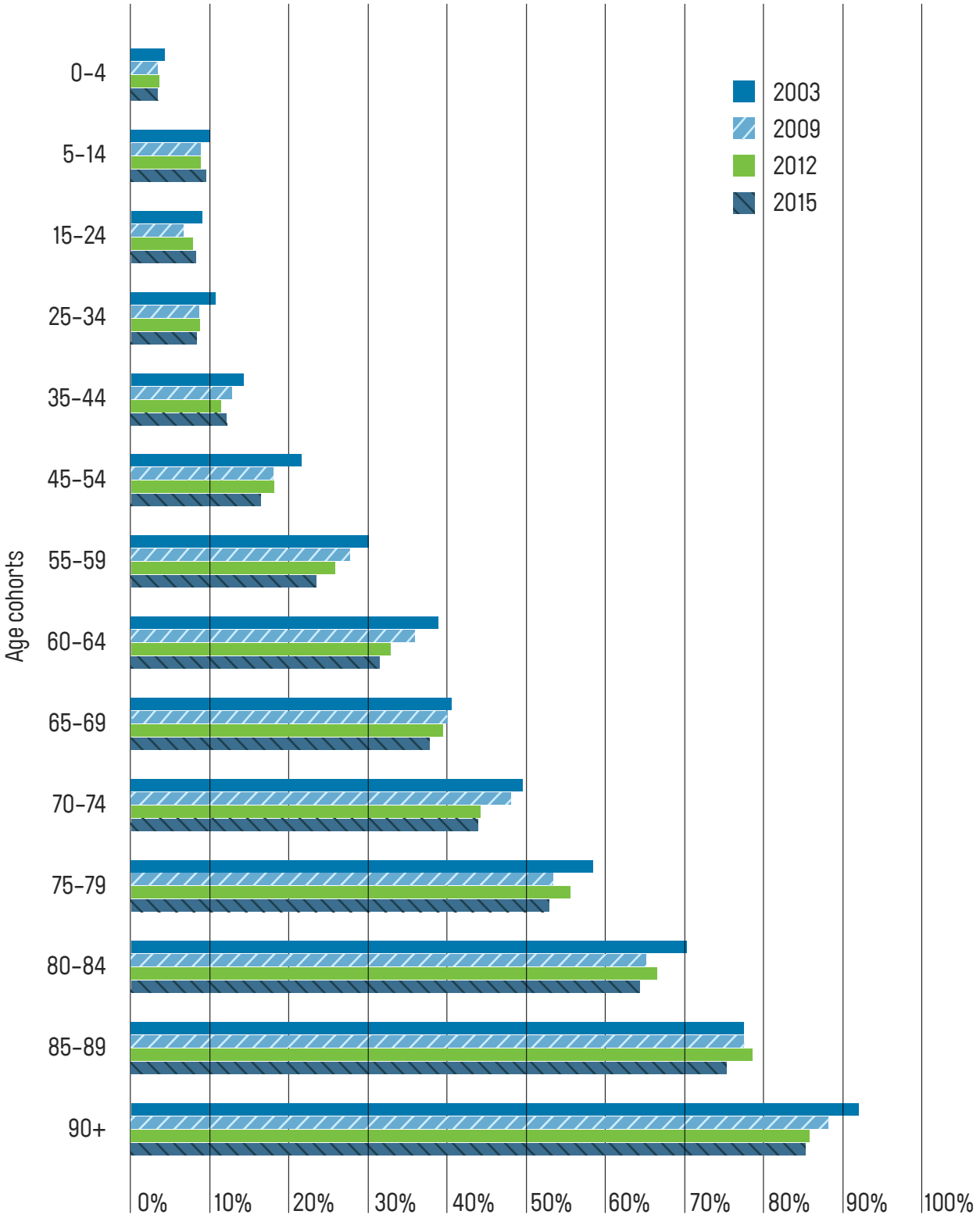
Christianity remains the most common religion in Australia (52.1% of the population). The Islamic population was the second largest (2.6%) followed by Buddhism (2.4%).

Religion (Top 5) [162]

Religion	2011		Religion	2016	
No religion	22.3%	4,804,267	No religion	30.1%	7,040,717
Catholic	25.3%	5,439,267	Catholic	22.6%	5,291,834
Anglican	17.1%	3,679,907	Anglican	13.3%	3,101,185
Uniting Church	5.0%	1,065,794	Uniting Church	3.7%	870,183
Presbyterian and Reformed	2.8%	599,515	Christian, nfd	2.6%	612,371

The 2015 SDAC data found that "the likelihood of living with disability increases with age, 2 in 5 people with disability were 65 years or older".[165] The following graph shows the disability status by age since 2003.

