Evaluation of the Culturally and Linguistically Diverse (CALD) component of the National Community Connector Program

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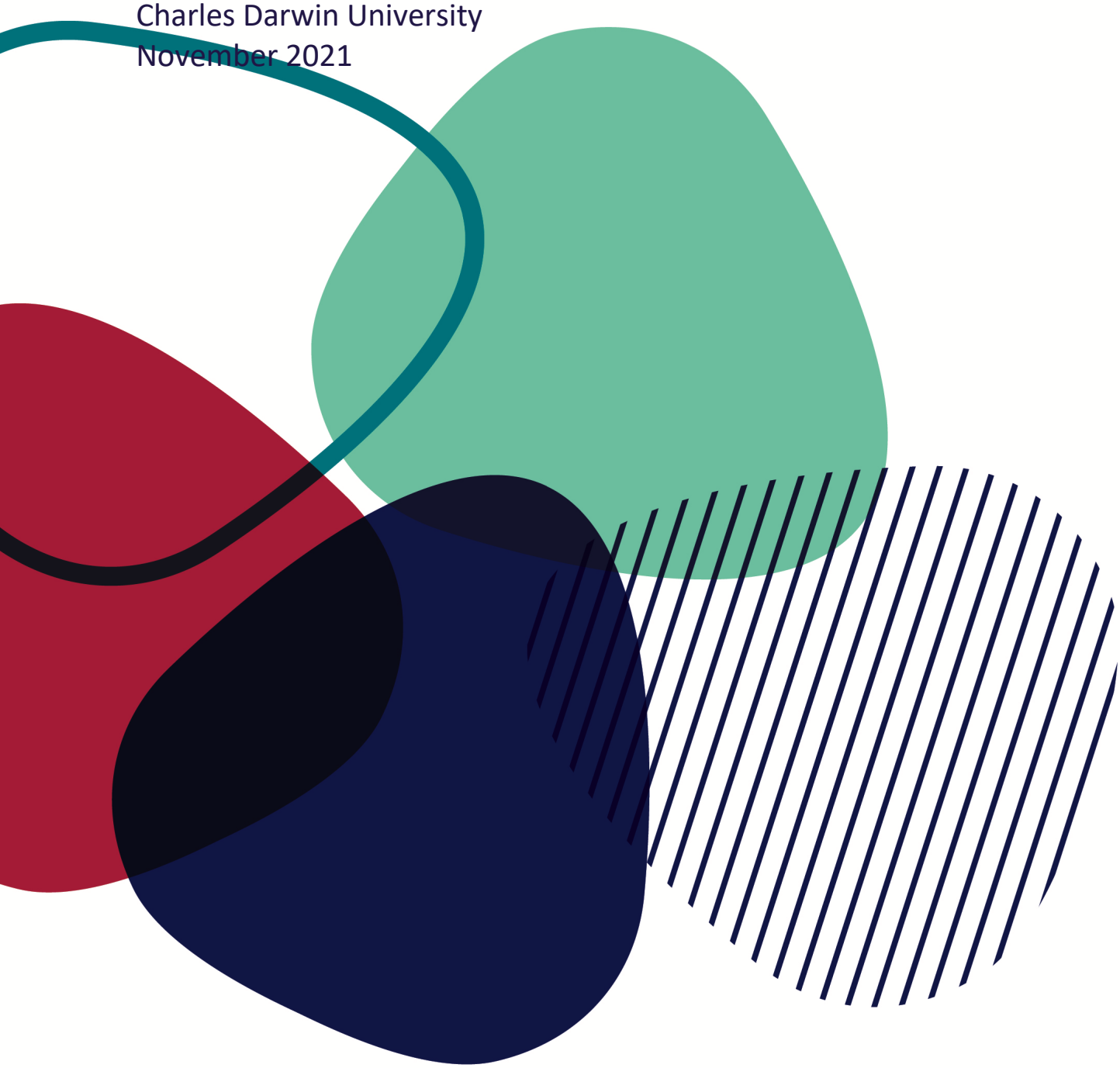

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Acronyms

ARF	Access Request Form
CaLD	Culturally and Linguistically Diverse
CoP	Community of Practice
CRPD	Convention on the Rights of Persons with Disabilities
ECEI	NDIS Early Childhood Early Intervention
FECCA	Federation of Ethnic Communities' Council of Australia
FTE	Full Time Equivalent
GPs	General Practitioners
LAC	NDIS Local Area Coordination
LGA	Local Government Area
NEDA	National Ethnic Disability Alliance
NCCP	National Community Connectors Program
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
PITC	NDIS Partners in the Community
TIS	Translation and Interpreting Services

Contents

Acknowledgements ii
Acronyms ii
Contents iii
Executive Summary 2
1.1 Who did the Community Connectors work with? 2
1.2 Barriers to access 3
1.3 Strategies to address the barriers 3
1.4 Limitations 4
1.5 Considerations for the future 4
2 Introduction 6
2.1 The CaLD component of the National Community Connectors Program 6
2.2 The National Disability Insurance Scheme 7
3 Methodology and methods 9
3.1 Development of Program Theory 10
3.2 Ethics 10
3.3 Data Sources 10
3.3.1 Client data 10
3.3.2 Education and Collaboration activities 11
3.3.3 Quarterly reports 11
3.3.4 Participant observation at Community of Practice meetings 11
3.3.5 Interviews and focus groups 11
3.3.6 Reflection surveys 12
3.4 Analysis 12
3.5 Limitations 12
4 Evaluation Findings 14
4.1 Overview of client characteristics 14
4.1.1 Gender and Age 16
4.1.2 Visa status and years lived in Australia 18
4.1.3 Cultures and preferred languages 19
4.1.4 Need for interpreter services 20
4.1.5 Types of disability 21
4.1.6 Location 22
4.2 Barriers to accessing the NDIS 22
4.2.1 Cultural barriers and understandings of disability 26
4.2.2 Misunderstandings about NDIS 27
4.2.3 Language and communication barriers 27
4.2.4 Difficulty navigating health and disability services 28

4.2.5 Addressing the barriers 29
4.3 Person-centered, tailored approaches to service delivery 29
4.3.1 Summary of services and outcomes 29
4.3.2 Program theory 33
4.3.3 Where it worked 36
4.3.4 Where it did not work 39
4.4 Assertive outreach 41
4.4.1 Where it worked 44
4.4.2 Where it did not work 47
4.4.3 Refined program theory for assertive outreach 49
4.5 Partnerships and Networks 50
4.5.1 Collaboration with NDIS PITC 53
4.5.2 Collaboration with cultural and community groups 57
4.5.3 Refined program theory 60
4.6 Education activities 60
5 Summary and considerations for the future 64
6 Appendices 66
6.1.1 Appendix 1: A brief introduction to Realist Evaluation 66
6.1.2 Appendix 2: Detailed evaluation design and ethics information 67
6.1.3 Appendix 3: Detail of initial program theory and data sources used for analysis 82
6.1.4 Appendix 4: Detailed quantitative findings 87
6.1.5 Appendix 5: Detailed description of the CaLD Community Connectors Program 93
7 References 98

List of Tables

Table 1: Community Connector Functions outlined in the NCCP Framework 6
Table 2: How program theory is articulated in a realist evaluation 9
Table 3: Socio-demographic characteristics of the client data sample (PWD and carers) 14
Table 4: Barriers at access and pre-access stages 25
Table 5: Combined reporting data for NEDA, FECCA and total for NCCP, 2020-2021 30
Table 6: Combined reporting data, 2020-2021, number of activities and people 43
Table 7: Types of education activities provided by Community Connectors 61
Table 8: CMOs for People with Disabilities and Carers 68
Table 9: CMO's for Organisations and Networks 69
Table 10: CMO's: Relationships (PWD&C) 69
Table 11: Relationships: Organisations – CC's 70
Table 12:CMO's: Using data to improve services 70
Table 13:Program Less likely to be effective when... 71
Table 14: Program less likely to be effective when 71
Table 15: Data dictionary for the Evaluation Data Collection tool 73
Table 16: Frequency of barriers encountered by people with disability who knew about the NDIS, but had not previously applied 87

Table 17: Frequency of barriers encountered by people with disability at pre-access and access stages of engaging with the NDIS 87
Table 18: Frequency of barriers encountered by people with disability at implementation and plan review stages of engaging with the NDIS 88
Table 19: Frequency of barriers encountered by carers engaging with the NDIS 88
Table 20: Specific ethnicities people with disabilities identified with 89
Table 21: Preferred language(s) spoken at home by people with disability 89
Table 22: Specific ethnicities carers identified with 90
Table 23: Preferred language(s) spoken at home by carers 90
Table 24: Types of disability and engagement with the NDIS 91
Table 25: Provision of information and referrals 92

List of Figures

Figure 2: Stage of engaging with the NDIS, per cent 15
Figure 3: Whether NDIS eligibility approved and whether utilising NDIS funding, per cent 16
Figure 4: Age and gender of people with disabilities in the client data set, per cent 17
Figure 5: Whether NDIS eligibility approved by age group, per cent of people with disability 18
Figure 6: NDIS eligibility status of people with disability, by time living in Australia, per cent 19
Figure 7: Whether people with disability and carers required an interpreter, per cent 20
Figure 8: Whether people with disability required an interpreter by age, per cent 21
Figure 9: Types of disability as reported by Community Connectors, per cent 22
Figure 10: People with disability (PWD) and carers: prior knowledge / previous attempt to access NDIS: 23
Figure 11: Approximate number of sessions per client 32
Figure 12: Types of partnership activities reported by Community Connectors, percent 51
Figure 13: Linkage to NDIS PITC, information and non-NDIS referrals for people with disability 53
Figure 14:Types of organisation/networks provided with education by Community Connectors, per cent 61

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Executive Summary

The Federation of Ethnic Communities Council of Australia (FECCA) and the National Ethnic Disability Association (NEDA) were awarded funding by the National Disability Insurance Agency (NDIA) to conduct the Culturally and Linguistically Diverse (CaLD) component of the National Community Connectors Program (NCCP).

The program commenced in July 2020 and ceased at the end of June 2021. FECCA and NEDA subcontracted 23 community-based non-government organisations to employ Community Connectors and commence operations. However, it took some time for all Connectors to be employed, and Community Connectors were instructed not to accept new clients after April 2021. This meant that local programs' direct service delivery component effectively operated for between 6 and 9 months.

This realist evaluation of the CaLD Community Connectors seeks to understand 'what works for whom' in supporting CaLD people with disability and their carers to access the NDIS. The purpose of the evaluation is to improve understanding of:

- the barriers to access to the NDIS for CaLD people with disability and their carers;
- the effectiveness of strategies to overcome barriers;
- how, for whom, and in what contexts strategies were and were not effective.

Methods used in the evaluation included:

- development of realist program theory for the program using participatory processes with staff from FECCA, NEDA and sub-contracted organisations;
- review of Quarterly Reports provided by services to the NDIS;
- a Client Data Collection tool designed for the evaluation;
- information about education and community development activities delivered by services;
- brief reflection surveys completed by Community Connectors;
- participant observation of Community of Practice meetings by the evaluator; and
- interviews and focus groups with Community Connectors, their managers, and program stakeholders.

1.1 Who did the Community Connectors work with?

In quarterly reports, Community Connectors reported assisting 2,557 people over the program. However, this number does not reflect discrete individuals because data were collected for all people served in the quarter, and some people (potentially a significant proportion) will have been assisted over two or more quarters. It is not possible to identify the number of discrete individuals served. Of the total served, 1,441 (including duplications) were requesting access to the NDIS. One hundred sixty-nine people with disability were successful in gaining admission to the NDIS within the project timeframe. It is not clear whether this number also includes duplications. Still, if successes were reported in the quarter they were notified, it is less likely than in other categories. The relatively low number of successful applicants likely reflects the short period the program was active[1] and the

[1] Some organisations took weeks or months to get established and all organisations were instructed not to accept new clients after April: organisations in the program were therefore only accepting new clients for between six and nine months.

relatively long time required to work through the application process. Community Connectors provided support to 458 people (including duplications) who needed ongoing support after successfully accessing the NDIS. This represents 18% of the total and highlights the importance of continuing support being available after the approval of applications.

The Client Data Tool sample (people with disabilities and carers who consented to share their information for the evaluation) provides insights into a smaller sample of people with whom Community Connectors worked. Data was provided for 349 people with disabilities and 186 carers. Similar proportions of male (51%) and female (48%) people with disability were clients. There were more males in the younger age groups and more females in the older age groups. At the end of the program, a higher proportion of males (12%, n=43) were using funding from an NDIS plan compared with females (6%, n=22). More than half (56%, n=196) of the people with a disability in the sample were Australian citizens, and 40% (n=138) were permanent residents. Less than half (45%, n=83) of carers were Australian citizens, and close to half (48%, n=90) were permanent residents. Only a small proportion of people in the sample were on temporary visas or did not have their visa status determined (3%, n=10).

There was great diversity in the cultures and languages of participants in the program. There were 19 cultures where 5 or more people were identified, and 60 were less than 5. The latter (those with less than 5 people in the data set) accounted for 29% of people with disability and 38% of carers. The most commonly identified cultural groups were Vietnamese (10% of PWD, 11% of carers), Bhutanese/Nepalese (9% of PWD, 8% of carers), and Karen/Karenni /Karrani (7% of PWD, 9% of carers). Seventy languages were identified. 59% (n=206)[2] of people with a disability and 52% (n=96) [3] of carers needed interpreter services: this was more common amongst older people. Thirty per cent (n=103) of people with disability in the client data sample[4] were reported to experience a physical disability, 20% (n=71) a mental disability, and 18% (n=63%) an intellectual disability. 18% were reported to have dual disabilities and 9% sensory disabilities. There are stronger cultural barriers to reporting intellectual and psycho-social disabilities than physical disabilities.

1.2 Barriers to access

Barriers to access were identified at all stages of the process required to obtain NDIS funding - pre-access, access, planning, plan implementation and review of plans. Common barriers included language and communication barriers, cultural barriers to disclosing disabilities, and low trust (particularly in government) due to previous experiences. Lack of understanding of the NDIS and lack of understanding of how to navigate the disability and health service systems to gather evidence of an application were both important barriers. Systemic issues included costs of and time delays for assessments and inadequate reporting of assessments, particularly by General Practitioners (GPs). Carers carried heavy loads due to cultural expectations about family responsibility for care provision.

1.3 Strategies to address the barriers

Community connectors used two main approaches to engage with and support CaLD people with disabilities and their carers. The first was a service delivery approach providing tailored individual helps

[2] Includes 7% (n=23) who required interpreters for complex matters only.
[3] Includes 5% (n=9) who required interpreters for complex matters only.
[4] This information was collected by the Connectors once they had adequate information based on their interaction with the client (that is, clients were not asked to self-identify as having a disability or the nature of that disability). For detail see the data collection tool in Appendix 2. Types of disability are consistent with the Convention on the Rights of Persons with Disabilities (CRPD).

to assist CaLD people with disability to successfully engage with the NDIS, and referrals to other services, including for those who were not eligible to access NDIS. The main forms of support provided to address barriers for people with disability at the access stage were assistance in gathering evidence; assistance in completing the Access Request Form; providing information about the NDIS access process; providing referrals to services; and addressing communication needs, including the provision of translated materials and use of interpreters.

Community Connectors speaking the client's language and/or face-to-face interpreters were important strategies for success in both community development and face-to-face service delivery. The use of telephone interpreters was reported to be less effective for service delivery, particularly in meetings to develop the NDIS Plan. The provision of same-sex workers was sometimes important for support workers (but not Community Connectors). The provision of support was less effective where there were barriers to the provision of assessment reports.

The second approach to engaging and supporting CaLD people with disabilities and their carers was a community development approach which included assertive outreach, collaboration, and education to raise awareness and develop partnerships and networks with organisations that support people with disability and their carers. Where stigma about disability remained strong and communities sought to retain their traditional care structures, community leaders sometimes acted as gatekeepers, reducing direct access to community members for Connectors and potentially reducing access to information for community members (this could not be assessed through the evaluation).

Lockdowns in response to COVID-19, particularly in Melbourne, were a significant barrier to community awareness-raising. So too was fear in response to COVID-19: even in the absence of lockdown, community members were reluctant to attend events for fear of COVID-19 transmission. Nonetheless, Community Connectors provided some 2,695 '*community activities*' over the year and reported reaching close to 42,000 people through a combination of those activities, social media, and community radio strategies. The 'natural experiment' in communication and outreach strategies in communities affected by lockdowns for COVID-19 demonstrated the importance of face-to-face communication and relationships in accessing CALD communities.

1.4 Limitations

The NCCP was a very short-lived program, implemented during a time of major social and economic disruption due to the COVID-19 pandemic. Evidence suggests it takes at least three years for the effects of social programs to be measured as impacts [King, 2009 #8]. The process of registering with NDIS is also protracted, meaning that many of the individuals supported by the program were awaiting decisions on their applications at the time the program concluded. These limitations have also constrained the extent to which a realist evaluation could be undertaken. Realist evaluations seek to explain patterns of outcomes and why they vary for different population groups and contexts. This is, of course, more difficult where the program itself is constrained from achieving outcomes and where multiple factors affect participation, the effectiveness of processes, and outcomes.

1.5 Considerations for the future

Despite the constraints noted, the evaluation has identified a series of factors that appear to enhance access to the NDIS for CaLD people with disabilities and their carers. Provision of tailored information and support by Connectors with demonstrated understanding of cultural perspectives on disability built sufficient 'initial trust' for (at least some) people with disabilities and carers to disclose the nature of disabilities and engage in the processes necessary to apply to the NDIS. Provision of information and

support in the languages spoken or preferred by community members or supported by face-to-face interpreters where necessary and acceptable increased the accuracy and understanding of information. This, in turn, increased the likelihood of fair assessments and the likelihood of the use of NDIS funding once approved. Because barriers to access are applied across all stages of the NDIS participant pathway, the availability of ongoing support is also necessary across all stages.

Psychosocial disabilities were more stigmatized in some communities than physical disabilities. Small communities had greater difficulties accessing translated information, and those with fewer interpreters faced more significant issues with privacy and confidentiality. It was harder to find and connect with CaLD people in rural areas than in metropolitan settings because they did not have the same social infrastructure. People who were isolated from their cultural communities were the most difficult for Connectors to access: longer-term strategies are required to address issues for these sub-groups who may face additional barriers.

The project could not demonstrate the effectiveness of long-term strategies to address the stigma of disabilities within communities because it was too short-term. Still, the impacts of stigma were identified, and the ongoing need for work to address it was thus highlighted. The assumption of capacity for self-advocacy is an inherent component of the NDIS. Still, that capacity is not widespread amongst CaLD people with disabilities and their carers: addressing this issue requires long-term, empowerment-oriented community development.

The findings of the evaluation – while not new or unexpected – support the need for strategies tailored to the particular needs of CaLD people with disabilities and their carers. This should include specific attention to these needs by LACs. FECCA, NEDA and the sub-contracted organisations should continue to advocate for this and for the provision of specialist CaLD connector roles within LACs. The ability to speak languages other than English should be regarded as a significant asset in such positions. FECCA, NEDA and the sub-contracted organisations should also, where feasible, contribute to activities to improve LAC cultural competencies and capacity. LACs, CaLD organisations, and disability organisations should be adequately resourced to work collaboratively on programs and activities. While there are concentrations of some cultural communities in particular locations, cultural and linguistic communities are based on connections that are not specific to the place. Future strategies to support CaLD people with disabilities and carers should not be restricted to specific locations with tight boundaries.

Many of the barriers to accessing the NDIS for CaLD people with disability and their carers are systemic. They require ongoing, systems-level strategies (including issues affecting assessments and assessment reports). FECCA and NEDA could continue to advocate for strategies to address them and, where feasible, collaborate with the NDIA and LACs to implement strategies. This could also include strategies to improve the supply of interpreters from a wide range of language groups who understand NDIS terminology and processes.

This evaluation has documented the barriers CaLD communities face in obtaining entitlements under the NDIS, identified promising practices for addressing barriers and identified differences within CaLD and disability sub-groups that affect the effectiveness of those strategies. Findings could be forwarded to the review of the NDIS Cultural and Linguistic Diversity Strategy, currently being undertaken as this report was written, to inform future strategies.

2 Introduction

2.1 The CaLD component of the National Community Connectors Program

The National Ethnic Disability Association (NEDA) and the Federation of Ethnic Communities' Council of Australia (FECCA) were awarded funding by the National Disability Insurance Agency (NDIA) to conduct the culturally and linguistically diverse (CaLD) component of the National Community Connectors Program (NCCP). Other components of the NCCP funded Community Connector roles to support Aboriginal and Torres Strait Islander peoples, people with a psycho-social disability, and ageing parents and carers of children with a disability. The NCCP was announced as a budget measure in 2019, recognizing the above-mentioned groups' barriers to accessing the NDIS.

