

CULTURAL DIVERSITY COMPETENCY FRAMEWORK

July 2015

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Preface

Recognition of the diversity of human beings and their experiences and the complexity that diversity brings to human interactions is, and always has been, a constant in the provision of high quality services. Service providers' ability to embrace and respond to diversity can be seen as a measure of their organisational capacity, capabilities and competence as a whole.

The effective provision of support to people with disabilities depends on organisations' and individuals' responsiveness to clients with complex and conditions and situations. In modern management "speak" this depends on an organisation's agility and resilience. These characteristics rely in turn on the on the service's culture, understood increasingly as those day to day discussions that put values into action.

The Cultural Diversity Competency Framework (CDCF) provides the foundation for a new approach to diversity within disability organisations. Funded by Ageing, Disability and Home Care (ADHC) in the NSW Department of Family and Community Services (FACS), the CDCF begins not with a blank slate, but from a position of acknowledgement and recognition of the strengths, visions and commitment that the disability sector already has in place to individuals and groups with diverse needs, experiences and expectations.

The Framework draws together and explores areas of common concern for providers, clients and communities, by employing an ecological approach which includes an understanding of how population (macro), community and service (meso) and individual (micro) needs shape the conceptualisation, utilisation and outcomes of services. It draws on the latest theories of quality improvement and change management, but for a very practical purpose, that is to assist clients and providers in working together to achieve the best possible outcomes for all those involved.

The aim of CDCF is to inform the development of disability services' in order to support their responsiveness to all clients and communities. The project as a whole has three objectives. These are to: capture and evaluate existing cultural competency models and approaches; to create an holistic approach to

responding to diversity; and create and support strategies and tools to support this approach.

This project utilises and builds upon the existing expertise of disability and diversity providers. Proof of concept was tested across systems, services and individuals and with experienced and newly engaged providers. The CDCF will help to improve outcomes by strengthening providers' ability to respond to the viewpoints, needs and expectations of individuals and groups Culturally and Linguistically Diverse Communities (CALD) backgrounds, through a set of staged processes, approaches and tools, which will be developed in the second phase of this project.

The authors would like to thank the members of the CDCF Advisory Committee, the Ethic Affairs Advisory Group of FACS and in particular, Ms Gosia Dybka and Mr Gavin Wesson from FACS, Katherine Orr from the NDS, and all the individuals and services who provided advice and direction to this project including Ms Mirella Di Genua, Ms Vivi Koutsonadis and Ms Mary Jackson. Special thanks to Kerry Stubbs from the Northcott Society under whose auspices and direction this framework was developed and Emanuela D'Urso, whose vision created and inspired this project.

Executive Summary

This document arises in response to the implementation of Australia's first National Disability Insurance Scheme (NDIS). The introduction of this scheme within the context of existing rapid social change and a highly dynamic disability environment raises a number of major considerations for the provision of support in the context of the diversity of Australia's population. It has been commissioned to provide a guideline to assist disability organisations, support providers and planners in their response to these significant, and unprecedented changes. While the report focuses primarily on cultural and linguistic diversity (CALD) it also acknowledges that this is only one aspect of a growing level of socio-cultural diversity in Australian society.

The report explores, explains and frames how the implementation of the NDIS and the disability sector can benefit from the development and application of a cultural competency approach to the provision of support. More specifically, this approach is situated in the context of an increasingly marketwise and market sensitive environment in which many providers will vie for the custom of individual clients and client groups, who in turn may require an unprecedented level of consumer information and advice in order to be able to understand, access and negotiate support providers.

Currently available data suggests that utilisation of disability sector by CALD communities remain below what would be expected. Understanding of the issues contributing to this situation remains poor because data collection is limited although changes in some sectors, including support for the elderly, indicate rapid improvements are occurring. A key feature of disability governance and reporting will need to address this issue more explicitly if access and equity considerations are to be effectively addressed.

The business model for disability providers will also benefit from a more engaged approach to CALD issues because in a market environment such groups are all potential clients and, it seems, many are currently poorly realised as potential consumers. The NDIS lends significant potential to change in this regard as does the promotion of person directed funding approaches to service design and delivery.

Cultural competency is a broad concept that does not exclude intersecting forms of social and cultural diversity, but instead opens up a central issue for discussion in the disability sector. That is, how will the sector operate under

the emerging NDIS funding paradigm in the context of Australia's cultural and linguistic diversity? How can it respond to profound social and economic changes in the way in which the delivery of disability support programs is organised, funded and regulated? How can organisations equip themselves and prepare for operating in a consumer-focused marketplace characterised by increasing levels and types of diversity in staff, carers (both paid and unpaid) and consumers? How do services ensure that they meet the measures of equitable access, quality, safety and outcomes for all consumers?

This is clearly a developmental pathway in which significant changes are anticipated and knowledge development will be significant. This report sets out some of the key issues for consideration and presents these in the context of the NDIS environment as a challenge for the disability sector generally and service providers in particular. New issues will almost certainly emerge as the NDIS program matures and as data collection and analysis improves. The situation we describe will change rapidly but consistent throughout will be the issue of diversity and how effectively it is incorporated into the sector.

The Productivity Commission (2011) acknowledged the many problems faced and identified many of the numerous gaps, overlaps and tensions that existed and continue to exist in this field. One of the key issues for the new, emerging disability environment will be the extent to which diversity remains a 'problem' to be solved or an afterthought to be considered once all 'mainstream' issues have been addressed, or whether the sector takes this opportunity to resolve past gaps in a meaningful way that builds a sustainable and culturally competent disability sector.

Recommendations

1. That a set of stepped tools be developed to accompany this framework, which allow services at all stages of their cultural diversity journey to engage with the principles and guidelines of the CDCF.
2. That an online interactive platform be developed to house the tools and to enable organisations to undertake an iterative process of engagement.
3. That a series of short, accessible publications be developed to assist organisations to understand key concepts within the CDCF, including:
 - a. Current demographics and future trends on disabilities in CALD communities in Australia
 - b. Current demand and future trends in need for disability support for CALD communities
 - c. Differences in the conceptualisation of disability within and across Australian society
 - d. Disability and diversity across the lifespan
 - e. Diversity within diversity: understanding individual and community concerns beyond culture
 - f. CALD communities and disability services in rural and remote areas
 - g. Current concerns of CALD communities, including refugees and asylum seekers
 - h. The business case for diversity
 - i. Barriers and facilitators to service provision for CALD communities
 - j. Capabilities of a culturally competent disabilities organisation
 - k. Establishing diversity data collection and monitoring systems
 - l. Capabilities of culturally competent disability professionals and assistants

- m. Integrating CDCF perspectives within and across the organisation
 - n. Creating a culturally safe organisation
 - o. Attracting and maximising the benefit from a CALD disability workforce
 - p. Language services and disability organisations
 - q. Creating collaborations with CALD communities and community services
 - r. Diversity training for disability organisations
 - s. Links and information to ethno-specific and multicultural disability advocacy and advice services.
4. That a tool that cross references the CDCF to the National Standards for Disability Services be developed.
 5. That the Department of Social Services be approached to formally acknowledge or integrate the CDCF into the next iteration of the National Standards for Disability Services.
 6. That a tool that assists disability organisations to integrate the CDCF into their strategic planning process be developed.
 7. That a Positive Organisational Review (POR) audit tool be developed.
 8. That an employment kit for increasing and supporting CALD workers be developed, addressing issues such as language utilisation and assessing skills in cultural competence.
 9. That a tool on how and when to use interpreters in disability services be developed.
 10. That a guide on how to create diversity action learning sets and guidelines for the establishment of CDCF communities of practice be developed.
 11. That a CDCF self-assessment tool for organisational leaders be developed.
 12. That a self-assessment CDCF alignment tool be developed for teams and workers in disability organisations.

13. That a guide on the use of the CDCF for students and associated materials be developed.
14. That key professional associations and regulatory bodies be approached in order to identify whether the CDCF tools and online activities could be eligible for Continuing Professional Development points.
15. That a Disability Information System that makes at least some of the key data (such as demographics, surveys results, official projections and the like) be made available within the one consistent format that could support the market in an equitable way.
16. That CDCF related training options could be made available to ensure that skills developed is addressed via a number of pathways suitable to the diverse nature of the disability service sector.
17. That current and future disability research funded through public mechanisms needs to more accurately reflect both this significant gap in the research base on CALD and other vulnerable groups, particularly in the context of the NDIS and a rapidly changing disability sector environment.

1. Introduction

There have, over several decades, been significant developments in the way in which people understand and organise the delivery of services with and to people with disabilities (PWDs). While the intent – to provide the best support possible – remains largely the same, the relationships on which the service delivery is built and the way in which services are provided, is changing rapidly. The advent in Australia of the National Disability Insurance Scheme (NDIS) is adding impetus to this process, but the process itself, rooted in social and disability rights movements and the increasing professionalisation of the field, has been well underway for many years.

The focus on putting clients at the centre of decision making and service delivery has many names: client or consumer directed care, personalisation, client or consumer centred care, person centred or person directed care, or in the case of New South Wales Department of Family and Community Services “Living life my way”. Each of these sound, and are intended to be, positive. But in the focus on the individual, it can be easy – although not inevitable - for other aspects of group experience to become subsumed.

The Cultural Diversity Competency Framework (CDCF) is designed to help services identify and address the way in which the collective experiences and concerns of people from Culturally and Linguistically Diverse (CALD) backgrounds, affect their access to, utilisation and quality of, and outcomes from disability services. These elements form cornerstones of the CDCF. For many services, these elements are not new – for others some elements, access for example, are more familiar than the others.

The CDCF was commissioned by the NSW Government’s Family and Community (Ageing, Disability and Home Care) Service (FACS). The aim was to provide disability services, both generic and ethno-specific, with a clear, practical framework by which to assess, review and improve their service delivery to all clients.

The CDCF is a step by step guide to improving care for people with disabilities from CALD backgrounds. It provides two mechanisms for this process. First it sets out a set of achievable organisational competencies (or capabilities) against which services can self-assess and choose strategic areas for improvement or development. Secondly it identifies a series of approaches and tools which services can use in order to make such improvements, drawing

on change management models to provide guidance for how to implement, diffuse and sustain positive changes across an organisation.

Underpinning both of these mechanisms are four principles. The first principle is focuses on the client, and acknowledges that ***each individual has a range of characteristics, capacities and concerns which will affect their needs and choices***. While the CDCF takes CALD and disability as primary foci, it acknowledges that people's gender, socio-economic status, age and sexuality, as well as their education, location, employment and so on, will all affect their the way in which they seek out and utilise services, and which services they consider most appropriate. Stereotyping is a persistent danger across all services; assumptions that an individual comes from a large, warm embracing 'ethnic' family and therefore has an extended support group is as dangerous for an individual seeking services as the assumption that sexuality is not a concern for an woman with disabilities, with a strong religious commitment.

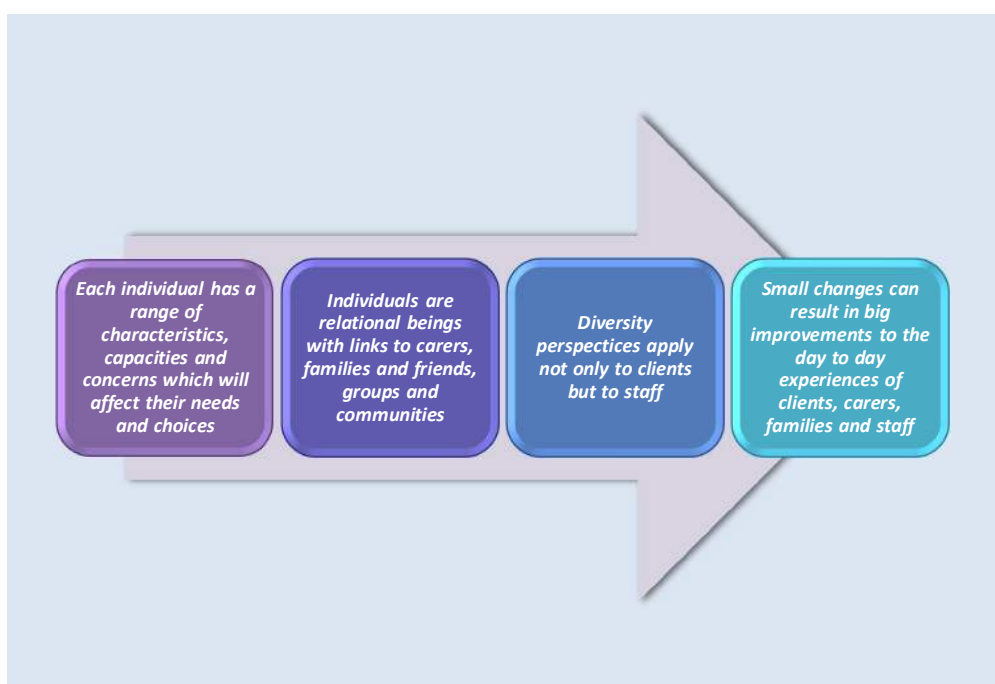
The second principle focuses on the community. It acknowledges that while consumer directed care rightly argues that the individual is in control of their choices, it also recognises that ***individuals are relational beings***, and that these relationships or ***context*** (often, but not always) ***link them to carers, families and friends, groups and communities***. These relationships have to be accounted for in the delivery of services. Moreover, it is important to acknowledge that patterns of disadvantage, in relation to our four cornerstones (access, utilisation, quality/safety and outcomes) occur within and across groups and communities, and therefore services cannot respond to individual needs without recognising and planning for community expectations and concerns.

The third principle recognises that ***diversity applies not only to clients but to staff***. Recognition and responsiveness to diversity is most successful when it treats staff with the same level of cultural competency as the clients: building on strengths, recognising challenges and affording all the choice as to which elements of their experience and identity with which they wish to acknowledge and engage in the service delivery process.

The fourth final principle addresses the improvement process itself. This principle is drawn from ***appreciative inquiry and positive organisational theory*** which seeks to build ***accountable, resilient and reflexive organisations***. These theories suggests that organisations should first seek to identify and strengthen what an organisation is doing right, and in the belief that ***small***

changes can result in big improvements to the day to day experiences of clients, carers, families and staff.

FIGURE 1: THE FOUR CDCF PRINCIPLES



2. Why the CDCF?

2.1 Introduction

Disability services have a strong advantage in the move to more client directed services. There is often a strong alignment between organisation's and workers' values and their motivations in delivering care for PWDs. Their very focus and approach has meant that most disability services have worked with PWDs and their families closely in order to find the type of service or service delivery mode that best meets the need of the individuals.

Despite this high degree of commitment to providing the best quality care to their clients, not all disability services have been able to meet the challenges of responding to clients from a perspective other than that of their disability. Women, people from Gay, Lesbian, Bisexual and Transexual (GLBT) and CALD backgrounds, individuals from a variety of religious backgrounds, prisoners and the elderly are amongst some of the groups where the delivery of services in the cross over points between disability and other forms of diversity has not been an easy fit (Goodley et al., 2012).

For newer services it may be an issue of knowing where to start. For more established services it might be an issue of responding to changing client profiles. In either case the CDCF is intended to provide services with a framework within which to assess, improve and evaluate their current delivery in order to improve the access, utilisation, quality/safety and outcomes for all clientele, but in particular for clients from CALD backgrounds.

What is new about the CDCF approach is the four key principles outlined in the previous section. The framework takes a situated and relational approach. It assists organisations to respond to each client as an individual, while at the same time acknowledging and responding to community patterns and concerns, as well as long standing structural and cultural barriers to the use of disability services. It supports staff in what they already do well, and facilitates organisational and professional reflection on what could be improved. It builds on the positive aspects of organisational culture, while recognising structural and operational inequalities or shortfalls which still need to be addressed. It seeks to improve the quality, safety and outcomes of, and satisfaction with, care for both workers and clients and their families.

One element which sets the CDCF apart is that ***it is a framework for organisations at every point in their journey toward cultural diversity competence*** (Recommendation 1). While worker and team competencies are nested within the framework, the purpose and intent of the CDCF is that it will be used to assess and advance organisational or service responsiveness to CALD communities, linking governance and leadership, to improvement strategies, access, utilisation, quality and safety and outcome measures.

