Culturally Competent Disability Support:

Putting It Into Practice

*A Review of the International and
Australian Literature on Cultural Competence*

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MDAA is a non-profit peak body for people from a NESB with disability and their families and carers in NSW.

Cultural competence training, further materials and information are available from MDAA.

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Introduction

Rationale

Over the past fifteen years cultural competence has gained momentum both in Australia and internationally, generating a large volume of literature across a number of fields. However, the disability sector in New South Wales (NSW) has recently begun to question what cultural competence actually means in practice as a mechanism to improve quality of service and results for clients from non-English speaking backgrounds (NESB). The Multicultural Disability Advocacy Association of NSW (MDAA), as the peak body for people from a NESB with disability and their families and carers in NSW, has been a principal advocate of cultural competence as a mechanism to improve service delivery to all consumers of disability services. Increasing inquiries from the disability sector in NSW to MDAA concerning the characteristics, processes, skills and strategies needed to implement a culturally competent approach led MDAA to investigate this further.

MDAA employed an external consultant to conduct a project on culturally competent practice over three phases. The first phase was a review of the international and local literature on cultural competence, and is the subject of this document. The second was to conduct interviews and consultations with advocates, consumers and service providers. Both phases one and two were used to inform the final phase, the production of a manual and tool designed to encourage culturally competent disability service delivery.

Aim of Phase One

To review the literature on cultural competence in order to propose key culturally competent tools, strategies and skills by which disability service managers and staff can provide quality services and improve outcomes for consumers.

Audience

Given the number of inquiries about how to work in a culturally competent way, MDAA decided to focus on individual practice and skills. Therefore the review primarily targets middle managers and workers in the 'front line' of service delivery and support. While this is the case MDAA recognises that culturally competent practice must be supported and encouraged by the system, organisation and program within which it occurs if it is to be

successfully implemented over time. MDAA also recognises, however, that individuals working towards cultural competence can and should act as agents for change at interpersonal, program, organisational and even systemic levels. Therefore where individuals can bring about change, systemic, organisational and program issues are discussed. Policy makers, board members and senior managers are encouraged to read, reflect on and apply the concepts and practices outlined in this document[1].

Method

Literature search

The literature search was conducted for published work using the databases Medline, Cinhal, Psychinfo, PsycARTICLES, Sociological Abstracts, Social Work Abstracts, and Ageline. The following key words were combined to perform searches on each of the above databases.

- Cultural
- Competent OR competence (where accepted Competen*)
- Support
- Practice
- Implement
- Process
- Evidence

Additional articles were also identified from the reference lists of reviewed articles. Referrals from specialists in the field provided other peer reviewed articles, other literature and documents related to practice. Internet searches,

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[1] For those at the system or service design levels, it is useful to note that cultural competence has been directly identified as a business improvement strategy (Brach and Fraser, 2002). Interviews in the US with experts in Government, academia, managed care, and community health care revealed that these people described cultural competence "…both as a vehicle to increase access to quality care for all patient populations and as a business strategy to attract new patients and market share" (Betancourt and colleagues, 2002; p. v). In addition, there was a clear connection made between cultural competence and quality improvement, and the elimination of disparities in care based on ethnicity or race; 'The ultimate goal is a health care system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or English proficiency.' (p.2) (see also Anderson, and colleagues, 2003; Brach and Fraser, 2002). Furthermore on the policy front improvement in quality is tied to improved access. For example, research from the UK points out that "Parents' and young people's poor view of service support means that they not only want better access to existing provision but they also want different kind of support that recognises ethnic, cultural and religious diversity. However, the distinction between the two – an important feature in the literature on deafness and disability – is rarely made by parents and young people. *To them access and appropriate support are bound up together*" (Jones and colleagues, 2001; p. 67, emphasis added).

primarily through Google, were conducted using the terms 'Cultural competence disability' / 'Culturally competent disability'. In order to fully include strategies directly designed to address culture and ethnicity within disability service delivery, these further searches on documents relating directly to disability services were chosen for their inclusion of issues relating to 'culture'. Where appropriate, these documents are used to support the areas suggested by the cultural competence literature.

To be included in the review, studies, reports, articles and documents had to demonstrate a focus on culturally competent practice and related strategies. The focus was on mainstream service delivery and not on competence with specific ethnic groups; ethnic or culture specific articles were limited to those with implications for general service delivery. Two principal yet overlapping disciplines emerged: Social Work (disability, aged care, children and family studies, welfare); and Health (clinical, primary care, nursing, occupational therapy, aged care, rehabilitation and mental health)[2].

Literature sources

Much of the published literature on cultural competence is from the US, where the approach was originally conceived (Suh, 2004). This work covers the range of disciplines outlined above. Australian work on cultural competence, both research and theoretical, has mainly been undertaken by Fitzgerald and colleagues. This extensive work covers disability, rehabilitation, occupational therapy, mental health, health, and education and training. Other cultural competence work has also been done in the UK, principally by Papadopoulos and colleagues in the field of nursing research. One useful cultural competence article in the occupational therapy literature was from the United Arab Emirates (Awaad, 2003).

While not termed cultural competence, there has been some very useful research and other work in the UK on ethnicity and disability. This has mainly been qualitative research with Black and South Asian communities, coupled with three excellent reports commissioned by the UK Department of Health on issues and strategies used to overcome barriers to race equality in care.

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[2] Not all the literature could be retrieved. Therefore, in some cases where relevant literature cited by other authors is used, it is acknowledged as such. Those interested are recommended to access this literature through these referenced authors.

Other sources of Australian literature on cultural issues, while not always under the banner of cultural competence, have been included. MDAA has probably been the most visible organisation in advocating for cultural competence in Australia. Multicultural Mental Health Australia, notably including the work of Fitzgerald and colleagues, has also recently produced useful work. Two qualitative research reports by Glenys Carlson and colleagues with occupational therapists (Francisco and Carlson, 2002) and intellectual disability service providers (Carlson and Prasad, 2001) in Queensland proved useful. Also included is a useful manual produced by Wentworth Area Health Service and Queensland health, and a model to encourage improved practice by NSW Health.

Structure and Findings

The structure of the review follows core areas of findings from the literature. Following a brief overview of Australian disability policy, the review is in five parts: definitions of cultural competence; culturally competent capacity; culturally competent interactions; involvement of others; and self-assessment. It is important to note that there is considerable overlap in the findings; cultural competence is a dynamic and fluid approach with areas and concepts connecting and overlapping considerably with each other across the structure that has been provided.

- *Part one* of the review covers definitions of cultural competence and the impact of these on practice, discussing levels of influence and the concepts of culture, competence, and cultural competence. Empowerment is also discussed.

- *Part two* covers the development of individual capacity to practice culturally competently. Developing cultural awareness and sensitivity is the focus of section one. Section two describes acquiring and using cultural knowledge. Section three outlines approaches to aid thinking culturally competently.

- *Part three* is concerned directly with cross-cultural interactions between workers and others. Section one outlines two approaches to improving the effectiveness of the cross-cultural encounter between staff and consumers. Section two discusses culturally competent communication. Section three details conducting cultural assessments.

- *Part four* moves beyond the interaction between the worker and consumer to the family, carers and community. Section one discusses family and carer involvement, and community participation. Section

two looks at community participation and outreach. Section three discusses information provision and dissemination.

- *Part five* discusses culturally competent self-assessment and growth, and practical specifics of these. The section concludes with a list of culturally competent characteristics.

A surprising finding across the literature was a lack of empirical work on cultural competence. The focus is mainly descriptive, theoretical and conceptual[3]. However, the depth of analysis by most authors is of great benefit for improving practice. In fact this depth gives an indication of the difficulties in evaluating or researching cultural competence empirically. It would be encouraging in future to see systematic empirical and theoretical work reinforce one another, particularly to evaluate the processes involved. The final section of the review touches on planning, monitoring and evaluating the process to improve and assess individual practice.

Terminology

Due to the varying sources of literature, a brief note on terminology is required. The Health literature usually refers to 'Patients', 'Clients', 'Nurses', 'Doctors', 'Practitioners', 'Clinicians' and 'Care'. The Social Work literature refers to 'Clients', 'Consumers', 'Providers', 'Practitioners' 'Professionals', 'Workers' and 'Support'. I have mainly used the social work terminology, and where appropriate changed the health terminology to reflect this. In particular, the term 'support' is more appropriate for practice with people with disability. I have also mainly referred to 'Consumers' as this is the term MDAA uses. In addition I have used the term non-English Speaking Background (NESB) rather than Culturally and Linguistically Diverse (CALD) for the same reason. Readers are referred to MDAA's 'Ethnicity and Disability Factbook' (MDAA, 2000a) for reasons underlying this terminology.

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[3] For a recent overview of a debate on this issue, see Sue (2003)

Background: Australian disability service delivery

Disability is bound up within the society[4] and culture in which it exists (Armstrong and Fitzgerald, 1996; Oliver, 1996). It follows that the application of cultural competence in disability service provision is inevitably influenced by the broader society within which it exists. Knowledge of the way services are delivered to people from NESB with disability provides a necessary backdrop to the findings of this review.

Australia is a multicultural society (DIMIA, 2004b). Presently 23.1 per cent of the Australian population were born overseas. Of those born overseas, 33.1 per cent were born in North-West Europe (mainly the United Kingdom and Ireland), 18.9 per cent in Southern and Eastern Europe and 12.1 per cent in South-East Asia (DIMIA, 2004c). At the latest Census, 10.3 % of the Australian born population had one parent born overseas, and 8 % had both parents born overseas (Community Relations Commission, 2004)[5]. For the purposes of this review, multiculturalism as a framework means that individual citizens have the right and are given the opportunities to maintain and develop their own culture and identity while maintaining equal status with other citizens (MDAA, 2000b).

The main Commonwealth legislative and regulatory mechanisms relevant to people from NESB with disability in Australia are the Disability Discrimination Act 1992 (DDA), and the Disability Services Act 1986 (DSA). The DDA protects all Australian residents against discrimination because of disability, or being an associate of a person with disability, in specified areas including work; accommodation; education; access to premises; clubs and sport; and in the provision of goods, facilities and services and land. The DDA aims to ensure equal rights for people with disability. The DSA regulates organisations funded by the Commonwealth to provide services to

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[4] Oliver (1996) provides a useful overview of the debate about 'individual' and 'social' models of disability. The former, traditionally put forward by the professional sector, has viewed disability as a 'problem' to be located in the individual. The latter, 'received much more enthusiastically by disabled people because it made an immediate connection with their own experiences' (p. 31), locates the effects of disability within the restrictions imposed on disabled people by the structures and systems of broader society. The social view has been taken up mainly in the UK. For example, research on ethnic minorities with disability in the UK has indicated that while disability is a product of impairment, socially created discrimination has led to barriers to full participation in social and other services, and life in general (Ahmad, 2000; in Mir and colleagues, 2001; Fazil, Bywaters and colleagues, 2002).
[5] In NSW the number of people born to parents from a non-English speaking country was 130,659. The numbers of people with disability who are second generation migrants offsets the 'health migrant effect' and often rely on their family (who are first generation), to provide support, and to negotiate the disability system on their behalf, or for themselves (MDAA, 2004d).

people with disability on a human rights basis, resulting in 10 Disability Service Standards. 'Access and Equity' are part of the broader social justice agenda in Australia, based on 'equity', 'equality', 'access' and 'participation', that aims to eliminate inequalities derived from cultural, racial, religious, or linguistic differences (DIMIA, 2004b). The Charter for Public Service in a Culturally Diverse Society[6] (DIMIA, 1998) also encourages access and equity in government services.

This federal framework is also reflected at State and Territory levels[7]. In NSW the Ethnic Affairs Action Plan 2000 – White Paper (1996) – encourages social justice, community harmony, and economic and cultural opportunities. Key aspects of this policy are to encourage program development responsive to linguistic, cultural, racial and religious diversity; cultural diversity in government and funded services; a culturally diverse workforce; and planning for cultural diversity reflecting current and future needs. The NSW Charter of Principles in a Culturally Diverse Society (1994) encourages full participation of the entire community in public life; respect and accommodation of the culture, language, and religion of others; use of, and participation in, relevant activities and programs provided and or administered by NSW Government institutions; and recognition of the linguistic or cultural assets in the NSW population. The NSW Social Justice Directions Statement (1996) states a commitment to fairness in the distribution of resources; recognition and promotion of rights; access to resources and services to meet basic needs and improve quality of life; and better opportunities for genuine participation and consultation about decisions affecting people's lives. Finally, the NSW Disability Services Act (1993) and the NSW Disability Policy Framework (1998) include clauses that recognise disadvantage based on ethnic origin; recognise the importance of preserving family relationships; give people with disabilities the right to choose their own lifestyle and access to information appropriate to their disability and cultural background necessary to allow informed choice; enable support for and sensitivity to the diversity of people with disability; and recognise and protect the legal rights of people with disability.

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[6] The practices in the cultural competence literature overlap considerably with the areas and strategies outlined in the Charter, and therefore can be useful approaches by services to implement this framework at the individual level.
[7] This brief overview is taken from MDAA's 'Less Talk, More Action' (2000b). For further detail the reader is referred to that document.

Service delivery in Australia is currently dominated by 'mainstreaming', which aims to strengthen multiculturalism by changing service provision for people from NESB from a marginal to a central concern of all services (Garrett and Lin, 1990). Mainstreaming means that services are delivered to the whole population eligible for them. The principles and goals of mainstreaming are multicultural, and do *not* encourage assimilating cultural and linguistic diversity into the dominant Anglo-Australian culture (MDAA, 2000b). In addition to mainstream services, in NSW there are currently few ethno-specific and multicultural disability services in place (MDAA, 2000b).

In short, both in Australia and NSW, providing accessible, responsive and non-discriminatory services is a *core element* of disability service provision and staff development. As shown in this review, a fully culturally competent approach provides this core element.

Part One
Definitions: Levels of influence; culture, competence, cultural competence; empowerment

There are many definitions of cultural competence throughout the literature. It is however possible to identify central themes across these definitions, providing a useful backdrop to more detailed discussions in the review. Discussion of these definitions relates first to the different levels at which cultural competence occurs, and secondly to the meaning of culture, the meaning of competence, and the meaning when the two terms are put together. Each is discussed in turn, followed by a discussion of the concept of empowerment that underpins cultural competence.

Levels of influence

One of the most cited definitions in the literature, particularly in the Health literature, is a variation of that proposed by Cross and colleagues (1989; Brach and Fraser, 2000). These mental health professionals defined cultural competence as a "…set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations." More recently, an amendment to The Developmental Disabilities Assistance Bill of Rights Act in the US, defined cultural competence as a "…set of values, behaviours and attitudes, and practices within a system, organisation, program, or among individuals and which enables them to work effectively cross-culturally. Further, it refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviours of individuals and families receiving services, as well as staff who are providing such services. Striving to achieve cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment to change" (1994; in Goode, 2000a).

Central to both these definitions is that cultural competence should occur across different levels – system, organisation, program, and individual - if it is to be fully effective at the level at which clients and providers interact (Brach and Fraser, 2000). For the purposes of the present review, which focuses mainly on individual level encounters, these definitions highlight an

important issue: difficulties will occur at this individual level if the organisation, programme or broader system does not provide the environment or supports that enable culturally competent abilities to flourish. While this review focuses on the growth of the individual in cultural competence, MDAA recommends that the strategies outlined be simultaneously supported by the growth of the system, programme and organisation in cultural competence.

However, because it is possible for individuals to have a positive influence on the system, programme and organisation within which they work, MDAA encourages individuals to grow, to provide culturally competent leadership that can influence these broader levels. A brief discussion of what is meant by the system, organisation, and programme is useful before turning to the individual focus of the review.

System, organisation and programme levels

The Australian disability service delivery system is a cultural system[8], currently reflecting Anglo-Australian cultural values (MDAA, 2000). For people working in the system, this culture has an impact on how disability is understood and the way services are designed and subsequently delivered to support those with disability. In addition, this culture can influence how people as individuals understand and respond to people from different cultures.

For people from other cultures, the Anglo-Australian values based system is difficult to understand. This difficulty includes what is provided, how it is provided, or how to get access to it. In addition, many people from different cultures may have a different way of understanding disability and caring for people with disability that may or may not include support being provided by a disability service system (Armstrong and Fitzgerald, 1996). For many, such a system may not have existed in their country of origin.

Bearing this in mind, Goode (2000a) provides a useful brief overview of what is required when a "system, organisation and programme" becomes culturally competent. This indicates areas that can be influenced by an individual (some of which are considered in more detail in later sections) "At the systems, organisational or program level, cultural competence requires a

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[8] For a useful academic discussion of health systems as cultural systems, see the work of Arthur Kleinman and colleagues (1978).

comprehensive and coordinated plan that includes interventions on levels of (1) policy making; (2) infra-structure building; (3) program administration and evaluation; (4) the delivery of services and enabling supports; and (5) the individual. This often requires the re-examination of mission statements; policies and procedures; administrative practices; staff recruitment, hiring and retention; professional development and in-service training; translation and interpretation processes; family/professional/community partnerships; *care practices and interventions including addressing racial/ethnic *disparities and access issues; *education and promotion practices/materials; and community and state needs assessment protocols" (p. 2)[9].

The individual

The focus now turns to definitions that relate directly to the individual provider. The first is used by the anthropologist Maureen Fitzgerald, who has undertaken extensive work in Australia on cultural competence as a concept to be applied both in disability and rehabilitation (Armstrong and Fitzgerald, 1996) and mental health (Fitzgerald and colleagues, 1996; 2000) education, theory and practice. For this work Fitzgerald cites a definition of cultural competence as "The ability of individuals to see beyond the boundaries of their own cultural interpretations, to be able to maintain objectivity when faced with individuals from cultures different from their own, and be able to interpret and understand behaviours and intentions of people from other cultures non-judgementally and without bias. Walker (1991)". The second definition is the most frequently cited in the nursing literature (Suh, 2004). This views cultural competence as "…the process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of a client (individual, family or community)" (Campinha-Bacote, 1999; p. 203).

To look at these definitions and their potential impact on practice more closely, it is important to discuss what is meant by culture, competence, and cultural competence.

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[9] Goode prefixes many terms here with 'health'. To make these more relevant to disability I have removed them and placed an *.

Culture, competence, and cultural competence

Culture

Fitzgerald and colleagues (1997) describe culture[10] as "an abstract concept that refers to learned and shared patterns of perceiving and adapting to the world. Culture is reflected in its products: the learned, shared beliefs, values, attitudes and behaviours that are characteristic of a society or population. Culture is not a static phenomenon; it is dynamic and ever changing, but it maintains a sense of coherence" (p.3). This can be broken down into four areas.