Age-Related Disability Status Data from the Four ABS Surveys[165]



The table below shows three major cultural characteristics (four if you include gender) of the diversity of the Australian population and their intersection with disability rates. Firstly, inner regional areas have the highest overall rate of disability. Secondly, English-speaking immigrants have the highest disability rates followed by those from non-English speaking immigrant backgrounds. Thirdly, where the language spoken at home is not English, the disability rate is lower than the English-speaking. Lastly, rural rates skew in towards men while country of birth and language rates either match or skew towards women.

The issue of having a 'profound or severe core activity limitation' expands this understanding in that for both country of birth and language spoken at home data, the non-English speaking background category had higher rates than the Australian-born or broader English speaking categories. Of particular note here is that the collection of country of birth and language spoken data was not very comprehensive, making the future collection of language usage data a key quality and customer service measure to consider for disability organisations going forward. In addition, we note that being 'Australian-born' does not negate the presence of cultural or linguistic differences in relation to disability service provision.

Survey of Disability, Ageing and SDAC 2015

Disability Rate, All persons by sex and selected demographic characteristics[166]

Major Characteristics	Disability Rate		
	Males	Females	Total
Remoteness			
Major cities	15.7	17.1	**16.4**
Inner regional	24.3	23.4	**23.9**
Other	23.4	21.3	**22.3**
Country of birth			
Australia	18.4	18.7	**18.6**
Other main English speaking countries	20.3	21.8	**21.0**
Non-English speaking countries	15.1	16.6	**15.8**
Main language spoken at home			
English	18.7	18.5	**18.6**
Other	12.2	15.1	**13.6**

6. REFERENCES

1. Australian Bureau of Statistics. Media Release: Census reveals a fast changing, culturally diverse nation; 2017 Available from: http://www.abs.gov.au/ausstats/abs@.nsf/lookup/Media%20Release3 accessed 26 March 2018.
2. Australian Bureau of Statistics. Disability, Ageing and Carers, Australia: Summary of findings, 44300D0020_2015, 2015. Available at: http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0
3. Zhou Q. Accessing disability services by people from culturally and linguistically diverse backgrounds in Australia. Disability & Rehabilitation 2016;38(9):844-52.
4. Huey SJ, Tilley JL, Jones EO, et al. The Contribution of Cultural Competence to Evidence-Based Care for Ethnically Diverse Populations. Annual Review of Clinical Psychology 2014;10(1):305-38. doi: doi:10.1146/annurev-clinpsy-032813-153729
5. Taylor-Ritzler T, Balcazar F, Dimpfl S, et al. Cultural competence training with organizations serving people with disabilities from diverse cultural backgrounds. Journal of Vocational Rehabilitation 2008;29(2):77-91.
6. Wong PTP. The Need for Existential Cross-Cultural Competency in Therapy and Supervision. PsycCRITIQUES June 2016;61:25.
7. Pal J, Hale L, Mirfin-Veitch B, et al. Injuries and falls among adults with intellectual disability: A prospective New Zealand cohort study. Journal of Intellectual & Developmental Disability 2014;39(1):35-44. doi: 10.3109/13668250.2013.867929
8. Garrod A. Cultural safety: living with disability. Whitireia Nursing Journal 2002(9):14-19.
9. Meydanlioglu A, Arikan F, Gozum S. Cultural sensitivity levels of university students receiving education in health disciplines. Advances in Health Sciences Education 2015;20(5):1195-204.
10. Rosenblatt PC. Cultural competence and humility. Harris, Darcy L [Ed]; Bordere, Tashel C [Ed] (2016) Handbook of social justice in loss and grief: Exploring diversity, equity, and inclusion (pp 67-74) xix, 293 pp New York, NY, US: Routledge/Taylor & Francis Group; US 2016:67-74.
11. Smith P. Cultural Competence: A Lifelong Journey to Cultural Proficiency. Physiotherapy 2013;99(3):268-68. doi: 10.1016/j.physio.2010.09.003
12. Leung K, Ang S, Tan ML. Intercultural Competence. Annual Review of Organizational Psychology and Organizational Behavior 2014;1(1):489-519. doi: doi:10.1146/annurev-orgpsych-031413-091229
13. Bernal ME, Castro FG. Are clinical psychologists prepared for service and research with ethnic minorities? Report of a decade of progress. American Psychologist 1994;49(9):797-805.
14. Sue DW, Bingham RP, Porche-Burke L, et al. The diversification of psychology: a multicultural revolution. American Psychologist 1999;54(12):1061-9.
15. Dillard M, Andonian L, Flores O, et al. Culturally competent occupational therapy in a diversely populated mental health setting. American Journal of Occupational Therapy 1992;46(8):721-6.

16. Kennedy MG. Cultural competence and psychiatric-mental health nursing. Journal of Transcultural Nursing 1999;10(1):11.