The CaLD NCCP program commenced in July 2020 and ceased at the end of June 2021. CaLD Community Connectors were 'navigators' who connected CaLD people with disabilities and/or their carers to the NDIS and provided support that enabled barriers to access to NDIS and/or disability support services to be overcome. The NCCP Community Connector Framework (National Disability Insurance Agency, 2020a) defined the role according to four main functions: engage, connect, collaborate, and advise. Figure 1 below defines these functions.

Table 1: Community Connector Functions outlined in the NCCP Framework

Function	
Engage	• Improving the awareness and knowledge of participants, potential participants and communities about the NDIS and about disability more broadly. • Reduce barriers to accessing the NDIS by providing assertive outreach to people with a disability and their representatives. • Educating local PITC staff regarding effective ways to identify and engage with target cohorts.
Connect	• Providing information to communities about the NDIS, broader supports and how they can support people with disabilities. • Providing information to the NDIA and to PITC that can improve access, planning and service delivery outcomes. • Support people with a disability and their representatives to connect with the NDIS, PITC and mainstream supports.
Collaborate	• Supporting PITC, NDIA staff and Support Coordinators to assist potential participants to access the NDIS and utilise their plan. • Supporting PITC to effectively engage target cohorts. • Supporting communication between NDIA staff, PITC, community and participants.
Advise	• Provide guidance and advice to PITC and Support Coordinators to promote equity in access to the Scheme.

Source: (National Disability Insurance Agency, 2020a, p. 4)

The Framework describes the NCCP as "a targeted program, delivering surge capacity in support of PITC [NDIS partners in the community], in order to identify, engage with and support hard-to-reach cohorts to gain access to the NDIS, where appropriate"(National Disability Insurance Agency, 2020a, p. 8). PITCs are service providers who deliver 'Local Area Coordination' (LAC); or 'Early Childhood Early intervention' (ECEI) on behalf of the NDIA.

FECCA and NEDA sub-contracted 23 community-based non-government organisations in the disability, multi-cultural, and community services sectors to employ the Community Connectors. Organisations

employing CaLD Community Connectors were located across all states and territories, in local government areas (LGAs) with high concentrations of CaLD populations and/or underutilisation of NDIS by CaLD people (as advised by the NDIA). NEDA sub-contracted organisations located in New South Wales, the Australian Capital Territory, and Western Australia; FECCA sub-contracted organisations located in Queensland, Victoria, South Australia, the Northern Territory and Tasmania. The program provided for 69 full-time equivalent positions (FTEs), of which some were shared by part-time staff so the total number of Community Connectors was higher.

During the establishment phase of the NCCP, NEDA and FECCA undertook negotiations with the NDIA regarding key aspects of implementation including the LGAs where the program would be delivered, the training for Connectors, and language/translation support. This contributed to delays in starting the program, reducing its length. Sub-contracted organisations undertook recruitment processes and Community Connectors commenced their roles between September and December 2020. The NDIA confirmed that the NCCP would not receive an extension in March 2021, and from April 2021 Community Connectors were directed to focus on a warm handover of clients to their respective PITCs and not take on new clients. Together, these factors meant that the actual implementation of the program lasted less than one year. Details of the NCCP's intended objectives, roles of the Connectors, key deliverables and service locations are in Appendix 5.

2.2 The National Disability Insurance Scheme

The National Disability Insurance Scheme was enacted in 2013, with a staged rollout across states and territories from 2016 (Buckmaster 2017, p. 275). The NDIS is intended to empower people with disability to determine their own goals by creating a personalized budget, as 'consumers' are able to exercise choice and control in selecting services that will best meet their needs (Carey, Malbon, & Blackwell, 2021). The creation of the NDIS was seen as positive by disability advocates championing choice where previously the system offered little. However, the underlying assumptions of self-advocacy and emphasis on individualization of need and personalization of care have been critiqued in terms of equitable access to services (Carey, Malbon, Olney, & Reeders, 2018). It is well-recognised that the concepts and complex processes of the NDIS are not easily translated into languages other than English (Lai, 2021).

Eligibility for the NDIS is determined by age (from birth up to 65; noting that children aged under 7 are eligible for ECEI) and residency (participants must be living in Australia and be either Australian citizens, permanent residents, or on a 'protected special category visa'). The eligibility process is legislated under the National Disability Scheme Act 2013 and requires an assessment of disability. The assessment relies on supporting evidence using a standardized and medicalized understanding of disability, described by some as a deficit understanding of disability (as distinct from the social model) (Horsell, 2020, p. 4).

Throughout the implementation period of the NCCP, changes to access and planning processes (specifically the introduction of independent assessments), were being considered by the Independent Advisory Council (IAC) to the NDIS. In July 2021 the Minister for the NDIS, Senator Linda Reynolds, met with state and territory disability ministers and agreed with the recommendation from the IAC not to proceed with independent assessments. The IAC also recommended LACs pivot from an emphasis on supporting individuals towards engaging more holistically with communities (Independent Advisory Council to the NDIS, 2021). At the time of writing, it was not clear either how that transition would occur or who would be expected to take on the role of providing support to individuals in developing their plans. In July 2021, the NDIA released a progress update on its 2018 Cultural and Linguistic

Diversity Strategy (NDIA, 2021), and at the time of writing was undertaking consultations to inform an update.

3 Methodology and methods

This was a realist evaluation. Realist evaluation addresses both accountability and learning but is more oriented to learning and program improvement.

Many evaluation approaches assume that the effectiveness of a program is best assessed by measuring the average result. Realist evaluation assumes that programs will work for some people or in some contexts but not others, and average results are not helpful for understanding either the outcome patterns or how they are caused. To improve programs, it is necessary to understand who they work for and who they do not, in what contexts they do and do not, and why. Realist evaluation aims to identify outcome patterns and explain how and why different outcomes are achieved for different groups or in different contexts.

To do this, realist evaluation develops theories about how, for whom and in what conditions a program is expected to work, and then collects data about how the program worked, in reality, to test and refine the theory. The program theory is expressed as a linked set of contexts (conditions that affect whether causal processes operate as expected), the mechanism (underlying causes of outcomes), and outcome (immediate, intermediate, and longer-term). This is often abbreviated to Context-Mechanism-Outcome configurations or CMO. One common understanding of program mechanisms (i.e., the causes of program outcomes) suggests that programs provide resources of various types, in response to which participants reason in different ways. The interaction between 'resources and reasoning' generates decisions that affect behaviours that generate outcomes (Pawson and Tilley, 1997). To develop and then test the theory, questions are asked about each of these three components, as shown in Table 2 below.

Table 2: How program theory is articulated in a realist evaluation

Context	Mechanism	Outcome
For which sub-groups within the target group?	What causes the change? How does 'reasoning' change in response to the resources the program provides?	What kinds of outcomes? How 'big' are the outcomes?
In what circumstances?		

The elements are not separate from each other but interlinked. Consequently, an evaluation answers the overall question, "For whom and in what contexts does the program cause what kinds of outcomes, to what extent, how and why?"

This was, to some extent, a participatory evaluation. Project personnel from FECCA and NEDA and Community Connectors and managers were involved in developing the initial program theory to be tested. Community Connectors collected client data and community engagement data. Information from virtual Community of Practice (CoP) sessions, held monthly for FECCA-contracted organisations and quarterly for NEDA-contracted agencies, informed some aspects of this evaluation, including barriers relating to GPs, communication issues with LACs, and the impact of COVID on service provision. Interim evaluation findings were also provided at CoP meetings.

While the program operated over a one-year period, the first months were spent on program establishment (appointing Community Connectors and so on) and on evaluation design. Data collection could not commence until after ethics approval had been granted. Data collection commenced in January 2021. Services were advised not to accept new clients after April 2021, but to refer them to other agencies. Quantitative data collection concluded at the end of June and qualitative data collection concluded in July 2021.

All interactions between the evaluator and evaluation participants were via remote video-conferencing to account for i) the program footprint being nationwide and ensuring equitable participation in the evaluation across all implementation sites; and ii) the repeated travel restrictions across Australia due to COVID-19.

Because realist evaluation provides findings about contexts, mechanisms and outcomes, the findings can be portable to other programs. In this case, the learning may be relevant to other navigator (e.g., Community Connectors) programs, and potentially to other programs aiming to better support CaLD populations and/or people with disabilities. For further information about Realist evaluation, see Appendix 1.

3.1 Development of Program Theory

The program theory was developed in three stages. The first involved developing rough sketches of a theory of action and hierarchy of outcomes for each of the two main approaches to the program – direct service provision to individuals and community development. These initial sketches were based on program documentation and discussion with the commissioning organisations (FECCA and NEDA). Feedback on the diagrams was provided in a workshop involving FECCA and NEDA personnel and managers in contracted organisations before most Community Connectors had been appointed. On the basis of those diagrams, a program theory survey was distributed to Community Connectors and their Managers, expected to tease out the program theory in a realist format. The results from the survey were used to select items for inclusion in the client data tool (see Appendix 2).

3.2 Ethics

Ethics approval was granted by the Charles Darwin University Human Research Ethics Committee in two rounds: the first for the program theory survey just described (Ref H20089, approval granted 23 September 2020); and the second for the remainder of the evaluation (REF: H20107, approval granted on 16 December 2020). Information sheets for the overall evaluation are provided in Appendix 2.

3.3 Data Sources

3.3.1 Client data

Two sources of data were available about clients. The first was Quarterly Reports (discussed in 2.3.3 below); the second was a Client Data Tool developed for the evaluation.

Client data items for the evaluation were developed from the draft program theory and workshopped with Community Connector organisations in October 2020. CDU provided training to Community Connectors on how to use the data collection tool during January 2021. Community Connectors collected client data during normal service delivery. This was intended to overcome barriers that might otherwise affect the evaluation, including low English language skills of people with disabilities and their carers and communication difficulties resulting from disabilities. Community Connectors sought informed consent from clients to provide de-identified information for the evaluation, and de-identified it using a randomly-generated client ID number. Data was provided to the evaluator in updated Excel

workbooks approximately once a month. It should be noted that services were instructed by the NDIA not to accept new clients in the final quarter, but to refer them to other services. Consequently, both the numbers of people assisted and the number who could provide consent for their data to be used were lower than might otherwise be expected.

A total of 349 CaLD people with disabilities and 186 carers provided consent for their data to be used. The small sample may reflect a number of factors: participation in the evaluation (consenting to share information) is voluntary and required the Community Connector to provide the necessary information to provide informed consent. Some Connectors noted that they preferred to build trust with clients prior to seeking consent for providing information for the evaluation. The evaluation data collection tool did not ask Connectors to note when a client declined to provide information for the evaluation, so the response rate cannot be calculated. Other factors affecting participation may have included a lack of understanding of evaluation or research in general or mistrust of confidentiality.

NEDA provided resources to develop an Easy English version of the information sheet and consent form for the evaluation, however, there were no resources available to translate written materials into other languages. Community Connectors noted that some clients did not understand what evaluation was, or did not trust research or evaluation. They needed to establish trusting relationships before gaining consent for information to be shared.

3.3.2 Education and Collaboration activities

Using the Excel data collection tool, Community Connectors also provided detailed reporting on education activities they provided and types of collaboration activities.

3.3.3 Quarterly reports

Quarterly reports provided by FECCA and NEDA to the NDIA provided data about the total number of people with disability who engaged with Community Connectors and community reach of program activities. Organisation-specific quarterly reports also provided qualitative information which was used to evidence context and mechanisms in relation to outcomes.

3.3.4 Participant observation at Community of Practice meetings

The evaluator took part in virtual Community of Practice meetings as a participant-observer. This included providing updates on the evaluation and listening to issues raised by CoP participants in the discussion. These observations supported the development of questions for evaluation focus groups and interviews.

3.3.5 Interviews and focus groups

Three focus groups of between 4 and 6 participants were held with Community Connectors and four focus groups were held with managers of Community Connectors. Connectors and their managers who participated in focus groups were from all states and territories. Four interviews were held with community groups who had worked with community connectors, three with Partners in the Community, and two with program managers at NEDA and FECCA. Sampling for focus groups and interviews was purposive: Community Connector organisations using common strategies (e.g., primarily a community development approach) were grouped together. Likewise, sampling for interviews was designed to understand how the strategies used by the Community Connectors worked to engage with CaLD communities. The sample of stakeholders external to the NCCP (community groups and NDIS partners in the community) provided data to test a subset of the program theory for "organisations and networks"; these participants were located in Vic, NSW, WA, Qld and SA (others

were invited but declined on the basis of being busy, or for PITCs because their policy was to approach NDIA for approval to participate). All participants in focus groups and interviews provided informed consent. CaLD people with disability and their carers were not approached to participate in interviews or focus groups.

3.3.6 Reflection surveys

Brief surveys (two or three questions) were distributed to Community Connectors and their managers using Qualtrix survey software on a monthly basis. Each asked for a brief reflection on key topics. Response rates to the surveys were low (ranging between 12 to 17 responses), however, because the data was qualitative (an open response rather than a quantitative survey) it remained useful and was included as a data source.

3.4 Analysis

Qualitative data were coded using MAXQDA software. The program theory provided the coding frame, with each component of the theory (context, mechanism, outcome) being evidenced using a variety of sources. This enabled triangulation of findings, which in most cases had supporting evidence from more than one type of data.

Quantitative data was analysed in Excel to produce descriptive statistics of the following.

- Frequencies for client characteristics: Total number of PWD, the total number of carers, and breakdowns by age group; gender; cultural identification; preferred language(s); whether interpreter required; location (metropolitan, rural, remote). Where population-level data is available for these characteristics, proportions accessing the services will be compared with population-level data to give an estimate of the proportions who could be reached by the program within its size, budgetary and time constraints.
- Proportions of clients who had and had not previously heard of, tried to access or had accessed the NDIS. This is to provide an estimate of the extent to which 'new' clients were accessed by the program and the extent to which it provided services to those not new to NDIS.
- Frequencies of barriers to accessing the NDIS reported by clients. This may be of relevance to service provider organisations, some of which may adapt their services in response to the data, and to the NDIA, which has overall policy responsibility for access to the program.
- Correlations between characteristics and outcomes achieved within the period (noting that some outcomes should be expected to take longer than is available in the program).

Select data were cross-tabulated and tested for statistical significance of associations using the Chi-Square test, which was the appropriate non-parametric inferential test for the available data. Comparison of outcomes for different sub-groups was intended but was not possible, given the relatively low number of clients who had progressed through the system to final outcomes. A summary of how each data source was used to test the program theory is provided in Appendix 4.

3.5 Limitations

The aim of a realist evaluation is to explain the overall patterns of outcomes. This requires analysis at two levels: firstly, how, for whom and in what contexts specific outcomes are achieved; and secondly, what explains the overall patterning of results (for example, why do some groups respond in one way and others in another?). This evaluation has focused on the first level but has been limited by the very short timeframe available for the program. Most outcomes evaluations are undertaken over at least a

two-year period, often three and sometimes five years (Haskins, 2014; King & Behrman, 2009). This is because it is widely recognised that programs take time to establish and to achieve consistent service delivery, and because decision-making in response to new information and/or behaviour change is not necessarily immediate. Time to achieve results is a particular issue for community development approaches, which are generally considered long-term.

Given that this program lasted less than a year, we have had no choice but to focus the evaluation on interim outcomes (for example, overcoming barriers to access) rather than later outcomes (for example, approval of NDIS funding, accessing services using that funding, or improvements to the quality of life as a result of access to services). We also note that the outcomes achieved in such a short program do not provide a fair, or therefore valid, assessment of whether the strategies used can be effective.

The second aim - explaining the patterning of outcomes - is often achieved by drawing on formal theories (Pawson, 2010). Because sufficient outcomes data could not be collected, we were unable to examine how the outcomes might be patterned. However, we have drawn on one formal theory that has previously been used in the evaluation of a health Navigator program (Fleisher et al., 2012). That theory is the Cognitive-Social Health Information Processing (C-SHIP) theoretical framework (Miller & Diefenbach, 1998; Miller, Shoda, & Hurley, 1996). In Fleisher et al.'s evaluation, it was used (amongst other things) to categorise barriers to access to health services as "1) practical barriers (i.e. health insurance co-pays), 2) negative cognitions (e.g., lack of understanding of treatment procedures), 3) negative expectancies and beliefs (e.g., fatalism), and 4) affective barriers (e.g., worry about diagnosis)"(Fleisher et al., 2012, p. 5). We have adopted that broad structure to categorise the barriers identified in this evaluation.

There are also some limitations to the data instruments. It is not possible to ascertain how many individuals were served by the program. The only data for that total comes from the agencies' quarterly reports to the Commonwealth, which reports unique individuals for each quarter and will necessarily include some double counting as the services worked with individuals across quarters. Data in those reports were provided for those seeking to access the NDIS and separately for those requiring support after their applications had been approved. There may also be double counting there, as it is likely that some individuals transitioned from needing support to access the NDIS to needing support after access had been granted. We note also that the evaluation does not include the direct voices and perspectives of CaLD people with disability and their carers. This was a pragmatic decision made in response to the range of constraints affecting the evaluation, including the short time frame, the budget, the costs of interpreters and so on. Neither did the evaluation include observations of Community Connectors undertaking their main functions: this was both a pragmatic consideration in relation to time and budget and a response to the constraints of COVID-19.

4 Evaluation Findings

4.1 Overview of client characteristics

The Client Data Tool sample (people with disabilities and carers who consented to share their information for the evaluation) provides insights into the people with whom Community Connectors worked. Data was provided for 349 people with disabilities and 186 carers. It is not possible to provide an accurate figure for the proportion that this represents of the total number of people with disabilities with whom the program worked. The only data for that total comes from the agencies' quarterly reports to the Commonwealth, which reports unique individuals for each quarter and will necessarily include some double counting (see Limitations, section 2.5).

Table 3 below provides an overview of socio-demographic information for the Client Data Tool sample. Further analysis is provided in subsequent sections.

Table 3: Socio-demographic characteristics of the client data sample (PWD and carers)

	People with disability (n=349)		Carers (n=186)	
Socio-demographic factors	%	n	%	n
Gender				
Male	51.0%	178	21.5%	40
Female	48.1%	168	77.4%	144
Unknown	0.9%	3	1.1%	2
Age group (years)				
Under 7	8.9%	31		
7 to 17	24.6%	86		
18 to 29	7.2%	25	10.8%	20
30 to 39	9.5%	33	28.5%	53
40 to 49	15.5%	54	21.0%	39
50 to 65	30.4%	106	15.6%	29
Over 65	0.9%	3	1.1%	2
Unknown	3.2%	11	23.1%	43
Identifies culture/ethnicity				
Yes	96.8%	338	97.3%	181
No	2.6%	9	1.6%	3
Unknown	0.06%	2	1.1%	2
Requires an interpreter				
No	40.1%	140	48.4%	90
Yes	52.4%	183	46.8%	87
For complex matters	6.6%	23	4.8%	9
Unknown	0.9%	3		

(Continued over page)

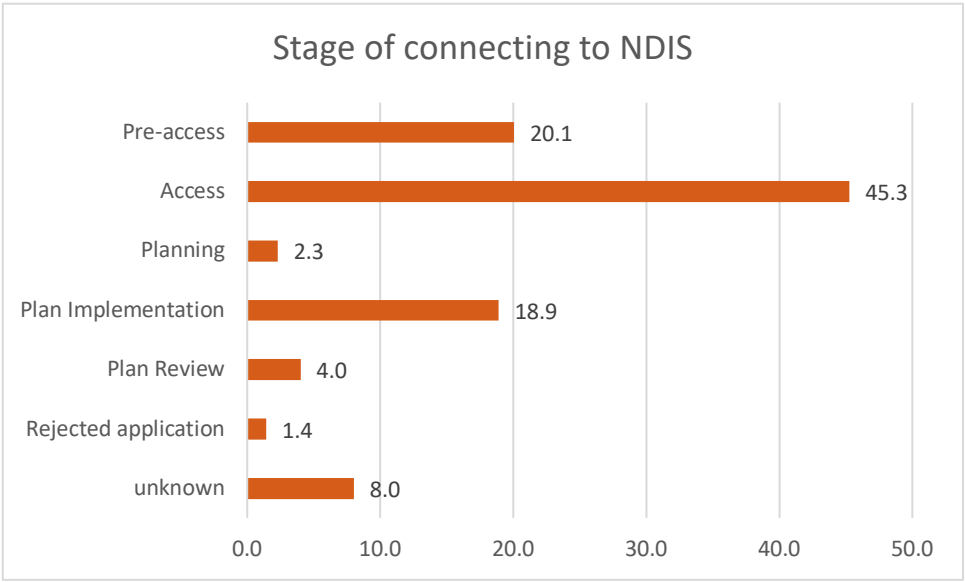
Table 34: Socio-demographic characteristics of the client data sample (PWD and carers) (Cont.)