The first concerns learned values and shared beliefs, attitudes and behaviours. Culture can be viewed as a lens through which each one of us makes sense of our lives (Helman, 2001). Culture provides us with guidelines for how we perceive and interpret the world of people and things around us (Armstrong and Fitzgerald, 1996); for deciding what is, what can be, how one feels about it, what to do about it, and how to go about doing it (Goodenough, 1981; in Fitzgerald and colleagues, 1996). Culture can be passed on through generations, the family or community and others in society, and is "shared with those from whom it is transmitted and with those to whom it is taught" (Bonder and colleagues, 2001; p. 1). Respect for these shared beliefs and guidelines is an important aspect of cultural competence, as shown in the US Developmental Disabilities Assistance Bill Amendment.

Second, culture is not a 'one size fits all concept', and cultural knowledge, beliefs, values, attitudes and behaviour are not equally shared by all people within any society (Armstrong and Fitzgerald, 1996). Regions, communities,

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[10] Rodriguez (1996) provides a useful observation on understanding culture by pointing out what culture is not. She points out that in workshops and training he is constantly reminding and cautioning participants against over-generalising or characterising cultural groups in a rigid, one-dimensional and static way. She points out that culture is NOT:
1. mere artefacts or materials used by people;
2. a laundry list of behaviours, values, and facts;
3. the pseudo-biological or pseudo-scientific trait of "race";
4. the ideal and romantic heritage or experience of a people as seen through music, myth, dance, holiday, and folklore;
5. stereotypic depictions of groups as seen in television, movies, newspapers, and other media;
6. objects to be bought, sold, and distributed;
7. generalised explanations about the behaviour, emotions, or values of groups of people sometimes applied haphazardly to individuals; or
8. higher class status derived from a knowledge of arts, manner and literature valued by the dominant society.

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families, and individuals are all different levels at which different interpretations of culture can occur (Awaad, 2003), hence the focus on 'individuals, families, and communities' in the definition by Campinha-Bacote (1999) above.

Third, knowledge of culture may give only some clues about the individual or their personality. Each person is different and each is the product of many influences (Working Together, 1995; in MDAA, 2004). In addition, and discussed in more detail under 'cultural awareness and sensitivity', culture belongs to every human being, not solely to people we view as 'others'; each of us is a 'cultural being' (Fitzgerald, 2000). Each of us (Anglo-Australians included) has a history that has an impact on our current and future selves, affecting our views on life and what it is to lead a healthy life (Kagawa-Singer and Kassim-Lakha, 2003). This is the reason for the focus on the individual in the definition used by Fitzgerald and the US Developmental Disabilities Assistance Bill Amendment.

Fourth, culture is a dynamic, ever changing and evolving concept (Awaad, 2003). Just as individuals and the broader systems (regions, societies, communities and families) within which they live are dynamic, constantly evolving and adapting to the surrounding conditions, so does culture. Indeed, culture helps us to adapt while being adapted by our behaviour and interactions. It follows that a person's cultural knowledge and skills change over the life course as that person encounters new objects, situations and ideas in their personal environment, and these experiences shape a unique person (Bonder and colleagues, 2001). This is the reason for the emphasis on process and context, discussed in greater detail later, in the definitions by Campinha-Bacote and the US Developmental Disabilities Assistance Bill Amendment.

In sum, culture is a broad term that encompasses more than assigning someone else as 'different' (Fitzgerald and colleagues, 1996).

Culture and disability

Culture plays a defining role in how disability is understood in a society, family, or by an individual. Different people 'explain' or perceive disability in different ways and there are considerable variations in definitions and categorisations of disability both within and between cultures (Armstrong and Fitzgerald, 1996). For example Western cultures usually explain

disability in medical terms[11], such as resulting from accidents, genetic disorders or viral infections (MDAA, 2000a). However, other cultures believe disability can be caught, or that it is a punishment, or a gift from a higher power (MDAA, 2000a).

Moreover, cultural explanations of disability affect the attitudes and behaviour of people with disability and their families concerning support and rehabilitation (Armstrong and Fitzgerald, 1996). Where disability may be viewed as related to the actions of the individual, an expectation of self-help, denial of family and community help, or both, may be the resulting reaction. Where an understanding of disability is located outside the individual, where interaction with and the opinions of others are valued highly, the response may be to keep the presence of disability private. What may result is an attempt to keep the presence of disability private and not to seek outside help (Armstrong and Fitzgerald, 1996). Culturally competent practice works with some of these culturally defined responses to disability when considering how an individual or family react to being offered support services (Fitzgerald, 1992). This is discussed further under the section titled 'Family Involvement'.

Competence

Competence refers to having suitable and sufficient skills, knowledge and experience for some purpose (Wells and Black, 2000), and implies the ability or capacity to function effectively (Este, 1996; Goode, 2000). This is the reason for the emphasis on effectiveness in the definitions by Betancourt and colleagues and US Developmental Disabilities Assistance Bill Amendment.

However, it has been pointed out the concept of competence is itself a cultural one, in that it is "located in the metaphor of American 'know-how'…consistent with the belief that knowledge brings control and effectiveness" (Dean, 2001; p. 624). Thus at face value, cultural competence as a term seems to imply that one can master[12] a body of knowledge such as pharmacology and, as a result, be competent. However when coupled with

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[11] An example of within cultural differences is the debate between those in Western culture who argue disability is a bio-medical condition and those who argue that it is socially governed (see Oliver, 1996).
[12] For example, Wells (2000) proposes a model of cultural competence which moves beyond cultural competence to cultural proficiency, described for the individual as "Mastery of the cognitive and affective phases of cultural development" (p. 193).

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the deeper understanding of 'culture' outlined above, 'competence' is given new meaning.

Cultural competence

Understood at a deeper level, functioning effectively becomes the ability and capacity to actively understand the world-view of others, which can be deeply influenced by culture. This is what competence means in the definitions of 'cultural competence' cited above. Effective work in cross-cultural situations requires more than mastery of a technical skill or memorizing facts (Leonard and Plotnikoff, 2000). It requires reflection, emotional growth, practice, and understanding and recognition of one's own values, attitudes, and perspectives. Rather than on control of knowledge of others, the emphasis of cultural competence is on effectively facilitating understanding, where all parties in the encounter - staff with clients, families or communities, or staff with staff - interact with and learn from each other in a "…respectful, non-judgemental, and deeply interested…" way (Dean, 2001; p. 628). The ability to communicate more effectively is coupled with an increased ability to reconcile differences in a mutually acceptable way (Kagawa-Singer and Kassim-Lahka, 2003). For consumers what follows is an increase in responsiveness and quality of support (Xakellis and colleagues, 2004). For staff what follows is an increase in harmony both with consumers and with each other, leading to greater quality and productivity (Brach and Fraser, 2002).

In addition, some authors argue that due to its dynamic nature, culture never has an endpoint, and that subsequently it is impossible to ever 'be' culturally competent (Cross, 1989; Tervalon and Murray-Garcia, 1998). What is encouraged in place of an endpoint, or outcome, of competence is an emphasis on the processes by which cultural competence occurs (Campinha-Bacote, 1999). As a result, it is useful to see cultural competence as occurring along a continuum (Cross and colleagues, 1989; in Goode and colleagues, 2002). The achievement of levels of competence along a continuum, including a level of competence that incorporates an acute awareness of culture as dynamic, is directly addressed in the final section of the review.

Cultural competence as everyday competence

To conclude this section of the review, it has been noted that the processes involved in cultural competence - introspection, self-awareness, respectful

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questioning, attentive listening, curiosity, interest, and caring - are in fact the same skills required in good medical (Dean, 2001), nursing (Dreher, and MacNaughton, 2002), psychology (Hall, 1997), occupational therapy (Fitzgerald and colleagues, 1997) and social work (Suh, 2004) practice. This is of major importance on two counts. First, this means that the shift to culturally competent practice should be easy, as culturally competent practices are not far removed from those normally employed in a caring situation; all that is needed is greater understanding of the influence of culture, and greater confidence and comfort in working with people from different cultural backgrounds (Tsang and Bogo, 1997). Secondly, if such practices are not being employed, then cultural competence is a valuable and tangible tool with which to improve their implementation for *all* consumers.

In summary, part one of the review has discussed important definitions of cultural competence outlined in the literature and their implications for practice. One important aspect of the definitions is that they encourage cultural competence to occur at a number of levels; across individuals, programs, organisations and systems. The concepts of culture and competence were then detailed in the light of these definitions. Four aspects of culture were discussed: culture as learned and shared guidelines; occurring at different levels; being interpreted by different individuals; and as dynamic and changing over time. Cultural understandings of disability were then mentioned briefly. Competence was discussed as meaning effectiveness, and implying mastery of knowledge. However, when added to the broad and complex definition of culture, it became apparent that cultural competence is not mastery, but is instead based on continued learning and deep understanding. The conclusion was that the similarities in cultural competence with practices that underpin many caring disciplines mean that cultural competence should either be easy to transfer into practice, or is a useful mechanism for individuals to start implementing good practices in their work. The next section of the review turns briefly to a concept that underpins cultural competence as an approach to service delivery: empowerment.

Empowerment

The literature, particularly the social work and disability literature, describes empowerment as "the most critical element of cultural competence"

(NCDDR, 1999). The concept of empowerment, of staff and of consumers and their families and carers, underpins much, if not all, of the literature on cultural competence. As a result, empowerment underpins all the concepts and strategies outlined in this review, and a brief discussion of what empowerment means and its implications for practice, is important.

For consumers, families and carers, empowerment implies "involvement, control, and ability to make choices" (Mir and colleagues, 2001). In addition it is important to foster empowerment in the broader ethnic minority community[13] to which consumers and their family and carer may belong (NCDDR, 1999). This is increasingly important in a diverse society such as Australia, where "…differences regarding language, religion and lifestyles can be barriers within the context of the dominant culture. These barriers can lead to racial prejudice, misunderstanding and frustration, and may result in minority groups being placed at risk of becoming disadvantaged and disempowered (Stevens, 1998)" (in Orb and Wynaden, 2001; p.31). Strategies to increase the empowerment of consumers, families, carers and communities are discussed in more detail in Parts Three and Four of this review.

The provider or worker is a key person in the empowerment process both for others and for themselves. Empowerment of others entails a shift in the role of the service provider and worker away from being an expert who provides a service to a passive recipient, towards consumers and carers becoming active partners in the support they receive (National Council on Disability, 2003). This means learning to identify and embrace consumers' cultural differences and develop strategies for integrating cultural practices and beliefs into the provision of care (DiCicco-Bloom and Cohen, 2003). As a result, the encounter between the provider and client becomes a learning opportunity, not only where the provider teaches the clients, but where the provider learns from the client in order to maximise communication (Manderson and Allotey, 2003). This involves "…caring, which builds supportive relationships; respect, which builds reciprocity; and the acceptance of differences, which builds trust" (Kalyanpur and Rao, 1991; p. 31, in NCDDR, 1999). What is

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[13] This is similar to the concept of 'cultural safety' used in New Zealand (for a detailed discussion see Polaschek, 1998). Cultural safety goes further than learning factual information about cultures and encourages exploring the society and politics within which cultural beliefs, for example about family, are situated (McPherson and colleagues, 2003). This broad understanding of empowerment within cultural competence concerns identity, disempowerment, self-awareness, and the ability to take action (Lister, 1999). Interestingly, in indigenous health in Australia there is an attempt to integrate both cultural competence and cultural safety (McDermott and Eisenbruch, 2003).

essential is for differences that occur to be reconciled in a manner acceptable to all parties involved (Fitzgerald, 1992; Kagawa-Singer and Kassim-Lahka, 2003; Tsang and Bogo, 1997).

Concerning the worker themselves, the process of cultural competence can mean a significant shift in self-empowerment through increased skill and ability. Individuals and their colleagues need to be aware of this shift for a number of reasons.

First, some authors have equated the development of cultural competence with the development of skills needed to become leaders in the workplace (Goode and colleagues, 2002). This beneficial increase in skills may also bring about changes in the workplace or system itself; "…because of the skills and sensitivities s/he has developed while acquiring cultural competence, [the worker] may be able to use those same skills and sensitivities to lead others toward greater system wide cultural competence, either informally among colleagues, or through involvement in policy activities at the state and federal level" (Rorie and colleagues, 1996; p. 99).

Second, with cultural competence abilities comes a growth in advocacy skills (Orb and Wynaden, 2001). Advocacy has been defined as a "way to defend the interest of a person, and to make sure their needs are met, especially someone who already feels disempowered" (Atkinson, 1999; in Mir and colleagues, 2001). Taking an advocacy role is important for two reasons. It not only recognises ethnocentrism and racism, but also does something about it on behalf of clients and society (Kim-Godwin and colleagues, 2001), "The most important component [of cultural competence] is the ability to recognize and challenge racism and other forms of discrimination as well as ethno-centricity" (Papadopoulos and Lees, 2002; p.262). In addition, requesting more culturally appropriate services for clients has been flagged as a quality improvement mechanism to increase responsiveness in managed care organisations in the US (Betancourt and colleagues, 2002).

Third, with cultural competence comes the less immediately positive issue of conflict, which individuals working towards cultural competence need to be aware of. This can occur both when leadership roles are encouraged (Goode and colleagues, 2002), and when other individuals, or the organisation or system are not at the same stage of growth as the individual (McPhatter and Ganaway, 2003). As a pertinent example of cultural competence change and

conflict, Nybell and Gray (2004) concluded from a decade of working with three child agencies in the US that, "What our empirical experience suggests is that progress toward these goals will emerge through a process of struggle among members of different racial or cultural groups; among clients, workers and management; between programs; and between staff with seniority and newcomers. It seems to us that achieving cultural competence in a predominantly white social services agency requires redistributing power toward clients, toward programs that disproportionately serve the most disenfranchised clients, to workers of color, and to representatives of communities of color. Redistribution of power frequently engenders conflicts…It requires risk taking workers willing to voice their concerns and courageous managers committed to engaging issues of race and culture, entangled as they are with existing hierarchies. It requires administrators who are willing to address conflict" (p. 25)[14].

Quotes such as this need to be taken constructively. It is important for individuals to be aware that conflict is not necessarily a negative concept. Conflict often stems from a legitimate need for change and can lead to significant beneficial change. Managers in particular need to be aware of this (Goode and colleagues, 2002). In addition, the alternative to culturally competent growth is to settle for a status quo that benefits neither clients nor their families from all cultural backgrounds, nor staff. Change can be a good thing for an organisation to foster.

Having discussed both the definitions of cultural competence and the concept of empowerment that underpins them, Part Two of the review turns to the meaning behind culturally competent practice with people from NESB with disability. In the words of Stanley Sue, one of the initiators of cultural competence in mental health, "By 'meaning', I am not referring to just its definition…Rather, I want to address the essence or character, namely, what constitutes cultural competence?" (1998; p. 441).

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[14] The authors also concluded from this work a recurring theme throughout the literature, that a "… characteristic that represented a symbol of hope was the role of the director, who, in each case, played an important part in committing to a culturally competent organisational change process" (Nybell and Gray, 2004; p. 20).

Part Two
Developing Cultural Competence Capacities

This part of the review discusses capacities an individual can develop that underpin culturally competent practice. These provide the personal element to working effectively in cross-cultural situations and encounters.

Cultural awareness and sensitivity

Awareness of and sensitivity to culture as it relates to the self and to others are noted throughout the literature as key first steps[15] to becoming culturally competent. Awareness is "the deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, life ways, practices, and problem solving strategies of clients' cultures…This awareness process must involve examination of one's own prejudices and biases toward other cultures and in-depth exploration of one's own cultural background" (Campinha-Bacote, 1999; p. 204). The culture of the self is discussed first, followed by the culture of others.

Awareness of the self refers to a state of being conscious[16] of oneself as a 'cultural entity' (Kim-Godwin and colleagues, 2001; p, 922) or 'cultural being' (Fitzgerald, 2000). Taking Anglo-Australians as an example, this means people from that background recognise that being 'Anglo-Australian' is to be part of a culture. This awareness of the self should also include recognition, through examination of our own backgrounds (Suh, 2004), that as part of a culture we as individuals also have lenses or filters for viewing the world in a particular way, and that may result in particular ways of viewing others

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[15] Although awareness and sensitivity are slightly different concepts, they overlap and therefore are placed together here, in line with the quote from Campinha-Bacote in which awareness becomes sensitivity. While it is not the focus of this review, some readers may wish to delve more deeply into some conceptual models in the literature that analyse cultural competence in an academic way. As a brief introduction, based on concepts borrowed from Psychology, awareness is often described as a cognitive (thinking) process, and sensitivity an affective (emotional) process [see Rounds and colleagues (1994); Suh, (2004) for a deeper discussion]. Papadopoulos (2003) and Papadopoulos and Lees (2002), provide an excellent action based model that that sees awareness, knowledge and sensitivity as separate stages leading to cultural competence, and then back to awareness. Models of cultural competence often refer to knowledge and skills as key components of culturally competent practice (for example see Kim-Godwin and colleagues, 2001). Reflecting this, knowledge and skills are discussed in detail later in this review.

[16] Fitzgerald (2001) comments that awareness of culture is "Much like professional craft knowledge, we know it without necessarily knowing we know it. We learn it without necessarily realising we are learning it. We use it without necessarily recognising that we are using it" (p. 153). Elsewhere, Fitzgerald and colleagues (1997) highlight that in practice, "The challenge is to move awareness to a more conscious level where it can be the basis for action" (p. 14).

(Leonard and Plotnikoff, 2000). At the same time these biases mean that we may unconsciously use our own culture as a benchmark to measure the standards of others (Steinberg, 2000; in Orb and Wynaden, 2001).

The system within which services are delivered is itself a product of the culture in which that system[17] occurs (Kleinman and colleagues, 1978). Cultural awareness also encompasses an understanding of this (Fitzgerald, 2000). The Australian disability system is based on Anglo-Australian culture, which influences how services are delivered (MDAA, 2000). The way professionals think about, communicate about, and conceptualise their work and the world around them is in turn influenced by that culturally created system (Fitzgerald, 2000). This system may be very different from the culture of the consumer or their family. Increased awareness of this is important for two reasons. First, this enhances the provider and worker's ability to understand that their work culture affects interactions with consumers and families (Rounds and colleagues, 1994). Secondly, the process of being sensitive toward others begins as awareness is raised of the experiences that families from different backgrounds might have faced, or might face, when attempting to access, or receive services within the system (Rounds and colleagues, 1994).

Becoming culturally competent challenges biases within us that may arise due to our belonging to a culture and working in a cultural system (McPhatter and Ganaway, 2003). This new level of self-awareness leads to a conscious acknowledgement and appreciation of, sensitivity to, and active steps to understand and work with[18] the diverse cultural beliefs and practices of others (Rounds and colleagues, 1994).