While a significant body of research exists on cultural competence in health and welfare work in general, much less is known about its utilisation in disability services, and even less about how it might operate within disability services or organisations (Robey et al., 2013; Lewis, 2009). It is important to note that the gap is in the *published* literature. There are many important and innovative multicultural disability programs and services have been developed across Australia, commencing with the work of the Ethnic People with Disabilities Program in NSW and Action on Disability in Ethnic Communities in Victoria, and now through peak organisations like the National Ethnic Disability Alliance. Comparatively little research has been published, however, in ways which would allow the spread of important practice innovations. The CDCF project will work with these groups in developing the Framework and associated, building upon and expanding on this rich source of knowledge and skills.

The CDCF is a framework which will help disability services to improve their care for people with disabilities from CALD backgrounds. It is essentially a set of standards based on organisational competencies, or capabilities, addressing the needs of CALD people and communities, coupled with change management strategies. In the next sections we will break down into their constituent parts, considering how they came about, why they are considered important, and offering at least some level of critique where appropriate.

2.2 Diversity and Disability Re-considered

The disability concept is a highly dynamic and adaptive one. Concepts of and attitudes towards disability have changed over time and appear to be in a period of rapid evolution as issues such as rising socio-cultural diversity, population mobility, and systemic reforms and responses see a global position towards disability emerging from the United Nations (UN) and the World Health Organization (WHO) work in association with changes within individual

nation states. At the centre of disability as a fluid and adaptive concept is the additional notion of diversity. This is reflected in factors such as: the expansion of the diversity construct to include 'new' groups or categories; the gradual transition from an impairment model to a functional capacities approach; the social model of disability; and the need to continually adapt to shifting social and epidemiological conditions all clearly indicate that diversity is a continuing feature of both disability theory and disability work. It is also even more apparent that the people affected by disability are enormously diverse since they reflect the full spectrum of the human experience.

The fixed categories of personhood common to earlier forms of social policy and health and social service design are increasingly contested by advocacy groups and others. The overlaps between disability and other socially ascribed phenomena such as gender, sexuality, age and the social prejudices often attached to these constructs (sexism, homophobia, ageism, racism) suggest that disability work will continue to develop and expand as new identity groups, and intersections, emerge and seek their acknowledgement within existing frameworks through their adaptation, expansion or fundamental change (Barton, 2013; Stetsenko, 2012)

It is also the case that some observers want to keep the disability and diversity constructs separate as diversity can be seen to be so broad as to permit the inclusion of perspectives and agendas that are not supportive of disabled people, including the long history of eugenics and institutional controls over people with disabilities (Baynton, 2013; Black, 2003). Others have pointed to a need to de-colonise the disability agenda because it has been so influenced by a range of powerful social institutional approaches that the social model of disability has only been able to gain political influence in that past few decades (Meekosha, 2011). In this context the names of many disability organisations have been changed in recent years from their original titles to more inclusive ones that better reflect this societal-level change.

More problematic is that approaches to people with disabilities emerging from the 19th century were often similar to and influenced by other forms of structural prejudice including those discriminating on the basis of class, gender and 'race'. The implementation of a variety of social policies that naturally utilised similar taxonomic systems, classifications and terminology means that there is both a shared, and often unpleasant, history between disability and diversity and a varied number of social struggles to achieve both recognition

and improved treatment on the part of people discriminated against by these structural forms. It is sometimes difficult to keep a clear view of what has been gained, against what odds and the often shared nature of the pathways that led to these recent achievements. This also makes for a genuine concern that, in the face of often persistent attacks on social policy supports and costs, what has been so difficult to gain might just as easily be lost again.

There is, therefore, a larger history and discourse that needs to be considered when we talk about disability and diversity within the same context. Both constructs are already substantial in their own right and their intersections need to be better understood especially so as the global disability information program develops and the various contextual factors that encompass the lives of people with disabilities are better understood. The major trends of population ageing, increasing urbanisation, migration patterns (internal and external), as well as climate change and shifting environmental vulnerabilities are all part of this wider background of contextualised disability. This is embedded within an increasingly global discourse and series of negotiated responses. We can expect the issues discussed below to make their own contributions to where this global discussion on disability heads next as it is very clear that the disability sector will be different again in another decade or two.

2.3.1 Global disability

Disability how sits within a broader human rights context, especially so since the passing of the United Nations Declaration on the Rights of People with Disabilities in 2006. This has been endorsed by a number of countries with continued growth in membership over time. More recently still a draft strategic plan for the years 2014-2021 has been endorsed which includes the setting of specific outcome measures for the plan to provide an evidence base for measuring change across key disability areas (World Health Organization, 2013). The development of this plan should also promote and encourage the development of both existing and new information collection systems, such as census data collection and periodic surveys of people with disabilities and their families and carers. Establishing a plan has also created the basis for global developments on disability by expanding the concept of disability (e.g. including pain syndromes and a rising variety of other conditions such as autism), mediating or resolving outstanding issues such as disability versus impairment, and establishing a platform for agreed on approaches to issues

such as disability service provision, rehabilitation and so forth. The field of disability is entering a new and dynamic phase as those countries which have endorsed the UN Declaration undertake developmental changes and systemic improvements to meet their commitments to change in this key social policy sector.

The WHO World Report on Disabilities (2011) shows global and income-region estimates for disability by general age and sex cohorts for both severe and moderate-to-severe disability status. It indicates clearly how global disability is skewed in terms of gender (women) and age (with 46.1% of people with moderate or severe disabilities over the age of 60). The picture suggests that progressive population ageing will have a significant impact, especially as female life expectancy rates continue to exceed those of males at the global level. In addition, low to middle income countries will have both a 'burden' of disability to contend with at the same time population ageing begins to make an impact. This understanding is supported by the promotion of universal health schemes by the UN and WHO which recognise that social policy and resource development pathway for low-to-middle-income countries (LMICs) is not following the linear pattern experienced by the more affluent west. Many of these societal change factors are occurring at the same time for LMICs, adding additional pressures to their often fragmentary health and social care infrastructures (Evans and Etienne, 2010; Ooms et al., 2014)

It seems likely that even as these countries develop some significant infrastructure for both ageing and disability as separate constructs that they will already face their convergence and the associated need for systemic and social changes to address those issues. The evidence from the developed countries is that the systemic responses required will challenge existing systems, often built over long periods of time and established as formal and often conservative infrastructures in their own right. This can be seen in the political, economic and social policy arguments around the funding of ageing and aged care in the developed countries where there are strong ideological agendas of scarcity and generational 'merit' brought to bear on arguments about who can and should receive access to social resources (Coole, 2012). One of the common arguments we can expect to see deployed in policy debates about who gains access to what social resources is the scarcity argument. This is a well-established political and economic device that is often used as a rationale for limiting the allocation of social goods to people who lack the skills and authority to context these restrictions. Central to this

strategy is deliberately not defining key ethical principles in play and pretending that all claims to public goods are equal (for example industry claims to tax cuts, defence claims to new weapons). Some writers have even gone so far as to suggest that an older world may be a more peaceful and socially stable world which will have major implications for current global power relations (Haas, 2007). Disability and the care of disabled people will be central in how these discussions unfold.

Globally, information about people with disabilities remains poor, especially in comparison to many other key health and social policy areas such as those represented by the Millennium Development Goals (MDGs). In 2011 the World Health Organization produced a report about disability from a global perspective and indicated the need for improved disability information systems developments into the near future at both the international and national levels. Projects such as the Global Burden of Disease Study (e.g. <http://www.thelancet.com/themed/global-burden-of-disease>) are also serving to fill some of these gaps because their scope is so large that disability data comes through these additional information channels. However, it is also evident that, as with disability and diversity, our knowledge base has a long way to go before it provides a comprehensive global understanding.

What is also evident from the research conducted to date is that we will see a continuing dynamics in the definitional and epidemiological aspects of disability regardless of which models are utilised. Issues that once fell into a purely medical model, for example, are now being couched in socio-medical terms or extended as arguments for interventional policies because of the disabling nature of such conditions. These include recent reports on: hearing impairments and deafness (Stevens et al., 2013a); visual impairments and blindness (Stevens et al., 2013b); migraine (Steiner et al., 2013); musculoskeletal disorders (Smith et al., 2014); and cancer (Soerjomataram et al., 2012). Changes in social, medical and health understandings of illness and disability are also presenting a regular stream of new conditions, once completely unrecognized or poorly conceptualised, that now demand more informed responses.

2.3.2 Population Ageing and Disability

A major issue for global disability prevalence and incidence is population ageing. Disability status, type and severity are highly correlated with age and the phenomenon of population ageing is an increasingly global experience

(Rechel et al., 2009; Klijs et al., 2011). This issue is increasingly recognised internationally and has been accepted in Australia for some time now, with age and disability (and carer) research building on each other (Australian Institute of Health and Welfare, 2000). What is likely to prove both a challenge and an opportunity for the disability sector is how the sector responds to population ageing policy and service developments and how the disability concept grows to integrate age-related issues with the more established models of disability. There is already a premise for this in that many younger people who were born with or acquired particular disabilities have seen significant increases in life expectancy over the past few decades meaning that their mid-life mortality has reduced and old-age is now an experience that must be more fully considered for a much wider range of people with disabilities than was once the case.

Ageing is already under way in the most developed countries but the great majority of older people will soon be from the middle and lower income countries of the developing world. The numbers of older people will more than double by the middle of this century but also the great majority of them will be in those countries generally identified as the emerging economies. Illustrative of this trend is China which will soon have at least 300 million people aged 65 and over. This signifies a profound change in social and political arrangements because ageing and disability require genuine and practical responses in contemporary urban societies. The complex scope of disabling conditions will extend from the physical conditions acquired by people who have lived a lifetime of manual labour to the cognitive, memory and behavioural issues associated with extreme old age (United Nations, 2013).

The current relationship between youth and age will soon be reversed at a global population level (United Nations Department of Social and Economic Affairs, 2005). For most of human history the young have significantly outnumbered the old but by the year 2020 this pattern will have been reversed and the trend will steepen as older people continue to rise in terms of both their total numbers and their proportion of national populations. What is additionally interesting about this from a disability perspective is that the projected increase in disabilities associated with rising injuries and deaths associated with accidents in developing countries will occur at the same time the absolute numbers and proportions of those younger populations fall past the rise in ageing populations. Furthermore, this trend looks to be sustained into the much longer term, certainly until at least the middle of this century.

What this means is that we can expect to see a significant rise in both injury-related disabilities in younger to middle aged populations at the same time we see age-related chronic diseases and disabling conditions expand rapidly due to rapid and rising ageing.

This process is being described as *hyper-ageing* and it also means that the shape of population pyramids globally are changing in profound ways (Atoh, 2000; Klingholz, 2009). The scope of conditions described as disabling will grow as this hyper-ageing process progresses in many countries because the sheer numbers of older people will present a rise in what were once very rare conditions, with very small numbers of sufferers, and much larger numbers of people with commonly understood conditions, such as the dementias. Research also suggests that chronic diseases, rather than infectious diseases, are now the major cause of death for people worldwide. The growth of ageing and rapid lifestyle changes mean that the role of infectious disease is in rapid retreat as a major cause of death for people at the global level.

By the year 2030 the most significant increases in older people will be amongst the oldest old including centenarians. The total number of centenarians will more than quadruple globally by 2030 which means that although the absolute number will not change significantly, because this is a very small group, their rate of increase exceeds all other age groups. Even the 'oldest old', those aged 85 and over, will increase by almost 1.5 times by 2030. This has important implications for health and social care systems internationally. By contrast, those aged below 65 years are projected to grow only slowly as a total, even taking into account those countries that still have high fertility rates. Population ageing and its health and disability implications will characterize the whole of the 21st century. It has also been suggested that this process will not change significantly at any foreseeable point because the social and economic transformations underpinning ageing are unlikely to be reversed (Bremner et al., 2010; United Nations, 2013).

2.3.3 Frailty, Ageing and Disability

As already discussed, progressive ageing is correlated with a wide variety of health conditions including specific disabilities and conditions which can progress over time to a point where they disable the individual. Some conditions, such as chronic pain syndromes, have proven both difficult to diagnose and treat yet they can easily have disabling consequences for the patient. This is one example where developments in medical and related

protocols and interventions illustrate how the developmental knowledge we associated with disability is expressed in often very specific circumstances. One general medical syndrome that has an impact on some but not all older people, and which also tends to be progressive in its effects, is frailty (Clegg et al, 2013).

The concept of frailty is highly correlated with ageing and, as a consequence, is also seen as being connected to age-related disabilities given that both are so often seen together (Topinková, 2008). Frailty has been recognised for centuries but the development of geriatric medicine and the advent of population ageing has added some momentum to attempts to formalise the concept of frailty and gain an understanding of why it develops, how it progresses and its consequences for individual patients and at a systemic level (Fried et al, 2004; Xue, 2011). More recently still there have been efforts to develop measurement systems for frailty in an effort to operationalise it within, especially, geriatric medical environments (e.g. Fried et al, 2001; Rockwood et al, 2007). A characteristic of most conceptualisations of frailty is that it correlates with increased vulnerability across a range of potential health encounters including surgery. This is another area in which disability and age-related health problems share some similarities. People with disabilities are well-recognised as being a significant vulnerable group within healthcare systems, particularly acute medical environments (Travaglia et al, 2011).

Frailty is not associated with all older people and is generally seen in approximately 20-30% of older, clinical presentations to healthcare service providers but this can also depend on situational factors, such as the differences between community-dwelling older people versus those in some form of residential aged care (Rochat et al, 2010; Rapp et al, 2012). The three major clinical features associated with frailty are: (1) sarcopenia which refers to muscle loss or wasting; (2) osteoporosis or loss of bone density, more common in women and associated with the risk of falls and fractures; (3) muscle weakness or loss of strength which can affect mobilizing, balance and overall mobility (Clegg et al, 2013).

These significant issues for older people and their carers as they can significantly increase their dependence on others for even basic activities of daily life (ADLs and IADLs) and their effects can be highly disabling in the commonly applied sense of the word. Thus frailty can be seen as disabling in its own right and also as indicating a potential progressive pathway to disability

assuming that adequate interventions do not take place. As with other disabling conditions, the implications are significant for the individual who experiences them but also for the long chain of formal and informal support providers who constitute the overall system of care provision. It is also the case that many frail older people may lack immediate supports and be unable to access services until an acute event occurs such as a fall or similar outcome that forces a hospital admission.

The care of frail older people in hospital environments has also been recognised as a significant failure in the ability of institutions to deal with complexity. The multiple health conditions and lack of patient-centred care all impact on the overall quality and outcomes for this significant group. This is another area in which the experiences of older people and the broader category of people with disabilities, also often having complex care needs, is a shared feature of the institutional healthcare experience. The institutional focus on, often, singular health conditions has long been problematic for people with disabilities and is proving equally unsuitable for older people who, increasingly, make up the majority of admitted acute care patients (Cornwell et al, 2012). Eliminating these disparities in the context of rising levels of disability, from age-related and other contexts, has to be a priority for traditionally oriented healthcare systems and their community-level equivalents (Iezzoni, 2011).

2.3.4 Accident and Injuries

One key area where we can expect to see rapid global growth in acquired disabilities is in the area of accidents and injuries. Rapid urbanization and development globally includes the expansion of motorized traffic and traffic control systems. These conditions have seen rapid growth in the burden of accidents associated with changes in technology use, high speed motor vehicles of all types and an often slower pattern of adopting traffic management systems and the acceptance of social behaviours that support those systems, such as obeying road rules, abiding by loading requirements, drug and alcohol use while driving or operating similar technologies and so on. The World Health Organisation (Peden, 2004) estimates that motor vehicle accidents now account for approximately 1.2 million deaths per year worldwide with approximately 50 million people with varying degrees of temporary to permanent injury and disability. Even then, these figures only

account for just under 23% of all deaths related to injuries, accidents and related causes.

People with disabilities are also vulnerable to exploitation, abuse and physical violence across a broad spectrum of social and cultural environments. The WHO is addressing this issue in a special issue of *The Journal of Interpersonal Violence* to be published in late 2014 (see http://www.who.int/violence_injury_prevention/media/news/2014/12_06/en/).