17. Owiti JA, Ajaz A, Ascoli M, et al. Cultural consultation as a model for training multidisciplinary mental healthcare professionals in cultural competence skills: preliminary results. Journal of psychiatric and mental health nursing 2013 doi: 10.1111/jpm.12124

18. Manyibe EO, Aref F, Hunter T, et al. An Emerging Conceptual Framework for Conducting Disability, Health, Independent Living, and Rehabilitation Research Mentorship and Training at Minority Serving Institutions. Journal of Rehabilitation 2015;81(4):25-37.

19. King G, Desmarais C, Lindsay S, et al. The roles of effective communication and client engagement in delivering culturally sensitive care to immigrant parents of children with disabilities. Disability & Rehabilitation 2015;37(15):1372-81. doi: 10.3109/09638288.2014.972580

20. Balcazar FE, Suarez-Balcazar Y, Taylor-Ritzler T, et al. Race, culture and disability: Rehabilitation science and practice. Sudbury, MA: Jones & Bartlett Publishers 2010.

21. Park S, Brodwin M. Korean American parents of children with developmental disabilities reveal their experiences communicating with European American rehabilitation counsellors. The Australian Journal of Rehabilitation Counselling 2012;18(01):50-59.

22. United Nations General Assembly. Convention on the Rights of Persons with Disabilities. GA Resolutions. New York: United Nations, 2006:106.

23. Commonwealth of Australia. National Disability Strategy 2010-2020. Canberra: Commonwealth of Australia.

24. Shaw LR, Chan F, McMahon BT. Intersectionality and disability harassment: The interactive effects of disability, race, age, and gender. Rehabilitation Counseling Bulletin 2012;55(2):82-91.

25. Brah A, Phoenix A. Ain't IA Woman? Revisiting Intersectionality. Journal of International Women's Studies 2013;5(3):75-86.

26. Anthias F. Intersectional what? Social divisions, intersectionality and levels of analysis. Ethnicities 2013;13(1):3-19. doi: 10.1177/1468796812463547

27. Eddey GE, Robey KL. Considering the culture of disability in cultural competence education. Academic Medicine 2005;80(7):706-12.

28. Dupre M. Disability culture and cultural competency in social work. Social Work Education 2012;31(2):168-83.

29. Travaglia J, Roberston H. The SOTI (Systems, Organisations, Teams, Individuals) of Diversity. Concord, NSW: Georiography Pty Ltd 2000.

30. Baarnhielm S, Edlund AS, Ioannou M, et al. Approaching the vulnerability of refugees: evaluation of cross-cultural psychiatric training of staff in mental health care and refugee reception in Sweden. BMC Medical Education 2014;14:207.

31. Rogers-Adkinson DL, Ochoa TA, Delgado B. Developing cross-cultural competence: Serving families of children with significant developmental needs. Focus on Autism and Other Developmental Disabilities 2003;18(1):4-8.

32. D'Elia T, Black M, Carpio B, et al. Cultural competence in public health: The role of peer-professional partnerships. Ethnicity and Inequalities in Health and Social Care 2009;2(3):4-8.

33. Stahl GK, Maznevski ML, Voigt A, et al. Unraveling the effects of cultural diversity in teams: A meta-analysis of research on multicultural work groups. Journal of international business studies 2010;41(4):690-709.

34. Gonzalez JA, Denisi AS. Cross-level effects of demography and diversity climate on organizational attachment and firm effectiveness. Journal of Organizational Behavior 2009;30(1):21-40.

35. Beach MC, Price EG, Gary TL, et al. Cultural competency: A systematic review of health care provider educational interventions. Medical care 2005;43(4):356.

36. Ortlieb R, Sieben B. Diversity Strategies and Business Logic: Why Do Companies Employ Ethnic Minorities? Group & Organization Management 2013;38(4):480-511. doi: 10.1177/1059601113497094

37. Anderson L, Scrimshaw S, Fullilove M, et al. Culturally competent healthcare systems. A systematic review. American Journal of Preventative Medicine 2003;24(3S):68 - 79.

38. Fisher T, Burnet D, Huang E, et al. Cultural leverage: interventions using culture to narrow racial disparities in health care. Medical Care Research Review 2007;64(5):243S - 82S.

39. Henderson S, Kendell E, See L. The effectiveness of culturally appropriate interventions to manage or prevent chronic disease in culturally and linguistially diverse communities: a systematic review. Health Soc Care Community 2011;19(3):225 - 49.

40. Betancourt JR. Cultural competence and medical education: many names, many perspectives, one goal. Academic Medicine 2006;81(6):499-501.

41. Kim BS, Cartwright BY, Asay PA, et al. A revision of the multicultural awareness, knowledge, and skills survey-counselor edition. Measurement and Evaluation in Counseling and Development 2003;36(3):161-81.

42. Stewart MJ, Neufeld A, Harrison MJ, et al. Immigrant women family caregivers in Canada: implications for policies and programmes in health and social sectors. Health & Social Care in the Community 2006;14(4):329-40.