	People with disability (n=349)		Carers (n=186)	
Visa status	%	n	%	n
Australian Citizen	56.2%	196	44.6%	83
Permanent Visa	39.5	138	48.4%	90
Temporary Visa	2.3%	8	3.2%	6
Status not determined	0.6%	2	1.1	2
Unknown	1.4%	5	2.7	5
Years lived in Australia				
Less than 2 years	8.0%	28	5.9	11
2 to 5 years	26.6%	93	30.1	56
6 to 10 years	19.5%	68	21.0	39
More than 10 years	40.7%	142	40.9	76
Unknown	5.2%	18	2.2	4
Total	100.0%	349	100.0	186

Source: Evaluation Client Data

The clients were spread across the stages of NDIS engagement for people with disability. The largest group of NCCP clients were those seeking access (45%, n= 158) followed by those undertaking pre-planning (20% n=70). Almost a fifth of people were implementing a plan (19%, n=66), and a small proportion worked with Connectors during the plan review stage (4%, n=14).

Figure 1: Stage of engaging with the NDIS, per cent

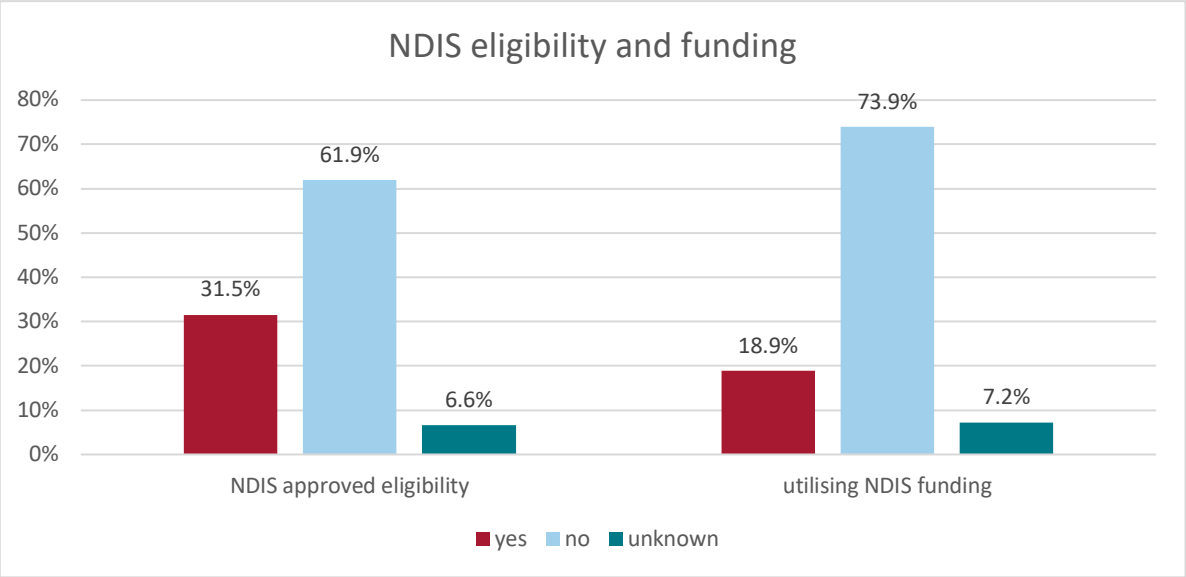


Source: Evaluation Client Data

Connectors reported whether a client had their eligibility approved by the NDIS, and whether clients were using NDIS funding. Almost a third (32%, n=110) of all people with disability who were supported by the program had their eligibility approved, and 19% (n=66) were using funding from their plan. (Note that not all clients were seeking access to the NDIS: if those not seeking access were excluded, the percentages would be higher). Note also that some clients were already on plans prior to working with the Connectors so the total cannot be interpreted purely as an outcome of the NCCP. Only five clients (1.4%) had their applications rejected (the label 'no' in the graph below includes those had had not

applied or who had applied but not yet received a decision). Many clients (n=30) who had received assistance from a Connector to lodge their application were awaiting the outcome of a decision by the NDIS at the time the program ceased.

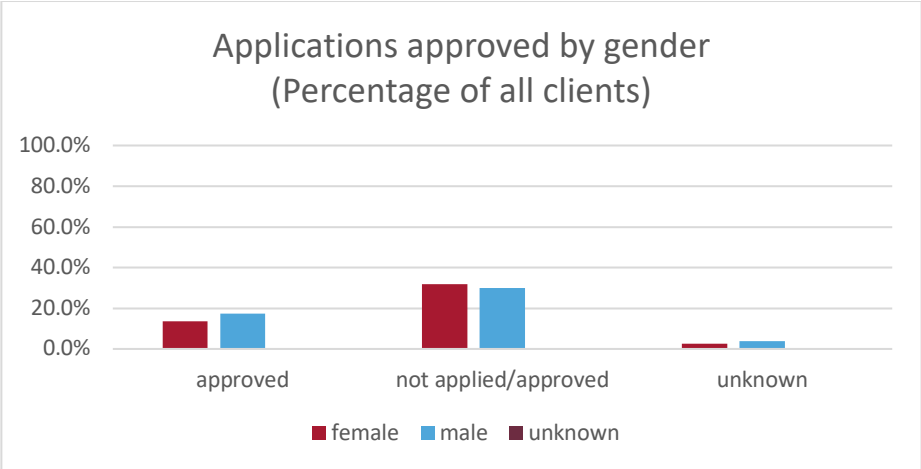
Figure 2: Whether NDIS eligibility approved and whether utilising NDIS funding, per cent



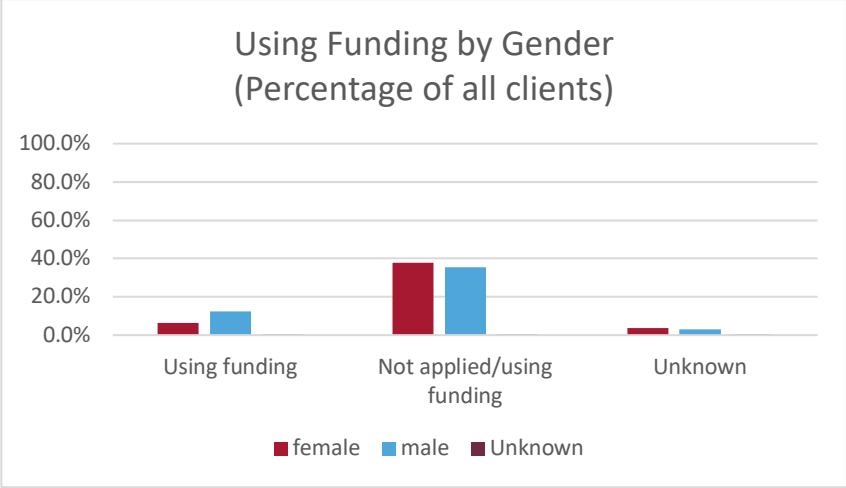
Source: Evaluation Client Data

4.1.1 Gender and Age

Similar proportions of male (51%) and female (48%) people with disability were clients of the Community Connectors. At the end of the program, higher proportions of males than females had NDIS funding approved and were utilising their funding. Sixty-one males (34.2% of male program participants; 17.5% of all participants) had funding approved compared to 47 females (28.1% of female participants, 13.5% of all participants). Note that the label 'not applied/approved' in these graphs covers all stages of the process up to approval, as well as rejected applications.



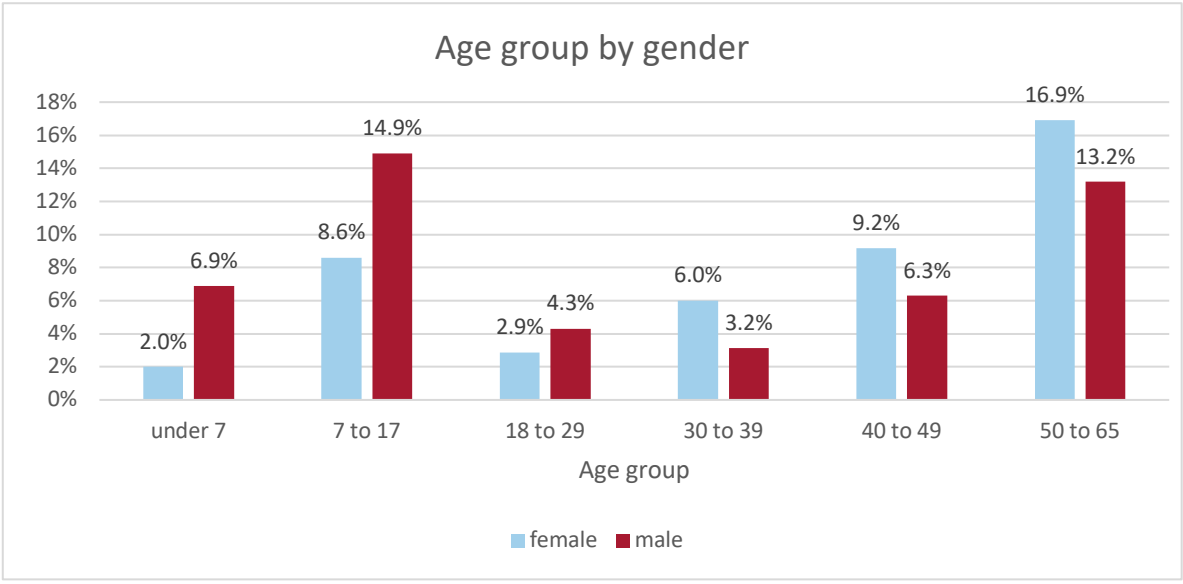
Forty-three males (24.2% of male program participants, 12.3% of all participants) were utilising their funding compared to 22 women (13.1% of female participants, 6.3% of all participants).



Wider NDIA analysis (i.e., not CaLD specific) also shows higher proportions of males than females using the program: only 37 per cent of NDIS participants are female (National Disability Insurance Agency, 2019). In the wider population, this disparity is largely explained by the high numbers of children in the scheme combined with the higher prevalence of autism and developmental delay in male children compared to female children (ibid pg. 5). As the tables below will demonstrate, it is possible that this also helps explain the findings in this evaluation.

The largest age group of people with disability in the data set were older people aged between 50 and 65 years (30%); the second largest age group were young people aged between 7 and 17 years (25%). In the younger age groups (persons with disability under 30 years) there were more males than females; and in the age groups over 30 years there were more females than males. The higher proportion of males in the younger age groups may reflect the patterns of disability for boys noted above.

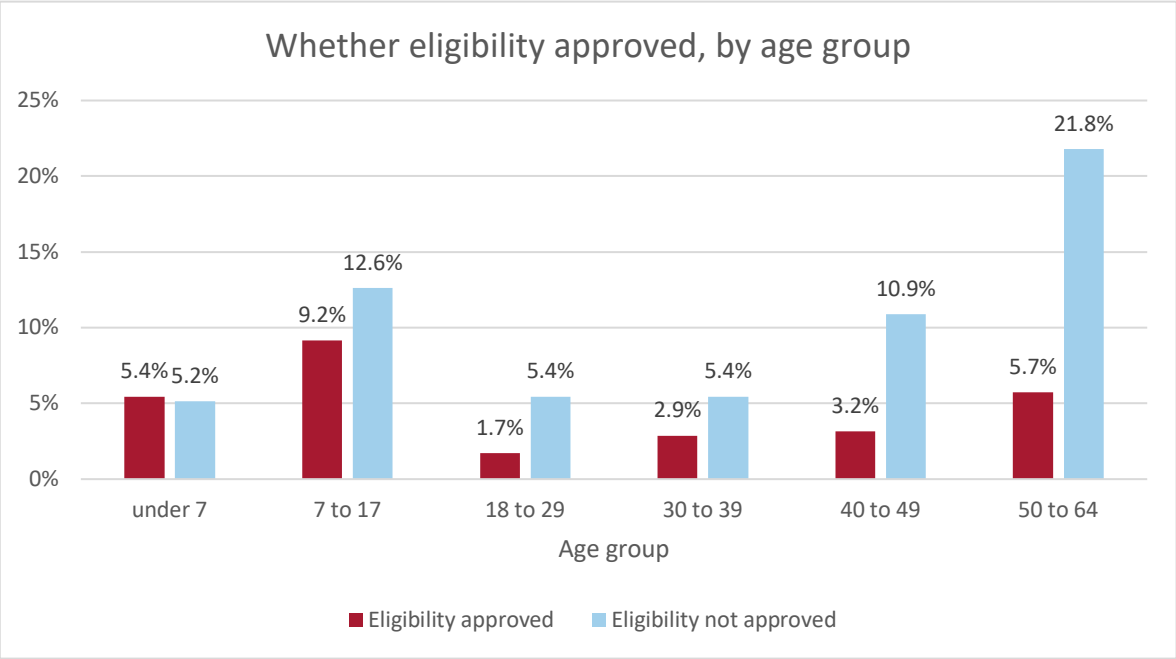
Figure 3: Age and gender of people with disabilities in the client data set, per cent



Source: Evaluation Client Data

By the end of the program, the highest percentage of people in the client sample who had their eligibility approved by the NDIS were those who were aged 7 to 17 years. (NB 'Not approved' in the label includes those who had not applied.)

Figure 4: Whether NDIS eligibility approved by age group, per cent of people with disability



Source: Evaluation Client Data

Over three quarters of carers were female (77%, n=144), compared to male (22%, n=40). The proportion of female carers is slightly higher than the national data which shows 72% of primary carers are women (Australian Bureau of Statistics, 2019). The largest age group of carers were those aged between 30 and 39 years (28%) followed by those aged between 40 and 49 years (21%). Note that almost a quarter (23%, n=43) of carer ages were not reported.

4.1.2 Visa status and years lived in Australia

During development of the initial program theory, Community Connectors and their Managers thought it likely that both visa status and the duration of time the person had lived in Australia would affect whether people with disability engaged with the program.[5]

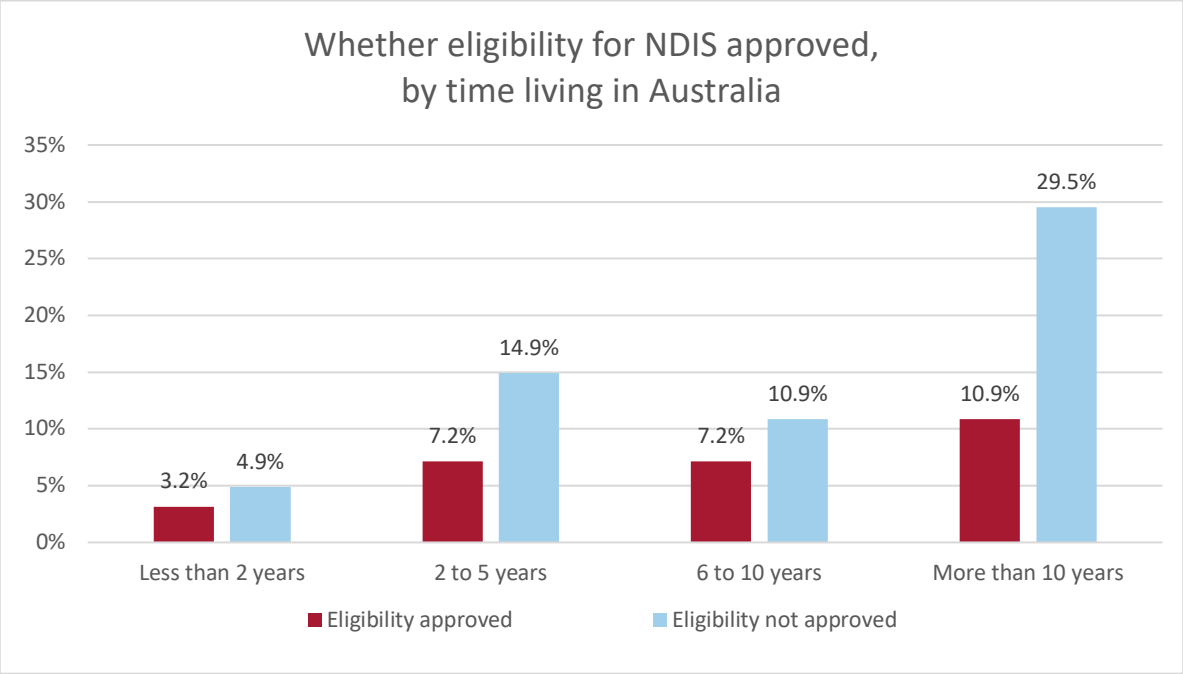
More than half (56%, n=196) of people with a disability in the sample were Australian citizens, and 40% (n=138) were permanent residents. Less than half (45%, n=83) of carers were Australian citizens, and close to half (48%, n=90) were permanent residents. Only a small proportion of people in the sample were on temporary visas or did not have their visa status determined (3%, n=10). These findings need to be interpreted with caution given that persons affected by trauma or who have recently arrived in Australia may be less willing to share personal information [Refugee Council of Australia et al., 2019]. The small proportion of people on temporary visas or whose visa status was un-determined may reflect either lower levels of engagement with the scheme by those groups, or lower willingness for their data to be used in the evaluation. The latter could reflect mistrust in official systems or a belief that sharing personal information could affect the outcome of their visa applications (which it can do).

[5] See Appendix 2: 88% of CCs thought it likely/very likely that the duration of time the PWD has been in Australia will affect whether they or their carers engage with the CC; 85% thought it likely/very likely that being a refugee will affect whether the PWD engages with the CC program; 93% thought it likely/very likely that visa status will affect whether the PWD or carer engages with CC.

Forty-one per cent of people in the sample had been in Australia for 10 years or more; and less than ten per cent had lived in Australia for less than 2 years. 35% (N=121) had lived in Australia for five years or less. While it is a very indirect comparison, the 2016 Australian census found that "Of the overseas-born population, nearly one in five (18%) had arrived since the start of 2012." The higher proportion of relatively recent arrivals (five years or less) in the client data sample suggests that the program was effective in reaching relatively new arrivals.

By the end of the program, there was no statistically significant relationship between the number of years the person had lived in Australia and whether the person's eligibility for the NDIS was approved.[6] Almost a third of the sample of NCCP clients (30%) had lived in Australia for more than ten years, and had not had their eligibility approved.

Figure 5: NDIS eligibility status of people with disability, by time living in Australia, per cent



Source: Evaluation Client Data

4.1.3 Cultures and preferred languages

The majority (97%) of people with disability and their carers identified with a culture/ethnicity. The most commonly identified cultural groups were Vietnamese (10% of PWD, 11% of carers), Bhutanese/Nepalese (9% of PWD, 8% of carers), and Karen/Karenni/Karrani (7% of PWD, 9% of carers). To ensure confidentiality in reporting, where less than 5 people identified with a culture, they were grouped as 'Other': this accounted for 29% of people with disability and 38% of carers.[7] Sixty cultural groups were identified in this 'other' grouping. Seventy preferred languages were identified. Those most commonly spoken at home by people with disability were English (16%), Arabic (14%) and Vietnamese (9%). Around a third of language preferences (34%) were categorised as 'Other' (less than

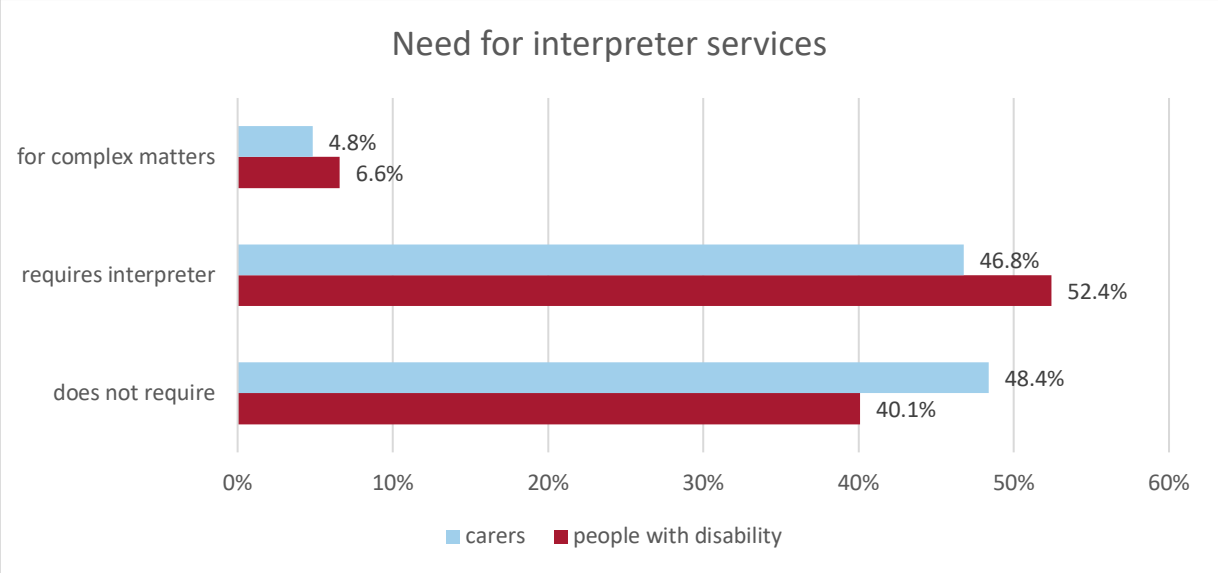
[6] A chi-square test of independence showed no significant association between number of years living in Australia and whether NDIS eligibility approved, p = .26, the result is not significant at p<.05.
[7] Details are in Appendix 4

5 people in the sample used the language).[8] The largest groups of preferred languages spoken at home by carers were Arabic (15%), Vietnamese (11%), and Karen/Karenni (11%). Over a third of language preferences (37%) were categorised as 'Other'.[9] As there was such great diversity of languages and cultures, it was not feasible to undertake further quantitative analysis of specific language or cultural groups.