For example, concerning disability, this includes an awareness of the culture through which we and other people may draw both to explain and respond to disability (Armstrong and Fitzgerald, 1996). This includes an awareness that "Circumstance, race, culture, language, experience, and belief can influence people's access to information and services; their roles in and treatment by

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[17] It is important to note that because of the dynamic nature of culture, these systems are as capable of change as the individuals who work within them. In fact, one of the reasons for the growth of cultural competence within human service systems worldwide is increased migration. This increase has created the multicultural populations that these systems and the organisations and professionals who work within them now provide services to.

[18] These steps are discussed throughout the next sections of this review.

agencies and by other individuals; their goals for rehabilitation and independent living; and the kinds and sources of information they find to be credible and useful" (National Center for the Dissemination of Disability Research (NCDDR), 1999).

Becoming culturally aware and sensitive is both challenging and rewarding. The process of examining our own beliefs to understand the beliefs of others better is "simultaneously stressful, challenging, and invigorating" (Leonard and Plotnikoff, 2000; p. 54). However, what challenges us the most often produces the most rewards and benefits.

For example, Fitzgerald and colleagues (1997) conducted in-depth interviews with 86 Australian occupational therapists. The researchers concluded that occupational therapists who were aware that their values and perceptions (and those of their clients, families and of occupational therapy in general) were key factors in interactions with each other, were more likely to take time to explore these values and perceptions before, during and after the interaction. It was argued that these therapists saw the practical benefit in doing so.

In addition, these therapists drew on core aspects of culturally competent practice. They were more likely to draw on formal and informal information sources to help their understanding, including the client and client's family; more likely to view the interactions from multiple perspectives; able to negotiate resolutions and compromises that everyone can live with; "and in the process appear to be more satisfied with their intercultural interactions" (Fitzgerald and colleagues, 1997; p. 14; emphasis added). In short, increased cultural awareness enables better, more satisfying practices to occur.

Cultural knowledge

Cultural competence is built on more than cultural awareness and sensitivity and requires moving beyond this state to actively seeking out and using knowledge about others (Campinha-Bacote, 1999; CECP, 2003; Jones and colleagues, 1998; Suh, 2004). This section discusses what cultural knowledge is, how to acquire and use it, and areas to watch out for.

Cultural knowledge is an educational foundation used to understand other cultures (Suh, 2004). It involves seeking and obtaining information about the various world-views of different cultures (Campinha-Bacote, 1999). This

knowledge provides the platform from which "to enter the world of culturally different clients in a manner that understands and preserves the legitimacy of the culture and effectively meets their needs" (McPhatter and Ganaway, 2003; p. 107). In other words, cultural knowledge provides providers with the practical understanding of how to work with others from different backgrounds in a culturally competent way.

Three related aspects of this acquisition and use of knowledge stand out in the literature: obtaining specific and general cultural knowledge; avoiding stereotyping; and acknowledging contextual influences.

Specific and general cultural knowledge

There are two approaches to cultural knowledge: the first is to take a specific approach; the second, a general approach. Some authors have argued that one is more useful than the other. Each is discussed in turn, followed by an outline of a model that resists naming one as more important than the other, incorporating the two approaches together.

Specific cultural knowledge

Culture specific competence is the ability to act competently within the culture of a specific group (Fitzgerald, 2000). To achieve this, providers need detailed knowledge of the specific cultural background of their clients. For example, one of the earliest proponents of taking a culturally competent approach to social work defined cultural competence as "The ability to conduct professional work in a way that is consistent with the expectations which members of a distinctive culture regard as appropriate among themselves" (Green, 1982; in Suh, 2004). Specific details to look out for are discussed first, followed by useful information sources and tips on using data.

Specific cultural details include how particular cultures influence family decisions, structures, rules and boundaries; care and parenting of children; meanings assigned to disability; help-seeking and coping; and family-professional interaction and collaboration (Rounds and colleagues 1994). To work with a specific culture requires learning about languages (Bernal, 1998; in Suh, 2004) and the elements of the culture, such as historical, political, social, and economic factors (Suh, 2004) and their role in shaping and defining behaviour (Wells, 2000). Also important is medical knowledge, such as

biological differences that affect the way drugs are metabolised in the body (Purnell, 2000).

Narayan (2003) provides a useful list of key areas to identify using cultural resources[19]:

- *Non-verbal communication patterns*: eg, eye contact; use of space; use and meaning of touch; facial expressions; and hand and body gestures.

- *Social etiquette customs and norms:* degree of formality; degree of deference; removing hat or shoes; importance of small talk or accepting offer of food or drink before 'getting down to business'.

- Health and illness beliefs, values and practices commonly found in the cultural group:

- reliance on different treatments and medications; non-Western medical knowledge and understanding; locus of control, that is, whether health is within our control or determined by God, fate, or destiny.

- *Beliefs, values and practices:* eg, 'good child rearing'; 'good ageing'.

- *Genetic variations and risk factors*: drug metabolism; body shape; skin colour.

- *Attitudes and responses to pain*: culture has a strong impact on how patients express and treat pain, including pain medication usage or not.

- *Nutrition and dietary practices:* food preparation (eg, Halal, Kosher). acceptability of particular foods, eg, animal products, pork, beef; foods that interact with medication; lactose intolerance; timing of meals; fasting important if need insulin; 'hot' and 'cold' foods.

- *Family roles and psychosocial norms:* how family members see their roles; care giving practices; which family members provide care to others; decision making; who is expected to hear information from a provider and to make decisions regarding care; how the sick role is played out (eg, whether there is a preference for independence or interdependence).

There are a number of ways to acquire culture specific knowledge. In Australia both MDAA and Queensland Health have provided useful community profiles and resources, both to further understanding of specific ethnic communities and their potential attitudes towards people with a disability (MDAA, 2000a) and as a "ready and useful resource to identify certain issues that you may wish to explore with your clients/patients" (Queensland Health, 2004). In addition, the academic fields of transcultural nursing, medical anthropology, cross-cultural psychology, and sociology are

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[19] Discussed in more detail in Part 2

minefields waiting to be tapped by the interested reader (Campinha-Bacote, 1999). The Internet is also a useful resource (Narayan, 2003). The media is another medium, but caution is required as the media often portrays stereotypes and generalisations about cultural groups (Heineken and McCoy, 2000).

Other authors argue that people are often the best source of information[20]. Sue (1998) points out that it is important to seek out culture-specific experts – for example, folk healers, acupuncturists, fortune tellers – from different cultures, who "are effective in their own cultures because they know the cultures and have the skills to translate this knowledge into effective interventions" (p. 446). Similarly, Green (1982; in Rounds and colleagues, 1994) recommends the use of 'cultural guides', who are community members who can assist outsiders with an understanding and appreciation of community members' attitudes towards help seeking, historical events that may have influenced these attitudes and how various cultural groups view and access formal services (Hanson and colleagues, 1990; in Rounds and colleagues, 1994).

Ethnic community workers and organisations are also useful people to work with. Formal collaboration not only with individual staff and other agencies is recommended by the US government as a key mechanism to develop culturally competent services (Department of Health and Human Services, 2001a). Work on best practice both in culturally competent healthcare in the US (Betancourt and colleagues, 2002) and in disability services in the UK (Mir and colleagues, 2001) has identified partnerships with both ethnic community-based workers and the organisations they work for to help establish culturally appropriate support.

In Australia, research with intellectual disability service providers in Queensland indicated that 'inter-sectoral collaboration' (links between the intellectual disability service sector and the ethnic communities' service sector) would improve service delivery to consumers from NESB (Carlson and Prasad, 2001). Strategies suggested by participants to facilitate this collaboration were for workers to:

- find out more about local ethnic community services and disability services;

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[20] See also the discussion on 'cultural brokers' in Part Four

- provide information about local disability services to ethnic community services and vice versa;

- organise joint individual support work between disability and ethnic community services; and

- organise inter-sectoral forums (Carlson and Prasad; 2001p. 9).

A number of benefits of such partnerships are highlighted in the literature. Such organisations may have existing resources, such as translated brochures, that can be useful (Francisco and Carlson, 2001). Ethnic community workers may be respected by ethnic communities (Brach and Fraser, 200), and can relay community concerns to the service or program, while educating the community about services and programs (US Department of Health and Human Services, 2001a). Partnerships with these individuals or ethnic services provide both culture specific expertise and useful access to the 'experts' of the community recommended in the literature (for example, see Mir and colleagues, 2001).

Turning to use of data, knowledge of general data on the specific cultural groups in the local region is an important aspect of cultural specific knowledge[21] (Giger and Davidhizar, 2002; Xakellis and colleagues, 2004). For managers, in addition to this community profile, monitoring who is taking up services is important[22] and can help with targeting future services to meet the needs of those who are currently not receiving them – where the data on consumers does not match that of the local profile (Mir and colleagues, 2001). For front-line workers, understanding the make-up of local communities means that they are able to research the cultural specifics of those communities that they might/ ought to be interacting with in future (Xakellis and colleagues, 2004). For consumers, this increased knowledge by providers and staff can lead to more culturally appropriate service plans (Department of Health, 2003).

General cultural knowledge

Some authors have argued that what is required is not familiarity with every culturally specific belief and behaviour, but a general approach to culture that

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[21] MDAA (2004b) has provided a useful three-step guide to accessing information on the number of local people from a non-English speaking country living with disability in the local community in NSW.

[22] Diversity of staff, another core aspect of providing culturally competent care, can also be monitored to match local demographics (Mir and colleagues, 2001; for a useful example see Flowers and colleagues, 1996).

respects the diversity of cultural perspectives that influence the health of individuals and communities (Armstrong and Fitzgerald, 1996; Hunt, 2001; in Xakellis, 2004). Taking this approach seems realistic in Australia, and in NSW in particular, where there are people from 242 countries speaking some 209 different languages (Community Relations Commission, 2003). A cultural general approach takes the pressure off staff to undertake such a huge task (Gomez, 2002; Queensland Health, 2004).

General and specific

What becomes apparent from a deeper reading of the literature, however, is that what is required is to take *both* a general and specific approach (Purnell, 2000). Sue (1998) proposes that there be a clear distinction between general skills that promote cultural competence and specific skills that enhance effectiveness in a particular culture, while recognising that both are equally important[23].

In the UK, Papadopoulos and colleagues (Papadopoulos, 2003; Papadopoulos and Lees, 2002) have taken this idea further, suggesting a dynamic model in which specific and generic knowledge are intertwined. Culture-generic competence here is viewed initially as similar to the cultural awareness processes described above; one learns awareness of one's own culture and applies that knowledge to the cultures of others. When this awareness extends across ethnic groups, this level of culture-generic competence provides the ability and skill to further develop culture-specific competence, which in turn feeds into the ongoing expansion of cultural generic competence and so on.

In other words, rather than taking an either or approach, employing one reinforces the other; each layer of culture-specific knowledge adds to an ever increasing backdrop and repertoire of general knowledge about how to work across different cultures (Papadopoulos and Lees, 2002). This is a more inclusive approach, in that it does not reject one approach over the other but sees them as mutually reinforcing. As a result, this combination of approaches appears to be the most useful strategy to use.

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[23] Sue (2003) also contends that ethnic specific research may be important in laying the foundation for cultural knowledge (termed 'theoretically driven research' p. 967) because in the past this knowledge has been based on Western imposed values and views on specific cultures (etics), rather than generated from within those cultures themselves (emics).

Implementing any cultural knowledge, however, requires the avoidance of stereotyping and an appreciation of the influence of social context.

Avoidance of stereotyping

The literature is clear that cultural knowledge should not be used to perpetuate stereotypes about individuals, families, communities or groups.

Stereotypes occur when an individual's characteristics are confused with the characteristics attributed to the group (Sue, 1998). Rigid preconceptions that all or most people who are members of a particular group share some characteristic, while rejecting that there are individual differences in values and behaviours, runs the risk of negative stereotyping (Fitzgerald and colleagues, 1996). Stereotypes by professionals often emerge from over-generalisations about what these people have learnt or been taught, or insufficient knowledge (Sue and Zane, 1987). Stereotypes affect behaviour and decision-making by professionals and can lead to discriminatory practices (Betancourt and colleagues, 2003). In practice, generalisations should never override what matters to the individual (Department of Health, 2001).

The problem with stereotypes is that the assumption that all or most of the people from a group share an overarching characteristic is often wrong. For example, recent research in the U.K with parents of children with disability challenged the assumption often made by professionals that Pakistani and Bangladeshi parents have high levels of extended family support[24] (Fazil, Bywaters and colleagues, 2002). Other work, again from the UK, concluded that their "...findings offer no comfort to any professionals or service providers who seek to argue that the fatalistic attitude of ethnic minority parents to disability is a key reason for low uptake of services … the low uptake of service provision was more likely to be the result of socially created barriers to access than parental attitudes" (Bywaters and colleagues, 2003; p. 508)[25].

Stereotyping in any form is unacceptable in culturally competent practice; "The culturally competent person does not make assumptions about the characteristics of any individual based on cultural stereotypes. The culturally competent person examines all generalised statements about cultural groups

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[24] See Schofield (1990) for a similar discussion across communities in Australia.
[25] See also the discussion on 'Family involvement' in Part 2

and questions their validity" (Fitzgerald and colleagues, 1996; p. 48). Approaches that can help with this questioning are discussed in the section on 'Approaches to Thinking in a Culturally Competently' below.

The influence of social context

Understanding and addressing the social context that influences people's lives has emerged as a critical component of cultural competence (Green, Carillo, and Betancourt, 2002; in Betancourt and colleagues, 2003). By social context, what is meant are issues such as socio-economic status[26]; poverty[27]; local area of residence (Nybell and Gray, 2004); other environmental influences; lifestyle; sexual orientation (Focal Point, Fall 2002); gender (Fitzgerald and colleagues 1997); country of origin and length of residence in a host country, for example, Australia (Papadopoulos and Lees, 2002); and acculturation[28] issues (Fitzgerald and colleagues 1996; Narayan, 2003).

All these factors lead to considerable variation within cultural groups and the lives of individuals and their families. It is therefore difficult to learn a set of 'facts' about people from any particular group and hope to be effective in providing support to them (Betancourt and colleagues, 2003). It is an over-generalisation and a mistake to assume that an individual's life is based solely upon culture, separate to and over and above other social contextual aspects that surround peoples' lives (Clowes, 2003). Stereotyping, generalisations and discrimination often result from this misuse and misunderstanding of cultural knowledge (Papadopoulos and Lees, 2002).

Culturally competent care has also been argued as a holistic approach to health care that involves "…a critical examination of the socio-cultural context in which care is delivered" (Orb and Wynaden, 2001; p. 36). This holistic

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[26] For example, Walker (2001) found that low-income caregivers of children with emotional and behavioural disorders in the US were more likely to be dissatisfied with service providers' understanding of their personal situation.

[27] Poverty is a major characteristic of the lives of people from NESB with disability in Australia (Schofield, 1990) and NSW (MDAA, 2000).

[28] Acculturation is a natural process by which people adapt to new or different cultural influences or changes. The degree to which a person will have acculturated is influenced by a host of factors and will differ among individuals. For example, even within a single family, one member (a child going to school) may have greater exposure to cultural differences or change than another member (Fitzgerald and colleagues, 1996). When working culturally competently it is important to take into account the degree to which individuals have acculturated to mainstream culture or retained their own ethnic or cultural traditions (Randall-David, 1989). Minas (1990) notes that definitions and attempts to measure acculturation may place varying emphasis on variables such as economic changes, education patterns, behaviour patterns, values, linguistic change, leisure activities, family structures and roles and modes of dress.

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approach is argued to be particularly important when planning services culturally competently so that physical, psychosocial, and spiritual needs are incorporated (Evans and Garwick, 2002).

Approaches to thinking culturally competently

Cultural awareness, sensitivity, and knowledge are all key aspects to practising culturally competently (McPhatter and Ganaway, 2003; Rounds and colleagues, 1994; Suh, 2004). In order to put these into practice effectively, the literature also includes specific techniques to encourage active thinking in a culturally competent manner. Discussed first is critical reflective thinking, scientific mindedness and a model to put these into practice. How to take a different perspective follows this.

Critical thinking

An important element of cultural competence is critical thinking (Fitzgerald, 2000; Kim-Godwin and colleagues, 2001). Some authors argue that critical thinking and cultural competence "…will not occur without the other" (Wittman and Velde, 2002; p. 456). Other authors point out that through critical thinking, people "…will be able to provide culturally competent care and contextually meaningful care for clients rather than simply memorising the esoteric health beliefs and practices of any specific cultural group" (Andrews and Boyle, 1999; p. vi).

Fitzgerald (2000) terms this type of thinking 'critical reflective thinking', suggesting that "reflective thinking leading to reflective judgment…may be more critical than …possessing specific knowledge or having a particular kind of attitude towards specific groups" (p. 188).

A critical reflective thinker:

- identifies the assumptions that underlie his or her thoughts or actions;
- evaluates the accuracy and validity of these assumptions; and
- reconstitutes these assumptions as necessary. (Brookfield (1990); in Fitzgerald, 2000).

In the cultural competence literature, Wittman and Velde (2002) cite an approachable and accessible article on critical thinking by Facione (1998). Facione argues that critical thinking "is about how you approach problems, questions, issues. It is the best way we know of to get to the truth". He adds that critical thinking encourages and requires "…a critical spirit, a probing

inquisitiveness, a keenness of mind…" (p. 7)[29]. At its essence this means that the critical thinker *critically questions* the 'truth' that anyone, be they a co-worker or a professor, offers to explain something. What is being put forward as a point of view or argument may well be true, but equally it may not. Or it may be close to the truth but based on poor evidence.

To get to the bottom of what it is, Facione breaks critical thinking down into interpretation, analysis, evaluation, inference, explanation, and self-regulation. The overlap with the definitions of culture and cultural competence above are remarkable.

Interpretation refers to understanding and expressing the meaning or significance of a wide variety of experiences; situations; data; events; judgements; values; beliefs; rules and procedures; and criteria. It includes being able to identify the significance of events and clarify their meaning. Examples of interpretation are recognising a problem without bias; reading a person's intentions in their facial expressions; and identifying a point of view.

Analysis is identifying the intended and actual ways people make inferences (see point 4 below) through relationships within and between statements, questions, concepts, descriptions or other forms of expression of belief; judgement; experiences; reasons; information or opinions. This includes being able to examine ideas, detect and analyse arguments. Examples include identifying the similarities and differences between two approaches to the solution of the same problem; picking out the main claim in a statement and tracing back the supporting argument given.