43. Evans T, Garwick A. Children with special health care needs: a health care model for families from diverse cultural and linguistic backgrounds. Journal of Social Work in Disability & Rehabilitation 2002;1(2):7-24.

44. Wray EL, Mortenson PA. Cultural competence in occupational therapists working in early intervention therapy programs. Canadian Journal of Occupational Therapy 2011;78(3):180-86.

45. Green TD, Mathiesen SG. Who CARES? Interprofessional Competencies for Meeting the Complex Needs of Culturally and Linguistically Diverse Foster Youth With Disabilities. Advances in Social Work 2016;17(2):166-86. doi: 10.18060/18337

46. McCormack C, Collins B. Can Disability Studies Contribute to Client-Centred Occupational Therapy Practice? British Journal of Occupational Therapy 2010;73(7):339-42. doi: 10.4276/030802210X12785840213328

47. Dupré M. Disability culture and cultural competency in social work. Social Work Education 2012;31(2):168–83.

48. Taylor–Ritzler T, Balcazar FE, Suarez–Balcazar Y, et al. Engaging ethnically diverse individuals with disabilities in the vocational rehabilitation system: Themes of empowerment and oppression. Journal of vocational Rehabilitation 2010;33(1):3–14.

49. Corral I, Johnson TL, Shelton PG, et al. Psychiatry resident training in cultural competence: An educator's toolkit. Psychiatric Quarterly 2016:No Pagination Specified.

50. Gregg JMDP, Saha SMDMPH. Losing Culture on the Way to Competence: The Use and Misuse of Culture in Medical Education. Academic Medicine June 2006;81(6):542–47.

51. Sumsion T, Law M. A review of evidence on the conceptual elements informing client–centred practice. Canadian Journal of Occupational Therapy 2006;73(3):153–62.

52. Hammell KRW. Client–centred occupational therapy in Canada: Refocusing on core values / Recentrer l'ergothérapie au Canada sur les valeurs fondamentales de la pratique centrée sur le client. Canadian Journal of Occupational Therapy 2013;80(3):141–49. doi: 10.1177/0008417413497906

53. Fellin M, Desmarais C, Lindsay S. An examination of clinicians' experiences of collaborative culturally competent service delivery to immigrant families raising a child with a physical disability. Disability & Rehabilitation 2015;37(21):1961–9.

54. Fellin M, King G, Esses V, et al. Barriers and facilitators to health and social service access and utilization for immigrant parents raising a child with a physical disability. International Journal of Migration, Health & Social Care 2013;9(3):135–45. doi: 10.1108/IJMHSC–07–2013–0024

55. Fawcett B. Children and disability: Constructions, implications and change. International Social Work 2014 doi: 10.1177/0020872813515011

56. Trajkovski S, Schmied V, Vickers M, et al. Using appreciative inquiry to transform health care. Contemp Nurse 2013;45(1):95–100. doi: 10.5172/conu.2013.45.1.95

57. Aggarwal NK, Pieh MC, Dixon L, et al. Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review. Patient Education & Counseling 2016;99(2):198–209. doi: 10.1016/j.pec.2015.09.002

58. Lindsay S, Tétrault S, Desmaris C, et al. The cultural brokerage work of occupational therapists in providing culturally sensitive care: Le travail de médiation culturelle effectué par des ergothérapeutes offrant des soins adaptés à la culture. Canadian Journal of Occupational Therapy 2014;81(2):114–23.

59. Diller JV. Cultural diversity. 4th ed. Belmont: Brooks/Cole 2011.

60. King G, Desmarais C, Lindsay S, et al. The roles of effective communication and client engagement in delivering culturally sensitive care to immigrant parents of children with disabilities. Disability & Rehabilitation 2015;37(15):1372–81.

61. Lindsay S, King G, Klassen AF, et al. Working with immigrant families raising a child with a disability: challenges and recommendations for healthcare and community service providers. Disability and rehabilitation 2012;34(23):2007-17.

62. Olaussen SJ, Renzaho AM. Establishing components of cultural competence healthcare models to better cater for the needs of migrants with disability: a systematic review. Australian Journal of Primary Health 2016;22(2):100-12.

63. Tribe R, Raval H. Working with interpreters in mental health. London: Routledge 2014.

64. Pecukonis E, Doyle O, Bliss DL. Reducing barriers to interprofessional training: Promoting interprofessional cultural competence. Journal of interprofessional care 2008;22(4):417-28.

65. Nijhuis BJG, Reinders-Messelink HA, De Blécourt ACE, et al. Towards integrated paediatric services in the Netherlands: a survey of views and policies on collaboration in the care for children with cerebral palsy. Child: Care, Health and Development 2007;33(5):593-603. doi: 10.1111/j.1365-2214.2006.00719.x

66. Park J, Turnbull AP. Cross-cultural competency and special education: Perceptions and experiences of Korean parents of children with special needs. Education & Training in Mental Retardation & Developmental Disabilities 2001;36(2):133-47.