When we include the already prominent field of elder abuse, the intersections between the existing disability sector's focus on these issues and the data on cross-cultural and intergenerational abuse of older people, including those with disabling conditions, will only continue to rise. Claims have also been made that some cultures respect their elders more than others, including the filial piety argument common to Chinese and other East Asian cultures with a Confucian heritage. However, while this may be true to some extent research conducted in Japan over the past two decades, for example, has shown that elder abuse has grown significantly even within the context of social and cultural environments where there are claims that older people are more respected and valued than elsewhere (Soeda and Araki, 1999; Masuda, 2011; Arai, 2006). It seems likely that this is another area of overlap in which there will be current and emerging points of intersection as well as a potential for interventional programs that link different forms of personal abuse, exploitation and violence as part of a broader social discussion and response program (Anetzberger and Yamada, 1999).

2.3.5 Disability and Mortality

Another important aspect of the demography of people with disabilities includes the dynamic nature of disability across the life cycle. In particular, some significant shifts in life expectancy for particular conditions have occurred over the past few decades. This means that disabled populations in many countries are dynamic and that some sections of those populations are living significantly longer than previously. Having said this it is also the case that researchers have identified an important gap in the relationship between the production of knowledge about health and the actual conditions that contribute to the disabling conditions that contribute most to the global burden of disease. Evans et al (2014) describe the relationship between the two as extremely 'loose' at best. Even with the World Health Organisation's focus on the issue of disability and rapid growth in some countries about local

patterns of disability it seems clear that there is still a long way to go in fully understanding the scope and complexity of disability at the global and sub-global levels.

This situation for some types of disabilities has changed so much that now many people with disabilities live long enough to experience disabling conditions once associated primarily with the elderly. These include chronic physical conditions and the varied cognitive impairments that have traditionally been the experiential domain of older people. A small but useful literature also exists on the specific mortality differentials associated with having a disability. Swedish researchers Vikström and Haage (2013), for example, have been using historical records to examine the correlates of mortality on a cohort of people with disability to examine the impact of social factors on their life expectancies. How issues like this intersect with the disabled in CALD communities is unclear at this stage but would be an important issue for data collection and analysis as well as service design and packages in the context of the evolving nature of the NDIS.

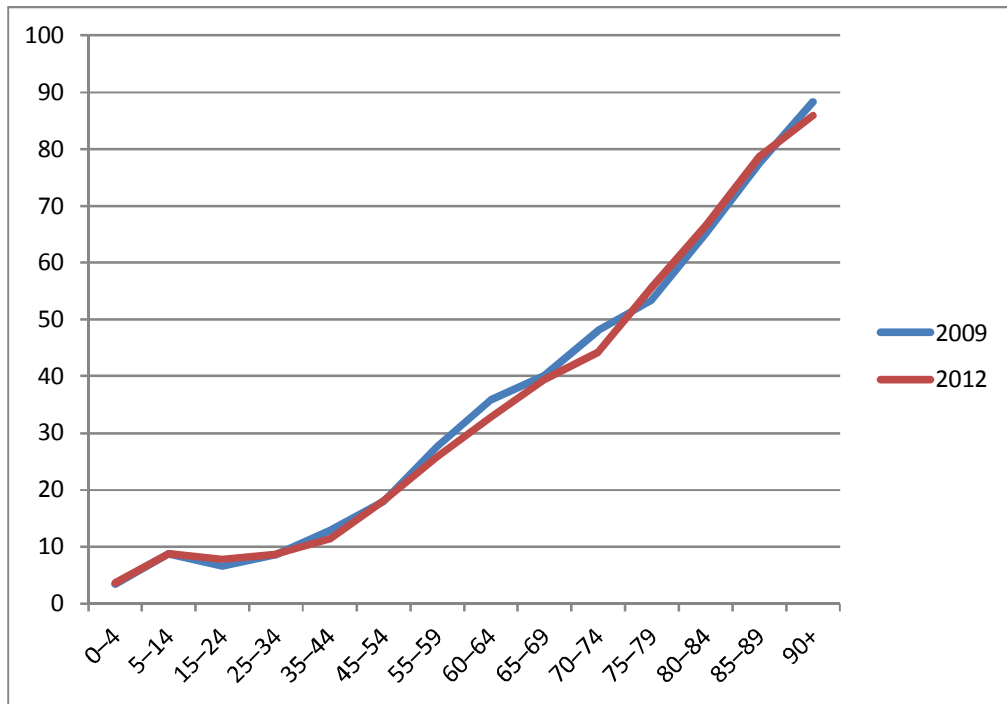
2.3 Disability in Australia

In the Australian context, there exist a number of regular and periodic information projects about people with disabilities. These include data collected in the Census, regular surveys by the Australian Bureau of Statistics (ABS) and reports from the Australian Institute of Health and Welfare (AIHI). The establishment of the National Disability Insurance Scheme (NDIS) and its current pilot projects has also confirmed the need to improve the current information base. A research project based at the University of Sydney is auditing current research Australia-wide being conducted on people and with disabilities and with disability organisations. Information presented at the 2014 Centre for Applied Disability Research indicates that a number of groups have been identified within the disability sector for whom data quality and quantity remains poor (see section 2.8 for further details). One of those groups consistently identified is people from CALD. Anecdotal evidence continues to point to a lower utilization of disability services by people from these communities. This is a long-standing issue in Australia and may be reflective of indigenous and immigrant peoples' engagement with disability services in other countries as well.

Estimates of disabilities in CALD communities vary according both to definitions (overseas born, at least one parent born overseas) but also on understanding of factors contributing to rates of disability in various communities. The health migrant syndrome (that the selective screening of individuals in the post-World War II period) combined with denial of entry to people with disabilities as immigrants could suggest a lower than average rate of disability in CALD communities overall. Competing with this argument are the higher rates of work related injuries (particularly, but not only in post WWII immigrants), increased risk of mental illness due to immigration stresses, and potentially increased rates of both mental health and physical problems in refugees and asylum seekers (and in particular in survivors of wards, torture and trauma). Patterns of disability will also differ across communities (a factor discussed later in this section) based on prevalence of various conditions and impairments amongst different groups (for example higher rates of thalassemia in communities from the Mediterranean).

Information from the 2012 ABS Survey of Disability and Carers began to be released in 2013. The results illustrate a number of key considerations including the relationships between disability, age, gender and geography. The ABS will continue to release data from this survey through 2014. This data is utilised in Figure 2 below showing how the age-correlated pattern of disability in Australia has remained largely unchanged between the 2009 and 2012 surveys. As noted above, ageing will drive a significant component of disability prevalence into the future and especially so as the population ageing progresses in Australia.

FIGURE 2: DISABILITY RATE BY AGE IN AUSTRALIA (2009 AND 2012)



The data from the 2012 survey (Figure 3) shows just how profoundly the relationship between age and disability is in Australia. The trend curve is not directly linear because the rate at which disability affects each succeeding cohort is significantly greater than its impact on the preceding cohorts. The only minor exception to this life-span pattern is the 5-14 age grouping identified above which is higher than the early childhood and later teen years prevalence. By the time people are in their 70s more than half of them will be living with some form disabling condition, often associated with long-term health conditions, and this rises to almost 90% of people in their 90s and over.

FIGURE 3: AGE AND TOTAL DISABILITY IN AUSTRALIA

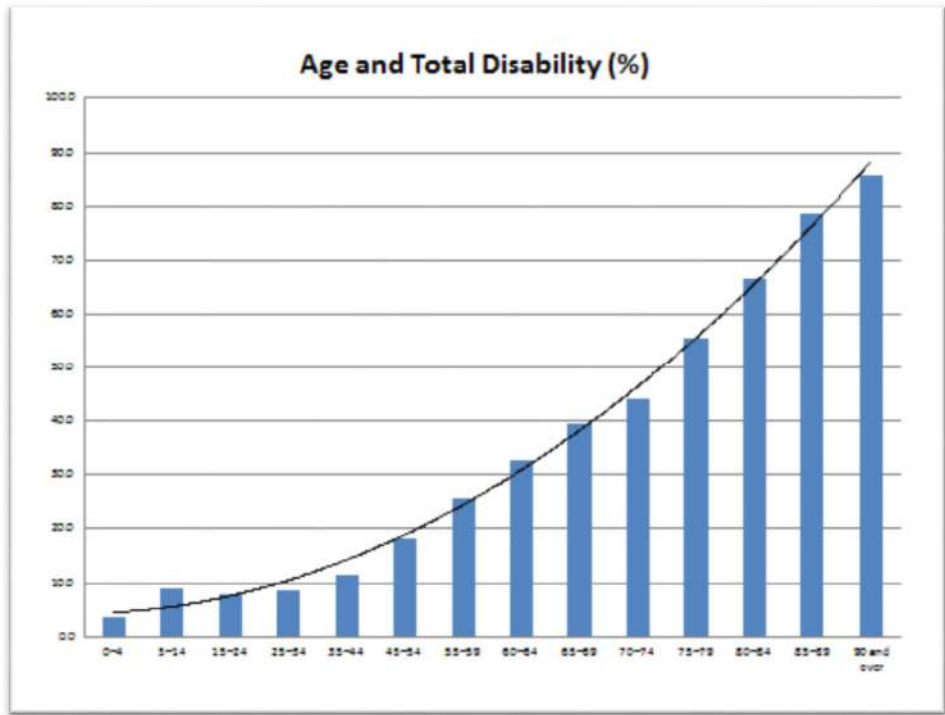


Figure 4 below illustrates how profoundly disability is patterned by age and sex. Males and females both show a spike in disabilities in the 5-14 age grouping but this is much higher for males than females. By way of contrast, female disability rates begin to climb steeply from later middle age and this trend steepens significantly from the 70s onwards. This means that women will be much more likely to experience disabling conditions in later life and their life expectancies are already higher than males, making for a significant pattern of older women living with disability. Disability rates for both men and women drop somewhat in very old age but this may be a healthy survivor effect in that men and women with severe disability conditions have other health problems that shorten their life expectancies while the most robust older people survive to very old age in greater numbers. It is useful to note that with current medical advances, as has happened with many disabilities in younger age groups, the survival rates for older people with existing disability conditions may also continue to rise.

FIGURE 4: PROFOUND DISABILITY STATUS BY AGE AND SEX

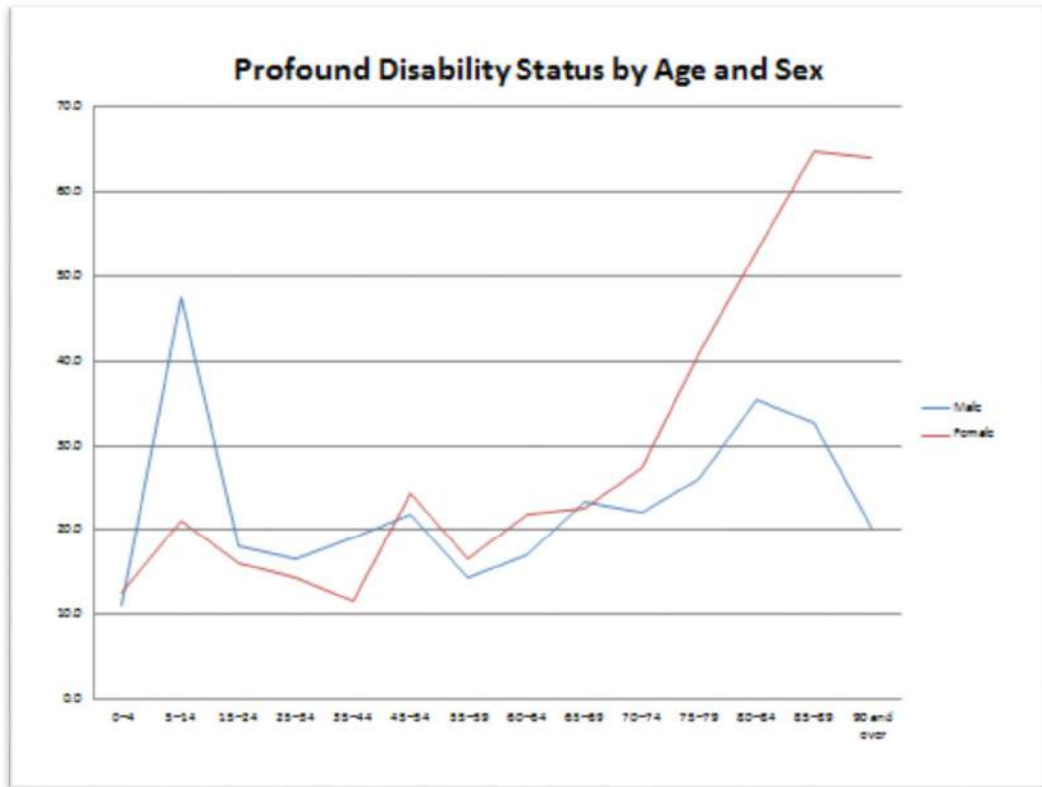
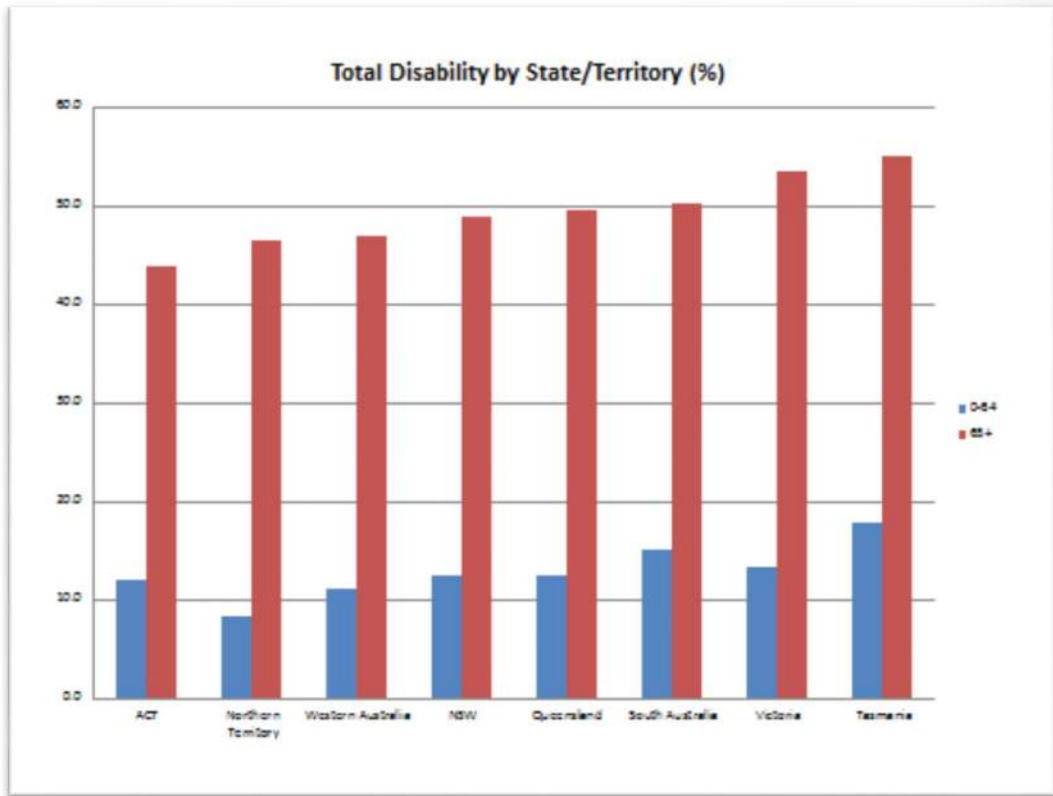


Figure 5 shows how geographic variation is a factor in the pattern of disability in Australia. The Northern Territory has the lowest rate of disability recorded for those under 65 years of age and the second lowest for those 65 and above. Tasmania is the state with the highest rates of disability for those aged both under and over 65 years of age. In contrast to this, the ACT has the lowest rate for those aged 65 and over but still a significant rate for those under 65. In addition, the ACT is a territory with a fairly mobile population including a proportion of older people who retire elsewhere which may be reflected in this lower disability rate for the retirement age group.