Evaluation is assessing the credibility of statements or other accounts or descriptions of a person's perception, experience, situation, judgement, belief or opinion; and to assess the logical strength of the intended and actual ways

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[29] Facione quotes a consensus reached by a panel of experts on the *ideal* characteristics (which can be developed) of a critical thinker: "The ideal critical thinker is habitually inquisitive, well-informed, trustful of reason, open-minded, flexible, fair-minded in evaluation, honest in facing the personal biases, prudent in making judgments, willing to reconsider, clear about issues, orderly in complex matters, diligent in seeking relevant information, reasonable in the selection of criteria, focused on inquiry, and persistent in seeking results which are as precise as the subject and the circumstances of inquiry permit" (1998; p. 14). In case this ideal type appears too difficult, consider another quote by Facione that rams home the significance of critical thinking. Concerning the reasoning of lawyers (who for some people, for example, people with disability, are no more important than disability support workers) Facione comments, "Imagine your life and the lives of your friends and family placed in the hands of juries and judges who let their biases and stereotypes govern their decisions, who do not attend to the evidence, who are not interested in reasoned inquiry, who do not know how to draw an inference or evaluate one" (p. 13).

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people make inferences via statements, descriptions, questions or other ways of representing these. Examples include comparing the strengths and weaknesses of alternative interpretations and positions; determining the credibility of a source of information; and judging whether evidence that has been gathered supports the conclusion made.

Inference is identifying and securing elements needed to draw reasonable conclusions; form conjectures and hypotheses; to consider relevant information; and to be aware of the consequences of the data, statements, principles, evidence, judgements, beliefs, opinions, concepts, descriptions, questions or other ways these are represented. This includes querying evidence, being aware of alternatives and their implications and drawing conclusions. Examples include seeing the implications of a position someone is advocating; and when faced with a problem, developing a set of options for addressing it (see 'scientific mindedness' below).

Explanation is being able to state the results of your reasoning; justify that reasoning based on evidence, concepts, methods and contextual influences through which your results were based; and present your reasoning in the form of understandable (to yourself and others) arguments. This includes stating results, justifying an action, and presenting arguments. Two examples are citing the sources of evidence gathered to accept or reject a person's position on a topic; and writing down ideas in an ordered fashion for future reference.

Self-regulation is to monitor one's own thinking, the elements used in that thinking and the results of that thinking, particularly by applying skills in analysis and evaluation to one's own inferential judgements with a view toward questioning, confirming, validating or correcting either one's reasoning or results. This includes both self-examination and self-correction (in other words, it is okay to be wrong!). Examples include examining your views about a controversial issue with sensitivity to the possible influences of your personal biases or self interest; separating your personal opinions and assumptions from those of other people; reconsidering your interpretation of events in the view of further facts; changing your conclusion when you realise you misjudged the importance of certain facts and issues when coming to an earlier decision.

Scientific mindedness

Similar to several elements of critical reflective thinking, Sue (1998) suggests that a vital ingredient in cultural competence is being 'scientifically minded'. This approach means that those who provide support and care "form hypotheses rather than make premature conclusions about the status of culturally different clients, who develop creative ways to test hypotheses, and who act on the basis of acquired data" (p. 445).

The Mental Health Council of Australia (1998) has produced a useful resource for consumers that includes a section on 'decision making'. This is remarkably similar to scientific mindedness, but is a user-friendlier introduction to the idea of hypothesis testing. In cross-cultural situations, this is an excellent tool for overcoming difficulties that may arise, and the problems and solutions should be identified based on previously acquired cultural awareness, sensitivity and knowledge. The steps of this decision-making 'tool kit' are (remembering to avoid stereotyping):

- define the problem;
- break the problem down into manageable parts;
- identify (for example, brainstorm with others) some solutions;
- rank or prioritise the solutions;
- decide how the preferred solution will be implemented; and
- work out how it will be evaluated and when. (MHCA, 1998; p. 17).

A model to turn thinking into practice

While not from the cultural competence literature, NSW Health (2001; 2002) has provided a useful tool to encourage putting critical and scientific thinking into practice to improve care and support. This is called the Clinical Practice Improvement (CPI) model[30]. The model is geared towards clinicians in health services but can be usefully adapted to culturally competent practice in disability services. What is involved is the recognition of a problem;

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[30] Interestingly, NSW Health (2001) promotes the CPI model as a useful way for individual workers and their colleagues to effect change in their broader organisation or system, in line with the cultural competence literature discussed above: "The PDSA cycle, small scale tests, linked to reflection are powerful tools for learning in complex systems when the aim is to improve systems … However, the inculcation of the small-scale test of change as part of the daily routine and as essential steps in the continuous search for improvement is not easy. The alternative however, is much worse; to accept an inadequate status quo or to take blind stabs at change…" (p. 18).

measurement of the size and scope of the problem; identifying strategies that may reduce the problem; implementing these; and re-measuring to ascertain whether the strategy has been successful.

There are two central components to the CPI model.

- The first is to answer three fundamental questions that can be addressed in any order.

  What are we trying to accomplish? For example, find out the family's needs and expectations.

  How will we know that a change is an improvement? For example, greater understanding of the family's needs and expectations.

  What changes can we make that will result in an improvement? For example, use an interpreter.

- The second is to apply a number of tests to determine what changes are going to result in improvement. This occurs within a cycle called Plan Do Study Act (PDSA). A model of this PDSA process is shown in Figure One.

Figure One: PDSA
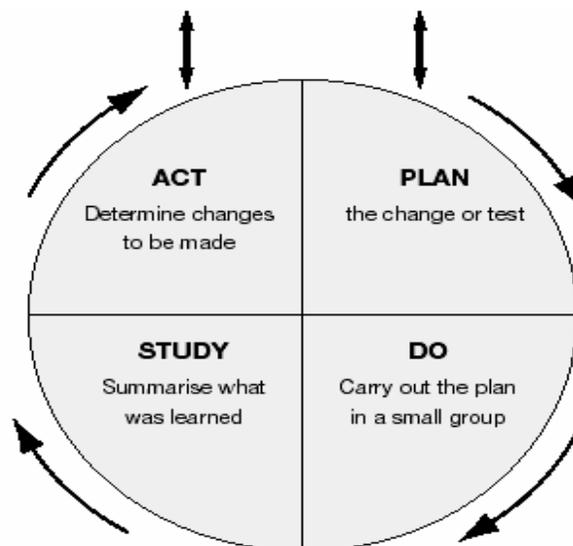
Underpinning the model are a number of important issues. The first is that improvement begins with setting *aims*. This means coming up with clear, firm intentions to make a change. The aim should be expressed in specific

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[31] The model mentions under 'Do' that it is useful to carry out plans in small groups. While this is useful for some plans, others could easily be done by individuals.

terms, eg, a 30% increase in documentation of the family's needs in a three month period.

Second, changes that lead to an actual improvement need to be *measured*. For example, the number of questions that were discussed with the family, as opposed to a simple nod of the head or questions that were misunderstood.

Third, "all improvement requires making a change but not all changes result in an improvement" (NSW Health, 2001; p. 18). Some conversations may be better than others and it is important to find out why. For example, conversations in which families reveal more about their needs and expectations may involve simpler concepts, less jargon, and be easier to understand for the family. Different sources can be used to gain good ideas about what may be important for improvement, "…critical thinking about the current system, creative thinking, watching the process, a hunch, getting insights from a completely different situation, and more" (NSW Health, 2003).

The model is based on what NSW Health (2001) term a 'trial and learning' approach to improvement: trying something; observing the consequences; and then learning from those consequences. The completion of each PDSA cycle then leads directly to the start of the next cycle. This is because to sustain improvement, continued monitoring and planning is needed. Taking a cyclical approach to cultural competence and strategies to encourage this are discussed in Part Five of this review.

Taking a different perspective

Another culturally competent strategy outlined in the literature concerns "seeing and hearing from a different position"[32] (NCDDR, 1999). What this means is that workers move beyond describing cultural awareness, sensitivity, and knowledge, to interpreting what these mean to the consumer and the consumer's family or community (Fitzgerald and colleagues, 1997; emphasis added). To do this, workers need to be able to enter the world of the consumer (family or community) and adapt their skills to that consumer's (family's or community's) cultural reality (Green, 1982; in Rounds and colleagues, 1994).

The method used in the literature to do this is termed taking an 'ethnographic' approach (Bonder and colleagues, 2001; Rounds and

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[32] This relates directly to the definition of cultural competence by Fitzgerald highlighted in part one.

colleagues; 2004). Prior to assessment (discussed in the next section), key ethnographic techniques that can be used are participant observation and ethnographic interviewing "to gather data and generate hypotheses about why people behave the way they do and what underlying assumptions support their behaviour" (Jones and colleagues, 1998; p. 45). Both require the worker to move beyond the agency setting to meet individuals and their families on their own ground, and within their everyday lives and social context. For example, Rounds and colleagues, (1994) comment concerning early childhood and disability that "The experience of coping with early childhood disability and developmental delay is best understood within the context of children's family and community and within the context of their culture". In addition, visiting the family in their own home can help foster trust building processes (Carlson and Prasad, 2001).

Concerning participant observation, once the worker has familiarised themselves with the literature on cultural differences, they should then move beyond the agency and learn through direct observation and participation in daily routines (Green, 1982; in Rounds and colleagues, 1994). Both observing and participating in the daily routines of a consumer increases the worker's awareness of how culture affects parenting, care giving and views on disability (Rounds and colleagues, 1994).

Ethnographic interviewing is similar to conducting ordinary conversations. However, the level of intensity in listening to what is said is increased, and the interviewer should be aware of any biases they may bring. The essential element is careful listening for meaning not only in content but in tone, word choice, body language and other contextual cues (Rubin and Rubin, 1995; in Bonder and colleagues (2001).

In summary, part two has discussed developing the capacity of individual workers to practice cultural competence. Developing awareness and sensitivity of the self and of others as cultural beings, and of the cultural system within which services are delivered, was discussed first. The challenging nature of the process was highlighted, along with the rewards in becoming more aware and sensitive. This was followed by discussion of issues concerning acquiring and using cultural knowledge. A distinction was made concerning cultural specific and culture general knowledge. Various sources of information and issues to look out for when gaining specific

cultural knowledge were highlighted. However it was suggested that using a combination of both specific knowledge and general cultural knowledge was a useful strategy. An explanation of and a warning against the use of stereotypes was included, as was the need to take into account the influence of social context. The final section outlined specific techniques to encourage thinking in a culturally competent manner; thinking critically and reflectively; and taking a different perspective.

Part Three
Cross-cultural Interactions

Part three of the review turns outward from the individual to issues concerning cultural competence in cross-cultural interactions. The focus is on interactions between the individual worker and consumer, but could equally be applied to cross-cultural interactions with other staff, or with family or community members. Section one outlines two strategies that can be implemented to enable more effective cross-cultural interactions between individual providers and consumers. Section two discusses the specifics involved in culturally competent communication. Section three details conducting a cultural assessment.

Effective cross-cultural encounters

This first section turns to two culturally competent approaches outlined in the literature that workers can use to build supportive relationships, respect and trust. Empowerment is central here, with the provider taking the role of expert and learner simultaneously, encouraging consumers of disability services to articulate their needs. The first approach is called 'Engagement', the second 'Credibility and Giving'.

'Engagement'

From the field of multicultural social work, Tsang and Bogo (1997) have suggested the concept of 'engagement'. The aim of engagement is to establish a space within which effective working relationships with consumers can occur. It refers directly to the initial contact between the provider and the client: "When the client is successfully engaged, differences and potential incompatibilities can be effectively addressed and a working relationship can be developed" (p. 75). Two key processes are identified in engagement: negotiating compatibility and establishing trust.

Underpinning both processes is an understanding that while specific cultural knowledge is useful, it should not be relied on exclusively. More important is to establish a learning situation in which the client and worker can collaborate; the client to learn about new ways to make sense of the situation that may or may not be part of his or her internalised cultural responses, and

the worker to learn about the client's situation and experience, and cultural understanding and influences. Negotiating compatibility is discussed first, followed by establishing trust.

In 'negotiating compatibility', the task is for the worker to discuss with the client their views and concerns, often heavily influenced by culture. Some clients, for example, may not be familiar with the mainstream approach concerning role relationships (the worker assuming an expert role (Durst, 1992; in Tsang and Bogo, 1997). Successful negotiation is based on recognition of initial differences and workers should remain open and flexible to working with these differences[33]. Specific areas to explore are an understanding of clients' specific cultural experiences, and the consumer's expectations regarding what is being offered, including perceptions of time; preference for direct or indirect communication; the importance placed on emotional support, increased self-understanding and the expert knowledge of the worker.

Establishing trust[34] is a key aspect of engaging consumers effectively. 'Trust' is produced by the client's positive expectations regarding the worker's intention to help; the worker's ability to help; and the worker's acceptance of and respect for the client. In order to increase feelings of trust the worker should demonstrate warmth, be non-judgmental, communicate empathy and understanding, and express curiosity. In addition, the worker's discomfort -

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[33] A recent report by the UK Department of Health found that patience was a key factor when working with disability service users from minority backgrounds, "At a deeper level, some staff can betray impatience at the apparent passivity of service users, who see themselves as submitting to 'God's will', and need reassurance that services in no way interfere with their faith" (Department of Health, 2001; p. 32). Work in Australia on inter-cultural communication and health care has argued that "Patience, and a sense of humour, may well be essential attributes of effective helping professionals" (Barker, 1991; p. 77).

[34] T*rust* is key to culturally competent encounters. For example, in the health literature Betancourt and colleagues (2003) point out that when cultural and linguistic barriers in the clinical encounter negatively affect communication and trust, this leads to patient dissatisfaction, poor adherence, and poorer health outcomes. In a qualitative study conducted in Queensland, occupational therapists suggested that it is important to "take time to develop rapport and trust…to encourage communication and a willingness to ask questions" (Francisco & Carlson, 2001). Narayan (2003) notes that sensitive questions can enable the patient to feel heard and understood and as a result promote trust in the nurse. In addition, a survey of families of children using mental health services in Florida found that these families judged the cultural competence of providers in terms of trust, respect, honesty, support, equality, acceptance, and mutual growth that were produced by their relationships with providers (Gomez, 2002).

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or if they are anxious[35] or wary - negatively affects trust and relationship building (Griffith, 1977; Tsui and Schultz, 1985; in Tsang and Bogo, 1997).

Credibility and giving

From the field of cross-cultural psychotherapy, Sue and Zane (1987) proposed the concepts of 'credibility' and 'giving' to enhance the therapeutic encounter. Credibility refers to the client's perception of the therapist as an effective and trustworthy helper. Giving is the client's perception that something was received from the therapeutic encounter. Credibility is discussed first, followed by giving.

Credibility can either be ascribed or achieved. An *ascribed* role is one that is given by one person to another on a preconceived understanding. This means that some specific cultures may have ascribed roles that the consumer will adhere to, based on their culture and that the therapist should be aware of. For example, youth being subordinate to elders, or specific gender roles. *Achieved* credibility refers more directly to the skills of the therapist in engendering trust, faith, hope, or confidence in the client. A provider who can provide empathetic understanding and the ability to assess clients in a way that is culturally appropriate is a good example of this. Achieved credibility can be achieved or undermined across three areas[36]. Each represents an important area that may reduce the credibility of the provider in the eyes of the client and that can be resolved to benefit the client:

- 'Conceptualisation of the problem', where the therapist's/ provider's and consumer's understanding of the problem may be different.
- 'Means for problem resolution', where the therapist / provider may require responses from the client that are culturally unacceptable.
- 'Goals for treatment', where the definitions of goals for therapy/ service provision by the therapist/ provider and client are incompatible.

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[35] An additional problem with anxiety has been highlighted in the UK, where it was found that anxiety or uncertainty about how to engage with disability service users from different cultural backgrounds can lead to an over-concentration on practical matters of care to the exclusion of offering emotional support to individuals who are struggling to come to terms with disabilities. The serious impact of this on trust and empathy is described by the comment, "It is unsurprising that many black and minority ethnic users simply do not believe that non-black and minority ethnic staff can empathise with the sometimes overwhelming impact not only of racism within the host community but also of the strong prejudices against disability which may still be prevalent within some of their own black and minority ethnic communities" (Department of Health, 2001; p.32).
[36] Each of which can be subject to critical thinking.

Where credibility is lost, it should be restored by two approaches. In one approach the therapist may need to demonstrate to the client that the therapist's perspective is effective. Alternatively the therapist may need to re-examine the appropriateness of the strategies they have used, "For example, are the (treatment) decisions guided by the therapist's limitations in understanding the culture and context of the client or by well-thought out outcome considerations for this client?" (p. 41). A useful model for approaching beliefs that may be harmful to health is discussed in detail in the next section on 'assessment'.

'Giving' refers to clients' need to feel a direct benefit as to what is being provided to them (eg, an outcome from therapy). Mechanisms to encourage this are, first, to explain what is being provided, which allows for realistic expectations about the service. The second is to build rapport and establish a relationship of trust. Some examples of 'gifts' that can be offered to the client by the therapists through this process are "anxiety reduction, depression relief, hope and faith, skills acquisition, a coping perspective, and goal setting" (Sue and Zane, 1987; p. 42). Sue and Zane do not push the cultural perspective on these. However they do mention that the therapist should ask themselves questions such as "What kind of gift is important to provide?" and "How can I offer this gift?"[37]

This section has discussed two useful strategies for disability workers and service providers to employ when interacting with consumers from diverse backgrounds. By using these culturally competent approaches, the relationship between the provider and consumer is put on a more equal footing. The provider becomes an active learner concerning the needs of the consumer, and the consumer is empowered to articulate these needs.

The next section turns to specific communication issues involved in cross-cultural interactions.

Communication

Communication provides the mechanism by which individuals interact (Davidhizar and colleagues, 1999) and culturally competent practice is, at its

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[37] Noticeably absent in Sue's discussion is the degree to which the concepts used are empowering. The power of the 'gift' appears to rest with the therapist, not the client. This is problematic if the aim of cultural competence is to build an equal status relationship. From a culturally competent empowering perspective, and one that is MDAA's perspective, the *consumer* should define what that gift actually is, and whether it is wanted or not.

essence, about communication in cross-cultural interactions[38]. The word communication originates from the Latin verb 'communicate' "to make common, share, participate, or impart" (Guralnik, 1984; in Giger and Davidhizar, 2002). At its root therefore, communication refers to the means by which culture is shared, transmitted and preserved (Giger and Davidhizar, 2002).

Communication in general is discussed first, followed by specifics of oral and non-verbal communication. Awareness of these, when coupled with the strategies outlined above, should enable providers and consumers to find ways to articulate and reconcile differences in a manner that it satisfying to all involved.

General communication

Communication establishes a sense of commonality with others and permits the sharing of information, signals or messages in the form of ideas and feelings. Therefore lack of communication not only creates barriers in accessing services but undermines trust in the quality of care received (Anderson and colleagues, 2003). Research in the health literature in particular has shown that provider-patient communication is directly linked to patient satisfaction and adherence, and subsequently to health outcomes (Betancourt and colleagues, 2003). Overcoming communication difficulties is argued to enable greater involvement of consumers in care, higher levels of satisfaction, and better (health) outcomes (Cooper-Patrick and colleagues, 1999; in Manderson and Allotey, 2003).