4.1.4 Need for interpreter services

The initial program theory hypothesized that the need for interpreters would affect engagement with the program.[10] Analysis of the evaluation client data sample shows 59% (n=206)[11] of people with a disability needed interpreter services; and 52% (n=96) of carers needed interpreter services.[12]

Figure 6: Whether people with disability and carers required an interpreter, per cent



Source: Evaluation client data

People aged 50 to 65 were more likely to require an interpreter[13] than young people aged 7 to 17 years.[14,15] This is a small contribution to meeting the need for more information about CaLD people's need for interpreters (Australian Institute of Health and Welfare, 2018, p. 275).

[8] Details are in Appendix 4 4

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[9] Details are in Appendix **Error! Reference source not found.**3.

[10] See Appendix 4: 91% of CCs thought it likely/very likely that needing an interpreter would affect whether the PWD and their carer engage with the CC program.

[11] Includes 7% (n=23) who required interpreters for complex matters only.

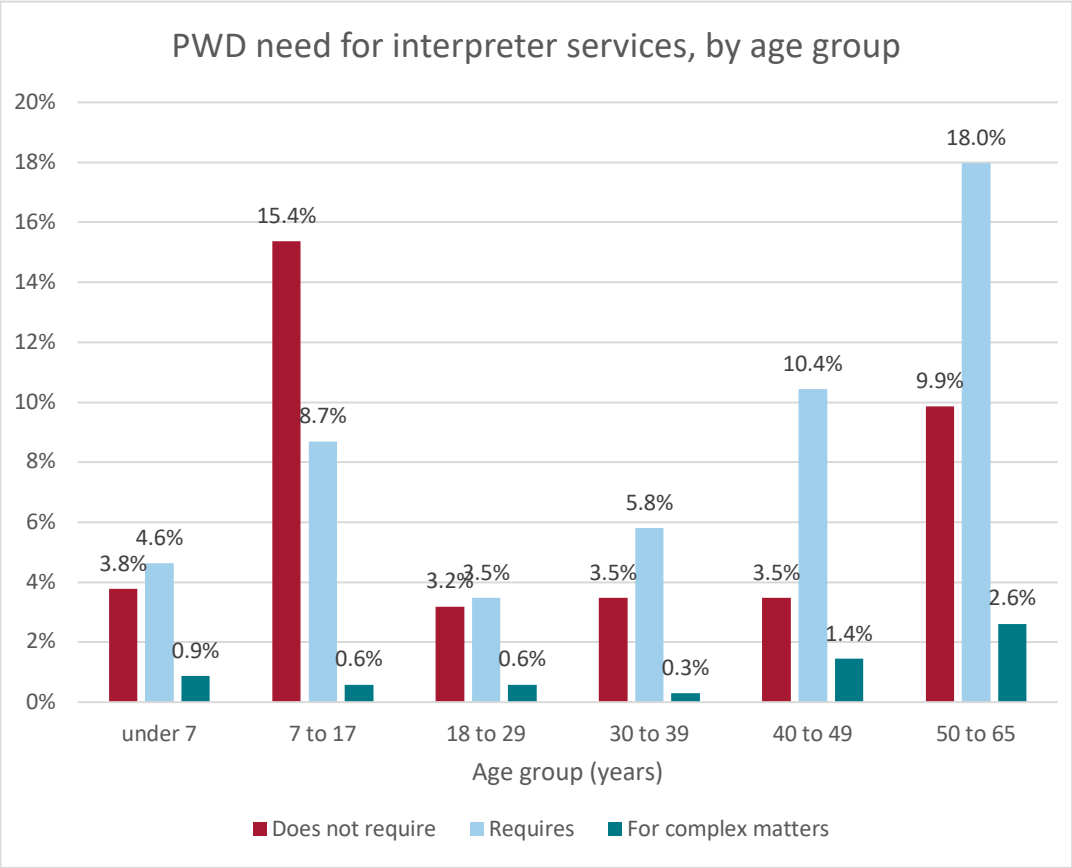
[12] Includes 5% (n=9) who required interpreters for complex matters only.

[13] When including need for complex matters (21%, n=71).

[14] 15% (n=53) do not require an interpreter; 10% (n=32 when including need for complex matters).

[15] A chi-square test of independence showed that there was a significant association between older age and the greater need for interpreter services, statistically significant at p< .05.

Figure 7: Whether people with disability required an interpreter by age, per cent

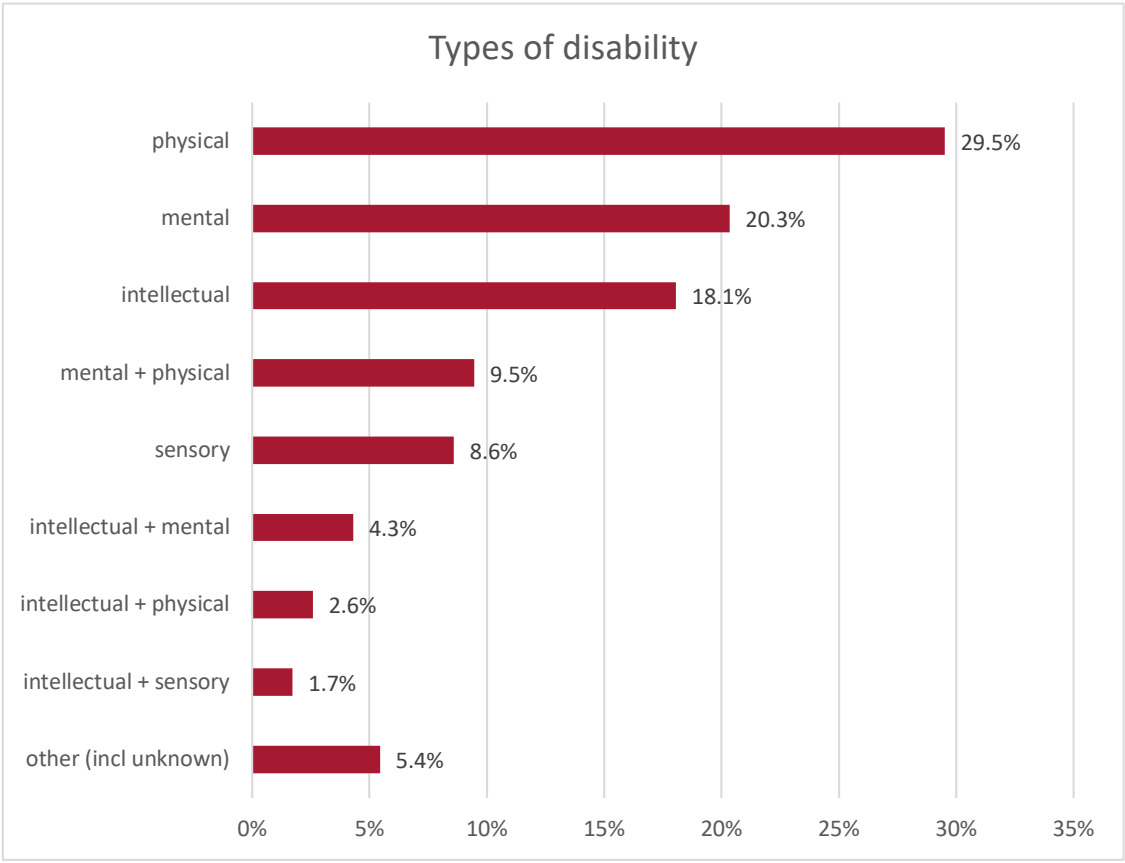


Source: Evaluation client data

4.1.5 Types of disability

FECCA, NEDA and CDU acknowledge the complexities involved in categorizing disability status. For the purpose of this evaluation the response categories for type of disability were consistent with the Convention on the Rights of Persons with Disabilities (CRPD), which states: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (United Nations Human Rights Office of the High Commissioner, 2008). Responses to this item were made by the Connectors once they had adequate information based on their interaction with the client (that is, clients were not asked to self-identify as having a disability or the nature of that disability). Thirty per cent (n=103) of people with disability in the client data sample were reported to experience a physical impairment, 20% (n=71) a mental impairment, and 18% (n=63) an intellectual impairment. 18% were reported to have dual disabilities and 9% sensory disabilities.

Figure 8: Types of disability as reported by Community Connectors, per cent



Source: Evaluation Client Data

4.1.6 Location

The initial program theory hypothesized that where the person lives will affect whether they engage with the program. Connectors were asked to provide the name of the suburb if in a metropolitan area or nearest town if in a regional area. As the program evolved, it became apparent that demand for Connector services fell outside of the Local Government Areas (LGA) intended 'footprint' of the program; further discussion of this is provided under the topic of 'assertive outreach'. It was not possible to determine the extent to which the program met 'need' within LGAs based on the sample of client data collected.

4.2 Barriers to accessing the NDIS

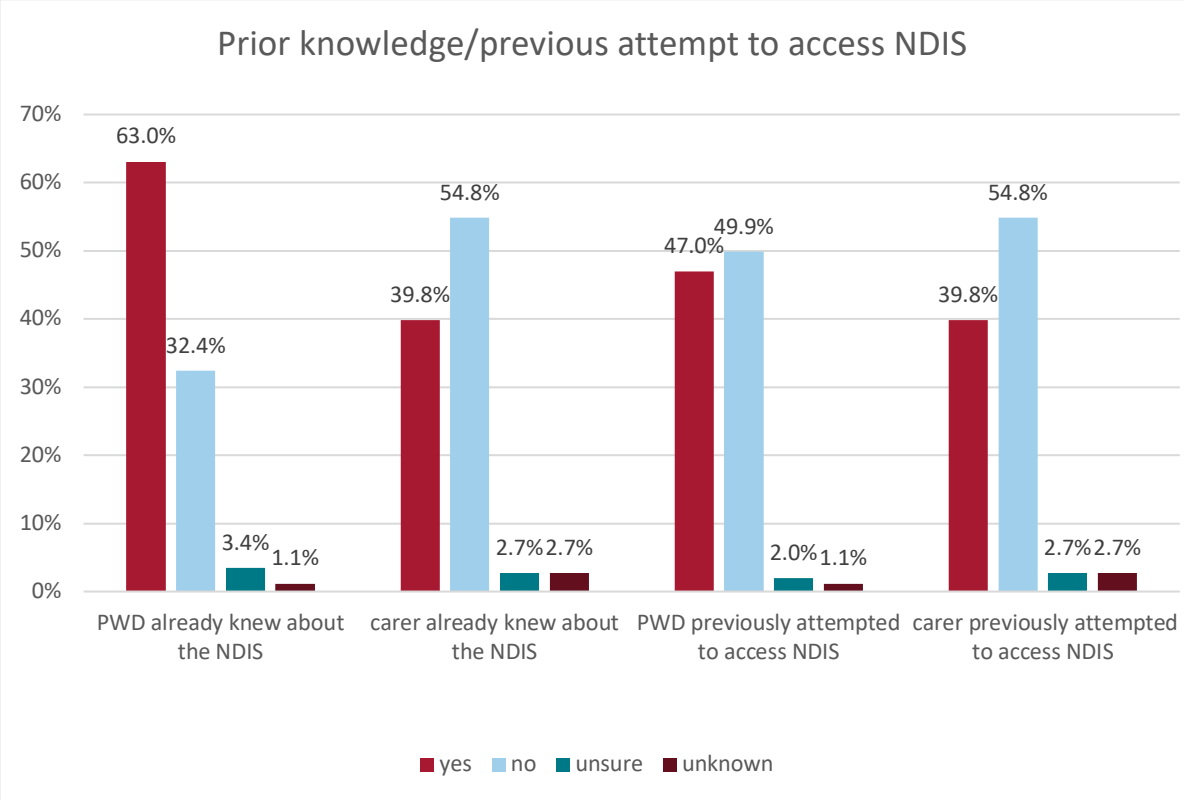
Client data collected by Community Connectors provide an overview of the barriers encountered by people with disability, and their carers, and the stage at which they were engaging with the NDIS system. The data demonstrates three key points:

1. **CaLD people with disability and their carers experience barriers at multiple stages**. It is not only during pre-access or access stages that support is required. For example, the Community Connectors found people who were eligible and had received an NDIS plan in English but had not been able to read it or understand that they could utilise funded supports. No one had followed up on why they were not utilising supports. CaLD people with disability and their carers were unaware of their rights (e.g. to receive support for translation in meetings or to receive a plan translated into a language other than English).

2. **Common barriers are experienced across the stages.** These include lack of understanding of how to navigate the disability and health service systems to gather adequate evidence, language barriers, low trust due to previous experiences, and carers carrying heavy loads due to cultural expectations about family responsibility for care provision (Poon & Lee, 2019). While the NDIS assumes a principle of 'choice and control through self-advocacy', Community Connectors commonly supported CaLD people with disability who did not have the capacities necessary to enact it.

3. **The majority of clients had some awareness of the NDIS prior to working with the Community Connectors**. In response to the question "Did the person already know about the NDIS before your organisation worked with them?", 63% (n=220) of people with disability were already aware of the NDIS prior to working with a Community Connector. Close to half (47%, n=164) of those in the sample had attempted to access the NDIS prior to working with a Community Connector. Sixteen percent of people with disability had prior awareness of the NDIS but had not attempted to access it. More than half of carers (58%) were aware of the NDIS prior to working with the Community Connector; over a third (40%) of carers had previously attempted to access the NDIS; 18% were aware of it but had not tried to access it. Around a third (35%) were not previously aware of the NDIS.

Figure 9: People with disability (PWD) and carers: prior knowledge / previous attempt to access NDIS:



Source: Evaluation Client Data

A follow-up question asked Connectors to state why the person had not previously accessed the NDIS ("if not, why not, what type of barrier?"). There were 187 responses to this question. Responses were 'free text', and Connectors described the barrier in their own words, based on what they knew of the person's situation. Responses to the question were initially grouped according to similar types of barriers.

The most common reasons provided by Connectors were:

- lack of information and knowledge about the NDIS
- language and communication barriers
- lack of evidence or diagnosis of disability
- did not know how to apply.[16]

Connectors were also asked to report on barriers encountered while providing support to people with disability. The responses to these questions were again 'free text'. Responses to this question were grouped according to the stage of engagement with the NDIS the person with a disability was at (pre-access or access/plan implementation/plan review). Data about the barriers was available for 84% (n=292) of people with disability within the sample. Approximately[17] 63% of people with a disability experienced barriers at the pre-access or access stage – this included people who previously had access to the NDIS denied. Approximately 20% of people in the sample experienced barriers while implementing an NDIS plan or undergoing a plan review[18]; and the remainder were ineligible for the NDIS due to their age, visa status or diagnosis being a health condition rather than a disability.

The most common barriers experienced by people with disability at pre-access and access stages were (where n= the number of times this barrier was reported):

- needing help in gathering required evidence for applications (n=66)
- language barriers (n=43)
- not understanding how the NDIS works (n=22)
- difficulty navigating the NDIS due to lack of support (n=13).[19]

We also analysed barriers according to the Cognitive-Social Health Information Processing (C-SHIP) theoretical framework (see Section 2.5 for description).

[16] These types of barriers are presented in **Error! Reference source not found.**; note that because people experienced multiple barriers, the total frequency of barriers is greater than the sum of responses.
[17] Approximations because not all data fields were completed to report a precise number of people per stage; where this information was not available, analysis of supports provided in response to the barrier were used to group people according to an approximate stage of engagement eg. 'provided support to complete access request form' was categorized as access stage.
[18] Noting that the detail of barriers encountered was not provided for all clients; over a third (36%, n=127) of people with disability in the evaluation client sample had already registered with the NDIS prior to working with a Community Connector.
[19] See **Error! Reference source not found.**

Table 4: Barriers at access and pre-access stages

Barriers at access and pre-access stage by C-SHIP Framework		
	%	n
Practical barriers		
needs help gathering evidence	31.4%	66
language barriers	20.5%	43
difficulty navigating NDIS/lack of support	6.2%	13
not eligible	4.8%	10
GPs lack of experience with NDIS/reluctant to complete ARF	3.3%	7
delay from LAC/NDIS	3.3%	7
needs help to find OT for functional assessment	2.9%	6
transport	2.4%	5
needs help meeting with LAC	1.9%	4
waiting on medical evidence	1.9%	4
difficulty completing ARF	1.4%	3
recently moved, no local support networks	0.5%	1
cannot afford appointments to obtain evidence	0.5%	1
Negative cognitions		
low awareness/knowledge of how NDIS works	10.5%	22
Negative expectancies and beliefs		
influence on decision from family - unlikely to proceed	1.4%	3
Affective barriers	0.0%	
anxiety/complexity of process	3.8%	8
psychological issues/ psycho-social disability	3.3%	7
Total frequency of barriers (not individual PWD)	100.0%	210

Source: Evaluation Client Data

For those people with disability who experienced barriers during the implementation stage, the most common barriers were (where n= the number of times this barrier was reported):

- Not understanding how to use their NDIS plan, and the support coordinator[20] had not explained how to use the plan (n=19);
- A breakdown in communication with the support coordinator (n=11);
- Needing to have NDIS processes re-explained or explained (n=10).

Connectors also collected information about barriers experienced by carers. Their most common barriers were:

- Lack of information about the NDIS (n=17);
- Having insufficient evidence or no diagnosis of disability for the person they cared for (n=11);
- Not knowing how to apply for the NDIS (n=11). [21]

[20] For detail on the role of an NDIS support coordinator see: https://www.ndis.gov.au/participants/using-your-plan/who-can-help-start-your-plan/support-coordination

[21] See Error! Reference source not found.Error! Reference source not found.

Client data provides 'high level' quantitative information about barriers. Qualitative information sourced from quarterly reports provides further insight about the common cultural barriers, low awareness of disability supports and knowledge of the NDIS, language and communication barriers, and challenges associated navigating health and disability services to gather evidence to support NDIS applications. These are described below.

4.2.1 Cultural barriers and understandings of disability

Connectors found that denial about disability, often expressed in response to shame, stigma or cultural taboos, meant that barriers existed for individuals, within families, and across communities. Despite needing support, people experiencing a psycho-social disability experienced strong stigma and were unwilling to identify with the disability. Many trauma survivors had experienced psycho-social disabilities, which hampered their willingness to access services or to trust sharing their needs with others. Additionally, "in some languages, disability does not exist as a word or may have a different meaning such as insane, curse, etc." (Quarterly Report Jan-Mar 2021).

Some families whose children had a developmental delay identified in an early learning setting hoped that the child would 'grow out of it'. Some primary caregivers sought assistance through the Community Connector. Still, when applying formally for the NDIS, the application would stall as other family members would deny the child had a disability and assert that no further support was required outside of the family. Carers would at times 'play down' the impact of the disability on their family and their need for support as a way of coping with the stigma. Analysis of the evaluation client data sample found that 66 carers (35% of the sample) were primary carer for more than one person with a disability. It is not clear whether this proportion is unusually high or whether this influences either use of the Connector service or the willingness for their data to be used in the evaluation. This indicates a significant care load as carers attempted to navigate the NDIS system. Many CaLD communities believe that it is the family's responsibility to look after the person with a disability, and seeking outside assistance is seen as reducing the family's autonomy in decision-making over care choices:

> *In some communities, "letting NDIS in" can be seen as letting a stranger take over your role as carer of your loved one. Or it can be seen to take away your autonomy over the support you need. (Quarterly Report Oct-Dec 2020)*

Privacy was a strong concern for some families, who did not want the shame of others in their community finding out. This was more common in Arabic-speaking groups and in small communities with few interpreters. Some would refuse to use an interpreter in meetings for fear of knowing the interpreter personally. Australian rules and conventions about privacy and confidentiality in meetings such as these were unfamiliar to participants from some cultures.