FIGURE 5: TOTAL DISABILITY BY STATE AND TERRITORY



2.4 Diversity and Disability

As noted above, the issue of socio-cultural diversity and disability is poorly understood globally and especially in the context of immigrant-receiving societies that operate complex health and social care systems that may not have existed in the immigrants’ countries of origin. While there is much focus on the stigma attached to disability in some communities (as with mental illness, sexuality and so forth) it is also true that many host societies have made very limited efforts to engage with immigrant communities, even long standing communities, and outreach and engagement processes have frequently been very poor indeed.

Some research, such as that conducted by Ahmad and colleagues in the 1990s also indicated that the intersection of ethnicity and disability could create an additional burden of exclusion or mistreatment for minority groups produced

through mainstream health and social care systems (Ahmad and Bradby, 2007; Ahmad, 2000; Ali et al., 2001). Their work with South Asian communities in the United Kingdom showed how a focus on the pattern of consanguineous marriages in some of these communities often stigmatized the children resulting from those unions within the mainstream health system, especially if a child was born with a disability (Atkin and Ahmad, 2000; Atkin and Ahmad, 2001; Croot et al., 2012). Consequently there are several issues that already exist with the way genetically and congenitally acquired conditions are engaged with and also how counselling systems interact with people from effected communities. The question remains as to how well mainstream systems and disability services in particular engage with CALD communities and to what extend models of engagement and communication are adapted for different communities including cultural, language and religious groups.

Lastly, shifting immigration patterns lead to quite significant changes in which communities experience particular categories of disability at particular times as they progress through the lifecycle and as subsequent generations are born into those communities. For example, newly established communities in Australia may have higher rates of disability in the early childhood years or disability acquired through work-related injuries and accidents. Much older communities, such as Italians and Greeks, are more likely to be experiencing age-related disabilities as their most profound issue even while possessing conditions acquired as adults, such as work-related arthritis and hearing loss.

Another poorly addressed issue is that of intergenerational disability and care since many people with disabilities will be born in Australia into families from CALD backgrounds. In these contexts language and cultural factors that are different from those of the wider community may still need to be addressed, especially if equity of access and outcome are to be fully realized.

Understanding disability from an intergenerational perspective is likely to be a highly useful research process because it may explain when and how perceptions of disability in general, and specific disabilities in particular, are altered over time within particular cultural and linguistic groups and sub-groups. We know very little about the intergenerational transfer of understandings of and attitudes towards disabilities or how specific communities respond to complex disabilities and issues such as genetic screening and interventional medical care. Some work has been done in Australia on genetic counselling but the work is limited and patchy (Barlow-

Stewart et al., 2006). Some years ago the Jewish community introduced a genetic screening program for inherited disorders which proved successful enough to plan for its extension to some other CALD communities with a higher prevalence of conditions such as thalassemia.

Available information to date suggests that accessing disability services at the levels that could be expected of CALD communities remains a significant issue. Most significant data collectors' estimate that rates of utilisation remain well below expected and that this has been the case for decades. While social stigma is often attributed as reason for CALD communities not accessing mainstream disability services it is also unclear as to what extent these mainstream services, as a general category, have made practical and appropriate efforts to inform such communities of their availability.

Rationing of services, common in healthcare, is an issue in immigrant receiving societies, especially where those services make limited efforts to engage with immigrants or perpetuate stereotypes about their attitudes to said services. The NDIS is developing and supporting research programs that may begin to answer these questions more adequately but what does seem clear is that, with some exceptions, mainstream disability services have some way to go in ensuring that the whole community knows of and understands their rights to access such services, especially those directly funded under state and federal regimes.

2.5 Data and Disability

A key issue recognized by the UN, WHO and national disability funders, researchers and service providers is the scope and quality currently available on people with disabilities. This ranges from basic prevalence and incidence data to service utilization rates by various groups and categories of persons with disabilities. As well as there being issues with data availability it is worth noting that data frequency is an issue too. Censuses only take place every five years in Australia, and even less frequently in some countries, making an overarching update of our knowledge a regular but infrequent occurrence. The current range of disability surveys by the ABS also take place every three years on average due to the survey collection and data analysis phases required to produce a final result. Potentially the NDIS and its implementation of enhanced data systems and a rapid expansion on the research base on disability may help to address some of these issues.

2.6 A Brief Background to the National Disability Insurance Scheme (NDIS) and National Standards for Disability Services

2.6.1 The Productivity Commission Inquiry on Long-Term Disability Care and Support

Initiated in 2010, the Productivity Commission conducted a public inquiry on the long-term future of the disability care and support system receiving more than 1,000 submissions from concerned individuals and organisations. The resulting report was released by the government in 2011 (<http://www.pc.gov.au/projects/inquiry/disability-support/report>). The major issues the Commission had been asked to address included:

- How a scheme should be designed and funded to better meet the long-term needs of people with disability, their families and carers;
- How to work out who is most in need of support, the services that should be available to them, and service delivery arrangements;
- The costs, benefits, feasibility and funding options of alternative schemes;
- How the scheme will interact with the health, aged care, informal care, income support and injury insurance systems;
- Its impacts on the workforce;
- How any scheme should be introduced and governed;
- What protections and safeguards should be part of the scheme.

One of the outputs of the Commission's analysis was to begin costing some aspects of the options available to the government. The focus is on long-term care and support (but not income replacement) for people with severe disabilities. There was also an acknowledgement that the current arrangements for people with disabilities were not adequate at the present and that problems with the system were likely to expand significantly going forward, including the variability in funding arrangements that disability services and clients were subject to. A key aspect of the proposed strategy was the need for a national system rather than reverting to a 'federated' system which the Commission described as "flawed and unfair" (Productivity Commission, 2011:2).

The Commission identified a range of options and emphasised a need for a no-fault national injury insurance scheme, a separate scheme for people with traumatic life-time injuries such as spinal and brain injuries, and that the overall scheme should promote innovative approaches to disability care and support. The target for the NDIS, as proposed by the Commission, is that everyone is insured with approximately 410,000 people receiving long-term funded support through the scheme.

2.6.2 The National Disability Strategy

The Council of Australian Governments (COAG) produced the first coordinated national approach to disability issues in 2011 with the *2010-2020 National Disability Strategy* (hereafter *The Strategy*). This drew directly on the United Nations Human Rights Framework for People with Disabilities which Australia had ratified in 2008. It also integrated Australian disability position statements such as consultation conducted in 2008-09 by the National people with Disabilities and Carer Council and reported in *Shut Out: The Experience of People with Disabilities and their Families in Australia* (NPWDACC, 2009). Amongst the drivers for this long-term planning view was an acknowledgement that population ageing would be a central feature of future disability demography in Australia (*The Strategy*, pg. 9). *The Strategy* also specifically identified Aboriginal and Torres Strait Islanders and people from culturally and linguistically diverse backgrounds (CALD). The final planning document identified six key areas for development in disability. These were:

- Inclusive and accessible communities;
- Rights protection, justice and legislation;
- Economic security;
- Personal and community support;
- Learning and skills, and;
- Health and wellbeing.

Central to the plan and its focus out to the year 2020 is the understanding that changing demography and social circumstances are likely to impact significantly on emerging disability care and support scenarios. The Strategy specifically mentions a potential decline in informal support provision (p. 20) based on Productivity Commission projections. There is, as with ageing, a keen

awareness that current support arrangements rely heavily on ‘informal’ support provided by families, social networks and communities. However, changing demography is likely to reduce the overall capacity for informal care at a time when the numbers and complexity of people with disabilities is on the rise.

This has direct implications for service frameworks, infrastructure and the overarching cost, and broader economics, of disability support as identified in the NDIS. It seems likely based on the issues identified in this report, that between the dynamic social and demographic trends associated with disability prevalence/incidence and current disability supports, as well as the many groups who have rarely accessed formal care systems and benefits that this scenario can only grow in size and complexity in the foreseeable future.

Central to these projected scenarios and interactions will be the scope and quality of disability data available for analysis. A recent report on *Cultural and Linguistic Diversity Measures in Aged Care* (2014) from the Australian Institute of Health and Welfare, for example, suggests that a variety of barriers to service access continue to be relevant in ageing, grouped under the major headings of: cultural; structural; service/assessment related and; individual factors including dementia, PTSD experience, social isolation and geographic location. This report also notes that very few CALD measures are currently employed in standard aged care data sets and that, as with other data and information limitations identified in this report, is an ongoing problem in an era when person-centered funding and care strategies are the claimed basis for design and delivery systems (p. 22).

It would seem that this particular report has emerged at a useful time for the disability sector which will need to confront similar issues as the NDIS moves forward and as the demographic and social changes flagged by the Productivity Commission, amongst other, being to make their effects felt. A second but equally important issue to consider is the extent to which support services, such as respite care providers, are also adequate for this new environment in which a highly diverse group of clients *and* carers will be needing to understand and able to access service providers and their offerings (e.g. Stockwell-Smith et al, 2010).

The National Disability Agreement, which was introduced in 2009, was the peak partnership agreement between the Australian and state and territory governments. This included the establishment of a working group, a research

and development agenda with a budget of \$10 million and the development of a National Need and Supply Model by the consulting firm Pricewaterhouse Coopers (see <http://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/government-international/national-disability-agreement>).

The first *National Need and Supply Modelling Report* for 2010-11 found that almost 60% of the potential population under 65 years old was receiving some form of disability support. Data from the same year on the use of both disability services (DS) and Home and Community Care (HACC) services also indicated that a proportion of people were living much longer with disabilities and that as they aged they required a more sophisticated service mix to meet their higher needs (Australian Institute of Health and Welfare, 2013). The data further suggested that these were not the only service domains these individuals were accessing.

The legislation for the NDIS was presented to the Federal Parliament in late 2012. The trial projects established as part of a progressive implementation program include the Hunter Valley in NSW, Barwon in Victoria, Tasmania, the ACT, the Barkly region of the Northern Territory, and two regions in Western Australia. By 2015 this is expected to cover 20,000 people. The NDIS scheme aims at a progressive developmental program of funded disability support services that is seen as generational change in disability arrangements in Australia. The costs are uncertain but likely to be substantial as the extension of the system from its current pilot project approach develops into a fully national scheme meeting the needs of perhaps as many as 410,000 people. This will still not address the full extent of the needs of people with disability in Australia and nor will it at this stage resolve the issues associated with older people with disabilities identified above.

The creation of a generalised market in disability services is another issue that will present issues for CALD communities as negotiating complex disability service arrangements relies on a good understanding of both: (a) what is available and; (b) what entitlements an individual may have across the system. The extent to which such services will be required to take into account diversity-related issues seems unclear even if the general issue has been identified. Clearly issues associated with language capacity, communication planning and service delivery for inquiries from and delivery to CALD clients will be major issues of concern as the NDIS develops.

Overall, the NDIS represents a significant opportunity and an additional challenge in relation to the complex socio-cultural diversity that is represented by Australia's population. Monitoring diversity measures in this sector as it undergoes these changes will be an important issue and while this has been identified it is also clear that noting the problem is not the same thing as addressing it. Other areas with similar issues of access and equity, such as multicultural health, have never fully resolved the gap between entitlement and actual access to services. Mainstream health services still have a very limited agenda in terms of their accommodation of or response to cultural and linguistic diversity. The potential for sustained inequalities in a reformed and fast changing disability sector seem to be significant and both planning and reporting processes will need to be carefully considered in dealing with these concerns.

2.7 National Standards for Disability Services

The National Standards for Disability Services (NSDS) (Department of Social Services, 2015) pre-date the NDIS by several decades. First produced in 1993, and updated across the following decades to reflect changes in the philosophy, approach and funding of services, they set out the quality expected of disability services. The Standards define cultural competency as:

"... the term 'cultural competency' describes individuals and organisations with a set of behaviours, attitudes, knowledge, skills, practices and processes which enable effective work in cross-cultural settings. It is more than cultural awareness. It means that individuals and organisations are proactive, rather than responsive, regarding cultural diversity to ensure effective and relevant service delivery or supports." (Department of Social Services, 2015: 15)

The six National standards only include two specific indicators for diversity. These are included below. Each of the standards however, have specific implications for the delivery of services to people of CALD background (and indeed for other groups including specifically peoples from Aboriginal and Torres Strait Islander backgrounds) and these have been integrated into the CDCF.

1. **Rights:** The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence.

- 2. Participation and Inclusion:** The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.

Indicator of Practice 2.6: The service uses strategies that promote community and cultural connection for Aboriginal and Torres Strait Islander people.

- 3. Individual Outcomes:** Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.

Indicator of Practice 3.4: Service planning and delivery is responsive to diversity including disability, age, gender, culture, heritage, language, faith, sexual identity, relationship status, and other relevant factors.

Indicator of Practice 3.5: The service collaborates with other service providers in planning service delivery and to support internal capacity to respond to diverse needs.

- 4. Feedback and Complaints:** Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.
- 5. Service Access:** The service manages access, commencement and leaving a service in a transparent, fair, equal and responsive way.
- 6. Service Management:** The service has effective and accountable service management and leadership to maximise outcomes for individuals.

2.8 The Australian Disability Research Audit Report

The scope and composition of disability research in Australia has been analysed in a recent report produced by the Centre for Applied Disability Research at the University of Sydney. The Report of Audit of Disability Research in Australia (CADR, 2014) canvassed the disability research environment, including the scholarly and grey literature, for the years 2000 to 2013. The research process identified 2011 research documents in that undertaking. The final report identified significant gaps and a lack of overall strategic thinking in the research current disability research environment as well as significant under-funding from the major social research supports such as the Australian Research Council (ARC).

The focus of the report addresses six main issues:

- Policy and regulatory
- Demand need and preferences
- Market composition and structure
- Workforce and employment sustainability
- Evidence and research into practice
- Community and social impact

These are all central to the development of the NDIS and will, therefore, have a significant impact on the disability sector in general and the NDIS funded portion of the disability services sector. The National Disability Research and Development Agenda identified four groups for particular focus in the research and analysis stages including: Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds (CALD); women with disability; and, lastly, people in regional, rural and remote areas. The Audit indicates that the bulk of the available research does not address these groups to any significant degree. In other words, as identified elsewhere in this report, the research base in the disability sector also fails to provide sufficient, useful information about these vulnerable groups in the context of disability.

The report addresses these findings by making some specific recommendations. These are most explicit in recommendations 7 and 9 in the report which are:

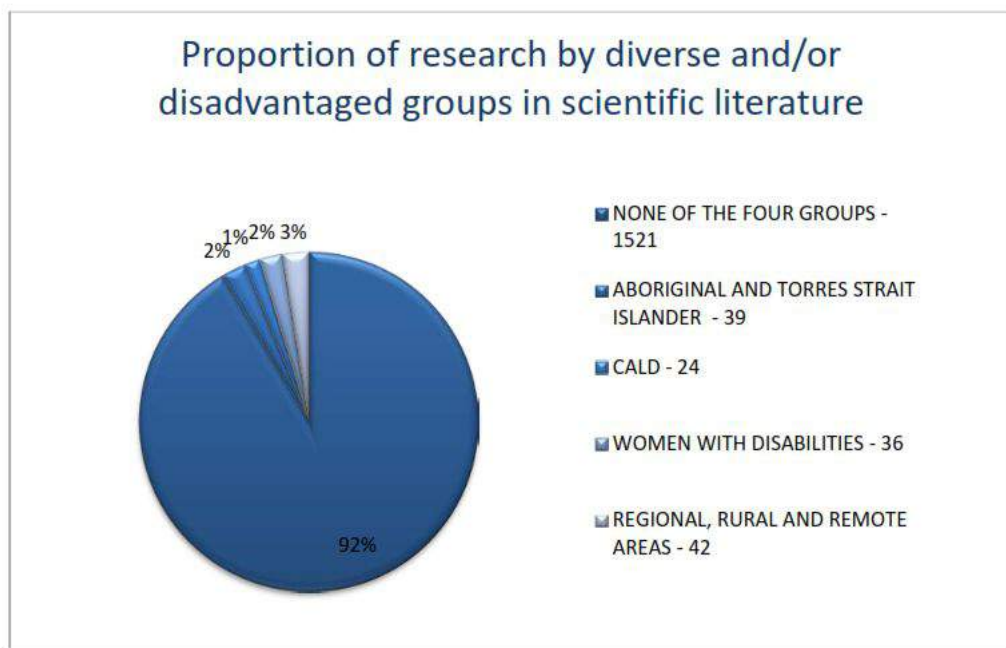
7. Collection of more comprehensive data and stimulating research on priority groups including Aboriginal and Torres Strait Islander people

with disability, women with disability, culturally and linguistically diverse groups and people living in regional, rural and remote areas and children and young people.