Communication is also tied up with expectations, understanding and empowerment[39]. For people with disability as consumers of services, and their families and carers, communication provides the mechanism to understand clearly the issues, requirements, limitations and benefits of

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[38] Type of disability also plays an important role in communicating with consumers. It is important that workers familiarise themselves with communication strategies required to work with people with intellectual disability; acquired brain injury; psychiatric disability; vision impairment; hearing impairment; and mobility disability. The NSW Department of Ageing and Disability (now DADHC, no date given) produced a useful communication handbook, which includes a brief section on NESB consumers.

[39] Carlson and Prasad (2001) have suggested an interesting empowerment strategy for consumers from a NESB with an intellectual disability and with limited English. These authors concluded from their research with Australian service providers that they "could offer individuals choices relating to their cultural background and learn from their non-verbal responses". These choices could range from contact with other people from their own cultural or linguistic group, to types of food, music, room décor and annual celebrations" (p. 11).

services. For service providers, communication provides the mechanism to understand clearly the needs and circumstances of those they seek to assist (NCDDR, 1999). For consumers, carers and families, poor explanations and a lack of information may not be questioned as people may rely on decisions taken by professionals concerning the information they should have, which in turn impacts on coping and decision making abilities (Mir and colleagues, 2001).

In addition, work in the UK has shown that language should be seen as more than just a means of communication, but as a significant primary barrier to families securing information – about their child's impairment and information about services – which is a precursor to service access (Fazil, Bywaters and colleagues, 2002). Moreover, other UK research has shown that people with disability may rely on their carers or family for information, and therefore poor communication with carers or family also has direct implications for the person cared for (Jones and colleagues, 2001; Mir and colleagues, 2001).

Oral communication

Concerning oral communication, in addition to using interpreters (discussed later), a number of specific strategies[40] have been outlined in the literature. One of the most important is not to assume English proficiency; even when a person is bi-lingual, this does not automatically mean English proficiency (MMHA, 2002). Speaking clearly and slowly is also necessary, as is the avoidance of technical terminology[41], abbreviations, professional jargon, colloquialisms, slang and abstractions (MMHA, 2002). Others suggest using the same words as the consumer and their family, and repeating them for validation of meaning and context (Heineken and McCoy, 2000). Awareness of words that may not translate (eg, 'carer') in other cultures is important, as is awareness of the degree of accuracy of the information individuals are

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[40] In addition to the general strategies concerning interactions discussed earlier.
[41] Hasnain and colleagues (2003) provide a useful example of the difficulties in expressing technical issues to communities. They concluded from the implementation of a successful outreach programme to encourage community participation and consumer involvement, "…the project faced some difficulties in engaging individuals from these diverse populations. By far the greatest challenge was explaining the concept and the benefits of the person centred planning process to these individuals. Not only was it difficult to translate the service delivery terminology and jargon, but the concepts themselves often had little meaning to people of different cultures… This reaction is understandable for people who come from … countries where there are no or few vocational rehabilitation programs and services for people with disabilities. Therefore, consumers and families needed to hear the program and its strategies described with real life examples before they would decide to become involved" (p. 14).

willing to divulge (Awaad, 2003). It may also be useful to learn some words in the language of the consumer or their family (Warden, 1996; in Francisco and Carlson, 2002).

Awareness of our own cultural influences and speech patterns is also important (Carlson and Prasad, 2001; Orb and Wynaden, 2001). For example, when asking questions 'Westerners' are often characterised by directness and boldness, and answers are expected to be direct and complete[42]. However, many other cultures value small talk and 'chitchat'[43], even in a crisis, and this indirect conversational approach may be more tactful, effective and comforting (Heineken and McCoy, 2000; Narayan, 2003)[44]. Other examples of indirect conversational techniques and questions used by nurses are listed in Figure Two below – (Leininger, 2002; adapted by Narayan, 2003).

Figure Two: Examples of Conversational Approach to Cultural Assessment (Reproduced from Narayan, 2003)

At times like this, many people draw on their religious/spiritual beliefs to help them.

- Is there anything the nurses can do to help you find the spiritual strength you need at this time?
- Are there spiritual practices that we can facilitate for you?
- Is there a religious leader/healer who you might find helpful?

Your nurses and therapists want to be polite and respectful to you and your family.

- How would you like to be addressed by our staff?
- Are there certain cultural courtesies we should practice when we come to visit you?
- Are there things we might do that you would find offensive?
- Could you please let us know if anything we do seems rude or offensive so we can fix it?

Everyone has cultural beliefs and customs that they find help them to heal.

- Are there special beliefs or customs you would like to keep related to this health problem?
- Are there special herbs/foods/treatments that you have found helpful?
- Are there healers from your community who might also be able to help you?
- How does your family think this illness should be treated? What do you think about that treatment?
- What are the characteristics of a good doctor? Of a good nurse?

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[42] In an interesting example of the risk of stereotyping with the blanket term 'Westerners', Orb and Wynaden (2001) cite research that suggests that Anglo-Saxon Australians are less direct than Hebrew, Canadian French, Argentinean, Spanish, and Germans.

[43] Both 'small talk' and 'chit chat' are interesting examples of culture and miscommunication. For some cultures, small talk may not be at all 'small' at all, and chitchat may not be merely 'informal conversation about unimportant matters' (as defined by an on-line dictionary - http//www.freesearch.co.uk/dictionary/chit-chat).

[44] One non-direct technique is to ask the consumer what a family member thinks about the question. People may be more likely to reveal their cultural beliefs when they are ascribed to another, especially when they fear that the person asking the question may be scornful of these. Often the consumer describes how a family member thinks about the issue, and then the provider can ask (non-judgementally) what the consumer thinks about the practice (Narayan, 2003). Personal observations when conducting interviews with consumers to research this project led me to ask questions about what others in the consumer's community, or in their country of origin, would think about the issue. This strategy revealed much information about personal responses.

Fitzgerald and colleagues (1996; p. 27) highlight three styles of oral communication that are important to be aware of in culturally competent interactions. Each should be viewed as occurring along a continuum:

- *Direct – Indirect* (as above): In direct oral communication, active verbs are preferred and desires, feelings, wants and needs are directly conveyed through the choice of explicit words and statements. In indirect oral communication the passive tense is used and meanings and feelings are hinted at rather than expressed directly.

- *Elaborate – Succinct*: In elaborate oral communication, expressive colourful language is used that is enriched by adjectives and adverbs. Succinct is characterised by understatement and frequent use of silences and pauses.

- *Person oriented – Status oriented*: Person oriented emphasises the 'person', conversations are informal and equality is valued. In status oriented conversations role relationships are more formal and power relationships (status and position) not expected to be equal.

Non-verbal communication

Non-verbal expression differs considerably among ethnic groups (Giger and Davidhizar, 2002). As a result, the cultural competence literature stresses the importance of taking into account non-verbal communication at all times (Awaad, 2003).

Fitzgerald and colleagues (1996) provide a useful overview of non-verbal communication. They point out that non-verbal communication includes the things individuals intend to communicate and a vast array of other messages embedded in the way people look, sound, move, feel and smell. Non-verbal communication is a powerful way to convey and express attitudes and emotions towards others such as interest, respect and attention. It also includes eye contact, facial expressions, gestures, style of speaking, pronunciation, rate and volume of speech, the complexity or simplicity of the words we use and the emotional tone we use to deliver them. Managing conversations through being aware of interpreting non-verbal cues such as gestures and pauses is also an important mechanism in culturally competent practice. Part of this approach is to realise that "the meaning ascribed to the behaviour is not necessarily an accurate representation of what the person intended" (p. 24).

Not being alert to non-verbal cues can cause difficulties and even offence, and therefore sending and receiving non-verbal (and verbal) messages accurately

and appropriately is important (Campinha-Bacote, 1999). Some examples of non-verbal behaviour that can be construed differently in different cultures are:

- Eye contact: While mainstream Australians hold that eye contact is important and may even suspect those who don't maintain eye-contact of dishonesty or disrespect, in many cultures it is disrespectful to look directly at persons in authority (Orb and Wynaden, 2001; Salimbene, 1999).

- Use of space: Personal space is the area that surrounds a person's body (Davidhizar and colleagues, 1999). Different cultures have different understandings of the required space between people when they interact (Giger and Davidhizar, 2002). Standing too close may be threatening to people from Anglo-Saxon background, while being appropriate for other cultures (Orb and Wynaden, 2001).

- Use and meaning of touch: Touching a person's head in many Asian cultures is disrespectful, even to children (Salimbene, 1999).

- Hand gestures: Hand gestures that are appropriate in one culture may be offensive in another (Orb and Wynaden, 2001).

Interpreters

Working effectively with interpreters[45] is a major element of culturally competent practice in the literature (NCDDR, 1999; Salimbene, 1999; Xakellis and colleagues, 2004). Elsewhere MDAA (2000a) has provided a comprehensive guide to the use of interpreters for disability services and readers are referred to that document for practice issues. However, the broader cultural competence literature does highlight other important issues about using interpreters.

First, it is important to use trained interpreters. Untrained interpreters can distort or withhold aspects of information being provided (Orb and Wynaden, 2001). This can increase stress and create further barriers to providing accurate information (Mir and colleagues, 2001).

Second, it is important to be aware of the cultural match concerning interpreters, as ethical issues may arise. For example, some people who speak the same language may not share the same ethnic, religious or political background (Orb and Wynaden, 2001). Similarly, gender issues within cultures (ie, male not wishing for a female interpreter or vice versa) may also

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[45] Working effectively with sign language interpreting is also important.

be important for some cultural groups on religious or ethical grounds (Giger and Davidhizar, 2002).

Third, the use of family as interpreters can raise ethical issues (Hume, 1984; in Awaad, 2003) and is generally not recommended because of confidentiality, imperfect knowledge of medical terminology and a potential harmful impact on family relationships (Riddick, 1998; in Brach and Fraser, 2001; MDAA, 2000a). However, friends and family can play an important role, especially to break the ice and build rapport with individuals who initially are uncomfortable using professional interpreters (MDAA, 2000a).

A good example of the complexities of the use of family members as interpreters was recently highlighted in research with young Asian deaf people in the UK. Being accompanied by their parents and/ or older sibling was common. However, as children got older they found this involvement more intrusive, with parents often withholding information. This was particularly frustrating as these children were dependent upon their parents to broker contact with services because of communication difficulties. Confidentiality and lack of privacy emerged as specific difficulties. The reliance on gatekeepers complicated communication for these young people and they felt they could not fully express themselves, particularly complex ideas, when going through a third party (Jones and colleagues, 2001).

Bi-cultural staff[46]

Bicultural staff (who can relate well to both Australian culture and the culture of the client or their family) have an obvious advantage over others when attempting to communicate effectively with consumers from the same cultural and linguistic background. Not surprisingly the employment and use of bicultural staff is stressed throughout the literature (National Council on Disability, 1999). For example, "Perhaps more than any other single characteristic, the literature stresses the need for the staff of culturally competent organisations to reflect the racial, ethnic and cultural diversity of intended consumers" (NCDDR, 1999). In addition to superior communication (Bywaters and colleagues, 2003), the presence of staff from diverse cultural backgrounds has been argued to increase the 'user-friendliness' of

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[46] The literature generally refers to bi-lingual staff. However when doing so reference is usually made to more than language, the importance of which is highlighted below. Therefore, where appropriate, I have used the single term 'bi-cultural'.

organisations for consumers from diverse backgrounds (Nickens, 1992; in Brach and Fraser, 2000). Research has also shown greater patient satisfaction when bilingual staff are employed (Betancourt and colleagues, 2003).

However, there are two important issues to consider when using bicultural and bilingual staff. First, these staff also need to be trained in culturally competent communication as research has shown that ethnic match of staff and consumers does not necessarily result in greater understanding or effective communication between them (Sue, 1998; 2003). While linguistic issues may be facilitated, bi-lingual staff also need to be aware of the values and concerns of particular communities (Mir and colleagues, 2001). Secondly, bi-lingual staff should not be solely responsible for working with consumers from NESB. This can lead to a 'ghettoisation' within organisations (Mir and colleagues, 2001), leading to unnecessary pressure on these staff members.

Ghettoisation is completely at odds with the concept of mainstreaming. For example, in the UK, Mir and colleagues (2001) made the important observation that "Many professionals feel ill equipped to respond to people from a different background and rely on specialist workers who share the same linguistic and cultural background. Ethnic professionals play a vital role in enabling access to services for many families; however, studies have recommended that *all* professionals should increase their competence in this area by improving awareness of all the cultural backgrounds of the people they serve…This would also have positive consequences for minority ethnic staff. A culture of *joint* responsibility towards non-English speaking service users could prevent them, and bi-lingual staff members, from being marginalised within service organisations. It would also ensure that both staff and users have access to the whole range of opportunities that are available" (p. 55; emphasis added).

The use of bi-cultural individuals extends beyond staff to people who are referred to as 'cultural brokers'. This is discussed under the section on 'Community participation'.

Assessment

The practicalities of conducting comprehensive assessments with clients from culturally and linguistically diverse backgrounds have been a major topic in the cultural competence literature (Campinha-Bacote, 1999; Giger and Davidhizar, 1995; Heineken and McCoy, 2000; Narayan, 2003; Suh, 2004).

This section looks first at the assessment process, followed by culturally competent tools and strategies used to provide more culturally informed assessments.

The assessment process

An important area in which services can empower consumers from NESB with disability is during assessment. A central reason for this is that traditional standardised assessments, usually designed for use with clients from the dominant culture, are highly problematic when used with individuals from other cultures (Bonder and colleagues, 2001).

In addition, assessment needs to take into account aspects of the individual's life, rather than those areas defined by professionals. As a result of this holistic focus individuals and their carers should be directly involved in the assessment process (Mir and colleagues, 2001). Listening, offering choices and tailoring options to individuals' needs are key features of assessment programs and design of support packages. Underpinning this type of assessment is empowerment, which "…requires more information about procedures, the removal of cultural bias from assessment tests, and the recognition of languages other than English" (Mir and colleagues, 2001; p. 31).

Explanatory models

An essential aspect of cultural assessments discussed in the literature, particularly from the field of multicultural mental health, is to elicit 'explanatory models' (Fitzgerald and colleagues, 1997). Explanatory models[47] look at the client's, family's, therapist's/ provider's, and biomedical explanations of health and illness beliefs (Kleinman and colleagues, 1978). Eliciting explanatory models is particularly important because they foster awareness and a willingness to accept that alternative values, beliefs and attitudes may be involved in a person's, family's or carer's understanding of disability (Fitzgerald, 1992). This leads to increased levels of empathy and the likelihood of providing support that is satisfying and 'sensible' to all the people involved (Fitzgerald, 1992; p. 40).

The questions enable reflection on and identification of discrepancies between the provider and client's beliefs that may cause problems in the future. These relate to the causes of, appropriate responses to and consequences of illness,

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[47] See also the section in Figure 2 below on 'Patient's Explanation of Health Problem'.

injury or disability; other culturally constituted health and illness related beliefs, behaviours and expectations, including self-help and the use of alternative healing methods; and the roles of others (especially family members) (Fitzgerald and colleagues, 1997; p. 13).

Kleinman and colleagues' (1978) original work was to compare cultural understandings of health, and this has some problems translating to disability service practice[48]. However, Multicultural Mental Health Australia (MMHA), have recently adapted the Explanatory Model questions[49] to design a 'Cultural Awareness Tool' for mental health workers to 'enhance your understanding of the patient's perception of their problem' (p. 29). With some adaptation taking into account the consumer's disability type, the nine questions suggested by MMHA could be usefully adapted for disability service practice[50]:

- What do you think caused your problem [use patients words *]
- Why do you think it started when it did?
- What do you think your [*] does to you? What are the chief problems it has caused for you?
- How severe is your [*]? What do you fear most about it?
- What kind of treatment/ help do you think you should receive?
- Within your own culture, how would your [*] be treated?
- How is your community helping you with your [*]?
- What have you been doing so far for your [*]?
- What are the most important results you hope to get from treatment?

MMHA point out the questions should be asked gently, leaving the client plenty of time to consider replies and to expand on them. The importance of such questions is that they enable the patient to be heard and understood,

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[48] This point recalls the debate concerning 'individual' and 'social' models of disability. Explanatory models focus on illness and disease, which while being socially created and defined within social systems, are sub-concepts of 'sickness' and communicated as 'health problems' (Kleinman and colleagues, 1978; p. 252). The 'social' model of disability however, views disability not as 'sickness' to be explained by an individual as a health problem, but as a product of restrictions imposed on disabled people by the structures and systems of broader society (Oliver, 1996). For disability services wishing to use explanatory models, it would be useful to focus less on terms like 'problem' and to include questions that elicit responses about societal restrictions. For example, for question 3, 'What are the daily restrictions you experience?'.

[49] See also Fitzgerald (1992).

[50] Given the intention of the original model by Kleinman and colleagues (1978), these questions should also be adapted to elicit the family's and provider's responses so these can be compared to assess any discrepancies (see also Fitzgerald, 1992).

thereby promoting trust (Narayan, 2003). Moreover, Fitzgerald and colleagues (1997) argue that it is the depth of discussion about each response that is important.

Assessment tools

There are many different cultural assessment tools[51] in the cultural competence literature. These all aim to provide a comprehensive and culturally competent assessment of clients from diverse backgrounds, and most are complex and lengthy. One of the more comprehensive yet accessible and brief tools that could be usefully adapted for disability services is Narayan's (2003) 'Cultural Assessment Checklist'. This was written for use by Home Care nurses to gather the cultural data most likely to impact on a care plan developed for culturally diverse patients. The aim of the assessment is to inform the development of "…a plan of care that is mutually agreeable, culturally acceptable, and potentially capable of producing positive outcomes" (p. 617). Substituting 'care' for 'support', this again can be usefully adapted to disability support.

After gathering specific cultural knowledge (discussed in part two above), the questions used cover a comprehensive range of cultural topics, which are then put into a cultural assessment form. These are provided in Figures 3 and 4 over.

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[51] For example, in Australia, Queensland Health (2004) provides a valuable cultural health assessment tool via their website. Giger and Davidhizar (1991) have produced an excellent book on general and specific (to ethnic groups in the US) cultural details to watch out for in assessment and intervention in transcultural nursing.

Figure Three: Cultural Assessment Checklist (Reproduced from Narayan,2003)

Degree of Acculturation
- How strictly does the patient/family adhere to the belief/values/practices of their culture of origin?
- Is the patient/family traditional (maintains ways of culture of origin)? Acculturated (understands and is able to move in/out of old/new culture)? Assimilated (has internalized the new culture's norms)?