67. Khanlou N, Haque N, Sheehan S, et al. "It is an Issue of not Knowing Where to Go": Service Providers' Perspectives on Challenges in Accessing Social Support and Services by Immigrant Mothers of Children with Disabilities. Journal of Immigrant and Minority Health 2015;17(6):1840-47. doi: 10.1007/s10903-014-0122-8

68. Croot EJ. The care needs of Pakistani families caring for disabled children: how relevant is cultural competence? Physiotherapy 2012;98(4):351-56.

69. Desai PP, Rivera AT, Backes EM. Latino Caregiver Coping With Children's Chronic Health Conditions: An Integrative Literature Review. Journal of Pediatric Health Care 2016;30(2):108-20. doi: 10.1016/j.pedhc.2015.06.001

70. Campinha-Bacote J. A Model of Practice to Address Cultural Competence in Rehabilitation Nursing. Rehabilitation Nursing 2001;26(1):8-11. doi: 10.1002/j.2048-7940.2001.tb02201.x

71. Suarez-Balcazar Y, Balcazar F, Taylor-Ritzler T, et al. Development and Validation of the Cultural Competence Assessment Instrument: A Factorial Analysis. Journal of Rehabilitation 2011;77(1):4-13.

72. Cumming-McCann A, Accordino MP. An investigation of rehabilitation counselor characteristics, white racial attitudes, and self-reported multicultural counseling competencies. Rehabilitation Counseling Bulletin 2005;48(3):167-88.

73. Lindsay S, Tétrault S, Desmaris C, et al. Social workers as "cultural brokers" in providing culturally sensitive care to immigrant families raising a child with a physical disability. Health & Social Work 2014:hlu009.

74. Beagan BL, Chacala A. Culture and diversity among occupational therapists in Ireland: when the therapist is the 'diverse'one. The British Journal of Occupational Therapy 2012;75(3):144-51.

75. Hook JN, Watkins CE. Cultural humility: The cornerstone of positive contact with culturally different individuals and groups? American Psychologist 2015;70(7):661–2.

76. Hammell KR. Occupation, well-being, and culture: Theory and cultural humility. Canadian Journal of Occupational Therapy – Revue Canadienne d Ergotherapie 2013;80(4):224–34.

77. Suarez-Balcazar Y, Rodawoski J, Balcazar F, et al. Perceived levels of cultural competence among occupational therapists. American Journal of Occupational Therapy 2009;63(4):498–505.

78. Campinha-Bacote J. A model and instrument for addressing cultural competence in health care. Journal of Nursing education 1999;38(5):203–07.

79. Miville ML, Duan C, Nutt RL, et al. Integrating Practice Guidelines Into Professional Training. The Counseling Psychologist 2009;37(4):519–63. doi: doi:10.1177/0011000008323651

80. Greatrex-White S. Uncovering study abroad: foreignness and its relevance to nurse education and cultural competence. Nurse Education Today 2008;28(5):530–38.

81. Koskinen L, Tossavainen K. Benefits/problems of enhancing students' intercultural competence. British Journal of Nursing 2003;12(6):369–77.

82. Jain S. Experiential training for enhancing intercultural sensitivity. Journal of Cultural Diversity 2013;20(1):15–20.

83. Cross T, Bazron B, Dennis K, et al. Towards a culturally competent system of care. Washington, DC: Georgetown University Child Development Center 1989. http://files.eric.ed.gov/fulltext/ED330171.pdf

84. Shen ZW. Cultural Competence Models and Cultural Competence Assessment Instruments in Nursing: A Literature Review. Journal of Transcultural Nursing 2015;26(3):308–21. doi: 10.1177/1043659614524790

85. Pernell-Arnold A, Finley L, Sands RG, et al. Training Mental Health Providers in Cultural Competence: A Transformative Learning Process. American Journal of Psychiatric Rehabilitation 2012;15(4):334–56. doi: 10.1080/15487768.2012.733287

86. Cultural competence: An evolutionary perspective. Nursing forum; 2002. Wiley Online Library.

87. Young S, Guo KL. Cultural Diversity Training The Necessity of Cultural Competence for Health Care Providers and in Nursing Practice. Health Care Manager 2016;35(2):94–102. doi: 10.1097/hcm.0000000000000100

88. Seeleman C, Suurmond J, Stronks K. Cultural competence: a conceptual framework for teaching and learning. Medical education 2009;43(3):229–37.

89. Côt D. Intercultural communication in health care: challenges and solutions in work rehabilitation practices and training: a comprehensive review. Disability & Rehabilitation 2013;35(2):153–63. doi: 10.3109/09638288.2012.687034

90. Hertzsprung EAM, Dobson KS. Diversity Training: Conceptual Issues and Practices for Canadian Clinical Psychology Programs. Canadian Psychology August 2000;41(3):184–91.