9. Routine reporting of disability statistics, including prevalence, living circumstances and health and wellbeing, by age, sex, geography, ethnicity and Aboriginal and Torres Strait Islander peoples.

In addition, Figure 6 (p. 30) of the report quantifies and charts the minimal presence of the four vulnerable groups in the research documents collected. The report shows

FIGURE 6: PROPORTION OF RESEARCH BY DIVERSE AND DISADVANTAGED GROUPS



This chart shows that collectively, the four groups are only represented by 8% of the documents captured. For the purposes of this report, the figure for CALD communities explicitly addressed by the disability research falls to 1%. Knowing anecdotally that research in this area is poor this figure still suggests that the disability research sector does not represent the needs of the four groups, each specific group or even overlaps between these social category

groupings. We can only assume at this stage, for example, that CALD women with a disability are virtually invisible in the existing research base.

There is a clear need to democratise the research base given the findings of this research and low funding for research provided by the major research structures in Australia. As noted elsewhere in this document and in the disability sector more generally, there is a central human rights dimension to disability work, including research, and an issue of adequate representation. The research and data/information sectors currently appear to not meet these principles in any sense that could be described as adequate. This data explicitly reinforces the centrality of cultural competence in a sector which, operating on the principles it claims as its own, fails to in any way represent these four groups and the issues for CALD communities.

3. Why cultural competency?

Competencies and competency standards have been used in industries including education, health and welfare since the 1950s (White, 1959) as a way of identifying, teaching and assessing the knowledge, skills and attitudes required for work in specific professions and trades (Eraut, 1998; Russ-Eft, 1995; Cheetham and Chivers, 1996). The attraction of competencies lies in the ability to isolate and measure particular individual (or organisational) attributes, and change in those attributes over time.

A common critique of the competency approach is that competencies are too atomistic and that the 'sum of the parts does not add up to more than the whole' (Norris, 1991) or that it is a 'fuzzy' concept (Le Deist and Winterton, 2005; Huey et al., 2014). In the case of cultural competency, the concern is that individuals may be able to tick all the elements or boxes, but still not be able to work effectively with individuals from different cultures, in other words, whatever the list of competencies, they have "... not always translated into a worker's ability to work more effectively with her clients." (Garran and Werkmeister Rozas, 2013: : 98). This issue will be taken up in the change chapter of this report.

The idea of organisational competencies is similar to that of individual professional competencies, although perhaps closer to the holistic notion of capabilities rather than the competency elements. It includes the organisation's vision and mission, as well as its culture and core competence.

The notion of core competence relates to those characteristics of an organisation which set it aside from other, similar organisations (Prahalad and Hamel, 1990). In disability organisations, for example, a commitment to client or person centred care would be expected. A core competence for some organisations (and not others) however, might be the ability to work with individual from refugee or asylum seeker (as well as local) backgrounds, or an innovative inclusive approach to families and carers in the provision of services.

The idea of competence or competencies can be applied at different levels: systems; organisations or services; teams or units; and individual professional, staff and managers. The SOTI model (systems, organisation, teams and individuals) of diversity competence was developed and tested by Travaglia

and Robertson (2000) and forms the basis of the practice theory which underpins part of the CDCF project.

3.1 What do we mean by cultural competency?

Cultural competency emerged in the in the 1980s and 1990s as a response to growing awareness of the need for a method for overcoming cultural and linguistic barriers which affected the quality and safety of health and related services. Nursing (Campinha-Bacote, 1994; Leininger, 1981) and psychology (Bernal and Castro, 1994; Sue et al., 1999) were amongst the first professions to employ cultural competence approach. Mental health as one of the first, and is still one of the largest disability fields to take on this method (Dillard et al., 1992; Kennedy, 1999; Owiti et al., 2013).

Huey et al (2014) note that the notion of cultural competency has evolved over time, and through input from various disciplines. This evolutionary process can be seen in the range of terms utilised in overlapping ways (cultural adaptability, cultural appropriateness, cultural sensitivity, cultural awareness, cultural astuteness and so on), in whether the approaches are concerned with knowledge, skills, attitudes of the provider (or any combination of these) of these or the process(es) undertaken, and or in the levels at which the cultural competency is they are meant to operate. Recent meta-reviews indicate that that are over 30 models of intercultural competence and over 300 related constructs (Leung et al., 2014).

3.1.1 Organisational cultural competence

Many definitions for cultural competence were identified in Leotta's companion document to this report (Leotta, 2013) and therefore these are not reproduced here. To provide a context, however, arguably the most common definition of cultural competency (at least in the English speaking world) is:

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations. (Cross et al., 1989)

For Cross et al (1989) this encompasses most of the elements of cultural competency in organisations. It argues that culturally competent organisations 1) value diversity, 2) have the capacity for cultural self-assessment, 3) are

conscious of cultural dynamics, 4) have ‘institutionalised’ cultural knowledge, and 5) are able to adapt their service delivery to reflect an understanding of cultural diversity.

For the purposes of this study, we would like to put forward and test the following definition based on common definitions of cultural competence, for the use of disability services:

A culturally competent organisation is one which recognises, respects and responds to diversity in order to achieve the best possible outcomes for all its clients.

3.1.2 Individual cultural competence

Competencies are intended to provide clear and achievable outcomes, which assure the public, profession (trade or work group) and employer, that when achieved, the individual is able to undertake work tasks at an appropriate level.

The development of cultural competencies largely began with a focus on individuals (Huey et al., 2014). There is a significant body of work outlining the specific competencies required by health, disability and welfare professionals in general, and for specific professions (eg occupational therapists, psychologists and mental health workers) in particular. The attraction to cultural competencies was that it moved the field away from more difficult to measure attributes such as ‘sensitivity’ (although this is still included at times as an attitude) towards more specific and measurable skills such as the ability to use an interpreter, or knowledge, such as the ability to identify the specific barriers faced by refugee and asylum seekers in utilising services (Saha et al., 2008). A list of these common competencies is presented in Ms Leotta’s report.

One important aspect to note as part of the CDCF is that in general, the additional competencies required to work effectively across cultural groups have not been widely recognised in Australia. Recognition has largely been located through the creation of job roles – either ethno-specific or generalist multicultural or diversity positions, but there is little recognition or reward for the staff member in a generalist position (including, importantly, administrative staff) that develops and draws on these skills in their daily work, be it with their own, or other communities. The implication of this will be discussed later in this report.

It is important to note here that while staff from CALD backgrounds may often be culturally competent, this is not a given. Having a common ethnicity will of course provide additional insight into clients of the same background, however there are many other differences (including age, gender, socio-economic background, religion and religious practice, political beliefs, social status, immigration experience, attitudes to towards disability, sexuality and so on) which affect how an individual understands another from their same country of origin. Cultural practices, beliefs and values also change over time and may change in different ways and at a different rate in diasporas compared to source countries (Burnard and Naiyapatana, 2004).

Knowledge of a common background and recognition of this knowledge is very important within the CDCF, however, it is not taken for granted or assumed: individuals from all backgrounds need to be supported by the organisation to assess, demonstrate and consistently work to improve their cultural competency, rather than to assume its existence.

While much of the attention in terms of cultural competence was and remains directed at professional practice, be it in individuals or teams, there has been a sustained recognition of the need for organisational and well as individual competence since the mid-1990s (Lavizzo-Mourey and Mackenzie, 1996; Cassidy, 1999). Once again, mental health led the diversity field in this area (Siegel et al., 2000; Bhui et al., 2007).

3.1.3 Criticisms of cultural competency

Some critics argue that cultural competency on its own is not enough to address structural inequalities, power differentials or disparities and that it had tended to 'equalise' a range of oppressions under one cultural construct (Abrams and Moio, 2009; Drevdahl et al., 2008). Other critics feel that cultural competency has failed to deal with the complexities of diversity – that in focusing on culture the approach has neglected to recognise the socially complex and dynamic nature of individual and collective identity (Fong, 2007; Garran and Werkmeister Rozas, 2013), each strand of which (being a Jewish person of a CALD background, being a woman with a disability) cannot be 'teased out individually' (Brah and Phoenix, 2013). This concept, known as intersectionality (Anthias, 2013), provides the theoretical base for the CDCF.

The CDCF acknowledges the specific context within which people experience their lives and from which they negotiate services (the client-centred part),

and the collective positioning of individuals within groups who can and do experience systematic inequities in terms of individual and personal outcomes (the structural and organisational response part). While the function of the CDCF is to help diversity services to meet the needs and concerns of CALD groups, it is not based on the claim that culture is the sole or even primary concern of any or all individuals in their choice of services, but rather that services have an obligation to plan for and address these concerns as seriously and comprehensively at both the level of individuals and communities.

It should be noted here that alternatives to cultural competency, as a response to client diversity, exist. Anti-oppressive practice, for example, is used in working with both disability and CALD groups by various disciplines. This approach responds to diversity from the perspective of power relationships and client vulnerabilities in the context of both direct service delivery and wider social inequities (Dominelli, 2002; Martin and Younger, 2000; Hart et al., 2003; Sakamoto, 2008). Critical race theory addresses ethnicity (and 'race') from a similar viewpoint, that of structural inequalities and the discourses which contribute to these, as well as including post-colonial critiques of the unique position of Indigenous communities (Brown, 2003; Ford and Airhihenbuwa, 2010; Barker, 2010; Meekosha, 2011).

The concept of cultural safety emerged in New Zealand at the same time as cultural competence, with particular reference to the provision of services to Maōri communities (Ramsden, 1990; Sherrard, 1991). It now often used in conjunction with cultural competence approaches (Rowan et al., 2013), but retains its post-colonial stance, an underlying concern with power relations and structural inequalities, and a specific focus on Indigenous and other traumatised communities, including refugees (Reavy et al., 2012).

3.1.4 What do we mean by diversity?

Many cultural competency frameworks and strategies utilise only the notion of culture as a primary indicator of their concern. In these cases culture is often a shorthand for ethnicity, meaning that the framework addresses issues of how characteristics like language, cultural and religious practices and perspectives and social and societal experiences (including those leading to disparities and disadvantage) may affect the concerns, capabilities and capacities of specific groups.

Diversity, in comparison, refers to the broader range of human expression. As such, it can be used as a *normative descriptor*, meaning that it can be used to indicate the range of human ways of being and their expression (ethnicity, culture, disability, religion, gender, age etc). It is at the same time, a *critical account* of the social inclusiveness of individuals and groups within organisations, systems and societies. Finally, it can be used as an *imperative for equity*, that is, as a shorthand way of referring to the discrepancies or differences in access, utilisations, quality or outcomes which occur when the first two perspectives are combined (difference and inclusiveness) (Gardenswartz and Rowe, 1998).

As the CDCF has been designed specifically address both ethnicity and disability, the wider term “diversity” is included to flag this broader perspective. Kreitz defined diversity as “... *any significant difference that distinguishes one individual from another*” (Kreitz, 2008: : 102). This includes differences which individuals may choose (or not) to disclose.

3.2 Why use the CDCF?

Many disability services want to or need to reach out to clients and communities. All want to provide the best quality support possible. Delivering services to people from CALD backgrounds can seem, and indeed be, complex. But so too is the delivery of services which meet the needs of people with a variety of disabilities.

Experience and research shows that many of the strategies utilised to improve service delivery to CALD communities also improves the quality of care provided to all individuals. This is because the strategies address issues that are relevant to all clients: knowing your existing and potential client base; establishing strong and positive relationships between clients and carers; and continually striving to improve the quality, safety and outcomes of care. But why, specifically, should disability services use the CDCF?

3.2.1 Access: ethical and regulatory requirements

The CDCF is based on the assumption that disability services are committed to providing the best possible service to all their clients. The ethical requirement to do so come from four sources: professional ethics (that no service provider should provide a lesser service to an individual because of any characteristic, be this age, sexuality, ethnicity, socio-economic status, disability); regulatory

requirements (in terms of anti-discrimination legislation, with the recognition that this may apply in different ways depending on the type of organisation providing the service); registration requirements (both professional and organisations); and compulsory or voluntary accreditation standards. One of the reasons cultural competency has been utilised so widely in the United States is because it is embedded in both their state and federal regulations (Truong et al., 2014).

The UK Acheson Inquiry into health inequalities outlined how the principle of equity should operate. For Acheson, the equity principle means 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] (Acheson, 1998).

For many disability services having strong roots in a historical commitment to social justice and equity with and for PWDs provides the baseline for the CDCF. Ethical considerations go beyond the question of following the letter of the law in terms of service provision. They relate also to how the individual client, staff member and/or their communities are viewed by the service: is being from a CALD background seen as an additional difficulty or deficit to be surmounted (in the way that PWDs can be viewed by some 'generalist' services) or is it seen as part of a strengths perspective, where what the individual and community bring to the disability context can increase the complexity, but also the value of their work (Fawcett, 2014; Trajkovski et al., 2013)?

3.2.2 Utilisation: disabilities and disparities

There is little systematic evidence, but what evidence is available would suggest shortfalls in CALD communities, families and individuals' access to and utilisation of disability services. In the health field, this shortfall is denoted as a 'disparity' that is a differential outcome which can be attributed to an individual's ethnicity when other factors (such as socio-economic background) have been accounted for (Lewis, 2009).

The Institute of Medicine's (IOMs) report "Unequal treatment" (2009) identified a number of barriers which can contribute to differences in outcomes. While these have been shown to operate in a health, rather than

disability context, there is a substantial body of practice evidence which would suggest they are worth considering in both contexts. Modified with disability services in mind, these include those identified in Table 1, below.

TABLE 1: SOURCES OF DISPARITIES

LEVEL	SOURCE OF DISPARITIES
Client	<ul style="list-style-type: none"> • Individual preferences • Perceptions of appropriateness of services • Refusal of existing services • Underutilisation of existing services • Delay in seeking services
Providers	<ul style="list-style-type: none"> • Generalisations, stereotyping • Bias, prejudice, discrimination • Uncertainty on the part of staff • Diagnostic overshadowing (ie seeing only culture, or only disability to the exclusion of other issues or concerns)
Organisation	<ul style="list-style-type: none"> • Availability of services • Type and cost of services • Language barriers • Geographic barriers • Availability of alternative services • Availability of community based care

The IOM’s antidote for these factors does clearly apply to the disability context. Again, modified for the disability sector and the CDCF, these include: a review of the fragmentation of services; the strengthening of relationships between clients and providers; creating protections for clients; providing evidence based services; creating incentives for staff; utilising interpreters; supporting community based services; operating through multidisciplinary teams; conducting diversity education; and ensuring adequate data collection and monitoring.

3.2.3 Quality/safety of care and outcomes

Most of the research and practice conducted in cultural competencies has addressed issue of access and utilisation. This is partially because these elements (how many people from CALD are clients of the service, how many

services they use and for how long) are slightly easier to measure. The last two elements in our foundation for the CDCF, quality and safety of care and outcomes are poorly understood and measured.

The latest systematic review of cultural competency approaches published this year found only moderate evidence that cultural competency (in healthcare) resulted in improvements in access, utilisation and provider outcomes, but weaker evidence of improvements in outcomes for clients (Truong et al., 2014), although this might be due to a lack of 'methodological rigour' rather than the actual effectiveness of the interventions. This finding supports previous work, including in the disability sector which points to, but does not find clear causal evidence of the link between cultural competency interventions and improved quality of care (Betancourt and Green, 2010) and or client outcomes (Barksdale et al., 2012).