Religion/Spiritual Needs
- Are there spiritual practices that nurses can help the patient to keep (e.g., special prayer times)?
- Are there religious articles that the patient likes to use, wear, or keep close?
- Are their special rites/blessings for the sick? Spiritual leaders/healers the patient finds helpful?
- Are there dietary prescriptions or restrictions that should be kept?

Language and Communication
- What language is the patient most comfortable speaking?
- The patient has a right to a medical interpreter. Would the patient like one?
- Is patient able to read in English or in preferred language?

Patient's Explanation of Health Problem
- What do you call the problem you are having? (Use the patient's term instead of "the problem" when asking the rest of the questions.)
- When and how did your problem begin? Why do you think the problem started when it did?
- What do you think caused this problem? Why do you think you developed this problem and not someone else? What might others in your family/community think is wrong with you?
- Do you know someone who has had this problem? What happened to that person? Do you think this will happen to you?
- What are the chief problems this condition has caused you? What problems has it brought into your life? What do you think will happen?
- What do you fear most about the problem? How serious is this problem? Do you think it is curable?
- How have you treated the problem so far? What have you done to feel better? Have you tried remedies like herbs or remedies from your homeland?
- How do you/your family/your community members think the problem should be treated? Who in your family/community/religious group can help you? Are you consulting other healers?

Nonverbal Communication Patterns
- Is eye contact considered polite or rude?
- Is personal space wider/narrower than American norms?
- When, where, and by whom can the patient be touched?
- What is the meaning behind certain facial expressions and hand/body gestures?
- Is special meaning attached to loud or whispered conversations?

Etiquette and Social Customs
- How would you like to be greeted and addressed by our staff?
- What behaviors are expected of guests? Taking shoes off? Accepting food/drink?
- Is punctuality important?
- Is it polite to engage in "small talk" before getting "down to business"?
- Should discussions be direct and forthright or subtle and indirect?
- What topics are not acceptable? Is it appropriate to share emotions and feelings? To discuss reproduction, sexual, or elimination issues? To discuss the possibility of negative outcomes?

Health/Illness Issues
- Are there health problems that carry a stigma in the culture?
- Are there culture-bound illnesses (i.e., illnesses that are only identified within the culture)?
- Are there tests/procedures/treatments that violate cultural norms?
- In past experiences with the healthcare system, what has the patient found helpful? Offensive? Confusing?

Life Span Rituals/Practices
- What beliefs, values, and practices surround life events (birth, childcare, aging, death)? Ask as appropriate to patient's situation.
- When the patient has a terminal disease, should one "tell the truth" or "maintain hope"?

Biophysical/Risk Factor Variation
- Are there genetic variations or endemic diseases frequently encountered within the patient's group?
- Do members of the culture commonly engage in practices that are harmful?

Pain Assessment
- Does the patient tend to be stoic or expressive when in pain?
- What does pain mean to the patient?
- Is pain generally described in quantitative or qualitative terms?
- Is the numerical scale confusing?
- What is the patient's attitude about taking pain medications?
- What is the worst pain you have ever had? How did you cope with it? How did you treat it? How well did the treatment work?

Nutrition Assessment
- What is eaten and when is it eaten? Perform a 2-day diet recall.
- Are there dietary patterns that may be in conflict with the plan of care (e.g., fasting)?
- Is there potential for food/drug interactions with traditional foods?
- What foods are thought to promote health? What foods are considered good for sick people?
- Does the patient ascribe to the cold-hot theory of disease and treatment?
- Are there religious food prescriptions and restrictions?

Medication Assessment
- What is the patient's attitude toward Western medications? Are they valued or distrusted?
- Could there be genetic variations in the way the patient responds to medications?
- Are there traditional remedies, such as herbs, teas, or ointments that the patient uses?

Daily (Health) Practices and Routines
- Are there special rituals/practices associated with bathing, toileting, hair/nail care?
- Are there gender/age/social class restrictions on who can help a person with ADLs?
- How important is modesty? How is modesty shown?
- Are there special morning/evening rituals or practices that are important to the patient?

Psychosocial Assessment
- Who is considered "family"? What impact does the illness have on the family?
- Who is the head of the family? Who makes decisions for the patient?
- With whom should we discuss your care? Is there someone who helps you make decisions?
- How will family members be involved in the patient's care?
- Who helps when you are sick? How do they help you? How would you like them to help you?
- What health/support services are available through the patient's cultural community?

Figure Four: Cultural Assessment Form (reproduced from Narayan, 2003) –
Use Cultural Assessment Checklist (Figure Three) to complete this form

Patient _____ Patient Number _____

Culture/Ethnicity _____ Acculturation: _____ Traditional _____ Acculturated _____ Assimilated

Religion _____ Spiritual Needs _____

Preferred language _____ Interpreter/Phone # _____

Able to read preferred language? _____ English ability: _____ Understands _____ Speaks _____ Reads

Patient's Explanation of the Health Problem _____

Nonverbal Communication Patterns _____

Etiquette and Social Customs _____

Health illness issues _____

Life Span Rituals (as appropriate) _____

Biophysical/Risk Factor Variation _____

Pain Assessment _____

Nutrition Assessment _____

Medication Assessment _____

Daily Health Practices and Routines _____

Psychosocial Assessment _____

Decision maker _____ Relationship _____ Contact Info _____

Cultural/ethnic community resources _____

Narayan (2003; p. 617) makes some useful suggestions about uncovering cultural factors that affect the patient's needs and support. These also provide a good example of how to use previously gained culture specific information strategically.

- *Pain Assessment:* Acknowledging cultural information about pain management with declarative statements and then asking if the consumer feels the same or differently is helpful. For example, to a consumer whose cultural group tends to be stoic, the nurse might say, "Some patients tell me they wouldn't admit they were in pain even if they were. Would you hesitate to tell me when you are in pain?".

- *Nutrition Assessment:* One way to determine the cultural dimensions of a consumer's (patient's) diet is to ask what the person has eaten in the past two days. Another way is to include questions cued by the cultural resources, such as asking about fasting (if common in the patient's culture) or about foods the consumer considers healing or harmful during the present illness.

- *Medication Assessment:* To determine whether traditional remedies are being used that may interact with the patient's prescribed medications,

the provider/ nurse might say, "Some of my consumers tell me about traditional remedies that are helpful when they are ill. Are there remedies, such as herbs, ointments, or teas that you have found helpful?". To determine whether the consumer has particularly strong feelings about Western medications or has had difficulties related to types of medication, the nurse can ask about past experiences with prescribed medication.

- *Functional Assessment:* Many cultural groups have special rituals for hygiene or rising and going to sleep. In addition, the cultural value placed upon modesty—who can be involved in bathing and toileting—should be explored, especially for taboos related to caregivers of the opposite sex.

- *Psychosocial Assessment:* The provider, with the consumer, should determine who should be informed about the consumer's status and involved in decisions about the patient's care. Who—the patient or another—is the decision-maker? How do the consumer and family or carers view the "sick role"? Do different family members have different degrees of acculturation to the mainstream culture causing intergenerational conflict over how illness should be treated?

Working with health beliefs

An important aspect of cultural competence is that the consumer's or their family's culturally based understanding of disability, health or illness may well diverge from the provider's and in some cases may be seen by the provider as harmful to the health of the consumer. Leininger (2002; in Narayan, 2003) has provided a useful approach that addresses these discrepancies directly. Leininger recommends that a 'maintain-preserve; accommodate-adapt; and restructure-re-pattern' framework be used to develop a 'culturally congruent plan of care'. This framework categorises the cultural assessment data (gained from the assessment) into three categories:

- 1. *Maintain-Preserve:* helpful to plan and should be preserved.

- 2. *Accommodate-Adapt:* neither helpful or harmful, and can be safely incorporated into the care plan; and

- 3. *Restructure-Re-pattern:* harmful and should be re-patterned to be health enhancing but culturally acceptable.

These can be seen in Figure 5 below, which shows which cultural practices should be preserved, accommodated, or restructured.

Figure 5: Cultural Care Planning Worksheet (reproduced from Narayan, 2003)

Patient _____ Patient Number _____

Cultural Patterns to Preserve _____

_____

_____

Cultural Patterns to Accomodate _____

_____

_____

Cultural Patterns to Restructure _____

_____

_____

Restructure Plan (LEARN) _____

_____

_____

Referring to the final section of this worksheet, when faced with cultural practices that are truly dangerous or risky to the health of the consumer, Narayan (2003; p.618) suggests implementing the LEARN model (Berlin and Fowkes, 1983, in Narayan, 2003) to restructure the behaviour:

- *Listen* to the consumer, drawing out why the harmful practice is important. Eliciting the consumer's explanatory model is considered useful here.

- *Explain* the biomedical reasons for changing the harmful practice and the adverse health effects that can occur if the practice continues. The provider (nurse) should not speak in a disparaging way about the practice, but remain respectful of all the consumer's practices, even while attempting to change those that are harmful.

- *Acknowledge* the differences and recognise the similarities in the consumer's and the nurse's perspectives. As the provider and consumer share the same goal —the consumer's health and well-being— this should be emphasised, while respectfully acknowledging each other's differences of opinion in achieving that goal.

- *Recommend* a plan that is as mutually acceptable as possible. By starting within the consumer's cultural framework, the nurse seeks a way to

honour the consumer's cultural needs and still alter the practice that is harmful.

- *Negotiate* the proposed plan with the consumer until both consumer and provider believe they have a mutually acceptable plan that will meet the consumer's goals. Although the consumer has the right to maintain cultural practices that, from the nurse's perspective, are harmful, the provider should not 'give up' on the consumer prematurely. Instead of an 'either-or' approach to care options there may be a win-win way to reach mutually agreeable goals.

In summary, this part of the review has focused on culturally competent interactions between staff and consumers. The first section outlined two culturally competent approaches to cross-cultural interactions between workers and consumers, 'Engagement' and 'Credibility and Giving'. By taking the role of both expert and learner, workers were encouraged to use these strategies to build supportive relationships, respect and trust and encourage consumers of disability services to articulate their needs. Section two focused on the specifics of cross-cultural communication. Oral and non-verbal communication and the use of interpreters and bicultural workers were all discussed. Section three focussed on conducting culturally competent assessments in order to avoid cultural bias and inappropriateness in assessments usually designed for consumers from an Anglo-Australian background. Eliciting explanatory models and a detailed cultural assessment tool proposed in the literature were discussed. Finally a strategy for working with culturally defined health beliefs that may be considered harmful to health was detailed.

Part Four

Involving Others

Part four of the review moves from a focus on provider and consumer interaction to involvement of the family, carers, and the broader community. It is important to note that this area of the review moves closest to organisational level cultural competence. Without the backing of the organisation many of these strategies will be beyond the control of the individual worker. However, these are central aspects to cultural competence in practice and must be included if an individual is to practice culturally competently.

Section one describes the issues facing families and carers of people from diverse backgrounds with disability, and highlights strategies to increase their involvement. Similarly, section two discusses the rationale in the literature behind the emphasis on community participation and strategies to achieve community engagement and involvement. This includes a section on various outreach initiatives, recommendations and strategies. Section three discusses the provision of culturally competent information.

Family and carer involvement

In both Australia (DIMIA, 2004a) and overseas (US, Office of Minority Health, 2001; UK, Mir and colleagues, 2001) involving the family and carers in decisions about support is seen as important in the provision of culturally appropriate support. This is also reflected in the cultural competence literature where it is recognised that for people in some cultural groups, family takes on more significance than personal, work-related, or national influences (Davidhizar and colleagues, 1999). Indeed, "a strong emphasis on the importance of family as defined by culture is a critical element of becoming culturally competent" (Benjamin and colleagues, no date given; in NCDDR, 1999).

Involving families and carers in decision making concerning services and care is not only an important way to empower them and the consumer (Mir and colleagues, 2001), but also improves the cultural competence of staff. For example, from Fitzgerald and colleagues' (1997) research with Australian occupational therapists, the authors concluded that "Therapists who are

aware that families may play a different, and more intimate role, and that including them when culturally appropriate may lead to more satisfying outcomes, often view family as assistants rather than adversaries. They are also more likely to avoid using stereotypes and generalised assumptions. They seem more comfortable in dealing with situations when the client does not fit their expectations of someone from a particular cultural group; for example they do not automatically assume that the family will take on a specific role." (p. 14).

Issues facing families and carers are discussed first, followed by strategies to incorporate family and carer involvement in decision making.

Issues facing families and carers[52]

In NSW, MDAA has been at the forefront in arguing that families and carers from NESB are highly likely to experience 'burn-out', often only seeking assistance when at crisis point. This is due to a number of reasons, "multiple layers of disadvantage" (MDAA, 2000b; p. 26) including poverty, lack of family support, lack of sufficient and appropriate services, and being wary of being perceived as a failure. Other research in NSW has found additional hardship among NESB carers of people using health and other support services. Many of these carers reported additional health problems directly related to the caring role, coupled with problems in accessing services due to inadequate information about services or how to apply for them, inability to communicate in English and culturally inappropriate services - including services that would not respect family dynamics - (Plunkett and Quine, 1996). Australian research on people from NESB with an intellectual disability has consistently shown that consumers and families often lack information about services available to them; understand the term 'disability' differently; perceive services as unresponsive to their needs; and often the 'stigma' of having a family member with disability prevented them from seeking services and support (Action on Disabilities within Ethnic Communities, 1995; Fitch, 1989; 1991; in Carlson and Prasad, 2001). In addition, the widely held belief that NESB immigrants have extended family support networks that assist

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[52] While family and carers are placed together here, it should be noted that not all family are carers, and not all carers are family. However, the cultural competence literature quite often fails to distinguish between the two. As a result where 'carers' is the term used in the literature, it is correspondingly used in this review.

with substantial social support for families of a person with disability has long been discredited by numerous reports (Schofield, 1990).

Research in the UK has highlighted similar issues facing carers of people from minority backgrounds with disability, and which impact directly on culturally competent practice. The Department of Health (2001) found that a heavy expectation in some ethnic families that its own members, usually the female members, assume the total caring role for any disabled member, can result in seriously inhibiting carers from articulating their own needs. The report therefore encourages assessors to spend time explaining the purpose of any support or advice in such a way that carers neither feel that their role is being undermined, nor that they are in any way failing their 'duty'. Instead, carers should be assured that the role of the service is to enable them to go on caring by not placing their own health at risk.

Other UK research (reported in Mir and colleagues, 2001) highlights that carers often do not voice needs for services as a result of negative experiences with professionals and difficulties in communication, and may fear that complaints will threaten services they are receiving. Indeed, this report suggests that many carers experience what is termed 'learned helplessness' towards services, leading to fewer attempts to access services. For example the authors comment that "Non-response, racism and difficulties in communication lead many carers to feel that no-one will help them and there is nothing they can do to improve their circumstances." (p. 35).

Concerning families, in one of the most comprehensive articles on cultural competence and disability in the social work literature, Rounds and colleagues (1994) point out that family structures differ considerably across cultures. This greatly influences how family members manage the multiple tasks of caring (for an infant or toddler) with special needs and how broadly the family is defined, as well as roles played by families in collaborating with professionals. As a result, "Whom the family includes within its boundaries varies considerably from culture to culture....To work within the cultural context of the family, social workers need to ask families to define and

describe their family in terms of its composition, structure, roles, and relationships"[53].

Other important issues facing families are (Rounds and colleagues, 1994):

- Families are faced with raising their children to live in their own culture and within mainstream society, even where these cultures may conflict with each other. It is therefore important for culturally competent providers and workers to recognise that this may be a particular difficulty facing such families.

- Religious beliefs[54] strongly affect a family's views about having a child with a disability. For example, some cultures view disability as a punishment for the wrongdoing of the family and others as a gift from God. It is important that the culturally competent provider and worker take into account these beliefs and their effects on the family.

- Help-seeking behaviour and how families and professionals interact are influenced by culture. Involvement of outsiders may run counter to normal patterns of help seeking and in some cases help seeking may itself be seen as a defect in the family, resulting in shame. Culturally competent providers and workers need to take these potential help-seeking issues into account. Indeed, it is important to ask and to respect how families would like to participate both in different ways and at different levels in care (see also Dean, 2001).

and (Narayan, 2003):

- *Caregiving:* Cultures define which family members can or should provide care to other family members. For example, it may be taboo for a husband to provide certain types of care for his wife. In addition the term 'carer' may not be understood in some cultures and attempts to promote such concepts within communities will need to ensure that the roles and expectations of the parties involved are made clear (Baxter and colleagues, 1990; in Department of Health, 2001).

- *Decision-making[55]:* In most non-Western cultural groups, it is not the patient but the head of the family or the family as a whole who is expected to hear the information from the provider and to make decisions regarding the patient's care.

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[53] For this reason others also point out that it is important to ask which family members are to be included in discussions concerning consumers; "the family will appreciate the respect and attention from staff" (Heineken and McCoy, 2000; p. 47).

[54] Determining how important religion is to the family is also important as this may lead to a family wanting representatives of their faith to be included in major healthcare decisions (Heineken and McCoy, 2000).

[55] Patient/ consumer autonomy in decision-making may not be culturally appropriate and family or community leaders may be preferred (Brach and Fraser, 2000). However, as has been discussed, there may be difficulties involved in using family as interpreters.

- *Sick role:* Western medical goals include patient independence and self-reliance. However, other cultural groups may feel that the best route to recovery is to be very passive, rest and allow the family to provide the care. Promoting independence may not be culturally appropriate and at odds with the wishes of families (Mir and colleagues, 2001).

Strategies to involve family and carers

The most culturally competent approach to families is based on recognition of family strengths and individuality (Rounds and colleagues, 1994). Similar to the strategies discussed above, a family centred approach which fosters a high degree of trust, mutual respect, and participation by both the family and the service provider is important in overcoming the potential difficulties outlined above (Rounds and colleagues, 1994). For example, recent research in the US found that providers who were more in tune with families from minority backgrounds indicated that they approached these families with humility (ie, not as experts but as equals) and respected their beliefs (Gomez, 2002)[56]. Work in the UK highlights that it is essential for services to have ongoing and meaningful consultation with families and carers of people with disabilities about their needs and how to meet them, as well as with the consumers themselves (Mir and colleagues, 2001).

Some interesting culturally competent strategies have been employed in the US to facilitate the empowerment and reduce the isolation of families and carers from diverse backgrounds with children with special needs. In New Hampshire a strategy has been put in place for services providing supports for children with severe emotional disturbances, called the Community Alliance Reform Effort (CARE-NH). This approach defined culturally competent strategies as "…those that honor a family's beliefs and ways while also effectively addressing the needs the family has prioritised…The core strategy for building cultural competence within CARE-NH is to build family and youth voices into the structures of decision making at every level of our system" (Clowes, 2003; p. 21).