In some communities, mistrust of government exists not only at an individual level, but attitudes have become social norms within cultures which are difficult to shift, particularly through a short-term program. Connectors noted that some people wondered "why would the government want to label my child with a disability"? Some community members did not want to have people with NDIS uniforms or name tags seen outside their homes as this would 'reveal' their interaction with a government program. Others, however, would only share information if the Community Connector was formally identified as being engaged to provide information or assist with the NDIS. No information is available for the reasons for this, but it likely simply reflects caution about dealing with strangers.

4.2.2 Misunderstandings about NDIS

Connectors from several organisations noted that some families were unwilling to access NDIS due to misinformation about NDIS supports affecting Centrelink payments (Disability Support Payments and Carers Allowance).

Some people feared interacting with the government, and it was reported that some had been told not to share personal information in a government program as this could affect the outcome of a visa application.

Some people were confused by what they believed to be differing residential eligibility requirements for the NDIS in comparison to Centrelink (for example, clients from New Zealand who believed they were potentially eligible for NDIS but not Centrelink).

Core concepts of the NDIS do not translate easily, and the Connectors found there was a misunderstanding about what the NDIS actually was. For some CaLD people the words "insurance" and "scheme" gave them the impression the Connector was trying to sell them an insurance product. During outreach, the Connectors needed to clarify that they were not salespeople.

4.2.3 Language and communication barriers

Underlying the concept of 'choice and control' in the NDIS is the concept of 'self-advocacy' (Carey et al., 2021). The concept of self-advocacy was new to many of the people the Connectors worked with:

> *The concept of self-advocacy is not common amongst many CaLD community members and that lack of self-advocacy skills can have a decisive impact on consumers' and participants' success and experience with the NDIS and the disability sector more generally. (Quarterly Report October-December 2020)*

Many of those people who had previously been unsuccessful in a previous NDIS application did not understand why their application had been rejected. Bureaucratic language referring to NDIS legislation in rejection letters stating that clients needed to 'demonstrate that all available and appropriate treatment options … have been explored' left people feeling frustrated, confused, or demotivated to go through the process of applying again. People also lacked an understanding of what is considered a medical condition and what is a disability.

Once people had been assessed as eligible by the NDIS, barriers to utilising plan funding were evident. In part these appeared to reflect poor communication by agencies charged with implementing the NDIS. One person had been on the scheme for two years and did not know how to use the plan or have a support coordinator to work with them to explain the plan. In another example, drawn from a quarterly report:

> *The NCCP client believed he had been denied access to the NDIS but in fact, had a plan for 18 months and had not been receiving services. On investigation, the plan was developed in a non-culturally appropriate way and therefore the client did not have any understanding of the plan or that he even had one, which went against the NDIS inclusion model. (Quarterly Report January-March 2021)*

The Connectors noted that some CaLD people were not comfortable talking with strangers over the phone or via online platforms, which meant that face-to-face interaction was more effective.

Connectors noted that CaLD participants and their families needed to proactively follow up to know the outcomes of NDIS decisions or for required information: there was no systemic process to ensure that

they received and understood the information or were able to implement a plan. In some instances, participants did not receive timely communication regarding the expiry of a plan.

While some NDIS-translated resources became available during the implementation of the program, the Connectors noted that this was for select languages and did not cover all the languages needed. The Access Request Form (ARF) was only available in English. Many NDIS resources use what Connectors described as 'dense' English rather than 'simple' or 'easy' English. The ARF was updated by the NDIS, taking effect on 15 February 2021, and the form became longer.

4.2.4 Difficulty navigating health and disability services

Obtaining the required evidence of disability was commonly cited as a barrier in the client data. The NDIS requires this to document and provide evidence for support. One element of this was the client's understanding of a formal diagnosis. A language or culture might not have the words or concepts which accurately describe a disability. For example, the language or culture might only consider more visible physical impairment a disability, rather than less visible intellectual or mental impairment. It is unclear whether or to what extent this reflects a misunderstanding about the need to provide evidence or whether denial about the existence of disability means evidence has not previously been sought.

> *Other groups have low health literacy and high stigma surrounding certain disabilities (e.g. psychosocial disability is understood as a stroke). (Quarterly Report October-December 2020)*

Connectors commonly reported that applications had been rejected by the NDIS on the basis of weak or inadequate medical evidence accompanying the application form. To obtain the required information, people needed to have knowledge and skills to navigate the Australian healthcare system. This includes understanding Medicare, private health, and referral pathways to obtain assessments from medical specialists, occupational therapists, psychologists, and other allied health practitioners. Other clients did not have their medical history documented in the Australian medical system, due to being newly arrived or having arrived as a refugee.

Connectors encountered General Practitioners who could not provide correct and detailed information for the Access Request Form (ARF). Specific barriers reported were inadequate time, lack of knowledge of the patient's history or functional capacity (sometimes due to the client accessing different GPs), and inadequate understanding of the NDIS requirements. The latter was evidenced in Quarterly Reports along with a call for further GP education: *"GPs need more education on how to fill out ARF forms to discuss functional capacity of disability especially in the area of psychosocial health issues"* (Quarterly Report Oct-Dec 2020). Some GPs did not see it as their role to assist with NDIS applications and were unwilling to do so (Quarterly Reports Jan-Mar 2021). Limited use of interpreter services during medical appointments contributed to communication issues. Connectors also noted an exception: that GPs in 'refugee clinics' provided more clinical detail than was required for the NDIS application process.

Many clients could not afford the cost of specialist assessments, such as the functional capacity assessment, and there were long waitlists to access bulk-billed/ Medicare-subsidised services. Some types of assessment require multiple appointments with specialists or allied health practitioners. Many people also needed transport support to attend appointments. Long waiting times (over 6 months) also resulted in carer fatigue.

> *One of the biggest challenges is obtaining reports from clinical psychologists. Clients are often required to meet with their psychologist several times before a report can be drafted. The waiting list to see the psychologists is several months, even between each appointment and many have stopped taking new referrals. In addition to this, cost is a big factor, especially when*

the client needs to make approximately 10 appointments to receive a report that may/ may not support their application. Cost is a concern even for clients seeking functional capacity assessments and supporting evidence in general. (Quarterly Report January-March 2021)

4.2.5 Addressing the barriers

Community connectors used two main approaches to engage with and support CaLD people with disabilities and their carers:

- a service delivery approach providing tailored individual supports to assist CaLD people with disability to successfully engage with the NDIS;
- a community development approach which included assertive outreach, collaboration, and education to raise awareness and develop partnerships and networks with organisations that support people with disability and their carers. Note that outreach, collaboration and education are distinct strategies and each would operate through different mechanisms and achieve different outcomes.

Some organisations placed more emphasis on individual service delivery, primarily building partnerships and networks to facilitate referrals. Others concentrated more on a community development approach. This in part reflected the types of organisations that were sub-contracted to deliver the program. Multicultural-focused organisations tended to focus more on the community development approach; while disability and disability advocacy organisations tended to focus more on individual service delivery.

Each of the two main approaches is addressed in subsequent sections of this report.

4.3 Person-centered, tailored approaches to service delivery

The first main strategy used by Community Connectors was person-centred, tailored approaches to service delivery. The initial program theory hypothesized that:

> Where relevant and accessible information is provided to clients (C) and organisations are culturally appropriate (C), people with disabilities' and their carers' knowledge of the disability service sector increases (M), resulting in people with disabilities or their carers finding or accessing services and supports (O).[22]

4.3.1 Summary of services and outcomes

4.3.1.1 Clients served

Two sources of data are available about the services provided: Quarterly Reports, and the Client Data Tool sample.

Table 5 (on the next page) provides a summary of the numbers of people with disability supported over the program, as provided in Quarterly Reports. Three things should be noted about this data. Firstly, data for carers assisted was not required in the quarterly reports, and so it is not possible to estimate the proportion of people with disability who engaged with the program without the support of a carer. Secondly, the numbers do not reflect discrete individuals, because data was collected for all people served in the quarter and some people (potentially a significant proportion) will have been assisted over two or more quarters. It is not possible to identify the number of discrete individuals served. Thirdly, the numbers for specific types of assistance (to access NDIS, ongoing support after accessing NDIS, and

[22] Details of evidence used for this analysis is at Appendix 3 – see CMO 1.5

referred to other services) do not add up to the total number reported. Other than people potentially sitting in more than one category, it is not clear why this is the case.

Community Connectors reported providing assistance to 2557 people (including duplications over quarters) over the program. Of these, 1,441 were requesting access to the NDIS. 169 people with disability were successful in gaining access to the NDIS within the project timeframe (it is not clear whether this number also includes duplications, but if successes were reported in the quarter in which they were notified, it is less likely than in other categories). It is very likely that the relatively low number of successful applicants reflects the short period within which the program was active[23] and the relatively long time period required to work through the application process. Community Connectors provided support to 458 people (including duplications) who needed ongoing support after successfully accessing the NDIS. This represents 18% of the total and highlights the importance of ongoing support being available after the approval of applications. Note that agencies' data was reported first to NEDA and FECCA and is collated under those organisations' names here.

Table 5: Combined reporting data for NEDA, FECCA and total for NCCP, 2020-2021

	NEDA			FECCA			Total NCCP		
Reporting period	Jul-Dec 2020	Jan-Jun 2021	Total 2020-2021	Jul-Dec 2020	Jan-Jun 2021	Total 2020-2021	Jul-Dec 2020	Jan-Jun 2021	Total 2020-2021
Total number of people with disability engaged over the period	648	871	1,519	212	846	1,058	860	1,717	2,577
Number of people with disability assisted to request access to NDIS	285	519	804	106	531	637	391	1,050	1,441
Number of people with disability assisted to request access to the NDIS who were successful	21	66	87	8	74	82	29	140	169
Number of participants having ongoing support after successfully accessing the NDIS	88	136	224	47	187	234	135	323	458
Number of people with disability assisted to link with support services	200	364	564	48	325	373	248	689	937

[23] Some organisations took weeks or months to get established and all organisations were instructed not to accept new clients after April: organisations in the program were therefore only accepting new clients for between six and nine months.

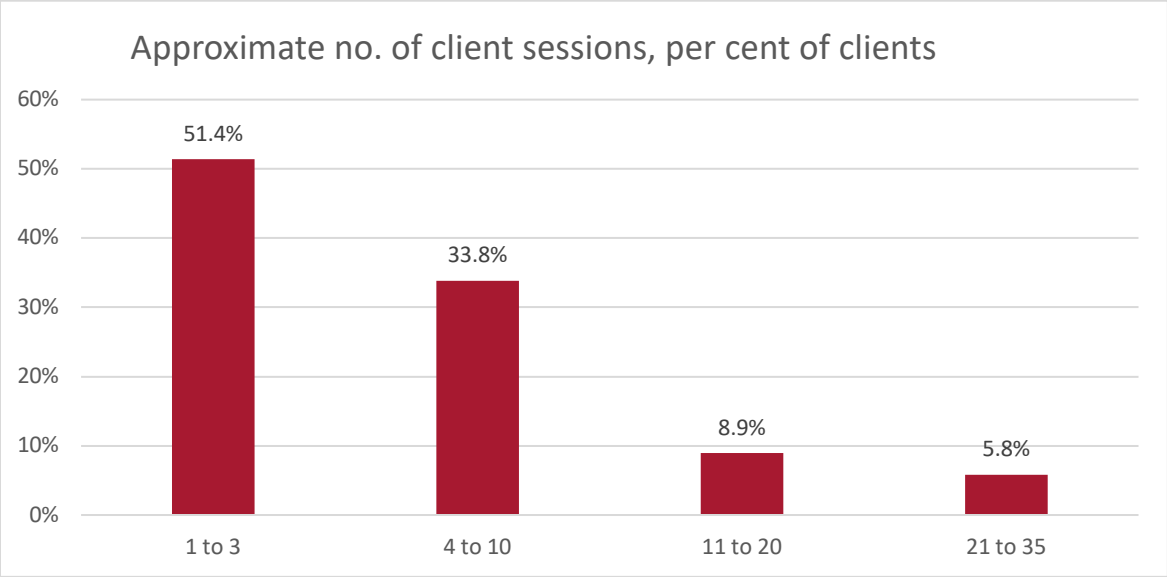
not provided through the NDIS			

Source: Quarterly Reporting data provided by FECCA and NEDA

Community Connectors linked a total of 937 people with support services that were not provided through the NDIS. Connectors provided information that enabled people to find or access a range of services and supports, not only those related to disability. In the Evaluation Data Collection tool, a third (33%, n=115) of people with disability had received a referral from the Connector to a service that was not specific to the NDIS.

Data from the Client Data Tool provides greater detail about the number of sessions provided for clients, albeit for a smaller sample of clients. Data for this item was available for 325 clients. Community Connectors added data in relation to each client on a monthly basis. Just over half of all clients (51%) had between 1 and 3 sessions. Almost one in five (19%) had only one session. It is likely that this includes clients who were referred to other services. Around a third (34%) had four to ten sessions while 5% had 11 to 20, and 1% had over 20 sessions. These last two groups likely represent higher needs clients.

Figure 10: Approximate number of sessions per client



Source: Client Data Tool

Opportunities for comments about the data entry were also possible. The comments suggested that some Community Connectors only counted face-to-face work as sessions whereas others included phone calls as sessions. This may reflect differences for Connectors who were working in lock-down, but it may also account for at least some of the small proportion of clients with very high session numbers if Connectors were recording each phone call as a session. One Connector commented that 'sessions' for one client could take up to 3 hours. Comments also regularly referred to additional work that was required between client sessions, including phone calls, emails, research, and contacting service providers. Interviews and focus groups also referred to taking some clients to appointments and providing support in sessions with assessors.

4.3.1.2 Referrals

Referral to appropriate services resulted from working with clients on a one-to-one basis over time and having a good understanding of the multiple barriers and holistic needs of families and individuals. Referrals included disability support drop-in with the LAC Partner in the Community, Settlement and Engagement Transition Supports (SETS) for eligible clients, or other mainstream supports such as Centrelink, housing and health.

4.3.1.3 Overcoming barriers

As described earlier, the most common difficulties identified in the evaluation client data when attempting to access the NDIS (noting that people often experienced more than one barrier) were 'practical barriers'. Almost a third (30%) of reported barriers for people with disability related to gathering evidence and almost one in five (19%) related to language barriers.

The main forms of support provided to address barriers for people with disability at the access stage were (where n= the number of times this barrier was reported):

- assistance in gathering evidence (n=95);
- assistance in completing the Access Request Form (n=39);
- providing relevant information about the NDIS access process (n=28);
- providing referrals to services (n=24);
- addressing communication needs, including provision of translated materials and use of interpreters (n=7).

The main outcomes of support provided at access stage were:

- ongoing evidence gathering including waiting on medical evidence (n=58);
- the application was in process with the NDIA (n=30);
- met access to the NDIS (n=17).

4.3.2 Program theory

The initial program theory hypothesized about the circumstances in which the program was most likely to be effective in addressing barriers, as follows:

- When skilled and knowledgeable Community Connectors provided sustained support and capacity building (C), people with disabilities and their carers gained the skills and confidence to speak up (M) and ask for services (O).[24]
- When Community Connectors sustained engagement with communities and individuals over time (C) and stigma and cultural beliefs about disability were addressed (C), people with disabilities and their carers awareness of their rights and funding and supports available under the NDIS increased (M), and they sought funding and support through the NDIS t (O).[25]
- When Community Connectors sustained 1:1 worked with individuals over time (C) and resources and translation were based on client needs (C), people with disabilities and their carers' understanding of how the NDIS works increased (M), so they said/did what was necessary to receive entitlements under an insurance-model system (O).[26]

The second and third of these propositions are very similar, although the focus in the second was more on understanding rights and entitlements to funding and support, and the focus in the third was on the specific behaviours required to make a successful application. We have merged the evidence about

[24] Details of evidence used for this analysis is at Appendix 3– see CMO 1.2
[25] Details of evidence used for this analysis is at Appendix 3 – see CMO 1.3
[26] Details of evidence used for this analysis is at Appendix 3 – see CMO 1.4

them in the text that follows. For ease of reference, we have given each proposition a short title ("Skills and confidence to speak up" and "Seeking access to the NDIS", respectively).

4.3.2.1 Skills and confidence to speak up

Some people, particularly those who have experienced trauma or come to Australia as a refugee, hold strong fears about 'speaking up' and asking for services. This can be a result of 'instructions' not to share personal information given when departing refugee camps.

> *[W]hen they were migrating over as refugees, when they were leaving the refugee camp, when they gave them their orientation … part of it was that they should be careful not to disclose anything about themselves to the government. Be careful who you talk to, be careful what you say to them, you need to become very private, don't share everything because you can easily get into trouble. ... So … this is what a lot of people from the CaLD community are living with... They're scared to talk, to speak up because they've been told not to before they even arrived in Australia. … …There is a lot of work that needs to be done in this space.* ***(Stakeholder interview)***

Individuals felt more confident when talking with someone in their own language who understood the social stigmas about disability experienced within their culture. They also felt more confident meeting with someone in their own home at a time that was convenient to them. The support and capacity building from the Community Connectors enabled people to articulate needs which had been previously hidden or unsaid. Resources and support from the Connectors also enabled clients to increase confidence to approach their medical specialist or other health service providers for the information required to support their application.

It is possible that some people who engaged with the services only once or twice were enabled to advocate on their own behalves, as a result of information provided. No information is available to test that hypothesis. However, for people who engaged more intensively, simply providing information about their rights was insufficient to enable self-advocacy Some people with disability and their carers developed confidence to speak up and ask for services with intensive support of Community Connectors. One example demonstrated that even articulating needs or asking for services could be a significant hurdle for others:

> *…supported a family, we did all the briefing and coaching about the appointment that was coming up, what the purpose was and what was going to happen, what they needed to be able to share. You have to do a session before the session, then you have to actually physically help them actually attend that session and then by the time they were in, you know, with the GP, they were like not able to articulate why they were there; it was a dog's breakfast. It was a different GP to their normal one and they didn't want to do anything until they were back … basically, without that high level support, and it wasn't even effective, we have to do it all again, but that's just an example … without that level of support, that family is never going to make it through that system because they can't even string together the concept and retain it to be able to articulate what they need to get to the next step, even though that's all gone through with the interpreters. It's just not where they're operating. (Connector manager focus group)*

Limited capacity for self-advocacy (particularly by those with additional vulnerabilities) may continue to be a significant barrier to accessing the NDIS. As a reflection survey participant suggested, the 'broad need' across CaLD communities is not only for information about the NDIS, but education and disability

empowerment training to support the development of self-advocacy as it is understood in the social model of disability.

> *What our CaLD cohort needs is a long-term local community development and engagement program about the social model of disability and inclusion in an adult learning setting using adult learning principles, not NDIS information sessions, but educational sessions using the empowerment model. This could co-exist with a program such as the CaLD Connector Program to support people individually. (Reflection survey response)*

4.3.2.2 Seeking access to the NDIS

Addressing mis-information and increasing community awareness of how NDIS funding interacts with other government payments was important for some families.

> *[W]e have a lot of people who are still concerned about the NDIS and Centrelink assistance because some people and some families think that once a person accesses NDIS, they will lose the government support they are getting, so they just hold on and say it's okay, I don't think I need support. So it's being not sure about how it will work in terms of finance. (Connector focus group)*

> *… people who fear to access NDIS because they feel they will lose some financial benefits. There are some people with disabilities who unfortunately, because of the carers fear of losing the carer payment, they don't like to join NDIS or the carers … tell them no, it's not something good for you, things like that. It is really unfortunate. It's really hard, most of the time, to convince a person around something about money (Connector focus group)*

This also related to mis-trust of government.

> *. …a number of people just deny disability for themselves or their relatives. Some of them say okay, if he goes for NDIS then he will belong to the government. Even some families think that if their children benefit from the NDIS, the government will take the children out of the families. It takes long to convince people about some of the stuff they think about. (Connector focus group)*

Organisations reported that community members responded to information by asking questions around the NDIS, seeking support, and initiating phone calls to the Connectors to enquire about progress or seek guidance. Some community members required additional support to get to that point.