91. Green D, Callands TA, Radcliffe AM, et al. Clinical Psychology Students' Perceptions of Diversity Training: A Study of Exposure and Satisfaction. Journal of Clinical Psychology 2009;65(10):1056–70. doi: 10.1002/jclp.20605

92. De Jesus A, Hogan J, Martinez R, et al. Putting Racism on the Table: The Implementation and Evaluation of a Novel Racial Equity and Cultural Competency Training/Consultation Model in New York City. Journal of Ethnic & Cultural Diversity in Social Work 2016;25(4):300–19. doi: 10.1080/15313204.2016.1206497

93. Kirmayer LJ, Rousseau C, Guzder J, et al. Training clinicians in cultural psychiatry: a Canadian perspective. Academic Psychiatry 2008;32(4):313–9.

94. Tomlinson-Clarke S. Assessing outcomes in a multicultural training course: a qualitative study. Counselling Psychology Quarterly 2000;13(2):221–31.

95. Mosko M-O, Baschin K, Langst G, et al. Cross-cultural training for mental health care service: Needs, concepts and challenges. Psychotherapeut 2012;57(1):15–21.

96. Harris P. Culturally competent disability support: Putting it into practice – A Review of the International and Australian Literature on Cultural Competence. Parramatta: Multicultural Disability Advocacy Association of NSW (MDAA) 2004. http://www.mdaa.org.au/images/strategic_documents/Harris-LiteratureReview.pdf

97. Duke J, Connor M, McEldowney R. Becoming a culturally competent health practitioner in the delivery of culturally safe care: A process oriented approach. Journal of Cultural Diversity 2009;16(2)

98. Hawthorne K, Prout H, Kinnersley P, et al. Evaluation of different delivery modes of an interactive e-learning programme for teaching cultural diversity. Patient education and counseling 2009;74(1):5–11.

99. Hutnik N, Gregory J. Cultural sensitivity training: description and evaluation of a workshop. Nurse education today 2008;28(2):171–78.

100. Bennett J, Kalathil J, Keating F. Race equality training in mental health services in england: does one size fit all? London: Sainsbury Centre for Mental Health 2007.

101. Chao MM, Okazaki S, Hong Y-y. The Quest for Multicultural Competence: Challenges and Lessons Learned from Clinical and Organizational Research. Social and Personality Psychology Compass 2011;5(5):263–74. doi: 10.1111/j.1751-9004.2011.00350.x

102. Lau PMY, Woodward-Kron R, Livesay K, et al. Cultural respect encompassing simulation training: being heard about health through broadband. Journal of Public Health Research 2016;5(1):36–42.

103. Johnson WL. Cultural training as behavior change. 6th International Conference on Applied Human Factors and Ergonomics (Ahfe 2015) and the Affiliated Conferences, Ahfe 2015 2015:3860–67. doi: 10.1016/j.promfg.2015.07.894

104. Fioravanti M, Mitchell A. Using Simulation to Teach Cultural Competency as a Component of SBIRT Training. Journal of the American Psychiatric Nurses Association 2013;19(1):15–16.

105. Jones JM, Begay KK, Nakagawa Y, et al. Multicultural Counseling Competence Training: Adding Value With Multicultural Consultation. Journal of Educational and Psychological Consultation 2016;26(3):241–65. doi: 10.1080/10474412.2015.1012671

106. Owiti JA, Ajaz A, Ascoli M, et al. Cultural consultation as a model for training multidisciplinary mental healthcare professionals in cultural competence skills: preliminary results. Journal of Psychiatric & Mental Health Nursing 2014;21(9):814–26. doi: 10.1111/jpm.12124

107. Whitehead G. Developing enabling environments in practitioner training. Asia Pacific Journal of Counselling and Psychotherapy 2015;6(1–2):80–88.

108. Lie D, Lee-Rey E, Gomez A, et al. Does cultural competency training of health professionals improve patient outcomes? A systematic review and proposed algorithm for future research. Journal General Internal Medicine 2011;26(3):317 – 25.

109. Paez K, Allen J, Carson K, et al. Provider and clinic cultural competence in a primary care setting. Soc Sci Med 2008;66(5):1204 – 16.

110. Ford-Paz RE, Kuebbeler A, Contreras R, et al. Training Community Opinion Leaders to Raise Awareness and Promote Early Intervention for Depressed Latino Adolescents. Progress in Community Health Partnerships 2015;9(2):191–201.

111. Uriarte JA, Cummings AD, Lloyd LE. An instructional design model for culturally competent community health worker training. Health Promotion Practice 2014;15(1 Suppl):56S–63S.

112. Thew DP, Smith SRMDMPH, Chang CMD, et al. The Deaf Strong Hospital Program: A Model of Diversity and Inclusion Training for First-Year Medical Students. Academic Medicine November 2012;87(11):1496–500.