Two strategies are of particular importance for this review. The central strategy employed to achieve this, at the service planning level, was to employ a (supervised) paid family partner who works closely with the family and plays an advocacy role in meetings with agency workers. In addition,

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[56] In terms of respecting beliefs, one worker commented "…go where the family is; don't change their beliefs, just work around them and make things better" (Gomez, 2002; p. 14).

family members are encouraged to identify and invite their traditional 'natural' community supports to attend family action planning meetings regarding a child. A second strategy aimed to dispel problems, similar to those identified in the UK, concerning wariness toward the 'system' by recruiting families from diverse populations to act as mentors for families entering the system of care.

The Children's Mental Health Division at Minnesota Department of Human Services[57] also argues "Cultural competence goes hand in hand with family involvement" (Ortega and colleagues, 2002; p. 18). The approach employed here is centred on creating 'parent leaders' from minority groups. These parent leaders sit on boards, help write clinical and organisational guidelines, form support groups for each other, and form advisory networks and committees for other organisations to work with[58].

In summary, this section has highlighted the importance of involving families and carers in decision-making about the support of consumers. Families and carers are often under specific pressures and use culturally defined strategies, that workers should become aware of when they are practising culturally competently. Culturally competent strategies to incorporate family and carer involvement were then described. The next section of the review moves to the next level in providing culturally competent services, community participation.

Community participation[59]

A major principle of cultural competence involves working in conjunction with 'natural, informal support and helping networks within diverse communities' (Cross and colleagues, 1989; in Goode and colleagues, 2002; p. 4). Taking a community development approach to culturally competent

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[57] The involvement of the Director of the service was instrumental in this case. "There was no research proving that a parent working inside government makes a difference. At the time, only two states had a caregiver representative…Our state's Children's Mental Health Director simply knew it was the right thing to do. She had a vision of a culturally competent and family driven system of care" (p.18).

[58] The report (Ortega and colleagues, 2002), available on line, contains excerpts written by parents themselves that provide excellent examples of how empowerment impacts the lives of parents of children with disability.

[59] 'Community participation' should not be confused with the NSW Department of Ageing, Disability and HomeCare's (DADHC) focus on 'Participation in Community Life'. The former, based on a community development approach, is concerned with communities being actively involved in decision making about issues that impact on their lives. In the latter approach decision-making is made by DADHC and aims to provide services to enable those eligible for DADHC's services to participate in community life.

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disability support has been flagged as an essential element for making disability service delivery more responsive to the needs of diverse consumers[60] (NCDDR, 1999; see also Mir and colleagues, 2001). The terms used for the approach in the cultural competence literature are either 'community participation' (HRSA, 2001) or 'community engagement' (Goode, 2001). Empowerment is again a critical element behind the approach in both the cultural competence literature (Goode, 2001) and the broader literature on culture, ethnicity and disability (for examples in Australia - Carlson and Prasad, 2001; in the UK - Mir and colleagues, 2001). The rationale for community participation/ engagement is discussed first, followed by an outline of what the approach entails. Strategies that have been implemented are then described, followed by a brief overview of providing outreach in a culturally competent manner.

Rationale

Both the US and UK governments have provided useful rationales for the inclusion of community engagement in service provision to consumers from diverse backgrounds. The US Human Services Department proposes that community participation is an essential element of good cultural competence practice: "Programs that are truly culturally competent involve clients and community members in identifying community needs, assets, and barriers, and in creating appropriate program responses. In this approach, clients and community members play an active role in needs assessment, program development, implementation, and evaluation" (US Department of Health and Human Services, 2001a).

Similarly, the UK Department of Health (2003) uses the term 'community engagement'[61], and flags the approach as a building block to the successful delivery of improved primary care and mental health services to people from minority backgrounds. "Without community engagement it will not be

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[60] Research in the UK investigating case management and assessment from an anti-racist perspective (Begum, 1995) also recommends taking up a community development model, where services encourage staff to work with local community groups to obtain referrals, develop care plans, and resource specific services. This was seen as the best method to alleviate difficulties regarding appreciation of people's religious or cultural requirements and dynamics of the diverse and unique nature of people's religious and cultural practices.

[61] Although not flagged as a specific NESB strategy, the concept of community engagement has also been encouraged by the NSW Government, again reflecting the Charter of Principles in a Culturally Diverse Society (www.communitybuilders.nsw.gov.au). See also the Department of Infrastructure, Planning, and Natural Resources (http://www.iplan.nsw.gov.au/engagement).

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possible for individual care plans/ treatments, and local services, to be designed around and capable of meeting the needs and aspirations of all racial and cultural groups within the local community. Community engagement will also improve the quality of the information available to commissioners and providers. This will enable them in turn to make services more appropriate and responsive to Black and minority ethnic communities, thus making the latter more willing to engage with services" (p. 11).

Similar to the involvement of families and carers, what community participation entails is encouraging community partners and key stakeholders to participate in meaningful ways, from serving on task forces or work-groups, participating in focus groups and consultations (see below), sub-contracting for specific services, to providing meeting facilities (Goode, 2001). As mentioned under culture specific knowledge, consulting with community members can provide useful mechanisms both to understand cultural definitions of disability, and to provide information on how to access services. However, community participation cannot be seen as 'tokenistic', but should be ongoing and informative (Mir and colleagues, 2001). It is also essential to demonstrate that contributions of each community partner are valued and respected (Goode, 2001), which should include a feedback strategy. In addition, as with family and carer involvement, it is important to recognise that individuals and groups will choose different levels of involvement and ways to participate (Goode, 2001). Indeed, it is important that what makes up a 'community' is defined by its members (Evans and Garwick, 2002; Goode, 2001).

Strategy examples

1. Cultural brokers

The National Centre for Cultural Competence (2004) in the US recently suggested using 'cultural brokers' as people who can bridge the gap between services and the communities they serve. The aim of the cultural broker is to build an awareness and understanding of the cultural factors of the diverse communities they serve and of the ways such factors influence communities. The concept is similar to the use of 'cultural experts' and 'cultural guides' discussed in Part Two.

Cultural brokers may not necessarily be members of a particular cultural group or community. However, they must have a history and experience with cultural groups for which they serve as broker including:

- the trust and respect of the community;

- knowledge of values, beliefs and health practices of cultural groups;

- an understanding of traditional wellness and healing networks within diverse communities; and

- experience navigating health care delivery and supportive systems within communities.

Particular tasks of the cultural broker are to:

- assess the values, beliefs and practices related to health in the community being served;

- enhance communication between patients/ consumers and other providers;

- advocate for the use of culturally and linguistically competent practices in the delivery of services; and

- assist with efforts to increase access to care and eliminate racial and ethnic disparities in health.

As with bi-cultural staff, cultural brokers need to be culturally competent if they are to be effective.

2. Diversity consultants

Similar to cultural brokers a second interesting recent example of culturally competent community participation is an outreach project in the US that used *diversity consultants* to improve vocational rehabilitation services for people from ethnic minorities with disabilities (Hasnain and colleagues, 2003). The approach used was 'person-centred planning'[62], defined as focusing on the needs and values of the individual, which incorporates cultural beliefs and traditions "understood on their terms, rather than based on a standard set by the dominant culture" (p. 11). The goal was "…inclusion of individuals with disabilities and their families within all aspects of the vocational rehabilitation system, with the ultimate goal being full community participation" (p. 11).

The initiative recruited individuals from a variety of communities, who represented people with disabilities, their families, or both, to serve as a pool

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[62] This is not to be confused with disability service planning being based on the Western values of individuality, which may not be a valued approach in non-Western cultures (Armstrong and Fitzgerald, 1996; Mir and colleagues, 2001).

of diversity consultants to implement various project activities. These consultants observed training and made recommendations to ensure that all project materials and activities were culturally sensitive. They also acted as translators and interpreters, enabling the project to be conducted in each person's native language. In addition they were trained to conduct marketing and outreach activities; person-centred career planning meetings which assisted individuals identify creative options and supports in their communities; and cultural sensitivity and networking training for different professional and community groups, where they acted as co-trainers. As a result, over a three year period, numbers of Black, Asian, Hispanic, and non-Caucasian consumers served by the project increased from 14% to 22.8 %.

3. Conducting community consultations

A third useful strategy comes from NSW Wentworth Area Health Service which provided an excellent step by step guide to undertaking community consultations as part of their "Culture in the Workplace Manual" (Bertram, 1997):

- Step One: Form a task group – with representatives of work team and target communities (for example cultural brokers).

- Step Two: Select language groups for consultation – examine statistical profile (see below) / select language groups using selection criteria / identify appropriate community representatives and invite to participate in task group.

- Step Three: Establish links with relevant networks of communities to be consulted – identify relevant networks / establish contacts / promote consultation process (what is being done and what is hoped to be achieved).

- Step Four: Develop, implement and evaluate the community consultation plan.

- Step Five: Summarise the information gathered and develop feedback strategies, using sample agreed format for recording information gathered.

- Step Six: Develop and implement a feedback strategy for communities consulted.

- Step Seven: Document the process that occurred throughout the strategy, completing a checklist of outcomes.

- Step Eight: Evaluate and provide feedback to all involved, including relevant documents that have been produced throughout the process.

Feedback to communities is crucial with sufficient information for the community to provide informed feedback. It is then imperative to listen and act on that feedback; "…consultation is not sufficient. This is based on the experience (yes, also bitter) that often NESB communities have been consulted and absolutely no change has occurred" (p. 10).

4. Outreach

Outreach is a vital strategy employed to facilitate community participation (Hasnain and colleagues, 2003). A recent review of the literature on outreach[63] for people with disabilities from diverse cultures in the US argued that, "…agencies must reach out to customers with disabilities from diverse cultures to ensure equality in opportunities for program and service awareness as well as participation" (National Council on Disability, 2003).

Outreach initiatives[64] need to be culturally competent (Office of Minority Health, 2001).

A number of key outreach strategies targeting ethnic communities have emerged from the disability literature.

From the same report discussed above on person-centred planning, outreach and community participation, Hasnain and colleagues (2003) made three recommendations to connect people with disabilities from diverse cultures with employment services and supports:

- Increase marketing efforts in ethnic communities to identify and address the unmet needs of underserved and unserved groups due to the lack of outreach to these populations by disability-related agencies.

- Use non-traditional outreach methods to inform ethnic and underserved communities of vocational rehabilitation service options, such as conducting informal presentations at community events and festivities, placing job notices with grassroots entities and using ethnic media.

- Conduct focus groups to identify the authentic employment and vocational needs of racial and ethnic individuals with disabilities and to incorporate them into future programs.

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[63] The many definitions of outreach are beyond the scope of this review and readers are encouraged to consider those discussed in the comprehensive review by the National Council on Disability (2003), which is also available on line (see references).

[64] It is important that outreach activities also recognise that people from NESB with disability who live in rural and remote communities may face additional hardships in accessing services in Australia. In the US the National Council on Disability (1997) produced an interesting report outlining strategies to provide better outreach to people living in rural areas. The report is available on line (see references).

They also recommend some strategies used by the project that contributed to improved outcomes for clients[65]:

Marketing Strategies

- Provide examples/stories to explain abstract concepts.
- Take services to the community.
- Work with community-based organisations and identify a contact person as a collaborator.
- Identify a gatekeeper (a representative of the community).
- Consult consumers and their communities.
- Avoid pushing American values of individualism into practice.
- Encourage community ownership.
- Avoid service acronyms and jargon.

Family and Cultural Influences

- Spend extra time getting to know the family.
- Note family dynamics.
- Include extended family members and kin relationships.
- Address the needs of both individual and family.
- Be prepared to spend time with the family after the meeting.
- Accept refreshments or insistent dinner invitations.

Communication Strategies

- Be sincere, patient, and take the time to listen.
- Avoid ethnic stereotyping.
- Build relationships and trust.
- Avoid rushing or giving that impression because it can lead to distancing.
- Respond in a non-judgemental way.
- Give people time to respond to questions.
- Provide language and other related services.
- Avoid the use of jargon and service delivery terminology.
- Note non-verbal communication cues and gestures.
- Make regular phone calls and meetings.

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[65] While the report does not directly comment on cultural competence it is interesting to note the similarity between the recommendations and the culturally competent strategies outlined throughout this review.

Building Capacity

- Use community members to assist in working with their communities.

- Use the media to inform the community (via ethnic newspapers, ethnic cable and radio stations).

- Work with existing entities where people gather (eg, community centres, religious affiliations, public library).

- Use a community worker to gather information and to generate possible referrals.

- Use networks of consumers/ parents to educate and inform other families about person-centred planning. (adapted from Hasnain and colleagues, 2003, p. 15)

Two further notable examples of outreach strategies come from the UK. The first targets 16-25 year old people from African and Caribbean communities with severe mental illness who find it hard to engage with traditional services or who have complex needs that community mental health teams find difficult to meet. The program, called Antenna, takes clients from non-traditional sources, allowing the service to offer earlier assessment and treatment. Antenna "…promotes social inclusion for its clients and builds bridges with the health sector and the community including churches, business communities, and youth teams. It trains young people who then become 'ambassadors' in the community. It has produced a video aiming to encourage young people to access help early. It operates a 360-degree[66] appraisal system whereby relatives and carers are invited annually to appraise its service" (Department of Health, 2003; p. 40).

The second strategy to consider from the UK was implemented in Bradford. A disability service that wanted to access local Asian communities began a touring exhibition using South Asian staff in public places accessible to South Asian people. These staff visited the city centre, Bradford Mela, mosques, community centres, temples, street corners and open events. Displays were made up of photographs as well as a video in Urdu. The exhibitions were advertised on a South Asian radio station, local press and in South Asian publications. What was highlighted by the initiative was that families do come forward when contact methods are relevant to their background and experiences. This not only increased referrals to services publicised but led to

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[66] The report is unclear whether this refers to a system that rotates or one that is fully transparent because relatives and carers are involved annually in evaluation. This is an interesting example of the use of jargon!

an increased awareness of disability within local communities, especially as media images of people with disabilities is missing in the UK (Mir and colleagues, 2001).

Information

Information and communication overlap considerably, and information is as important for the individual consumer as the family, carers, or broader community. However, information is included in this part of the review because it is a major part of making others outside the immediate interaction between workers and consumers aware of and able to access disability services, and feel comfortable once services have been accessed. General issues concerning culturally competent information are discussed first, followed by examples of strategies that have been implemented to improve information and information dissemination.

General Issues

Information provided by services to communities needs to be culturally competent, as information messages about services (ie, print materials, videos, television, or radio messages) developed for the majority population may be inaccessible or unsuitable for other cultural or ethnic groups (Giger and Davidhizar, 2002). Such messages need to be translated, accessible and appropriate to local communities (Anderson and colleagues, 2003; NCDDR, 1999) as the absence of translated and accessible materials contributes to low awareness and take-up of services (Mir and colleagues, 2001). Images and language used in information materials should be culturally appropriate (MDAA, 2000a). People's different education levels also need to be taken into account as individuals experience different levels of literacy, which affects how accessible information is to them (US Office of Minority Health, 2001). Furthermore organisations must make this information available within the organisation itself (US Office of Minority Health, 2001), and distribute it through appropriate channels within the community (Mir and colleagues, 2001).

The provision of culturally competent information has been extended to include the physical environment of the organisation, including materials and resources (Goode, 2000b). It is important that individuals are conscious of the organisational setting in which they work as this setting is key in making outsiders more comfortable with the environment. Pictures, posters and other

materials should reflect the cultural, linguistic and ethnic backgrounds of clients and families served by the service (Goode, 2000b; MDAA, 2000a). Magazines, brochures and other printed materials in reception areas should also reflect these (Goode, 2000b). At the reception area a large interpreter sign should be displayed indicating that people can use an interpreter in their language of choice (MDAA, 2000a).

Strategies

To provide effective information and dissemination, culturally competent information:

- Reflects the languages found in the local community, based on local demographics (US Office of Minority Health, 2001).
- Takes into account the specific cultural norms of the local communities (Anderson and colleagues, 2003).
- Avoids excessive technical descriptions or jargon (Mir and colleagues 2001; US Office of Minority Health, 2001).
- Takes into account the levels of literacy of consumers (US Office of Minority Health, 2001).
- Is not provided in a vacuum. The information produced should be linked to staff who can respond appropriately to queries concerning the information (Mir and colleagues, 2001; US Office of Minority Health, 2001).

In NSW, MDAA (2004c) has produced a useful fact sheet on translating and disseminating information and promotional material. Readers are encouraged to read it for further detail. Important strategies included are planning (including an estimate of costs); research (use the local data profile on local communities' cultural, religious and linguistic make-up); consulting specialists (cultural brokers) concerning translation of key concepts, including literal translation of disability; accessing translators; disseminating the information effectively (network, liaise and forge links)[67]; evaluating the effectiveness of the materials.

Work in the UK by the Department of Health (2001) highlights areas to be wary of in terms of leaflet production by disability services. Problems were found to be due to:

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[67] Disseminating information through ethnic electronic media organisations, newspapers and newsletters has been flagged elsewhere in Australia as useful (Carlson and Prasad, 2001).

- The language used in translation being pitched at the wrong level or wrong dialect, especially if they were not tested with local readership.

- The leaflets were not distributed to the most appropriate locations beyond social services offices, such as GPs' surgeries, religious or retail venues.

- Low levels of literacy in local communities were not accounted for.

- Cultural preferences for oral communication of information were not accounted for.

As a result the report highlights a number of local councils that were more creative in their use of different media approaches:

- The production of a number of video tapes in the form of 'soap opera' type plays (Bradford).

- A bi-monthly newsletter for Asian communities entitled Ujala and a video, in association with its local race equality council, in four Asian languages (Kirklees).

- Conferences which targeted minority communities (Nottingham and Rotheram).

- Employment of an ethnic link worker to disseminate information to communities (Rotheram).

Some other positive examples of information dissemination strategies are also given. Birmingham recruited volunteer organisations to network with others in raising awareness of visual impairment. Others have used ethnic communities themselves, for example Bradford was reported to have an Asian Disability Network of around 400 members, and Leeds and Kirklees have established networks for younger disabled members of minority communities. The report also flags the internet as a viable option (Mir and colleagues, 2001).

In NSW, MDAA[68] has also undertaken an innovative project, employing people from a non-English speaking background (NESB) with disability and their families and friends who are trained in public speaking and willing to share their stories. These 'community voices' attend services and events, encouraging discussion and raising awareness of diversity and disability issues among staff and the community.

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[68] Further details on 'Community Voices' can be found at
http://www.mdaa.org.au/work/index.html#voices

In summary, part four has covered critical areas of culturally competent practice that move beyond the individual interaction between workers and consumers. Family and carer involvement was discussed first, followed by community participation and outreach, and then information. The reasons behind taking a culturally competent to each area were highlighted. Following this, for each area examples of approaches, strategies and recommendations to improve practice were put forward.