Whether an objective, across-the-board comparison is possible with the collection of NDIS data (at least for those covered by the parameters of the scheme) remains to be seen. However, one of the key elements of the CDCF is that it will assist organisations to establish and assess their own measures and outcomes, as a way of progressively improving outcomes for their clients. The CDCF can help disabilities service review and improve how they:

- Plan their services
- Collaborate with communities
- Communicate with existing and potential clients
- Establish and maintain professional relationships with clients, carers and communities
- Provide safe, high quality care
- Assess and improve their clients' satisfaction with services
- Undertake ongoing quality improvement
- Attract, develop and retain their workforce
- Support staff
- Build organisational capacity to deliver culturally competent, client centred care

3.3 The Business Case for Diversity

3.3.1 The research case for valuing diversity

The business case for responding to diversity is well examined and supported in the United States (Dreachslin, 2007). In Australia, the arguments for organisational responses to diversity have tended to draw on arguments of equity or social justice, anti-discrimination and human rights legislation and conventions and government multicultural policies (Tomlinson and Schwabenland, 2010) although there was some seminal work on the economics of diversity undertaken in this field in the 1990s (Cope and Kalantzis, 1997; Karpin, 1995).

A recent review of the research literature (Department for Business Innovation and Skills, 2013) has shown the nexus between these two rationale (good business sense and good ethics). They found that:

- There is evidence that **services have gained business benefits** from taking an equality and diversity approach;
- The economic and organisational context and the **actions of leaders and managers, including how diversity is to be managed**, are **crucial if full benefits are to be achieved**;
- **No single approach** to gaining value from equity and diversity has been identified, but one common and crucial feature is that diversity and equality must be embedded within the organisation's business strategy and **not simply an add-on or ad-hoc issue**.

A similar argument was made by Slater et al (2008) who found that organisations with a strong commitment to diversity (that is, one which is embedded in the corporate culture) outperform their peers. In order for this to happen, senior management must demonstrate visible and ongoing support for diversity, the organisation must clearly articulate their own business case for diversity, line managers must be held accountable for the implementation of diversity strategies, programs and approaches, and training programs directed at communications, conflict resolution, and team building must be provided.

Research from Harvard University (Hewlett et al., 2013) discusses how diversity translates into business success. In a study of 1,800 professionals, 40 case studies, plus focus groups and interviews, the researchers identified that

there were two types of diversity: inherent (that is, the traits that an individual is born with) and acquired (that is skills obtained from training and experience). Looking primarily at leaders, they found companies where the leaders displayed at least three inherent diversity traits (ie for example, the leaders included people with a disability, women, people from CALD) and three acquired diversity traits (eg people who had worked overseas) as 2-D organisations.

Companies with 2-D diversity were 45% likelier to report a growth in market share in the year prior to when the research was conducted and 70% likelier to report having gained a new market. They found that diversity adds to an organisation's ability to attract and retain new customers because team members and leaders with diverse backgrounds have a better understanding of "un-met needs in under-leveraged" markets. Even more compelling was the spread effect – if one member of a team shares a diversity trait in common with a client or potential client, their whole team is 152% more likely to understand that client's perspectives than another team.

As in the UK, the US study, the key differentiators for successful companies are the same. Leaders who value difference, a critical mass of staff from diverse backgrounds, and an organisation that supports new ideas and approaches through the allocation of resources, and establishing a culture where diversity and innovation are valued (Hewlett et al., 2013).

Ortlieb and Sieben (2013) have developed a typology of the range of competencies that CALD workers take to their organisations. These they sort into four categories. These include "mere" labour (readiness to work for a low wage; readiness to work in undesired jobs); competences not related to ethnic background (professional knowledge, skills, abilities; work experience); competences related to ethnic background (language skills; cultural skills and knowledge; networks and contacts, new approaches to work tasks); ethnic background itself (as a symbol for internationality, authenticity, adherence to fairness dictates and discrimination prohibitions).

While it may be easier to find a formula to calculate the value of "hard" skills such as language or networks, the symbolic importance of having a diverse workforce should not be understated, particularly for organisations seeking new markets. The "feel" of organisations can be linked to experiences of socio-cultural dissonance (Chau, 1989) that is where clients and communities do not

see themselves reflected in the organisational environment (including workers and physical representations such as images).

These the authors then link these competencies organisational approaches to diversity: *exclusion* (where no CALD workers are employed); *adding value through “mere” labour* (employing CALD people simply because they are willing to work for low or lower wages. A corollary of this is to employ highly skilled people of immigrant background whose qualifications aren’t recognised – but whose skills are still utilised at a higher level than would be expected from a non-skilled person in the same position, so for example gaining the benefits of individuals who have nursing or medical training working as an aid, in the process of monitoring clients, or providing physical care including identifying health issues of concern); *antidiscrimination* (driven by legal compliance and morality); *adding value through ethnic backgrounds* (where the competencies of the CALD workers are valued in and of themselves); and *learning* (where CALD workers provide new perspectives and approaches to work). Other organisational approaches to diversity include intercultural awareness and education training, managing diversity, valuing differences and anti-racism (Hyde, 2012).

Despite these positive findings, it is important to note that the overall business case for diversity is overall is mixed (Powell and Johns, 2015; Kochan et al., 2003), as is the value of having a diverse workforce (Joshi and Roh, 2007). This may be as much a methodological issue as an actual indicator of the importance of cultivating diversity. Multi-level and multi-faceted concepts like diversity are difficult to measure by the very virtue of their complexity. However there are enough indicators to suggest that well managed diversity can make a positive contribution to the organisational climate, work group performance and job satisfaction (Pitts, 2009) workplace learning, and the creation of new markets, increase market share and competitive advantage (Dreachslin and Hunt, 1996) and in some cases greater relative profits (Herring, 2009). As Kochan et al argues,

It may be that the business-case rhetoric has run its course. Diversity professionals, industry leaders, and researchers might do better to recognize that while there is no reason to believe diversity will naturally translate into better or worse results, diversity is both a labor-market imperative and a social expectation or value. Therefore, manages might do better to focus on building an organisational culture, human

resource practices, and the managerial and group process skills needed to translate diversity into positive organisational, group and individual results. (Kochan et al., 2003)

3.3.2 Organisational Assessment of the Business Case for Diversity

The complex and conflicted nature of the evidence for a generic business case for diversity, it is possible to construct a case for an individual service or organisation. Economic modelling is a specialist skill, but there are more generic models such as Porter's five forces tool (Porter, 2008) that can be utilised to assess a services potential benefit from engaging with the diversity agenda.

Porter identified five specific forces that determine competitive power of an organisation. These include:

1. Supplier power: that is, the more you need your suppliers, the more power your suppliers have over you, in short how much power your suppliers have to drive up prices. A CDCF example might be the demand for specific bilingual workers or workers who have knowledge of particular communities.
2. Buyer power: that is, how many buyers they are, how important they are to your business, how easy it is for them to move away from your service to another service, in short how easy it is for buyers to drive down prices. A CDCF example of this is how many people from CALD you lose due to lack of appropriately trained staff.
3. Competitive rivalry: that is, how many competitors you have and how their products compare to yours. A CDCF example of this might be the organisations with whom you are competing for specific CALD communities or CALD communities in general.
4. Threat of substitution: that is, how else your clients can get their needs met. A CDCF example of this might be how many clients would utilise a ethno-specific service rather than yours, if one was available.
5. Threat of new entry: that is, new organisations which will compete with you.

Other consideration in developing an organisational assessment of the business case for diversity includes reviewing the **demand side** of the model, including demographics such as the:

- True demand for your service by CALD communities, based by age and sex
- Active demand for services (ie how many people from CALD backgrounds you current supply services to and how many are on your waiting lists)
- Latent demand, that is the difference between true demand and active demand
- Benefits of increasing awareness of your service to CALD communities on the bottom line of service providers, community support network and family support network.

Other issues to consider on the **supply side** of the model, as well as Porter's forces:

- Is demand for your service is outstripping population growth
- Are there changes in the number of and type of service providers
- Are there changes in the service mix as profitability defines what services are provided (which in turn will have an impact on efficiency, comprehensiveness and effectiveness of services offered)
- Where, when and what will happen if the demand to service ratio is unprofitable?

Indicators you might consider could include:

- What additional value or profit can be gained from meeting the CDCF standards?
- Where will you be able to access comparative benchmarking data and provider insights/
- What internal and external key performance indicators will you/have you met (eg the National Standards for Disability Services)?

What **levers** are controlling the sector and your organisation at this time?

- Community awareness of your service?
- Funding availability?

What internal and external **monitoring and feedback mechanisms** will you/have established?

- Service profitability, service levels, adequacy of service who, where?
- What databases, data collection, reporting mechanism you have, or do you have access to?

These elements provide a strong framework within which disability organisations can begin to judge the value of a commitment to diversity through the CDCF. As research has shown the balance needs to be between the economic and ethical commitment for organisations.

3.4 What does the CDCF involve in terms of resources?

The CDCF has been designed to integrate into general planning and quality improvement processes. The aim is that ***the CDCF becomes*** not something done in addition to, but ***an integral part of your organisation's work***.

This means that the CDCF framework should be utilised as part of your organisation's prospective strategic planning process. As such, the major resources required are some time at the start of your planning cycle (although of course, the CDCF can also be used as part of any emergent strategic planning) to see how and where the issues the CDCF raises fit into your organisation's vision, mission, goal and objectives. Based on the research discussed previously (Slater et al., 2008), part of the process could also involve the identification of CDCF champions or leaders (particularly, but not solely at senior executive level), willing to publicly support the process and provide guidance and support to other staff.

Team or service improvement or development projects, along with the development of staff, should be supported by adequate time and resources, but these can be implemented gradually. Tools to aid in the development of such projects will be produced as part of this project.

Three approaches: appreciate inquiry, learning organisations and or practice development approach are suggested as the change mechanism for the CDCF. Each of these approaches is in line both with the fundamental philosophies of the disability sector, and each allows the organisation or service to choose its rate and scope of change.

Appreciate inquiry (AI) starts from the perspective that is more important to identify and strengthen what an organisation or team is doing well, rather than blame and shame (provided of course what is not going well is neither illegal or dangerous to clients or staff) (McAllister and Luckcock, 2009; Moore, 2008). AI is in line with current theories about building the resilience of individuals and of organisations, which in turn is based on ideas of strengths based approaches and positive psychology, well known in the disability field.

Learning organisation approaches focus on supporting organisations to undertake double or even triple loop learning (Argyris and Schon, 1978). These involve (amongst other factors) identifying issues of concern and then taking an action research approach to identifying and implementing appropriate solutions, that is essentially, contained forms of trial and error. These approaches have, in supportive environments, produced effective results including higher levels of innovation and problem solving – attributes and outcomes which support a successful response to the complexity increased diversity brings to an organisation (Senge, 2006).

Practice development emerged from nursing, and takes a person centred approach to quality improvement. The approach requires skilled facilitators who work with small work groups to identify problems that require collective solutions and then support them in identifying appropriate solutions (McCormack et al., 2013).

3.5 What are the benefits of using the CDCF?

For clients, the CDCF will provide a recognition that they are seen and responded to as an individual within the context of the communities, that their concerns are acknowledged and recognised, that the service takes these concerns seriously, and treats them with respect.

For staff, the CDCF recognises the complexity of their work, values their full range of competencies, encourages and supports them to develop new or building on existing competencies and experience, and gives them the opportunity to identify, improve and innovate their and their organisation's work.

Disability services will benefit from the CDCF by ensuring that: they have a reputation for providing the best possible care to all clients; that they have an

evidence-based understanding of clients, communities and staff needs and expectations; that they build a culture of innovation and continuous quality improvement in clients' experience of care; and that they build their organisational capacity for resilience, responsiveness and sustained innovation and change.

4. The CDCF Framework

The organisational elements of CDCF is a model based on an extensive review of the research and previous work conducted and tested by Travaglia and Robertson (2001) as well as the findings from Leotta's study (2013). Figure 4 outlines the key elements of the model, and Table 2 some of the key questions for organisations, measures and proposed tools for organisations. These will be aligned with the findings from Leotta's report (2013). These will be modified and tested during phase III of the study.

Figure 4: Organisational cultural competence model (Travaglia and Robertson, 2001)



TABLE 2: ORGANISATIONAL CULTURAL COMPETENCE MODEL: KEY QUESTIONS AND SAMPLE MEASURES

Area	Questions	Sample measures
Population	<p>What are the parameters of the population(s) with whom you could be working?</p> <p>Who is in your current client group(s)?</p> <p>Who is missing?</p> <p>Which groups should or could you be targeting? How do you identify these groups?</p> <p>Are there emerging groups which will require your services?</p> <p>How do you track these emerging groups and changing circumstances?</p>	<p>Information collected and utilised on diverse population groups</p> <p>Information collected and utilised on current clients</p> <p>Process for identifying gaps</p>
Place	<p>Does your organisation and service reflect the diversity of its existing and or potential clients and staff?</p> <p>Does your organisation feel culturally safe?</p> <p>Are your clients reflected in the informational materials you produce?</p> <p>Are there places within your service that meet the needs of CALD clients and staff (eg prayer rooms)</p> <p>If your services provides catering, does this reflect the client and staff profile?</p>	<p>Individual and organisational environmental measures</p>
Personal	<p>How does the attitude of your staff and your organisation align with</p>	<p>Individual and organisational client</p>

Area	Questions	Sample measures
	<p>those of client centred and client directed care?</p> <p>Does the organisation and its staff treat each client with respect?</p> <p>Does the executive and its staff treat each staff member with respect?</p> <p>Are all clients cared for according to their needs (within the parameters of your service delivery)?</p> <p>Do you and your staff display cultural humility?</p> <p>Is there an ongoing dialogue between the organisation, staff, clients and community?</p>	<p>centred care measures (modified for CDCF to include CC)</p>
Philosophy	<p>What are the values that underpin your organisation?</p> <p>How do the values of your staff align with your espoused organisational values?</p> <p>How do your organisational and personal values align with a commitment to cultural competence, cultural safety, and valuing diversity?</p> <p>How does the physical environment of your organisation demonstrate a commitment to CC?</p>	<p>Individual and organisational client centred care measures (modified for CDCF to include CC)</p>
Policy	<p>Which, if any of your policies, planning and reporting processes specifically address diversity issues relating to language, culture and religions?</p>	<p>Method of policy review</p> <p>Range and appropriateness of CC policies</p>

Area	Questions	Sample measures
	<p>How often do you review organisational and regulatory policies to ensure that diversity perspectives are included?</p> <p>Do you have any policies which specifically address CC issues? Why or why not?</p> <p>How do clients, carers and members of the CALD communities input into policy and procedure?</p>	<p>Evidence of diversity requirements embedded in policies, planning</p> <p>Evidence of policy monitoring and implementation</p>
Planning	<p>Is the leadership of the organisation involved in planning, program and resource allocations for culturally diverse clients?</p> <p>Is the leadership or the service or the organisation involved in evaluating the service response for this client group, and consolidating good practice within the organisation?</p> <p>Where and how are clients, carers and members of CALD communities included in the providing advice and feedback to the organisation on planning, policy and programs processes (eg through advisory groups and client feedback)?</p> <p>How do you reach out to isolated members of communities, specific groups (e.g. refugees, children and youth) or people who are not aligned with mainstream representative bodies?</p>	<p>Methods of community engagement</p> <p>Degree of reach</p> <p>Understanding of limits of community organisations</p>

Area	Questions	Sample measures
	<p>What mechanisms for involvement do you utilise?</p> <p>How early in your planning processes are they involved?</p>	
Personnel	<p>Does your organisation recruit for cultural diversity expertise for its generalist positions?</p> <p>Is your staff culturally, linguistically and religiously diverse and reflective of the community you service?</p> <p>Does your staff demonstrate cultural competence?</p> <p>Do you support the development of cultural competence in your staff (through training, development experiences)?</p> <p>How does your staff profile reflect the clients you would like to/need to attract?</p> <p>Does your staff profile enable your organisation to meet the needs of all your clients?</p>	<p>Organisational CDCF measures (including staff demography)</p>
Practice	<p>Is your organisation's leadership fully committed to the CDCF?</p> <p>How is this demonstrated?</p> <p>What level(s) of cultural competence does your staff possess?</p> <p>At which levels? (Executive, management, practitioners, administration, ancillary staff)</p> <p>How do you know?</p>	<p>CC measures and assessment mechanisms (modified for CDCF)</p> <p>Organisational CDCF measures (including staff training and development)</p>

Area	Questions	Sample measures
	<p>Do you have CDCF champions within the leadership?</p> <p>Do you have CDCF champions across the staff?</p> <p>Do you have staff with specialist areas of expertise in working with people from different language, religious and cultural backgrounds?</p> <p>How is this expertise and good practice shared within the organisation?</p> <p>What support and development do you provide your staff in relation to CC practice?</p> <p>Are executive, management, professionals and staff engaged in ongoing dialogues with each other and with clients and their communities?</p> <p>Does everyone in the organisation practice deep listening?</p>	
<p>Programs</p>	<p>Are clients from different language, religious and cultural backgrounds accessing programs?</p> <p>How do your organisations' Programs/services/practices address the needs of your actual or potential clientele from diverse backgrounds?</p> <p>What evidence supports this?</p> <p>Are generalist staff trained on a service response for culturally diverse clients - working with interpreters, able to accommodate issues of cultural and religion in</p>	<p>Organisational CDCF measures (including range of products and services, uptake by different communities)</p>

Area	Questions	Sample measures
	<p>program delivery, assessment and support planning?</p> <p>What specific programs/practices do you have which address the needs of CALD communities?</p> <p>What new Programs/practices might be needed to respond to changing needs in the community?</p> <p>How often are your programs reviewed and evaluated? By whom? Do you invite feedback from CALD communities? If so, how?</p> <p>Do you share good practice within the organisation, to encourage continued learning and program development?</p>	
Products	<p>How do your products (including pamphlets and educational and informational materials) reflect the diversity in Australian society?</p> <p>Do you review your educational informational materials for appropriate levels of general and health/disability literacy?</p> <p>Do you translate your materials?</p> <p>Do you engage and partner with ethno-specific and multicultural organisations?</p> <p>Do you conduct community education? Outreach?</p> <p>How do you measure client satisfaction? Do you include specific measures for CALD clients?</p>	Organisational CDCF measures

Area	Questions	Sample measures
	Do you translate satisfaction surveys?	