> *I... realised that in some communities or organisations, it took more than one interaction or probably several interactions to get them on board. Eventually you'd find that they had … issues that we could work on together to try and help people or potential participants and sometimes participants in their NDIS journey. (Connector focus group)*

However, the process of seeking access required people to make otherwise private information known to others, without any guarantee of an outcome. Connectors recognized that going through the process felt risky for some clients:

> *You're doing all this stuff for an uncertain outcome and potentially risky outcome where you're having strangers involved in your very personal … family business in the matter that's … stigmatised and a bit complicated already. (Connector manager focus group)*

> *…one of the hard parts with doing an access request form. You need so much trust with the client and talking about when you are at your worst rather than when you are at your best.*

Most service providers who are working in a strength-based model and approach, it's a really hard conversation to have with someone to talk about when they're not well, when they really can't do their daily living chores or anything … and mental health wise. It's a long process… …for the purposes of getting an access request, you've got to have the dignity and shame of your worst day … in order to get the support you need... (Connector manager focus group)

There were also examples of families who were already on a plan but increased knowledge about the NDIS helped them realise they were not accessing all the supports to which they were entitled, and they worked with the Connector to arrange for a review of their plan.

The most significant change we can see is that through this process, people who already have an NDIS plan, in talking with connectors, realise that they could be getting more support than what their plan allows. Many people from the CaLD community that we have spoken to felt that even if the support provided was not sufficient that it was not appropriate to ask for more. As a result, we are supporting 4 families through review processes. (Quarterly report January-March 2021)

4.3.3 Where it worked

4.3.3.1 Use of interpreters

Section 3.3.2 above has identified a range of contextual factors are necessary for intermediate outcomes to be achieved. These include initial work to overcome the stigma of disability; a trusting relationship between the Connector and the person with disability and/or carer to obtain accurate information; and in many cases, a long-term relationship to work through the long-term process of obtaining evidence for an application. Additional factors may not be *necessary* but were clearly helpful for at least some people: being able to talk with the Connector in one's own language, and meeting in a place of one's own choosing (e.g. one's own home).

Another factor related to the use of interpreters where Connectors did not speak the language of the clients. While many Connectors were multi-lingual, they were allocated on a regional basis and needed to work with clients of all cultural backgrounds within their localities. The only initial program theory in relation to interpreters was framed in the negative – that is, it hypothesized that linkages to the NDIS would not be formed or the range of required services not provided where inadequate or inaccurate information was provided to people with disability due to interpreters with low skill levels.

In the Evaluation Client Data Tool, more than half (52%, n=183) of the sample of people with disability needed the support of interpreter services; and when complex matters were being discussed this rose to 59 per cent (n=206). A slightly lower proportion of carers required an interpreter service (47%, n=87), and when complex matters were being discussed this rose to more than half of carers (52%, n=96).

Where clients were comfortable working with interpreters, Connectors expressed a preference to be able to pre-book interpreters to ensure the availability of specific interpreters who were trusted by clients for specific appointment times. There were, on occasion, last-minute cancellations of pre-booked interpreter services.

However, people with disabilities or their carers were not always willing to use an interpreter when the service was offered to them, even if it was needed.

…a person who really was keen to get support from me and we told her about NDIS and she understood how much she needed it and services engaged with her were keen to support but then the person … due to the level of her…past trauma, she was really unable to engage for

assessments because she demonstrated … another trauma …because they had to use interpreters … she could not continue and she said it was traumatising her. (Connector focus group)

There were several reasons why people may have preferred not to use an interpreter: trauma associated with past experiences with interpreters, fear of someone from their language group knowing their personal circumstances, and a preference to use 'Easy English' to discuss matters directly.

Connectors had to be aware of these concerns and find solutions. The solutions included careful recruitment of phone interpreters or alternative translation technologies. Some clients were worried that there may be a relationship with the interpreter due to their small cultural or linguistic group. They did not want other people in their community to become aware of their personal issues or felt shame. Clients needed to be reassured about confidentiality and privacy when accessing interpreting services.

[I]t was just a complete refusal, as if they were scared. They … just couldn't be connected. They did not want anybody to know that they have a disability. Extremely fearful that anyone would know that they had a disability. They invited us at times where they would have no one in their home and we showed up just as somebody was coming out and they said very quickly, don't say that you're here for a disability related issue. … They were at the stage where they could understand more than they could speak so I spoke in English and they used Google translate. That's how we did it. (Connector manager focus group)

A connector who had skills in working with 'easy English' in a teaching context was able to use this skill in communicating with families who did not want to use interpreters and expressed preferences to use 'simple English' instead.

[T]heir sons can speak English because they've been born here and gone through their education but the parents I would say is broken English. They can understand and they can respond *but they refuse an interpreter every occasion. …this wasn't the only case where people from CaLD backgrounds who can speak good enough English were not confident in wanting to use interpreters and would prefer to use simple English, like I would just explain everything in easy English because I have a past experience of teaching refugees for six years so I was able to use that skill. (Connector manager focus group)*

Some Connectors used interpreter services to respond to new or prospective clients, and they would then make arrangements (where possible) for the client to receive Connector support from a person who could speak their preferred language.

Where interpreters had received NDIS terminology training, the quality of information was more accurate and the language and cultural barriers were reduced. Where interpreters had not received that training, and planners did not explain terminology sufficiently for the interpreter to interpret accurately, considerable confusion could result. Without clarification by the Connector, families could provide incorrect answers to questions which could contribute to incorrect or unfair assessments. Other research has also demonstrated challenges in translating NDIS terms for interpreters from cultures which do not have similar concepts about disability to Australia (Lai, 2021).

Connectors noted that stakeholders as well as clients reported the benefits of improved communication as a result of working well with interpreters. An ECEI PITC provided feedback on the benefit of having received support from a Connector about how to use the interpreter service and intended to share this with others in their organisations.

One connector noted that telephone interpreter services were less appropriate for planning meetings. Clients would report to the Connector that they did not understand their plan; the Connector's view was this was because of the long duration of the planning meeting, and that clients did not feel able to express that they were not satisfied with the level of communication over the phone.

> *Can I add that in terms of interpreters, helping participants through interpreting jobs, phone interpreting has been I think not a good thing to do when it comes to plan meetings … We've got a lot of people complaining that when they get assistance … the plan meeting is too long so when they are using phone interpreters in such long meetings, it's really hard and … … most of the people from culturally and linguistically diverse communities don't show that they are not happy when they are getting services. They just say okay, I'm fine because due to some cultural aspects, some people do not say they're not happy but then after the session they will say I didn't understand anything about my plan. (Connector focus group)*

Connectors also noted that while GPs have access to the Telephone Interpreter Service (TIS), some were reluctant to use it as it takes longer to communicate via an interpreter.

In terms of groups who may not benefit from translation services, a connector noted that people from small language groups such as some groups from Africa were less likely to be receiving translated materials in their primary language, and the pool of available interpreters may be smaller.

> *The good thing about the Middle East is of course there is a language that unifies the group, for example Arabic. There's a lot of materials in the Arabic language from the NDIS perspective but when it comes to Africa for example, there's no language that unifies Africa … Think about the 400 languages for example, which language are you going to use to translate and be inclusive? … So definitely with NDIS, my experience has been that there's a lot of people within the African communities that have missed out due to these reasons but also stigma and a lot of other similar things. (Connector manager focus group)*

4.3.3.1.1 Reframed theory for interpreters

The theory for working with interpreters has been refined as follows: [27]

Where people with disability or carers were willing to have an interpreter (C), face to face interpreter services were available (C)and Community Connectors had skills to work effectively with interpreters (C), information provided to people with disability or their carers was more accurate and/or more easily understood (M), enabling access to a range of required services (O).

4.3.3.2 Same sex workers

The initial program theory hypothesized that where cultural requirements for same sex worker were not met by the program (C), people with disability and their carers would not engage or would not be open about issues or needs (M), as a result of which linkages to NDIS would not be formed or the range of required services would not be recognized or provided.[28]

The evaluation found very limited evidence to support, refute or refine this proposition. There was evidence in Quarterly Reports that at least some organisations understood cultural requirements for same-sex workers and demonstrated this in two ways. First, by ensuring there were both male and

[27] Details of evidence used for this analysis is at Appendix 3 – see CMO 1.9
[28] Details of evidence used for this analysis is at Appendix 3 – see CMO 1.8

female Connectors available to communicate with communities using culturally appropriate conventions:

> *A male Oromo Community Connector (from Oromo himself and with a reputation within the community as a credible source of information and knowledge) attended a number of … Oromo Mosque sessions on Fridays to reach out to community and share information related to the NDIS … A female Oromo Community Connector (an emerging Oromo leader within the community) attended the Oromo Mosque for women-only sessions … The more connected male Oromo Community Connector formally introduced the female Community Connector at the Oromo Mosque. This followed the cultural practice where the more knowledgeable leader presents an emerging leader to the community at the Mosque so their community role has credibility and community respect. (Quarterly report January - March 2021)*

Second, one organisation recognized that a client's needs were not being met due to an NDIS provider not having a bilingual support worker of the same gender available. The Community Connector worked with a community leader and the service provider to resolve the issue, so that the client is now receiving culturally and linguistically appropriate support.

> *During this visit, the CC learnt that while [male client] is satisfied with NDIS support, his wife [female client] was not receiving support due to the provider being unable to recruit a bilingual female worker. The family voiced concern over the use of their "NDIS money" when no support was provided …The CC … linked the provider to a community leader. This resulted in the community leader linking a potential female support worker to the provider. Today [female client] is receiving culturally and linguistically appropriate support from that new support worker. (Quarterly report October - December 2020)*

4.3.3.2.1 Refined theory for same sex workers

The program theory for same sex workers has been refined as follows.

Where navigators recognise and respond to cultural requirements for same sex workers (C) and/or cultural protocols relating to gender (C), people with disability and their carers feel safe to engage (M) and stakeholders (services, families and community networks) can collaborate to provide appropriate services (O).

4.3.4 Where it did not work

Qualitative data shows that the program was less effective when

- Specialist assessments were unaffordable, or there were long waiting times for specialist appointments, which slowed the pace of NDIS applications;
- GPs were not able to complete NDIS Access Request Forms properly, which resulted in unsuccessful NDIS applications and increased the demand for Connectors to address problems related to gathering evidence.

The types of evidence required for NDIS assessments means that there is a high demand for specialists to provide detail about the full list of treatments available to determine whether all possible interventions have been exhausted. This has created a high demand for particular services such as occupational therapists (OTs) to undertake functional assessments and medical specialists who can provide diagnoses and certify that the diagnosis is permanent.

> *Rather than accepting a specialist's statement that a diagnosis is permanent, the NAT [national access team] insists on a full list of treatments to date and a specific statement that all possible interventions have been exhausted. This information is not available in regular reports from specialists to GPs which although confirm the diagnosis do not provide the specific wording re permanence or list of previous treatments undertaken and so further evidence has to be sought from specialists. (Quarterly Report April - June 2021)*

It is difficult to get appointments with specialists and some other workers. Wait times for appointments were reported to be up to 6 months. Where there were specialist services available in the public health system, wait times were greater than 12 months. Connectors noted that there was a huge demand for assessments to provide the necessary evidence.

> *[A]ssessments is the key thing to getting people in. Cognitive, functional. When we've had access to free assessments, we've been able to meet somebody, organise the cognitive assessment and a functional assessment and they're in within a couple of months. We've … been working with over 100 people. We've probably still got around 50 that we're waiting for assessments from specialists from, …I don't know who is going to write the functional one, we don't have access to free functional assessments. … hopefully the specialist can document that as well. …having just ready access to the cognitive and occupational therapy or the functional assessments just make so much difference to people. (Connector manager focus group)*

The time lags continued beyond making an initial appointment, as some assessments required multiple appointments and there was sometimes an additional wait time for the result after the assessment. Connectors described needing to follow up. This challenge was exacerbated in some cases by specialists who refused to provide evidence for NDIS access, saying that it was not their role and directing the person back to their GP. This resulted in inadequate evidence being provided and the application being unsuccessful (see next item for discussion of this issue).

> *Refusal of some specialists to write specific reports for NDIS access, even after long wait to see them. To quote one recent rheumatologist 'my role is to brief patients on their condition and what treatments are available - it is not my role to provide reports for the NDIS, you will need to see their GP for this.' …the NDIS NAT [national access team] has turned down people with significant disability as a result of not having detailed NDIS focused specialist reports confirming long term treatment and that all available interventions have been exhausted. (Quarterly Report April - June 2021)*

The cost of obtaining specialist assessments was also a significant barrier. It was challenging for Connectors to find functional assessments that were covered by Medicare. People who had arrived in Australia on humanitarian grounds struggled in particular to afford specialist appointments and also to have the medical evidence required to access specialist services. One refugee service relied on unpaid work to support gathering evidence where people lacked medical records. There were examples of people using mental health care plans to reduce the costs of assessments, however, these did not meet the full cost of the reports. The result of the high demand for specialists to provide assessments that meet NDIS requirements, and the inhibitive costs of assessments meant that many CaLD people with disability remained on waiting lists for assessments beyond the life of the NCCP program and were not supported by a Community Connector to complete the process.

1.1.1.1 Theory for barriers to access

Note that the refined theories provided in this report are intended to apply across any programs seeking to support engagement of CaLD people with disabilities and their carers, and may in fact apply even more broadly to a range of social inclusion programs. Consequently, the program-specific term 'Community Connectors' has been replaced by the more general term 'Navigators'.

CaLD people with disabilities who experience additional barriers (e.g., poverty, recent arrival in the country, language barriers) (C) are less able access private health services (M) and therefore experience longer waits for assessment (O) or cannot access the NDIS (O).

Where private assessments are unaffordable for the client and/or there are long waiting times due to a shortage of specialists/GPs available to do assessments (C), there is a loss in momentum in the NDIS application (M), and the application stalls (O).[29]

Where required services could not fulfil NDIS requirements (e.g. GPs not completing forms properly) (C), strict adherence to rules (M) causes the NDIS to reject 'incorrect applications' and the application is unsuccessful (O). Where navigator services exist (C) this increases time demands (M) on services to address problems (0); where services do not exist (C), it increases the risk (M) of inequitable outcomes for CaLD people with disability (O).[30]

4.4 Assertive outreach

The initial program theory hypothesized that connectors would undertake assertive outreach and deliver consistent information about the NDIS and provide resources in community languages. This would increase awareness of the NDIS, what it provides and how it works, which would enable organisations and community groups to support people with disability and their carers to access the NDIS. [31]

Assertive outreach is defined as "actively approaching people in places where they usually go, for the purpose of offering them supports which they may not have accessed on their own" (National Disability Insurance Agency, 2020b) .

Community Connectors attended, supported or undertook a total of 2,695 community activities between July 2020 – June 2021. (This number includes activities that should be classified as education or networking activities.) Fewer activities were reported by FECCA-contracted organisations between July – December 2020 (n=336) than in January – June 2021 (n=1,106). Quarterly Reports and discussions at FECCA Community of Practice meetings indicated that COVID-19 public health measures, in particular, lockdown in Melbourne from July to October 2020 (Dunstan, 2021) had a significant impact on face-to-face outreach activities in Victoria. The impact of COVID-19 health measures (social distancing and lockdown) is discussed in detail in Section 3.4.2.3 below. The different rates of program establishment in different organisations may also have affected rates of engagement.

The Community Connectors reported reaching close to 42,000 people through community activities. Analysis of quarterly reports and the evaluation data collection tool shows a variety of strategies were adopted, including social media and radio messaging in languages other than English. These strategies were primarily used by FECCA sub-contracted organisations from January to June 2021, which accounts for the high number of people reached during this period. Quarterly reporting data presented in Table

[29] Details of evidence used for this analysis is at Appendix 3 – see CMO 2.4
[30] Details of evidence used for this analysis is at Appendix 3 – see CMO 2.5
[31] Details of evidence used for this analysis is at Appendix 3 – see CMO 2.1.

6 shows the combined results of organisations sub-contracted by NEDA (in NSW, ACT, WA) and those sub-contracted by FECCA (in Vic, Qld, SA, NT, Tas).

Table 6: Combined reporting data, 2020-2021, number of activities and people

	NEDA			FECCA			Total NCCP		
Reporting period	Jul-Dec 2020	Jan-Jun 2021	Total 2020-2021	Jul-Dec 2020	Jan-Jun 2021	Total 2020-2021	Jul-Dec 2020	Jan-Jun 2021	Total 2020-2021
How many community activities have the CCs attended, supported or undertaken?	586	667	1,253	336	1,106	1,442	922	1,773	2,695
Number of people who have been reached through community activities	4,698	5,710	10,408	9,117	22,467	31,584	13,815	28,177	41,992

Source: Quarterly reporting by FECCA and NEDA

CaLD community networks are dispersed and are not limited to geographical boundaries. During the implementation of the program, Connectors raised questions with FECCA and NEDA about the local government areas (LGAs) focus of their work. There was a demand for Connectors outside of their intended service 'footprint'. There was uncertainty about whether Connectors were 'allowed' to provide services outside of the LGA specific to their contract; some organisations had a greater capacity to 'take on more' than others, based on their FTE (which varied across organisations) and the settlement patterns of CaLD cohorts within their 'foot print'. Connectors working in regional areas found finding and meeting with CaLD people more challenging because cultural groups tended to be more dispersed and less visible in comparison to metropolitan centres:

> *There are no ethnic enclaves of cultural groups like in metro centres … There are no concentrations of CaLD users by any service except for the one and only multicultural service in the region. This poses a huge challenge in both stakeholder engagement and 'effective' assertive outreach activities. (Quarterly report October-December 2020)*

To address the challenge of identifying and finding CaLD people with disabilities and their carers, a small number of organisations used strategies such as information desks in large suburban shopping malls to reach people who were not actively involved in CaLD community networks. However, this strategy did not result in significant numbers of people engaging. Greater reach (in terms of numbers reported in quarterly reporting) was achieved through radio interviews in languages other than English, such as Arabic and Hindi. There were also articles published on the SBS radio web pages after interviews (Merani, 2020). Some organisations developed podcasts and published videos on YouTube where they shared stories of lived experience in receiving support from the program, using simple English. These resources were shared with cultural networks on social media to increase general awareness of the NCCP.

Organisations commonly distributed flyers to share consistent information about the NDIS. NEDA and FECCA translated flyers into 25 languages and shared these with sub-contracted organisations in December 2020. One organisation, which already had translated materials about the NDIS because they ran a disability advocacy program, shared their materials with other NCCP implementing organisations. Community Connectors reported that flyers distributed at small community events proved effective,

because they provided community members with information about a service they could contact. Flyers were also valued by Connectors who were in lockdowns and unable to engage face-to-face.

Connectors noted that materials available on the NDIS website in languages other than English did not cater to the languages of all the groups they were working with, and the amount of information that was translated was limited. Some Connectors delivered messaging in 'Simple English' as well as languages other than English:

> *There was also a big barrier in terms of…the language and the stigma which we have tried to… approach by giving people in-language material. The last session that I did, I had to do it both in English and Swahili because I had a family from the Swahili speaking community and we didn't have a translator in that session. So I had to actually do the session first in English and then simple English and then do it again in Swahili. (Connector focus group)*

Connectors noted that ongoing outreach to community groups was required because multiple points of engagement and multiple information sessions are required to reach CaLD communities. Effective outreach in this sense was constrained by the short time frame of the program.

> *… some groups or some languages or some communities are quite diverse within their own communities, so by this I mean, for example if you are going to speak to, … people from Zimbabwe. You find that there are people who speak Shona in Zimbabwe, there are people who speak Ndebele in Zimbabwe and probably everyone speaks English but these people meet at different occasions and different places. You're meeting a Zimbabwean kind of group is probably not full representation of that community and it does not necessarily mean that, well, the message has gone across to everyone. It's a process thing that, it's not like you go to one group then that's done.* ***(Connector Focus Group)***

4.4.1 Where it worked

The initial program theory hypothesized that Community Connectors' existing relationships with cultural networks would enable them to find and connect with people who were not accessing services.

Some Connectors were community leaders (formal and informal) or were well-known members of community groups. Connectors with established cultural networks already had good 'reach' and knew whom to contact or follow up with in terms of appropriate assertive outreach for their community.

> *…we did a brainstorming to start with and put together a list of about 100 different possible contacts and then community leaders, religious leaders, CaLD focused GPs, mental health units, nurse navigators at the hospital who focus on CaLD service providers, schools, special schools. We went out and put brochures everywhere we could think of. (Connector Manager focus group)*

One of the main barriers for CaLD people in accessing the NDIS is language. Where the Connectors spoke the same languages (many Connectors were multi-lingual) they were able to communicate effectively with people with disability and their carers, as well as with others in those communities.

> *What I thought we'd do is we'd focus on those areas of our language groups to start with and then we'd broaden out. As it is, we've been inundated with referrals just from the twelve languages that our connectors speak … we've got more than enough work than we could cope with, with the people that spoke the languages that we speak.* ***(Connector Manager focus group)***

Existing relationships supported access to information in a number of ways. Just as Connectors knew who to reach out to, community representatives knew that there was someone they could contact to follow up about the needs of individuals. This could be important in cultures where expectations for people with disabilities were generally low and so too were expectations of support being available for them.