113. Chrisman NJ. Extending cultural competence through systems change: academic, hospital, and community partnerships. Journal of Transcultural Nursing 2007;18(1 Suppl):68S–76S; discussion 77S–85S.

114. Taylor KP, Bessarab D, Hunter L, et al. Aboriginal–mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance use issues. BMC Health Services Research 2013;13:12.

115. Villarruel A. Culturally competent nursing research: are we there yet? Journal of child and family nursing 1998;2(2):82–9; discussion 89–91; quiz 92.

116. Orlandi MA. Defining cultural competence: An organizing framework. In: Orlandi MA, ed. Cultural competence for evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities. Washington, DC: US Department of Health and Human Services 1992:293–99. https://eric.ed.gov/?id=ED351387

117. Wells MI. Beyond cultural competence: a model for individual and institutional cultural development. Journal of Community Health Nursing 2000;17(4):189–99.

118. Allmark P, Salway S, Crisp R, et al. Ethnic minority customers of the Pensions, Disability and Carers Service: an evidence synthesis. Norwich: HMSO 2010.

119. Thomson MS, Chaze F, George U, et al. Improving Immigrant Populations' Access to Mental Health Services in Canada: A Review of Barriers and Recommendations. Journal of Immigrant & Minority Health 2015;17(6):1895–905.

120. Cummings KP, Hardin BJ. Navigating disability and related services: stories of immigrant families. Early Child Development and Care 2017;187(1):115–27.

121. Brassart E, Prevost C, Betrisey C, et al. Strategies developed by service providers to enhance treatment engagement by immigrant parents raising a child with a disability. Journal of Child and Family Studies 2016:doi:10.1007/s10826–016–0646–8.

122. Robertson H, Travaglia J. Cultural Diversity Competency Framework. Sydney: Department of Family and Community Services, 2015. https://www.researchgate.net/publication/282735649_Cultural_Diversity_Competency_Framework_2015

123. Acheson D. Independent inquiry into inequalities in health: report: Stationery Office 1998. https://www.gov.uk/government/publications/independent–inquiry–into–inequalities–in–health–report

124. Heer K, Larkin M, Burchess I, et al. The cultural context of care–giving: qualitative accounts from South Asian parents who care for a child with intellectual disabilities in the UK. Advances in Mental Health and Intellectual Disabilities 2012;6(4):179–91.

125. National Ethnic Disability Alliance. Refugees and migrants with disability and the United Nations convention on the rights of persons with disabilities. Sydney: National Ethic Disability Alliance 2008. http://www.neda.org.au/index.php/reports/item/refugees–and–migrants–and–the–united–nations–convention–on–the–rights–of–persons–with–disabilities–july–2008

126. Bywaters P, Ali Z, Fazil Q, et al. Attitudes towards disability amongst Pakistani and Bangladeshi parents of disabled children in the UK: considerations for service providers and the disability movement. Health & Social Care in the Community 2003;11(6):502–9.

127. Smedley BD, Stith AY, Nelson AR. Unequal treatment: confronting racial and ethnic disparities in health care: National Academies Press 2009.

128. Reel LA, Hicks CB, Ortiz N, et al. New Resources for Audiologists Working With Hispanic Patients: Spanish Translations and Cultural Training. American Journal of Audiology 2015;24(1):11–22. doi: 10.1044/2014_AJA–14–0027

129. Truong M, Paradies Y, Priest N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Services Research 2014;14(1):99.

130. Betancourt JR, Green AR. Commentary: linking cultural competence training to improved health outcomes: perspectives from the field. Academic Medicine 2010;85(4):583–5.

131. Barksdale CL, Ottley PG, Stephens R, et al. System–level change in cultural and linguistic competence (CLC): how changes in CLC are related to service experience outcomes in systems of care. American Journal of Community Psychology 2012;49(3–4):483–93.

132. Purnell L. A description of the Purnell Model for Cultural Competence. Journal of Transcultural Nursing 2000;11(1):40–46.

133. Williams JF. Managing diversity: Library management in light of the dismantling of affirmative action. Journal of Library Administration 1999;27(1–2):27–48.

134. Aronson D. Managing the diversity revolution: Best practices for 21st century business. Civil Rights Journal 2002;6:67–68.

135. Trenerry B, Franklin H, Paradies Y. Review of audit and assessment tools, programs and resources in workplace settings to prevent race-based discrimination and support diversity. Melbourne: Victorian Heath Promotion Foundation (VicHealth) 2010. http://dro.deakin.edu.au/eserv/DU:30058485/paradies-reviewauditassessmenttools-2010.pdf

136. Multicultural Mental Health Australia. National Cultural Competency Tool (NCCT) For Mental Health Services. Parramatta: Multicultural Mental Health Australia 2010. http://www.mhima.org.au/pdfs/NCCT.pdf

137. Abrams LS, Moio JA. Critical race theory and the cultural competence dilemma in social work education. Journal of Social Work Education 2009;45(2):245-61. doi: 10.5175/JSWE.2009.200700109

138. Drevdahl DJ, Canales MK, Dorcy KS. Of goldfish tanks and moonlight tricks: can cultural competency ameliorate health disparities? Advances in Nursing Science 2008;31(1):13-27.