4.1 The organisational journey

Throughout this project a key concept was that any organisation should be able to pick up the CDCF and apply it to their organisation in a staged fashion. The cultural competence model above, which provides the heart of the core areas of the CDCF can be integrated into an organisation's existing strategic plan or used to create a new one.

Organisations can either choose to focus on one element at a time – that is to address population first, then place, then personal and so on as these have been arranged in a logical sequence. Conversely, a service might choose to pick only key elements or questions with which to engage as a starting point – so, for example, staff recruitment. The tools associated with the CDCF, including its online presence and full implementation package (with information and supporting materials) will enable organisations to proceed in a logical manner, but at a pace that is suitable to them.

5. Implementation guide

The conceptual framework which underpins CDCF is a model based on work by Travaglia and Roberston (2001) but further developed through research into culture change, organisational responsiveness and resilience, and organisational competence. The CDCF includes five key factors required to enable and sustain a culturally competent organisation or service. These are:

1. Proactive engagement with clients, carers and communities
2. Collaboration within and across disciplines, units, teams, organisation and sectors
3. Sustained dialogue and development between clients, carers, communities and practitioners
4. Critically reflective practice
5. Transformational leadership

5.1 Ensuring the success of change

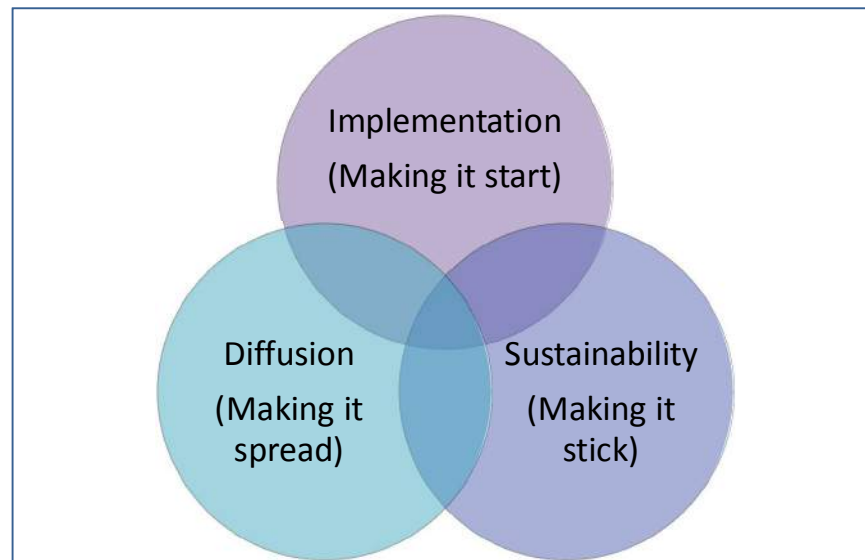
The implementation of any new approach or strategy is fraught with difficulties. One of the most oft cited studies in change management claimed that over 70% of all new change initiatives fail (Nohria and Beer, 2000).

In developing the CDCF there was a clear commitment to all parties involved that the end product should not simply be a set of competency standards. Over 70% of all change management programs fail. The costs are high. Staff can lose confidence in the organisation's commitment and capability to change. Communities and clients lose trust that anything is every going to change. Managers and leaders lose patience at the slow rate of change amongst staff and there can be a lack of appreciation amongst service users as to how hard change really is.

Bate et al (2008) provide some insight into why change strategies fail. For a start, many focus their efforts on only the first element of change - that is, the implementation process. These change programs focus on the challenge of implementation that is the introduction of changes (including most often new guidelines or policies, some training, and some restructuring).

But they often fall short on the next two steps. The implementation process does not include strategies for the two most important elements of change, which are the challenge of diffusion (making the change reach across the whole organisation) and the challenge of sustainability (making change last).

FIGURE 7: THE CHALLENGE OF CHANGE (MODIFIED FROM BATE ET AL 2008)



Factors such as organisational readiness for change (Williams, 2011), potential barriers and facilitators (Beune et al., 2011; Grol and Wensing, 2004) and mechanisms for spread, all need to be assessed and considered before the process commences (Greenhalgh et al., 2004).

One of the issues that complicates all change strategies, including cultural competency strategies, is that ‘one size does not fit all’ (Alegria et al., 2010). The research that is available has shown that interventions that work in one setting may not be transferable elsewhere (Bhui et al., 2007). This speaks to the need for organisations to select strategies with their specific context in mind: the goal is achieving equitable access, utilisation, quality/safety, and outcomes, but the processes need to be appropriate to the specific context of both the service and its clients.

5.1.1 Implementation (making it start)

One of the most common mistakes made by organisations wanting to implement an improvement strategy is to ignore the fact that all organisations have their own particular histories and that individuals and communities have memories. As we noted earlier, attempts at addressing cultural competency

and diversity are not new in Australia, with serious systematic consideration of these issues since at least the publication of the Galbally report in 1978 (Galbally, 1978) which amongst other innovations brought forth the Australian system of professional publicly funded interpreters and the Special Broadcasting Service.

The 40 year history of cultural diversity policies and strategies in Australia has resulted in a patchwork of responses from governments, departments and services. As Dass and Parker note, organisational responses can be episodic, freestanding or systemic (1999). The episodic nature of attempts to improve cultural diversity need in particular to be acknowledged and addressed, otherwise the “we tried this in 1993 and it failed” response is inevitable.

In order to establish and implement a cultural diversity framework a number of conditions should be in place. These include: creating an organisational vision for cultural diversity; a commitment by the executive, leaders and champions across the organisation; undertaking a cultural diversity audit; inclusiveness as a core value; and the recognition of diversity as a part of core strategic planning (including creating a compelling argument for undertaking the approach; an organisation-wide commitment and involvement in the project including the commitment of resources; executive sponsorship of and responsibility for the plan; clear goals which form part of the organisations overall strategic plan and key performance indicators (individual and organisational); and a set of metrics to measure achievement of those goals) (Williams, 1999; Aronson, 2002).

5.1.2 Diffusion (making it spread)

Researchers in the health and welfare fields have increasingly become concerned with what makes good ideas spread within and across institutions. The value of new approaches cannot be realised if they remain operative only as sidelines to the “main” or “real” business of the organisation. Some disability and multicultural units have in the past, been classic examples of this. When integrated and influential in shaping organisational strategy, policy and approaches, monitoring quality and outcomes as well as access and utilisation, and where necessary providing specialist services, they have assist in ensuring that the organisation’s culture as a whole is inclusive. Where they have operated as citadels or dumping groups (for both clients and staff), their impact was limited to symbolic representations (the ubiquitous “multicultural days”) or marginal adjustments.

5.1.3 Sustainability (making it stick)

How then can we make the CDCF innovation stick? Rogers (2010) argues that all innovation (be it new ideas, practices or artefacts – including tools such as the CDCF) are influenced by a combination of the innovation itself, the adopter (individual or organisation) and the environment within which the innovation is to be implemented. The success of any innovation, he argues is influenced by the: perception of the relative advantage of the change; the compatibility of the innovation with the existing structures; the degree of difficulty in making the change; the extent to which it can be trialled with limited resources; and the visibility of the outcomes. These elements are supported by other change theorists, but in particular Kotter (Kotter, 2012; Kotter, 1995) and Fullan (Fullan, 2001; Fullan, 2008).

5.1.4 Taking a positive approach to change

Positive organizational scholarship or positive organisational review (POR) is a relatively new approach to reviewing organisations, similar to that utilised by appreciative inquiry (Havens et al., 2006) and resilient health care (Wears et al., 2013). It examines the ways in which organisations produce good outcomes, but seeking out the organisational (systems, structures, capabilities), team (positive relationships) and personal (accountability, engagement) enablers that produce positive results (Dutton and Glynn, 2008; Cameron and Caza, 2003; Routledge, 2008; Losada and Heaphy, 2004).

This approach is particularly relevant to the CDCF. As discussed across this report, disability services already engage in many of the most effective elements required of cultural competency, including client centred and client directed care. The research project linked to the CDCF will be the first of its kind to systematically explore how the current practice of disability services can be extended further into addressing CALD diversity issues.

Once again we are mindful that the lack of systematic, published research does not represent a lack of practice or indeed a lack of research: in Australia there is a well-established tradition of specialist services who have worked with generalist mainstream providers (for example the Ethnic People with Disability Program in NSW and Action on Disabilities for Ethnic Communities program in Victoria, amongst others), many of whom have published important and ground breaking reports in this field.

A positive approach has also been chosen to counteract some of the residual impact of inappropriate, incomplete or incompetent approaches to cultural diversity development in the past. While there are serious structural and social inequalities that still need to be addressed in some services, including overt and covert discriminatory practices and ensuring the cultural safety of clients and staff, there is little evidence (as discussed previously) that a blame and shame approach improves the quality of service provision or its outcomes and much evidence that demonstrates the exact opposite in the broader health and welfare field (Woodward et al., 2009).

5.2 What needs to change?

Hindsight (looking backwards, reflection) gives insight (appreciation and understanding – sense making) which gives foresight (a view of how to get better at what we do in the future – perception and direction). (Bate et al., 2008: : x)

What needs to change if the CDCF is to be fully implemented? Three things: practice, culture and discourse (Waring, 2007). An organisation that wishes to adopt the CDCF needs to consider a flexible approach to service delivery. It is this flexibility, along with the CDCF which provides suggestions with a range of strategies, that enables organisations to respond effectively to a wide range of concerns. This change of practice applies both to the individuals within the organisation and the organisation itself.

Cultural competence demands that clinicians develop flexibility in thinking and behavior, because they must learn to adapt professional tasks and work styles to the values, expectations, and preferences of specific clients. This means that practitioners must choose from a variety of strategies that are useful for the range of cultural groups and social classes, levels of education, and levels of acculturation that exist among clients. (Pinderhughes, 1989: : 163)

One of the most of commonly cited definitions of organisational culture is “how we do things around here”. It is evident in organisational structures, policies, and even its physical environment, all of which are included in the CDCF (Nybell and Gray, 2004). Organizational culture has to be open enough and supportive enough to allow for the integration of the CDCF, which in turn needs to help shape the culture of the organisation so that responsiveness to

CALD communities is viewed simply as part of the daily routine. As Truong et al note:

Embedding cultural competency in organizational policy documents such as position statements and strategic plans are more likely to result in sustained change within organizations. There should be a commitment among the leadership of the organization and embedded key performance indicators supported by allocated resources. (Truong et al., 2014: : 14)

Discourse is a shorthand term for a complex way of understanding how human beings communicate and what meaning and power relationships are situated within and through the use of that communication (Alvesson and Kärreman, 2000). Both the disability and cultural diversity fields are replete with discourse analysis as theoreticians and practitioners grapple with how (for example) a valuing diversity compared to a tolerating diversity discourse might affect the lives of individuals and groups (Tomlinson and Egan, 2002; Lewis, 2005).

The seemingly esoteric nature of this approach belies its very practical application. Discourses are the sum total of how organisations and their staff, speak about, write about, represent (in image as well as in words), and respond to clients and staff. It is as much about what is not visible or spoken about (including difficult topics like racism and discrimination, which can apply to both clients and staff) as about what is. While disability services have a long history of inclusive approaches and inclusive language towards people with disabilities, this has not always translated to responsiveness for PWDs from CALD. The CDCF has been designed and will provide assistance with, this transition.

What ties together these three elements – practice, culture and discourse – is leadership (Guerrero and Kim, 2013). A commitment to the CDCF requires a commitment to transformative (Caldwell et al., 2008) and distributed leadership (Chreim et al., 2010) across the organisation.

6. Change process and tools

It is anticipated that in subsequent phases of this project specific support tools will be developed for those implementing this framework. This section provides an outline of the evidence base for a number of potential tools which could be employed by organisations wishing increase their cultural competence.

Sustainable change requires a sustainable approach to responding to the needs of all existing and potential clients (Travaglia and Roberston, 2001). This change model has been tested in the field and will be further modified for diversity services. It utilises appreciative inquiry and resilience approach (work out what we are doing well, strengthen those elements, and then address areas of improvement) combined with practice development and communities of practice (providing support for services and staff in a self-sustaining manner). Materials and tools associated with these approaches will be developed in the following phases of the CDCF process.

FIGURE 8: CDCF CHANGE PROCESS



6.1 Positive Organisational Review (POR) audit

Organisations and the individuals who operate within them, have and can choose to respond to cultural and other forms of diversity in numerous ways. These perspectives can be: *defensive* (resistance, denial or suppression some or all forms of “difference”, “tolerating” difference), *reactive* (meeting basic regulatory responsibilities, focusing on access and utilisation) or *proactive* (seeing diversity as part of organisational learning, relationship building approaches) (Thomas and Ely, 1996; Dass and Parker, 1999; Chemers et al., 1995; Podsiadlowski et al., 2013).

This continuum has also been labelled as the five diversity perspectives: reinforcing homogeneity, being colour-blind (i.e. not “seeing” difference, treating everyone the “same”), taking a fairness approach (recognising and addressing inequalities and inequities), focusing on access (positively valuing diversity, using it to build a broader client case), and addressing diversity as an integral part of the organisation and its learning (Podsiadlowski et al., 2013).