Connectors also understood the cultural issues relating to disability for their communities and were able to engage their community in discussions on sensitive topics appropriately. This meant that the stigma of disability and misbeliefs about the causes of disability could be addressed, role models provided, and information about the supports available for people with disability and their carers could be provided.

> *Community representatives, including key community members and leaders, have someone to contact who they know will follow up with individuals. Stigmas can be reduced when someone from their own community can discuss causes of disability, opportunities for a good life, supports available etc. and provide examples of others with disability who already have supports and greater independence. Information is provided at community and religious events so that people can hear what is available without having to go and look for it. This is important in communities where expectations for PWD are very low and opportunities are unknown and therefore not sought out. (Quarterly Report July - September 2020)*

When Connectors did not have direct relationships with cultural networks, they demonstrated cultural respect by establishing relationships with CaLD community leaders, which then allowed information to be provided to people with disability in the community.

> *We have been able to connect with people with disabilities through organisations that have been providing them with other supports such as settlement services, refugee health clinics and women's health programs. We have also made ourselves available in places where people with disabilities are already meeting for example in church groups, mosques and sporting community events. We have also engaged with community leaders of various communities to bring people together to share information about the NDIS and supports available for people with disabilities. It has become apparent that building a relationship of trust is important to be able to reach out to the different groups. It takes time for people to share their vulnerabilities and as such bringing destigmatising disability in communities helps to start the conversation and eventually leads to people coming forward to access support. **(Reflective survey)***

This strategy of working with community leaders of different cultural networks and providing them with information about NDIS supports was common. Community leaders were, generally speaking, receptive to learning more and working with the Community Connectors to provide education to their communities about disability supports and the NDIS (but see exceptions to this in Section 3.6.2.2 below).

> *[W]hat I have found is it is just good to encourage communities to move forward and try to actually address biases that people have within themselves because that's how they start then to move forward. We can give them a lot of translation material but then again people with a disability are expected to assimilate in the same community that we all live. Trying to actually encourage them to self-advocate and also to familiarise themselves with the services that are available. (Connector Focus Group)*

One organisation formally assessed and considered 'community readiness' to discuss disability, and worked to 'meet people where they were' in terms of readiness to discuss and engage on the topic of disability. They sometimes did this by 'piggy-backing' information about the NDIS onto an information session about other types of services.

> *… they … piggy-backed this kind of information with other things that they knew the community might be seeking like here's information about employment services that you can access … so they knew there'd be enough people that would come for that that they'd be able to smuggle in some NDIS info. (Connector Manager Focus Group)*

Community leaders also invited Connectors into their community meetings to present information to the community as a whole, to begin to address the stigma around issues such as psycho-social disability and mental health conditions.

Where fear or mistrust of the Government stopped people from engaging, Community Connectors were sometimes able to bridge the divide.

> *…a family, so it's a single mum, [other language][32] speaking and the child had actually had a plan for two years but had not in any way used the plan. The child had a significant disability ... the agency [NDIA] put them back into our system because … after a period of time, no one has been able to contact them … We were able to link this mum up with this [other language] speaking community connector and she explained to the community connector that … when the phone rang and it was no number…she wouldn't answer the phone because she thought she had done something wrong and the government were after her.* ***(PITC Stakeholder interview)***

A Partner in the Community (PITC) noted that some families sought to avoid being identified as being in contact with the NDIS, and suggested that the Community Connectors were better placed to make that connection because they were community based.

> *… a lot of families, when we used to go and visit in the family home, they'd say please don't have anything that says NDIS on it, you know, your car or your shirts because I don't want people in my community that my child might have a disability. You know, have nothing visual to indicate that you are from a government agency whereas the connectors sitting outside of the government, in a sense being community-based services that they're from, I think they were much more accepted within those communities.* ***(PITC Stakeholder interview)***

One service manager reported that other agencies would sometimes refer for less significant disabilities in an effort to open the conversation with a family.

> *We also had quite a few families referred to us for maybe like a speech delay or some … disability [that] had quite minimal impact and then really when you met the family and dug in and spoke to the teachers, it was clear that there was like an intellectual disability or quite a severe developmental delay. It would almost be like that was how … the schools wanted to initiate beginning those conversations.* ***(Connector manager focus group)***

[32] Language group not shown to protect confidentiality.

4.4.2 Where it did not work

The initial program theory hypothesized that "Where there were conflicts between the cultures of the Community Connector and people with disability and carers, there would be suspicion or a lack of trust from community leaders, and community groups would not engage with the program." [33]

The evaluation did not find evidence of cultural conflicts between Community Connectors and people with disabilities and their carers. There were other factors, however, which decreased the effectiveness of assertive outreach.

4.4.2.1 Stigma

There were a number of reports of cases where assertive outreach was not sufficient to overcome the stigma associated with disability. In some cases, one parent of a child with a disability (usually the mother) would make contact seeking support, but another family member (usually the father) would decide against pursuing support.

> *We had a lot of trouble with families wanting help and then backing out as well, especially in the early childhood space as they were dealing with the grief around their children may or may not have a disability. There was still a lot of work to do around that sigma area for a lot of the people that we were coming into contact with.* ***(Connector manager focus group)***

> *We had some very similar experiences as well around stigma, particularly because we did a lot of promotion to childcare centres. We would meet centre managers who recognised that a child might have a disability and want to refer to us but the family members didn't want to make that referral …, there's nothing you can do other than try and provide some education around that. (****Connector manager focus group)***

4.4.2.2 Disconnection from communities

At least one Community Connector reported that people with psycho-social disability and their carers, or who for other reasons did not have connections in the community were the hardest to reach.

> *The people that I feel haven't been reached are those that have got … either psycho-social disability or other disabilities that might cause them to withdraw from communities, that haven't got community connections, so those people are probably the hardest ones to reach. … people that are generally connected in the community would've received that information but those that are not engaged with communities definitely wouldn't have.* ***(Connector focus group)***

4.4.2.3 Impacts of COVID-19

The initial program theory hypothesized that the program was likely to be less effective due to COVID-19 social distancing restrictions. The refined theory is that lockdown restrictions due to COVID-19 made assertive outreach more difficult to undertake and, in states where there was prolonged lockdown, made outreach slower and less effective, connections between clients and other services more difficult, and assessments slower.

Organisations sub-contracted by FECCA engaged with a lower number of people with disability (n=212) during July-December 2020 than organisations sub-contacted by NEDA (n=648) during the same period. This would appear to be due to the effects of lockdown restrictions. Assertive outreach was not possible

[33] Details of evidence used for this analysis is at Appendix 3 – see CMO 1.6

during lockdowns: neither Connectors nor their potential clients could go to the places that they would normally attend, and FECCA-contracted organisations were located in the states most affected by lockdowns. This was most apparent in Victoria, because most Victorian Community Connectors were based around Melbourne, where 2020 lockdown restrictions were strictest and longest lasting. There was also a slight dip in activities by NSW agencies between October and December, apparently due to a Sydney lockdown: this is less obvious in the data because some NSW-based Connectors were based in non-metropolitan locations. Even when lockdowns concluded, community members were reluctant to attend events for fear of COVID transmission. Numbers of people at events were also restricted in some locations. This meant Connectors were still not able to attend community events or undertake planned partnership activities with NDIS PITC.

> *I think living the very short life that it did as a program, it would be hard to even evaluate because I don't think we have enough time … given the context that was COVID time... So really, were they able to go and do all the tasks that they were wanting to do? Were they ... out and about as much as they could have been? Because a lot of our core families might not have access to technology so … doing things virtually wouldn't have been as possible. …we were going to start to do things together … so if there was anything within our local council region for instance or an event, there'd be a community connector and a coordinator. … whereas that never happened, we didn't have time. COVID stopped it.* ***(PITC stakeholder interview)***

Understanding the impact of COVID is also supported by analysis of the quarterly report data for engagement of people with disabilities by State and Territory. The smaller states and Territories (SA, NT, ACT, Tas) showed small numbers of people recruited overall and slow rates of increase: it is likely that this reflects both smaller populations and fewer organisations employing Community Connectors. Western Australia showed a rapid increase over the first six months and steady, relatively high rates of engagement for the remainder of the project. NSW and Qld showed relatively steady increases over the whole project period, while Victoria saw slow recruitment during the protracted lockdown and a rapid increase in the second six months of the program. Similar patterns were evident for people with disability whose applications to NDIS were successful over time, with gradual increases in WA, Qld and NSW but a rapid jump after lockdown concluded in Victoria.

Connectors were concerned about their ability to engage with people who were isolated, had low literacy or were less able or unable to access digital technologies (referred to as 'digitally disadvantaged'). However, it should be noted that there was still some engagement in Victoria during lockdown, suggesting that broader community awareness strategies (social media, radio programs and the like) together with personal relationships between Community Connectors and people with disabilities (e.g. family and friends) were sufficient to reach and engage some potential clients. While our evidence is insufficient to support it, the broader community awareness strategies are likely most effective for those who are most confident and face lower barriers to engagement, leaving more disconnected and vulnerable people without access to support.

Connectors also noted that the lockdown restrictions made collecting evidence of disability a lengthy process and that people were uncomfortable leaving their homes to attend appointments.

> *[W]e've only touched the tip of the iceberg in relation to the communities because all the social groups are still not operating. What we would usually do, not COVID, is go to those groups, whether they're on the weekends or the evenings or whenever and let people know that that service was available.* ***(Connector manager focus group)***

Connectors adapted outreach strategies using online platforms, social media, radio, emails and electronic flyers and phone calls to reach out to contacts. However, they noted that there were low levels of engagement in online information sessions.

> *… we didn't have much success with it. We really didn't start getting a lot of referrals until they did face to face engagement. We tried to do information sessions … we only managed to get one community who wanted to do it online. So there was complete disinterest, really … I think probably that given the situation, that wasn't exactly surprising.* ***(Connector manager focus group)***

This meant that Connectors relied on their existing networks more heavily and then focused on institutions, such as schools, to make contact.

> *… they're really face to face communities that are not particularly online. …We did a lot of promotion and really got very little back from it in the first few months until we were able to go more face to face. So the places we got most of our referrals from initially were from community links that the community connectors already had so basically just them asking their friends and family if they knew of anyone, …and then since we've been able to do more face to face stuff, we've got in touch with a lot of schools and we've had a lot of referrals from them. They…have been very appreciative of that work because they have students who need support … but they don't know how to work the system themselves.* ***(Connector manager focus group)***

Connectors noted that some people do not feel comfortable to communicate with strangers through technology and will not answer the phone if they do not know the caller. Other research also shows that refugees and people who do not speak English are particularly disadvantaged in accessing health care using remote telehealth services (O'Mara, Monani, & Carey, 2021). Some connectors also noted that psycho-social disability was exacerbated by COVID-19. This is also supported by other research into the impacts of COVID-19, which demonstrated a higher percentage of people living in Victoria experienced psychological distress.[34]

Overall, both the quantitative data for engagement and for successful applications to the NDIS, and the qualitative data, all support the critical importance of face-to-face strategies to reach and engage CaLD people with disabilities and their carers.

4.4.3 Refined program theory for assertive outreach

The initial program theory hypothesized that existing relationships of Connectors with cultural networks would enable them to find and connect with people who were not accessing services (see Appendix 3 PT 1.1 and 1.6 for initial program theories). This has been largely supported by the data, but refined in a number of ways. It is not possible to identify, from our data, whether all strategies used by Community Connectors are in fact essential, but other research in health promotion suggests that multiple strategies and repeated access to information are in fact required.

The program theory has been refined below.

Where navigators are trusted members of communities or have existing positive relationships with those community networks (C), provide consistent information through culturally appropriate means (e.g. resources in community language, community radio programs) (C), demonstrate understanding of

[34] https://www.abs.gov.au/statistics/people/people-and-communities/household-impacts-covid-19-survey/jun-2021#emotional-and-mental-wellbeing

cultural issues and perspectives in relation to disability (C), and use face-to-face engagement strategies (C) AND CaLD people with disability and/or their carers have links to cultural networks (C), community members trust navigators sufficiently to engage with them ("initial trust") (M) and would therefore approach them on their own or others' behalves (O1), enabling navigators to begin work towards identifying and addressing barriers to access (O2).

Where navigators demonstrate culturally-relevant capacities (e.g. speaking community languages, understanding cultural perspectives in relation to disability) (C) and undertake outreach through mainstream organisations (e.g. schools and child care centres) (C), organisations are willing to refer (M) people with disabilities and their carers to navigators, enabling navigators to make initial contact with families of people with disability (O).

Where stigma about disability remains strong (C), decision-makers in some families are unwilling for other community members to find out that a family member had a disability (M) and decline support to access the NDIS (O).

Where programs are short-term (C), staffing allocations within programs are small and people with disability are disconnected from cultural networks (C), there is insufficient time or capacity (M) to engage those disconnected members, leaving them without the option to engage with NDIS.

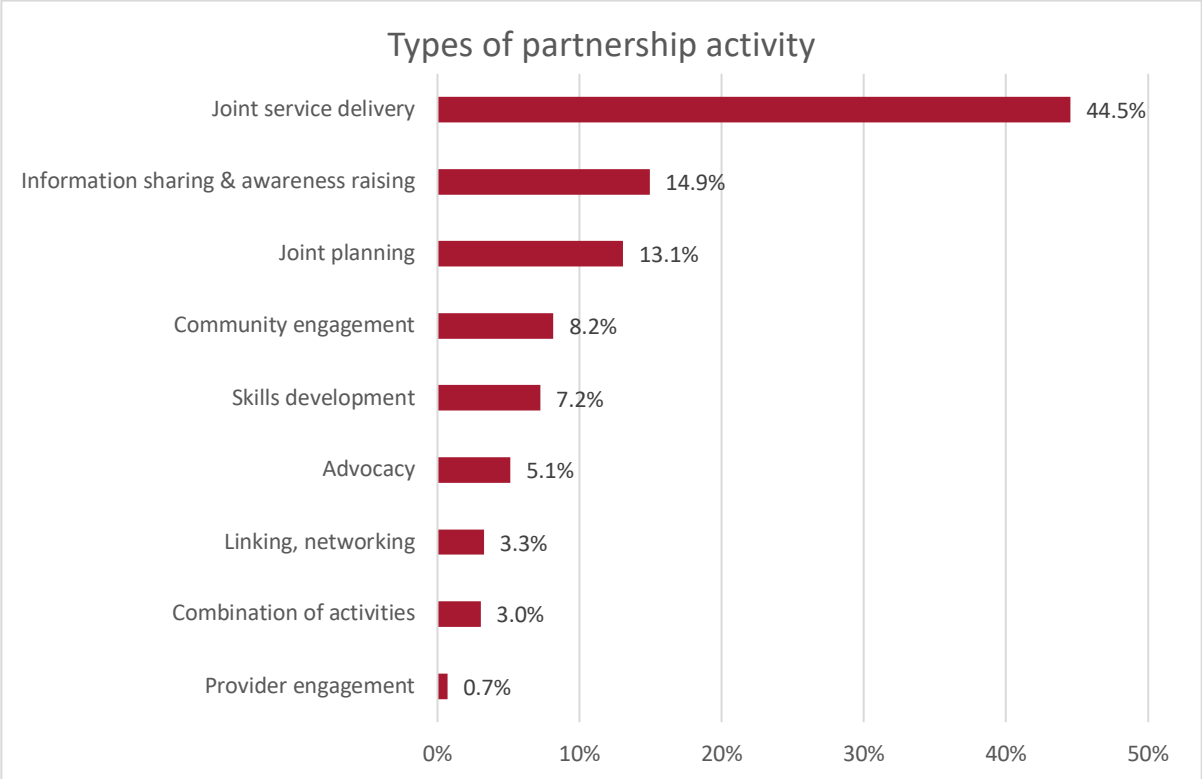
Where circumstances prevent face-to-face contact with community networks (e.g. COVID-19 lockdowns) (C), lack of direct contact between navigators and community members prevents "initial trust" being established (M) and less confident or more marginalised people with disability and carers remain disconnected from the program and other supports (O).

4.5 Partnerships and Networks

Partnerships and networks were hypothesised to operate as a source of inwards referrals (to Community Connectors), outwards referrals (to services required by people with disabilities and carers), and as a source of collaborative action in community development work.

Community Connectors reported on types of collaboration activities in the Evaluation Data Collection tool. Specific types of the partnership were listed, with the option of selecting more than one, and to nominate 'other' and use free text to describe the activity. Free text responses were grouped according to types of activity. Close to half (45%, n=191) of collaboration involved joint service delivery; 15% (n=64) sharing information and awareness raising (under 'other'); and 13% (n=56) were joint planning activities.

Figure 11: Types of partnership activities reported by Community Connectors, percent



Source: Evaluation Data Collection tool

Common outcomes as a result of joint service delivery were, in order of frequency reported:

- Relevant information being provided to the target audience;
- Referrals, and the creation of referral pathways to support assessment processes;
- Support for clients in plan review or application processes;
- Increased supports for clients through non-NDIS services.

An example of an effective partnership was Connectors working with nurse navigators, who provided existing evidence required for the NDIS application process:

> *Building that reciprocal referral relationship with the health networks actually worked pretty well because you were able to, for us, it was a lot of evidence gathering, … and that part of it was tackled by the nurse navigators who would refer these clients to us with that evidence already there. We had the medical documentation there to … apply for the NDIS. (Connector Focus Group)*

Partnerships and networks enabled linkages of cross-sectoral supports for CaLD people with disability such as health, NDIS, service providers, therapists, and schools to co-ordinate more comprehensive care. Community connectors worked with their partners and networks to provide appropriate referrals for those not eligible for NDIS support. One of the outcomes of outreach was the Community Connectors identified systemic service gaps for CaLD people who were living with chronic health conditions and required ongoing support but were not eligible for the NDIS. These clients sought to engage with the NCCP as a means of finding connections to the types of services they needed:

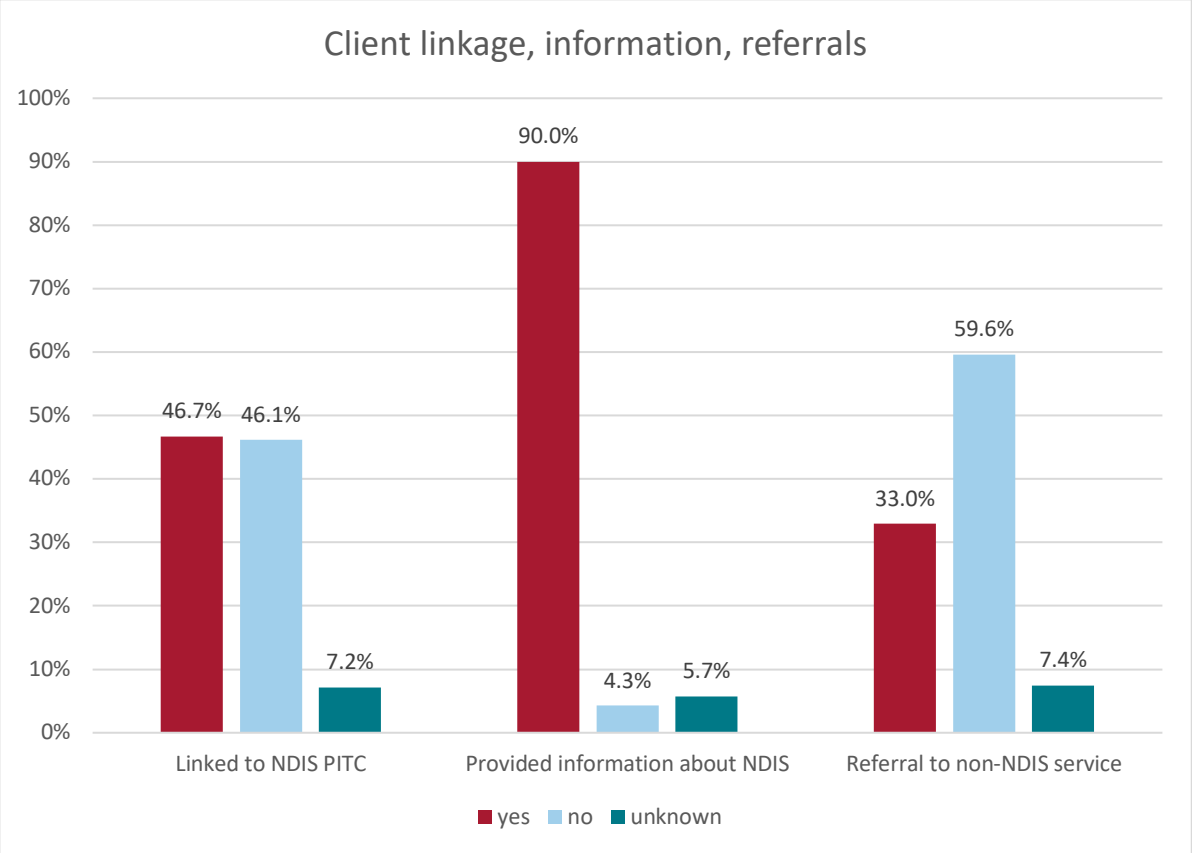
> *There is a significant gap in services and supports for people with chronic health conditions that substantially impact their functional capacity. …the supports and services available through the health system or in the community are inadequate, to provide the ongoing support according to individuals need in order to manage their conditions, and participate more fully in social and economic activities. This gap means that [Community Connectors] are frequently asked by people with chronic conditions for support to apply for the NDIS. In a majority of cases these potential participants are not able to gain access, but as they are not able to access the services they need through other avenues, must try to reapply for the NDIS again in order to try and access the supports they need. (Quarterly report Apr-Jun 2021)*

Determining whether or the extent to which the needs of people ineligible for the NDIS were met by referrals to other services was beyond the scope of this evaluation. Further research is required to better understand the service gap for CaLD people with chronic health conditions that are not considered a disability, particularly in the wake of the COVID-19 global pandemic (Dickinson, Carey, & Kavanagh, 2020; Kavanagh et al., 2021; O'Mara et al., 2021). In principle, Connectors were directed to refer clients who did not meet NDIS eligibility to the NDIS Local Area Coordinator (LAC) for referral on to other types of supports. However, some Connectors held significant concerns about the workload capacity and cultural capability of some LACs to communicate effectively with CaLD clients (noting they may, for example, provide services by telephone rather than face-to-face meetings; and not make appropriate use of interpreters).