139. Pacquiao DF. Nursing care of vulnerable populations using a framework of cultural competence, social justice and human rights. Contemporary Nurse 2008;28(1-2):189-97.

140. Fong R. Diversity in Diversity: Changing the Paradigm. Journal of Ethnic And Cultural Diversity in Social Work 2007;16(3-4):113-21. doi: 10.1300/J051v16n03_09

141. Garran AM, Werkmeister Rozas L. Cultural Competence Revisited. Journal of Ethnic And Cultural Diversity in Social Work 2013;22(2):97-111. doi: 10.1080/15313204.2013.785337

142. Bhui K, Warfa N, Edonya P, et al. Cultural competence in mental health care: a review of model evaluations. BMC health services research 2007;7(1):15.

143. Centre for Disability Resarch and Policy. Report of audit of disability research in Australia. Sydney: University of Sydney 2014. http://sydney.edu.au/health-sciences/cdrp/projects/auditresearch.shtml

144. Ramsden I, O'Brien L. Defining cultural safety and transcultural nursing. Kai Tiaki Nursing New Zealand 2000;6(8):4-5.

145. Leininger MM. What is transcultural nursing and culturally competent care. Journal of transcultural nursing 1999;10:9-9.

146. Leininger M. Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. Journal of transcultural nursing 2002;13(3):189-92.

147. Leavitt RL. Cultural competence: a lifelong journey to cultural proficiency. Thorofare, NJ: Slack Incorporated 2010.

148. Bunzl M. The quest for anthropological relevance: Borgesian maps and epistemological pitfalls. American Anthropologist 2008;110(1):53-60.

149. McDermott R, Varenne H. Culture as disability. Anthropology & Education Quarterly 1995;26(3):324-48.

150. Varenne H. Diversity as American cultural category. Democracy and Ethnography: Constructing Identities in Multicultural Liberal States 1998:27-49.

151. Kleinman A, Benson P. Anthropology in the clinic: the problem of cultural competency and how to fix it. PLoS Med 2006;3(10):e294.

152. Thackrah RD, Thompson SC. Refining the concept of cultural competence: building on decades of progress. Med J Aust 2013;199(1):35–8.

153. Meuter RF, Gallois C, Segalowitz NS, et al. Overcoming language barriers in healthcare: A protocol for investigating safe and effective communication when patients or clinicians use a second language. BMC health services research 2015;15(1):371.

154. Law K, Muir N. The internationalisation of the nursing curriculum. Nurse Education in Practice 2006;6(3):149–55.

155. Alizadeh S, Chavan M. Cultural competence dimensions and outcomes: a systematic review of the literature. Health & social care in the community 2015

156. Williams R. Cultural safety—what does it mean for our work practice? Australian and New Zealand journal of public health 1999;23(2):213–14.

157. Bainbridge R, McCalman J, Clifford A, et al. Cultural competency in the delivery of health services for Indigenous people. Pat 2014

158. Tomlinson M, Swartz L, Officer A, et al. Research priorities for health of people with disabilities: an expert opinion exercise. The Lancet 2009;374(9704):1857–62.

159. See the NDIS Annual Reports for more information, at https://www.ndis.gov.au/about-us/information-publications-and-reports/annual-reports

160. The Every Australian Counts campaign provides more information at http://www.everyaustraliancounts.com.au/opinion/disability-diversity-and-the-ndis/ Also see D. Wadiwel and B. Cooper, Disability and Multiculturalism, Data and the 'Healthy Migrant', 'For those who've Come across the Seas, Australian Multicultural Theory', Edited by A. Jakubowicz and C. Ho. 2013, p. 98.

161. NDIA Rural and Remote Strategy 2016–2019, 2016

162. Census reveals a fast changing, culturally diverse nation, Australian Bureau of Statistics, http://www.abs.gov.au/ausstats/abs@.nsf/lookup/Media%20Release3. viewed April 2018.

163. Australian Bureau of Statistics, Aboriginal and torres strait islander population, 2016, http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2071.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20Population%20 Article~12 viewed April 2018

164. Australian Bureau of Statistics, A profile of people with disability in Australia, Disability, Ageing and Carers, Australia: Sumamry of findings, 2015, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Latestproducts/4430.0Main%20

165. Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: Summary of findings, 44300D0020, Table 1.3, 2015, http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0 viewed April 2018

166. Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: Summary of findings, 44300D0020, Table 4.1, 2015, http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0 viewed April 2018

NDS gratefully acknowledges the support of the NSW Government in establishing the NDS Centre for Applied Disability Research.

National Disability Services

Centre for Applied Disability Research
An Initiative of National Disability Services