The first step in the CDCF process will be a Positive Organisational Review (POR) audit. This audit, based on the CDCF framework in section three of this report, will seek out the aspects of service delivery within individual organisations which actively align with the framework. The audit will be used as the basis for:

1. Planning for a diverse client base
2. Creating mechanisms for ongoing, sustained, community and consumer engagement
3. Building organisational and service capacity including, but beyond champions
4. Creating supportive management strategy including goals, plans, policies, procedures and quality control
5. Promoting and supporting attitudes, behaviours, knowledge and skills necessary for staff to work effectively with clients and each other
6. Creating active recruitment and retention strategies for skilled staff

6.2 Organisational development

The CDCF is based on the principle that the recognition and valuing of diversity applies not only to clients but also to staff. This is done for all the same ethical, governance and regulatory issues as the recognition of culture and diversity in clients, but with an added element. Research has consistently shown that the recognition of diversity leads to better workplace environment (leading to increasing the attraction and retention of staff) (Stahl et al., 2010; Gonzalez and Denisi, 2009) and to improved staff performance, productivity and problem solving abilities (Mannix and Neale, 2005; Williams and O'Reilly, 1998). The US Government Accountability Office commissioned a report looking at the best practices of diversity management and identified the following nine practices:

- *Top leadership commitment: a vision of diversity demonstrated and communicated throughout an organization by top-level management*
- *Diversity as part of an organization's strategic plan: a diversity strategy and plan that are developed and aligned with the organization's strategic plan*
- *Diversity linked to performance: the understanding that a more diverse and inclusive work environment can yield greater productivity and help improve individual and organizational performance*
- *Measurement: a set of quantitative and qualitative measures of the impact of various aspects of an overall diversity program*
- *Accountability: the means to ensure that leaders are responsible for diversity by linking their performance assessment and compensation to the progress of diversity initiatives*
- *Succession planning: an ongoing, strategic process for identifying and developing a diverse pool of talent for an organization's potential future leaders*
- *Recruitment: the process of attracting a supply of qualified, diverse applicants for employment*
- *Employee involvement: the contribution of employees in driving diversity throughout an organization*

- *Diversity training: organizational efforts to inform and educate management and staff about diversity.* (United States Government Accountability Office, 2005)

A culturally competent system or service responds appropriately to all its staff and clients at every point of their contact with organisation, from record keeping and information provision, to recruitment, selection and training of staff, throughout service provision, and issues such as psychological and physical environment. As a result the CDCF approach requires ongoing monitoring, development and evaluation of organisational responses to all forms of diversity. This includes organisational responsiveness to: **structural and systemic requirements** (including legislation, policies and procedures, planning and resource management); **frameworks** (including organisational, access, equity, anti-discrimination and human rights); **environment** (including 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); and **quality** (including monitoring, evaluation, improvement and research).

6.3 Workforce development

The CDCF approach to workforce development requires the identification of the current levels of cultural competence within and across all staff – professional, administrative and ancillary, followed by the development of these competencies to their optimum levels through training, education and a range of professional development activities. In order to be considered culturally competent, a staff member must be able to demonstrate a range of abilities which demonstrate their attempt to respond appropriately and effectively to every client.

These abilities, whilst based on sensitivity and awareness to cultural differences, extend beyond attitudes, and include a complex and critical knowledge of, and the skills associated with, being able to manage and modify processes and activities in a way which ensures an effective outcome for the individual client, whilst retaining one's professional, organisational and ethical integrity. Mechanisms to support this process can include:

- Diversity training (face-to-face, DVD, internet based) and or coaching;
- Education through existing higher education providers;
- Training programs run in conjunction with community groups and specialist services;
- Recognition and reward of existing cultural competencies;
- Inclusion of cultural competency in performance agreements and job descriptions;
- Alignment between individual and organisational competencies.

6.3.1 Cultural diversity training

Perhaps the longest and most well established tool for cultural competence is the use of cultural diversity training, and has been shown to increase cultural competence amongst different professional groups (Pearson et al., 2007; Lie et al., 2011; Vega, 2005). As with all training, results can be mixed, but more importantly, as with all training where individuals' values and attitudes are challenged, 'bad' training can have devastating effects.

The impact of cultural diversity training is mediated by organisational culture. Training of staff who then return to services, units or teams where it is 'business as usual' provides limited benefit. For training to work, the workplace culture and environment, its leaders and managers, need to support and encourage the changes they expect in individuals (Lie et al., 2011; Paez et al., 2008).

6.3.2 Employment of specialist workers

Modification of existing programs or the creation of new ones to meet the specific needs of CALD communities, including employing bilingual workers, can open up services to a wider range of clients and assist them to better meet the needs of existing ones (Anderson et al., 2003; Fisher et al., 2007; Henderson et al., 2011). Both Fisher et al (2007) and Henderson et al (2011) found that the employment of ethno-specific and or bilingual community workers and organisational brokers (or case worker) improved outcomes for CALD communities.

The demand for care workers has opened up the field to individuals of a variety of backgrounds, skill levels and experience. Australia has had a culturally

diverse workforce for decades, but these skills have not always been recognised or utilised appropriately (Kalantzis and Cope, 1995).

6.4 Evidence based practice (EBP)

Although seemingly self-evident, evidence based practice (EBP) is relatively new in the field of health, disability and welfare services. The aim of EBP is to ensure that decisions and interventions are supported by the best data, information and knowledge possible. The EBP movement now includes professional practice, but also evidence based policy and evidence based management.

In terms of cultural competency, as discussed earlier in this document, the evidence base can be limited. Yet in order for organisations and services to assess whether they are meeting their goals, systematic forms of data collection are required. At the level of individual workers there are numerous self, peer and staff assessment tools. In relation to organisations, there are fewer assessments available, fewer still that are Australian, and none that could be identified which specifically addressed cultural competency assessments for disability services. As Podsiadlowski et al. (2013) notes,

“... no study has shown how diversity is or is not approached in organizations in a quantifiable, systematic, and comparable way; nor have we found any study that showed how a specific diversity management strategy is supported by specific measures.”

One suggested form of organisational data collection which has been suggested is the use of document review (Bowen, 2008). In general, the CDCF will focus on two types of EBP. The first is the use of the latest available research to support the development of the Framework and its associated tools. This means evidence from cultural competency and diversity research of course, but also includes the latest evidence on organisational change and innovation, client centred and directed care, disability and diversity studies, and professional and staff development.

At a second, more pragmatic but equally important level, the CDCF will assist organisations to assess the types and level of evidence they wish to collect from within their own organisations. These including questions about data

(raw numbers), information (contextualised data) and knowledge (actionable information) including:

- What kinds of data, information and knowledge to collect?
- How to capture data, information and knowledge?
- How to manage data, information and knowledge?
- What to do with data, information and knowledge?
- Where to go for additional data and information?
- How to identify legitimate and useful data, information and knowledge?
- What client data to collect?
 - Country of birth (COB)
 - Language(s) spoken
 - Age
 - Sex
 - Literacy – language(s)
 - Health literacy
 - Religious affiliation
 - Other

6.5 Partnerships, alliances and engagement

At the heart of the CDCF is the principle of a relational mode of operating. This means recognising and responding to clients within their familial and community contexts, but it also requires an organisational commitment to the same approach within, and perhaps beyond, the disability and diversity sectors. No individual organisation, no matter how committed, can respond by itself to all forms of diversity, and nor should it be expected to.

The establishment of partnerships and alliances with community and advocacy groups for the purposes of consultation, evaluation and research and the active engagement of clients in service decisions enhance both the

organisations' and practitioners knowledge about CDCF issues and strengthens knowledge and trust between community and the service (Chrisman, 2007; Taylor et al., 2013). This approach requires both organisational and professional humility (Alsharif, 2012) and a deep listening approach (Swendiman, 2014), both of which will be integrated into the CDCF tools.

6.6 Evaluation and Innovation

The CDCF is based on the principle that even small changes can result in big improvements for services. In order for these improvements to be sustained, disability organisations need to commit to a process of continuous quality improvement. Numerous models of CQI exist, including the CDCF, which by its circular nature demands a constant review and evaluation of client and organisational outcomes.

The creation of communities of practice (Ranmuthugala et al., 2011; Boud et al., 2006) and the use of practice development theory (McCormack et al., 2009; McCormack et al., 2011; McCormack and Garbett, 2003; Wright and McCormack, 2001), which is widely utilised to create cycles of practitioner directed innovation and evaluation and which has been used extensively in the support of client centred care are both strategies which align with the philosophy and practice of the CDCF approach.

Closely aligned to the practice development approach is the use of action learning sets (Revans, 2011). Action learning establishes a team or 'set' of practitioners who work with a facilitator or coach (although these are not essential, and they themselves often work to build capacity in the team until they are no longer needed) to identify a problem that is important, critical and complex and then examine it from a place of inquiry and reflection. The set is committed to both action and learning.

6.7 Customising the CDCF

This report provides the broad structure and background for the CDCF. It is envisaged, however, that customisation of some competencies, and associated strategies will be required. This may on the basis of the: type and function the service itself (where it is along the spectrum of CDC 'maturity', the type of services it provides, it's context (size, location, number of workers etc); type of disability/disabilities for which the service caters; and the

characteristics (eg age) of clients. In addition to these variables, the needs of specific groups, such as refugees and asylum seekers, people with dual disabilities, or isolated individuals (for example prisoners, CALD individuals in rural and remote settings) will need to be addressed.

7. Proof of Concept

A proof of concept (POC) or proof of principle is an approach which is commonly used in the fields of business, pharmaceutical and software development and healthcare, to demonstrate the feasibility of a concept or principle. The aim of POC is to verify that the concept or theory proposed (in this case the CDCF) has the potential to be used. It is generally accepted that a proof of concept is generally limited and does not necessarily need not be complete, nor does it require a single method of data or information collection (Taksler et al., 2013; De Caterina et al., 2012).

Proof of concept was sought from several bodies, to date four have been received. Katherine Orr from the National Disability Service provided material from an unidentified consultant against which the CDCF was applied. This is presented in Appendix B.1. This group provided the system level test. A disability organisation Inala, with limited experience CALD issues provided the organisation test (Appendix B.2). A rural professional (Mary Jackson) working in the disability field provided the professional and non- metropolitan test (Appendix B.3). Finally two experts in the field of diversity and disability (Ms Vivi Koutsonadis and Ms Mirella Di Genua) provided the expert individual and expert organisation test (Appendix B.4).

All participants agreed that the material presented in this document was proof of concept. Each provided additional input which was integrated into the CDCF and the document as a whole.

8. Conclusion

We have provided a detailed background to the importance of cultural diversity within the disability sector in Australia and a more global context for the changes and developments that will impact on disability care and support in coming years. This report and a variety of other sources clearly identify the continuing absence of cultural and linguistic diversity as key considerations within the wider disability sector and elsewhere in Australian society. The generational change embodied in the NDIS and its implementation through specific pilot projects are likely to evidence this issue, positively and negatively, on a case by case basis as local environments produce particular versions of a national scheme. The CDCF aims at supporting these developments proactively by ensuring that the focus is on competencies that align with existing ethical and policy requirements.

The purpose of the CDCF is to support disability organisations in their quest to ensure that their services are accessible, appropriate and accessible (able to utilised), of the highest quality and safety possible, and that they facilitate the best possible outcomes for all clients. This document provides the supporting evidence and a broad outline for the Framework and builds on Leotta's report (2013) and should be read in conjunction with that document.

As noted at other points in this report, the disability environment is in a state of considerable change. These changes include specific Australian developments, such as the NDIS, and a variety of rapid developments occurring at the international level that are likely to reshape disability thought and practice into the future. Disability is already a diverse sector but one which has lagged in terms of addressing CALD issues specifically and social diversity more generally. These issues are situated within a national pattern as evidenced by the absences in the current research base.

The opportunity to address these issues is now when major change has opened about established attitudes and approaches to disability service design and definitions. The changing demography of Australian society is being acknowledged by disability sector organisations and the next step is to build the capacity of organisations to take these steps. The aim of this report is to provide a platform for building the competency of the sector from top to bottom by ensuring CALD issues can be integrated into existing organisational tasks and goals.

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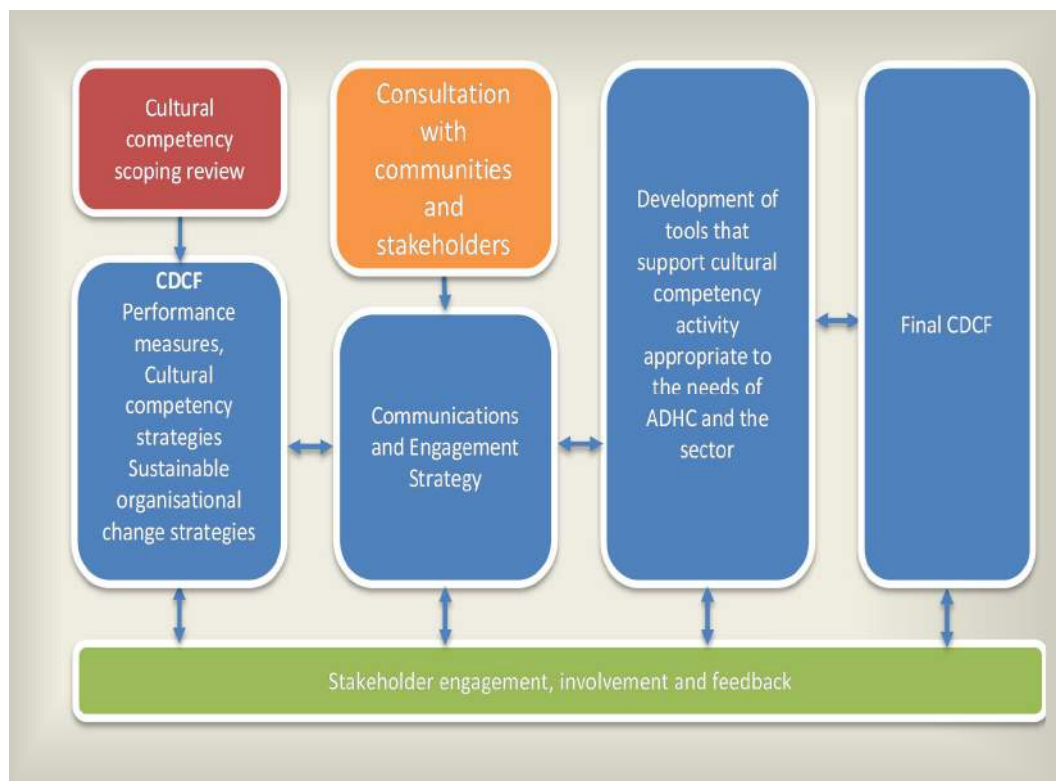
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9. Appendices

Appendix A: CDCF Project outline

The CDCF involves a three phase, multi-method research model, presented in figure 7. The project is driven by the reflexive participatory action research (RPAR) approach. RPAR seeks the active engagement of key stakeholders in the research, implementation and evaluation processes, and positions the researchers as collaborators with key stakeholders, rather than as distant experts. This approach to research facilitates the transfer of skills between the partner institutions and can facilitate the spread and sustainability of quality improvement innovations.

FIGURE 9: CDCF METHODOLOGY



CDCF is progressing through its first two phases, containing several sub-projects. This document is the result of the first phase which was finished in early July 2014. The final project report will be presented to the Project Steering Committee and EAG.

The initial phase of the CDCF development was undertaken by Ms Grace Leotta from Affirm Organizational Development and Training. Ms Leotta's brief was to: undertake a literature review, prepare and facilitate direct consultation with staff from ADHC direct and funded services and peak organisations, and analyse and synthesise information from a variety of sources to propose future cultural competency activity within ADHC and the ADHC funded sector. That report was completed in August 2013. That report provided the basis for the CDCF.

The brief for the CDCF was to: *assist ADHC to inform the move towards implementation of person centred approaches, individualised supports and NDIS [by embedding the principles of cultural competency in key policy, programs and practice. Understanding how these reforms can support clients, families and carers to meet their identified needs and goals and deliver the best outcomes for people with disability will require a workforce that has the capabilities and is ready to effectively interact with clients, families and employees from diverse backgrounds.*

The overall aim of the CDCF is: *to build sustainable diversity capabilities and enable and support staff in all areas of the sector to deliver culturally competent person centred and family centred planning, support and service provision.*

This will involve the creation of a comprehensive Cultural Competency Framework, inclusive of performance measures, that provides a range of concrete cultural competency strategies that will effect sustainable organisational change and enable more responsive service provision. Including a definition of cultural competency appropriate within an ADHC and sector context to achieve consistent understanding of the term and identification of core competencies appropriate to ADHC and the sector's needs.

The project's research team, Geriography, will undertake the key areas of developmental work for The Northcott Society and FACS/ADEC. This work will provide the evidence base and directions for the rest of the project.