Part Five

Culturally Competent Self-assessment and Growth

This part of the review returns inward to individual development through self-assessment for cultural competence. The reasons behind and elements involved in conducting a self-assessment are discussed first. This is followed by a discussion of checklists to assess culturally competent processes and a stage-by-stage model of culturally competent growth. Specific implications for practice are then discussed: measuring success; feedback from colleagues; involving consumers, families and carers, and communities; and competence as a goal. The final section puts forward characteristics of a culturally competent person, as outlined in the literature.

Rationale for self-assessment

The shift to cultural competence does not happen overnight, because cultural competence is a developmental *process* that evolves along a continuum of growth over an extended period (Cross, 1988; Goode and colleagues, 2002; McPhatter and Ganaway, 2003). A useful way of assessing and encouraging growth in cultural competence is to conduct a periodic self-assessment. There are two elements to this self-assessment. One is a checklist of culturally competent behaviour. The second assesses growth along a continuum. Combining the two promotes awareness, knowledge, and skill acquisition that leads individuals to higher levels of functioning (Goode and colleagues, 2002). In line with the long-term nature of growth, assessment should occur periodically as part of an ongoing staff (or personal) development program or as a mechanism for staff supervision or appraisal (Rounds and colleagues, 1994).

Checklist

Taking the checklist first, based on the work of the National Centre For Cultural Competence in the US (see also Goode, 2002; and Goode and colleagues, 2002), MDAA (2004b) has adapted a cultural competence checklist[69] to encourage cultural competence in disability services in NSW.

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[69] For specifics of the checklist see MDAA (2004b), available online at www.mdaa.org.au

The utility of such checklists lies in that they covers specific areas of culturally competent practice, or 'strengths', that can be identified as being successfully addressed, or where more work may be needed, or 'areas of growth' (Goode and colleagues, 2002; p. 2). The checklist covers the work environment, communication, values and attitudes, and is relatively short and easy to use.

Monitoring growth

Turning to monitoring growth along a continuum, McPhatter and Ganaway (2003) adapted[70] a model of change from the psychology literature (Prochaska and DiClimente, 1982; in McPhatter and Ganaway, 2003) for use by individuals[71] working towards cultural competence. This model identifies the level of growth at which an individual is operating, or at which they wish to operate in the future. In the words of the authors, "The concepts and proposed change model will catapult organisations and …professionals forward in addressing multicultural practice and service delivery" (McPhatter and Ganaway, 2003; p. 123).

The model occurs over five stages, each representing a level on a continuum of change. Parnell and Benton (1999), in the HIV literature, provided a very useful visual model of the processes involved at each stage of Prochaska and DiClimente's model of change. Their work illustrates how behaviour change can be achieved and maintained in an individual. A brief overview of this work provides a useful backdrop to the work on cultural competence by McPhatter and Ganaway (2003). There is considerable overlap with 'Approaches to thinking culturally competently' discussed in Part Two of this review.

At the precontemplation stage a person may not realise that change is possible, desirable, or even relevant to them. They have not yet begun to contemplate change. Later something happens that prompts them to think about change, at which point they begin the contemplation stage. Next is the preparation stage, when the person begins to prepare for change by gathering information; finding out how to achieve change; learning what skills are necessary; and deciding when change will take place. Eventually, the person

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[70] While the individual is the focus here, the model has also been adapted for use to assess organisations and interpersonal growth. This again highlights the need for cultural competence to occur throughout an organisation if is to be most effective, "Change involves engaging in processes at the right time with appropriate support at all levels of the agency" (p. 108).
[71] They include separate models for organisational and interpersonal growth.

will change their behaviour and move to the action stage. Here they act on previous decisions, experience, information, new skills and motivation for making the change. At the maintenance stage, practice of the newly adopted behaviour is required for it to be consistently maintained.

These stages are illustrated with a curved line, representing the fact that change is rarely a straightforward process.
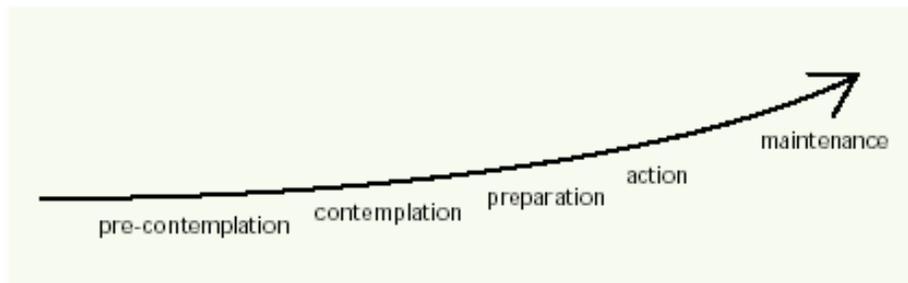
The first stages of behaviour change

(Reproduced from Parnell and Benton, 1999)

For all sorts of reasons people might move back to earlier stages and work through them again. This is not negative, simply realistic. However, people never move back to the precontemplation stage. They may though, return to the contemplation stage for more reflection and thinking, or to the preparation stage to gather new skills or more support, before continuing on again through the other stages. Because the starting place cannot be the same – both the person and the world around them are not the same – the illustration is a spiral rather than a circle.
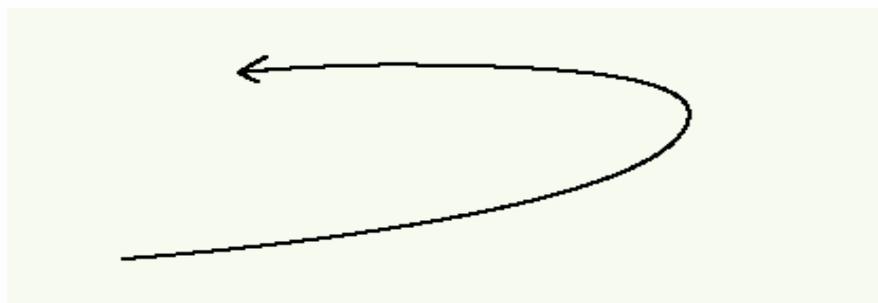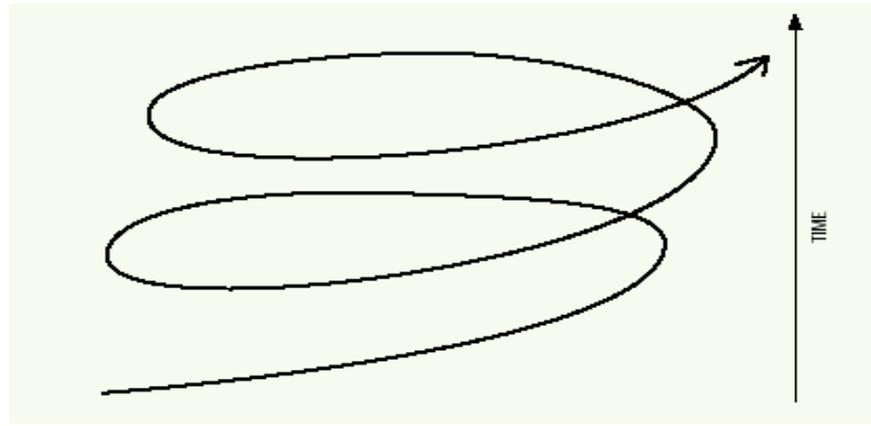
The ongoing spiral of behaviour change

(Reproduced from Parnell and Benton, 1999)

Maintaining behaviour means that a person may go through the same stages, or some of them, more than once. Once a person reaches the action stage

again, there may still be a return to the earlier stages. To illustrate this a longer spiral can be drawn. This represents change over the long term.

The full spiral of stages of behaviour change

(Reproduced from Parnell and Benton, 1999)

The culturally competent stages of this illustrated process as outlined by McPhatter and Ganaway (2003) are:

Precontemplation: Individual workers lack awareness of a need for change. For example, people attend training on cultural issues only because of pressure or requirements from supervisors.

The goal for this stage is to bring the problem into awareness and establish a beginning level of awareness about how culturally ineffective practice affects both the individual worker and consumers.

To achieve this, the individual worker must:
- begin a dialogue with colleagues and experts about their role in providing culturally competent services;
- acquire information that highlights the effects of culturally ineffective practice; and
- gain an understanding of issues and concerns related to cultural diversity.

Contemplation: Individual workers are aware that a need exists and may be giving major consideration to responding to this awareness, but have not yet committed to doing so.

The goal for this stage is to acknowledge the need for culturally effective practice.

To achieve this, the individual worker must:

- reflect on their level of effectiveness when working with diverse consumers;
- examine their own cultural backgrounds and potential biases;
- further explore the effects of culturally incompetent practice on consumers;
- begin to identify gaps in their awareness, knowledge and skills; and
- explore ways of filling these gaps

Preparation: Individual workers clearly state intentions to begin the process of becoming culturally competent and make a commitment to pursue this goal. Activities correspond directly to formal planning for culturally competent practice.

The goals for this stage are clearly stating the intention to be culturally competent; committing to becoming culturally competent.

To achieve this, the individual worker must:

- explore and understand their own belief systems as they relate to cultural diversity;
- explore whether they use stereotypes and have biases about racially, ethnically, and culturally different people;
- develop an individual worker education plan for acquiring knowledge and skills in culturally competent practice;
- establish a self-care process which includes stress management;
- develop mutually beneficial connections with key community leaders and cultural guides; and
- explore their own ways of dealing with and responding to stress and change, including denial and rationalising behaviour.

Action: Individual workers expressed commitment to change turns into observable activities, with time, energy and resources being expended.

The goal for this stage is to create and maintain behavioural indicators of cultural competence.

To achieve this, the individual worker must:

- participate in ongoing professional development activities such as education, training, seminars, research, and discussions on cultural diversity;

- expand connections with culturally diverse professional and community based groups and activities;

- actively pursue expert consultation and supervision relating to cultural competence goals;

- establish professional accountability with colleagues to address challenges of diversity issues;

- assess the cultural competence plan relative to the efforts of the individual worker; and

- engage in self-care activities, such as stress management and burnout.

Maintenance: Individual workers incorporate culturally competent actions and behavioural change into everyday actions and behaviour. During this stage the changes become routine. To maintain changes and prevent relapses, reinforcement needs to occur. It is necessary also to anticipate situational and personal factors that may become problematic in future work.

To achieve this, the individual worker must:

- examine problems that may have surfaced and become barriers to culturally competent growth;

- assess emotional reactions to cultural competence goals and organisational barriers;

- evaluate productive and non-productive behavioural responses to cultural competence goals, eg, what prevents moving forward, what needs to happen to move forward; and

- assess progress and level of competence in working with culturally diverse colleagues and clients (eg, using an extensive self-assessment checklist like the one proposed by Goode, 2002).

Implications for practice

Measuring success

As mentioned at the start of this review, there is a lack of systematic empirical evaluation of the success of cultural competence as an approach. This is a valid issue in many (Western) work cultures and systems where it is important to evaluate whether processes and outcomes are deemed successful or not. While it is recognised that empirical evaluation is beyond the

resources and abilities of many organisations and individuals in the disability sector, both the checklist and continuum tool provide an opportunity for an individual to evaluate 72 systematically using data, changes in culturally competent practice over time. Comparing data at each period of assessment means that people can compare changes as they occur over time both as individuals and, if the data is pooled, as a group or an organisation. Graphing this data can provide visual encouragement to change.

Feedback from colleagues

The literature highlights the collaborative nature of cultural competence (Goode and colleagues, 2002; McPhatter and Ganaway, 2003), and for assessment it may be worthwhile to approach other staff members for assistance. This may encourage comments and strategies that the individual on their own may not consider. However, although it is important to create an atmosphere that encourages critical thinking, it is important not to create an atmosphere that allows ridicule and blame[73]. As shown by the model of change illustration, individuals may vary greatly along the continuum at different times. It is therefore important to allow people to give honest statements of their level of awareness, knowledge and skills related to cultural competence (Goode and colleagues, 2002).

Involving consumers, families and carers, and the community

It is important to involve consumers, their families and carers, and where appropriate the broader community in the assessment (Goode and colleagues, 2002). The consumer, family and carer are often in the best position to comment on the worker's level of competence when interacting with them. This requires openness and honesty in the relationship with consumers and their family and carers, which in itself is a central component of culturally competent support.

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[72] In the course of researching Phase 2 of this project, it became apparent that including culturally competent measures as part of key performance indicators, followed up at staff appraisals, is an opportune time to conduct formal self-assessments.

[73] In an essay on critical thinking, Facione (1998) quotes a psychologist, "In classrooms and in companies people fear 'looking stupid' or asking something that is 'dumb'". So teachers and employers must start removing conformity and the fear of dumbness from the classroom and workplace.' (p.7). The same applies to people working with each other on cultural competence.

Competence as a goal

As discussed, some authors contend that cultural competence has no endpoint (Cross, 1989; Tervalon and Murray Garcia, 1998). This may be the case, as illustrated by the model of change. However, it is reasonable to suggest that reaching the maintenance level should be viewed as an achievable goal. Goal attainment in Western culture is positive, encouraging a belief in a person that they can achieve something. In addition a core aspect of operating at the maintenance level is an acute awareness that cultural competence is a process of ongoing change where we are continually learning about others and ourselves in a constructive way. The alternative is telling people, many of whom are acculturated to Western notions of achievement and success, that they will never achieve something. This could well be self-defeating.

Characteristics of a culturally competent person

Finally, to help encourage a sense of achievement, below is a list of characteristics of a culturally competent. These characteristics, while taken from one article on practice in primary health care, neatly tie up all the points in this review into a character profile of a culturally competent individual. All of these can be learnt or enhanced and all represent a considerable level of personal and professional growth.

Characteristics of a culturally competent person (Randall-David, 1994; in Rorie and colleagues, 1996):

- Moves from cultural unawareness to an awareness and sensitivity of his/ her own cultural heritage.
- Recognises his/ her own values and biases and is aware of how they may affect clients from other cultures.
- Demonstrates comfort with cultural differences that exist between her/ himself and clients.
- Knows specifics about the particular cultural groups s/he is working with.
- Understands the historical events that may have caused harm to particular cultural groups.
- Respects and is aware of the unique needs of clients from diverse communities.

- Understands the importance of diversity within as well as between cultures.

- Endeavours to learn more about cultural communities through client interactions; participation in cultural diversity workshops and community events; readings on cultural dynamics; and consultations with community experts.

- Makes a continuous effort to understand the other's point of view.

- Demonstrates flexibility and tolerance of ambiguity, and is non-judgemental.

- Maintains a sense of humour and an open mind.

- Demonstrates a willingness to relinquish control in encounters with others, to risk failure and to look within for the source of frustration, anger and resistance.

- Acknowledges that the process is as important as the product.

In summary, part five of the review has discussed culturally competent self-assessment and growth. A checklist tool was discussed, followed by a detailed discussion of a model of culturally competent change across a continuum. Key practice issues involved in assessment and evaluation were highlighted. The final section provided a list of culturally competent characteristics to encourage self-development.

Summary and Conclusion

This literature review has detailed key areas of culturally competent practice. Each of the tools, strategies, approaches and recommendations described will enable disability service managers and staff to provide quality and effective service and support. This will go a long way to improving outcomes for consumers of disability services.

The first part of the review began with a discussion of definitions of cultural competence and explored the practical implications of 'culture' and 'competence'. By adding competence to the broad and complex definition of culture, it became apparent that cultural competence is based on continued learning and deep understanding. A discussion of empowerment, which underpins much of the literature on cultural competence, followed. For consumers empowerment means increased, active choice and control. For workers it means a shift towards actively learning from consumers and is accompanied by an increase in leadership and advocacy skills.

Part two of the review discussed developing the capacity to practice cultural competence in the individual worker. This began by describing the shift from increased cultural awareness and sensitivity concerning the self as a cultural being, to increased awareness and sensitivity concerning others as cultural beings. This was followed by a discussion of the acquisition of specific and general cultural knowledge, and a caution against the misuse of cultural knowledge leading to stereotyping and a lack of appreciation of social influences on the lives of consumers. The final section looked at specific techniques to encourage thinking in a culturally competent manner.

Part three moved out from the individual to focus on culturally competent interactions between staff and consumers. The main emphasis was on a collaborative approach where the worker and consumer were open to learning about each other. The first section encouraged the use of two strategies to build supportive relationships, respect and trust and to encourage consumers of disability services to articulate their needs. The next section covered the specifics of cross-cultural communication. Verbal and non-verbal communication, and the use of interpreters and bilingual workers were all discussed. Section three outlined specific approaches to conducting a cultural assessment.

Part four moved beyond the individual interaction between workers and consumers to involvement of family and carers and the community. Issues behind the involvement of family and carers were discussed first, followed by strategies to increase their involvement. The rationale behind taking a culturally competent approach to community participation was then discussed. This was followed by examples of strategies employed and recommendations proposed to facilitate community participation, including outreach initiatives. Strategies for culturally competent information design and dissemination were then proposed.

The fifth and final part of the review detailed culturally competent self-assessment with growth in cultural competence along a continuum over time. A checklist to assess cultural competence was discussed. This was followed by a detailed discussion of an adapted model of change along a culturally competent continuum. Specific practice issues were then highlighted, which were the need to collect data; work collaboratively; to involve others including consumers, families and carers, and communities; and to treat competence as a valid goal to attain. The final section provided a list of culturally competent characteristics to encourage self-development.

To conclude, the depth and breadth of the literature on cultural competence, and culture and disability is formidable. While this literature is in the main not empirically based and relies more on theoretical and conceptual work, the level of conceptualisation is impressively detailed. In particular the high level of conceptualisation and writing in the Social Work and Disability literature has positive implications for disability service delivery. When combined with the literature from other fields such as Health, the base from which to deliver culturally competent support has yet greater strength.

Providing a structure to a process that is as complex, dynamic and interwoven as cultural competence is a necessary limitation. The structure provides a much needed exploration of the concept in order to answer the question posed to MDAA that provided the impetus for the review, 'What does cultural competence mean in practice?" However, it is hoped that the reader will recognise the fluid and interconnected nature of cultural competence.

The result of this review is that disability staff, services, educators and students now have a detailed description of a considerable amount of

literature on which to base future culturally competent practice as core elements of service delivery and staff and student development. While each local community and each consumer and their family is different, there is little need to 'reinvent the wheel' concerning culturally competent practice. Instead, it is hoped that each individual worker and each organisation within which they work, will think reflectively about the practices detailed and discussed in this review. From this they will be able to grow as individuals, as culturally competent practitioners and as leaders in their organisations. Most importantly they will be able to use these changes creatively to provide and where necessary improve the support of individual consumers and their families and carers.

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