Connectors reported on linkage to NDIS Partners in the Community (PITCs) and provision of information and referrals to non-NDIS services for individual clients in the evaluation data collection instrument. However, it was not always possible to identify PITCs as the evaluation form did not require them to be identified. Consequently, the results for linkage to PITCs may be underestimated. The available data

shows that 46.7% (n=163) clients were linked to the PITCs (see also qualitative data below). Most (90.0%, n=314) clients had received information about the NDIS from the Connector. A third of clients (33.0%, n=115) had received a referral from the Connector to a non-NDIS service (eg. support for housing).

Figure 12: Linkage to NDIS PITC, information and non-NDIS referrals for people with disability



Source: Evaluation Data Collection tool

4.5.1 Collaboration with NDIS PITC

No program theory was developed prior to the evaluation specifically for the relationship between Community Connectors and PITCs. According to NDIA training provided to Connectors at induction, the difference between assertive outreach from Connectors and other engagement by PITC was:

- "Partners in the Community serve particular places or geographic communities
- Sometimes people identify more strongly with their community of language, culture, or particular circumstance which might be spread across further distance so they may not meet their PITC or access services in their neighbourhood
- Community Connectors will support participants and prospective participants to connect with their local PITC or NDIA office, and the services that are appropriate for their personal circumstance." (National Disability Insurance Agency, 2020b).

There were mixed results for collaboration among Community Connectors and the NDIS PITCs. Qualitative data collected through interviews and focus groups with Connectors, their Managers and other stakeholders provide insight into the relationships between Connectors and the PITCs; where the collaboration worked well and where it did not.

4.5.1.1 Where it worked

One early-childhood PITC invested time in supporting a Community Connector agency to better understand their respective roles, resulting in more appropriate referrals to the PITC from Connectors.

> *…because they didn't have a lot of knowledge when they started, they weren't given a lot of information about the difference between the early childhood early intervention space and the LAC space. …. I attended a couple of … their staff meetings and gave some presentations about our role and the work we do and a better understanding of some best practice principles in our workspace … because you don't need a diagnosis in our under-seven space, you just need to be considered a child with a developmental delay or a disability... It's made it much clearer for them and that way, the hope with that was the referrals we did get would be correct referrals. That's how it did work. I don't think there were a lot of referrals from the community connectors because I think a lot of the time they were meeting with older age cohorts … but it's been a good working relationship, I think because in the beginning we spent a bit of time making sure we both knew our roles and how we can best work together.* ***(PITC Stakeholder interview)***

Another Community Connector agency established collaborative service delivery with an early intervention team, enabling direct referrals to the early intervention team. This was seen to be appropriate because NCCP was a short-term project.

> *We managed to build a really strong relationship with the early intervention team in the under sevens space and they actually came with us a lot of the time … so a lot of the referrals didn't actually come to us, it went straight to them which was really good because knowing it was a short term project, we weren't that link, that dependency link. … the other LACs were less supportive but that particular one was amazing.* ***(Connector manager focus group)***

Multiple quarterly reports identified that LACs referred clients to them because they did not have the capacity to deal with complex cases themselves and they found it useful to work collaboratively with Community Connectors. This raises significant questions about the capacity of LACs to absorb the work of Connectors after completion of the program.

> *33% of our referrals are from LACs. … the LACs love us. They're referring clients, it's a real collaborative partnership.* ***(Connector manager focus group)***

Another Connector tried to establish direct relationships between the CaLD community and PITC, but it was challenging because of technological issues and differences in availability. The Connector adopted another strategy to enable information to flow from the NDIS to the community. It should be noted that implementing such a strategy relies on a navigator position (or equivalent) being available.

> *In these Zoom sessions, we were hoping to invite the NDIA, community engagement and the [PITC] but a challenge…was the government don't use Zoom, they use Teams, so not being able to connect because of that. The other thing was the discussion forums were happening after hours, six o'clock to eight o'clock because that's when the community leaders were available. There is also that disconnect because then NDIS is not available for community …. In the end we ended up collecting the questions and emailing them to the community engagement officer and then waiting for their information to get back. We had wanted to build that connection but then that's how we ended up working.* ***(Connector focus group)***

4.5.1.2 Where it did not work

Stakeholder interviews, Community Connectors and their managers all identified instances of poor communication and lack of mutual understanding of roles. In some cases, PITC felt the funding for the program should have gone to them. This led some to suggest that the NDIA should have consulted with PITC about the proposed program and clarity of roles, as misunderstandings with Connectors had created unnecessary antagonisms.[35]

> *I think the foundational work would be done better. By that I mean …the agency [NDIA] engaging us. … I work very closely with the assistant director here that looks after that area and that would have been a conversation that we would have had in the six weekly meetings to say this program is coming on board, to pick our brains a little bit for the best ways of starting off and then we can sort of upskill them to where we are and … also having an understanding, … some sort of foundational agreement to say what sort of roles are we going to have because at one point it was almost us against them, we didn't realise there are partners and connectors. We are working at different places but we are sort of joining together.* ***(PITC Stakeholder interview)***

Some Community Connectors also believed that their own roles were not clear initially, which may have contributed to poor relationships.

> *[T]he first couple of months where we were at, we were trying to figure out our job role as well because okay, you're a community connector. That's great, what do you do? We didn't get a proper job description … for a good couple of months. We were just trying to figure out okay, so we're community connectors, we tie into the NDIS but what else do we do? Do we do projects in the community? How do we work with partners in the community? Kind of stuff like that. So that was really difficult as well but over time what we've realised is that your job role, it's more than a community connector. It's actually evolved to case working.* ***(Connector focus group)***

Beliefs across PITCs and Community Connectors varied about how the poor start could be rectified. Some Connectors wanted to learn from a PITC but were told it was not the PITC's job to provide them with clarification on their role. Another PITC was willing to provide training but perceived resistance from a Connector about admitting their lack of knowledge.

> *We would've expected at the very beginning that after their induction, as community connectors, …that basically we wouldn't have to induct them further … when they asked us that question, we asked them to go back to their contact in the NDIA to get clarification on what their role was because we weren't their employer.* ***(PITC Stakeholder interview)***

> *I feel like there was also a lack of admittance of a lack of knowledge, there was a resistance of getting training from us. I mean, we were doing this for a long time prior to the connector program. There was just always resistance and it felt like a lack of realisation that we are actually on the same team. … Whether some forms were not filled correctly because there was just no admittance of can you help me do this? I just feel that it was a wasted opportunity because there was a very big opportunity to collaborate but there was also a resistance there.* ***(PITC Stakeholder interview)***

[35] The NDIA described the NCCP as "a targeted program, delivering surge capacity in support of PITC [NDIS partners in the community], in order to identify, engage with and support hard to reach cohorts to gain access to the NDIS, where appropriate" (NDIA 2020, p.8).

Another Connector manager believed that greater capacity building for the PITC in terms of their capability to work with CaLD communities would have been useful.

> *… I would've liked to have seen… a lot more collaboration with partners in the community, not in the sense that we weren't communicating with them, we were communicating with them, but just in terms of … building their capacity around working with this particular cohort of clients and that would be long term …there were working relationships, it's more about getting them on board in terms of different ways of interacting with clients and getting the cohort that is very vulnerable.* ***(Connector manager focus group)***

Role clarification was reported to remain a problem in at least one area throughout the project. One Connector manager found it useful working direct with NDIA, effectively bypassing the PITC.

> *What I also found out, I discovered from this project is … we didn't need a PITC. We have established good relationships directly with the Department which is already a … a structure, in place, for a lot of organisations including community groups that can directly … start to access the NDIS but somehow that has been restricted and then channelled [through] specific organisations which has slowed everybody down and really makes the job too hard to understand to the participants let alone employees … we're still trying to define who does what. It's not really clear and that has been a problem throughout the project.* ***(Connector manager focus group)***

Other barriers to establishing relationships were also noted on both sides. In at least one case, the PITC reported increased workload because they were dealing with too many different connectors.

> *…we thought the main community connector was going to be doing the transferring of the information but what they did, they subcontracted it out which meant that we were dealing with a whole lot of different community connectors. That was challenging because it was difficult to build a relationship that we hoped for because there were too many of them and it was hit and miss.* ***(PITC Stakeholder interview)***

Likewise, another Connector wanted to build a relationship with a contact in the PITC who they could reach directly, but were told that they had to use a standard phone process to make contact.

> *[T]he other thing I feel would have been helpful would've been … our local area coordinator being more open to the community connector program so with the introductions, that took a long time to happen and then after that there was no real contact with them directly, … if I was … referring someone to them, I would have to just do the phone call process and that is really difficult whereas if there was… somebody in their office that I could've had that contact to connect the person to, that would've been much more helpful.* ***(Connector focus group)***

Another PITC suggested that at least a proportion of the resources allocated to the program would have been better allocated to them. This may reflect some level of under-resourcing for PITCs themselves.

> *I think because we have pre-existing relationships in the community, I would've liked more resources put into the partner in the community and have one person allocated to do that connector program in each region … I just do want to stress it would've been better to resource the partner in the community.* ***(PITC Stakeholder interview)***

These sorts of issues are common in programs in the early stages of development, and are indicative of why outcomes evaluations are not usually conducted until programs have had time to move past 'teething troubles'. It is likely that stronger relationships would have been built over time had the

program been of longer duration, and that benefits to CaLD people with disability and their carers would also have increased.

4.5.2 Collaboration with cultural and community groups

Organisations using a community development approach anticipated working collaboratively with cultural and community groups and other service providers to address barriers to accessing the NDIS. Two examples stood out, but other organisations also attempted community development to varying degrees. Organisations reported that it was necessary to move beyond community education to encourage communities to take 'ownership':

> *Information sessions just don't really give people what they need to actually get into the NDIS. It just doesn't, it's not deep enough. This new project, we're hoping as it rolls out that it will actually get the depth of the communities [who] will take more ownership in this space. (Connector Manager Focus Group).*

4.5.2.1 Where it worked

All sub-contracted organisations had the opportunity to apply for additional one-off project funding in late 2020. The organisation just quoted used this funding to partner with a community group which had very limited access to resources and was run entirely by volunteers to create their own 'community connector program'. The initiative provided a suite of information sessions and interactive discussion forums that aimed to develop some community members' capacity to educate and support others to access disability appropriate supports and services. This initiative ran for four months and was credited with starting to address the stigma associated with disability. Box 1 provides a description, in the words of the community leader who designed and delivered the project.

Box 1: Example of community development used during the CaLD NCCP

My role... is to support African women and empower them and our main program is the settlement engagement transition support which is to support refugees that have been here for less than five years … it's basically about empowering the African women that have come from all parts of Africa as refugees and helping them to settle ... It's a very small organisation but always looking out for opportunities to help the CaLD community. … We've got the executive committee that's made up of volunteers, they're refugees themselves and got experiences of the struggles their people face. We've also got a management committee that is made up of all the leaders from the African community, the women leaders. They formed the management committee as volunteers supporting the organisation as well to carry out these duties to ensure that we support our people appropriately.

I saw this as a pilot project … introduce it to our people to let them know we are aware of some of the challenges that they have and we want to start talking about it. So I then developed a program where within the four months we had four different topics to deliver so I developed that which was around disability in Australia because obviously from the African perspective, … it's completely different. The perception of disability is treated differently in Africa compared to here. So we wanted to discuss that and share that information with them ... Then we also talked about understanding of the NDIS so that was another session that we delivered … The initial idea was to also educate people within the community like community educators so they would be positioned where people needed support within their community … I knew that just delivering the information session is not going to be enough … we have a discussion forum where we invite key participants for respective communities to be part of a discussion forum, so unpack what has been delivered within each session … we also invited the local area coordinators that were able to come in and be involved and answer a lot of questions … We were very excited to have been fortunate for FECCA to recognise the need and that additional funding came to us.

… these are not easy conversations in our communities. So many things stand in our way… what we learnt was the importance of looking for help and if we get that early enough, the impact is reduced and I am glad because attitudes have changed, people now understand the need of just opening up. Before it was just difficult, we could talk about other things but disability was a bit hard. Even to look someone with a disability in the eye, it's a form of disrespect sometimes. So we don't really want to talk about those things but we're now at a point where we can talk about those issues without fear and we know that it's actually good for us.

Source: Community Stakeholder Interview

4.5.2.2 Where it did not work

Some community leaders with whom Community Connectors sought to engage acted as 'gate keepers' for their communities. Some of these leaders would deny there was disability within their community, most likely due to cultural taboos. They could also filter what information about the NDIS would be provided to community members. Therefore, the Connector's reach into particular communities relied on whether the person passed relevant information along to the broader community.

> *Working with, you know, through community leaders and I say this with a caveat because I think that that strategy would've begun to borne more fruit had we had more time because I think the issue, we did get some pushback from some community leaders who you know, were perhaps in a bit of denial about the existence of disability in their communities. It just wasn't*

something that necessarily affected their community. I think that's a much more long-term process to sort of work with communities and you know, start to breakdown that stigma to provide more education etc. (Connector Manager Focus Group)

In another community, it was a matter of the Connector finding the best contact with whom to have a conversation about disability. This was not necessarily the leader of the community, but a person who was appropriate to speak with about sensitive issues inherent to the program.

[F]inding the right gatekeeper. Sometimes like you thought that you found the leader, you thought you found the key person of the community or the organisation but it might not be the person that is the perfect fit for the program and the conversation, you have to do it again through another gatekeeper. (Connector Focus Group)

In a third example, the Connector found that the community already had support networks in place for community members for disability. Information was provided to the people undertaking the support roles, but this did not result in direct connections between people with disability or their carers and the Connector. However, it appeared that the information could have resulted in people with disabilities applying to the NDIS.

…the hardest community to break into were the recent migrants from Muslim communities. We couldn't get past the gatekeepers at the mosque. …. We went and did education sessions, we …went with one of my colleagues that speaks Arabic to meet with them but it was very hard. ... But …we just found out they have a really good network of support and workers that were already doing that … they had a kind of social workers, not in the professional sense but they already had … people from the mosque that had a job to help others. So we provided the information to them and I think they got on with the work of helping people to apply. (Connector Manager Focus Group)

It appeared that parts of the community were reluctant to seek assistance from 'outside'. At least two community organisations were in the process of being audited by the NDIS so they could be formally registered to provide culturally safe supports to community members whose needs they understood.

The Mosque believe that there are not enough culturally sensitive NDIS services for their community, they would like to address this barrier by becoming a registered NDIS provider to support their community needs. They find that their community is split into 2 groups - those that are open to accepting help and reaching out and those that are proud and resist reaching out. (Quarterly Report January -March 2021)

4.5.3 Refined program theory

The program theory has been revised as follows.

Box 2 Refined program theory

> Where both navigators and PITCs demonstrated a balance of understanding of their own roles and expertise with a willingness to learn from each other (C), positive mutual understanding and willingness to collaborate (M) enabled actions to improve service delivery to clients (O).
>
> Where navigators did not have existing relationship with cultural networks (C), working with community leaders (C) built trust (M). Provision of information (C) began to reduce stigma about disability (M) which enabled provision of information about disability services and supports to other community members (O).
>
> Where stigma about disability remained strong (C) and/or community leaders sought to preserve traditional structures (C), community leaders acted as gatekeepers (M), and navigators could not provide information directly to people with disabilities and their carers (M)(O).

4.6 Education activities

The initial program theory hypothesized that:

- Connectors would provide ongoing cultural awareness education to disability organisations, to increase the disability awareness of people within cultural organisations/networks, and increase the likelihood of culturally appropriate services and supports being offered. [36]
- Connectors would provide ongoing disability education to cultural organisations and networks, to increase the disability awareness of people within cultural organisations/networks, and increase the likelihood of disability-appropriate services and supports being offered. [37]

Two sources of data were available to the evaluation about community activities, including education activities. Quarterly reports to the Commonwealth reported 2,695 'community activities' in total over the year, but did not specify how many of these were education or awareness raising activities. That number is, therefore, an over-estimate of education activities. The Evaluation Data Collection tool asked Connectors to describe the type of education activities they delivered. That tool described a total of 857 events. However, some Connectors did not complete the data collection tool each month, so that number is an under-estimate.

The majority of education sessions (84%, n= 708) in the Evaluation Data Collection tool were described as information and awareness raising. 'Other' types of education activities were reported to be speakers from organisations and information sharing, suggesting that the true proportion of information and awareness raising activities may have been somewhat higher.

[36] Details of evidence used for this analysis is at Appendix 3 – see CMO 2.2.
[37] Details of evidence used for this analysis is at Appendix 3 – see CMO 2.3.

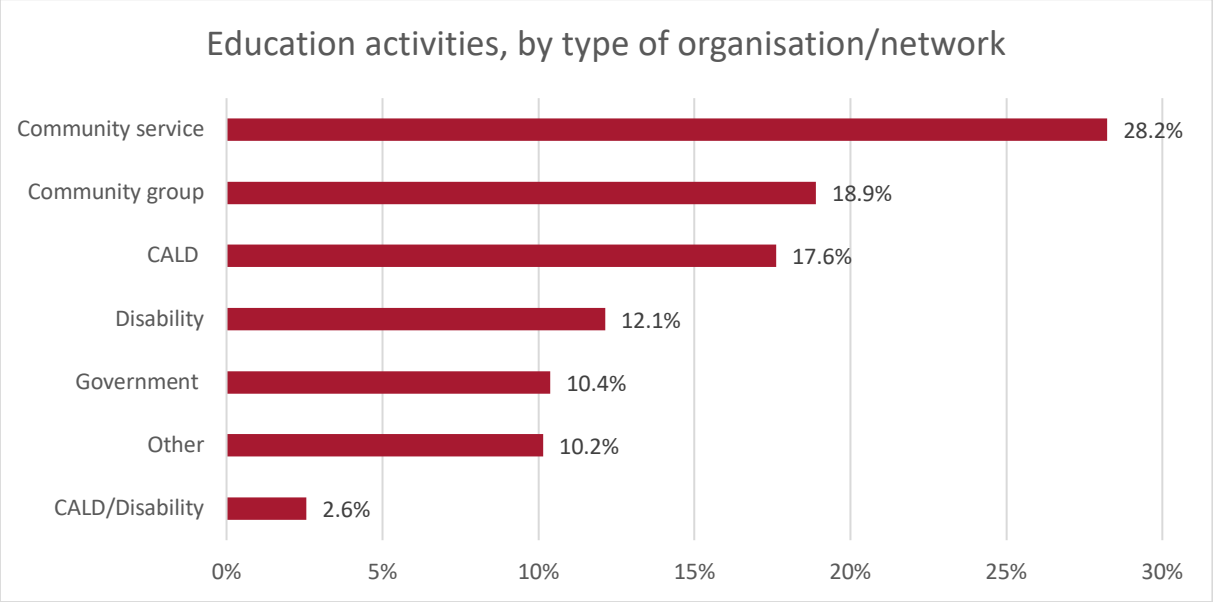
Table 7: Types of education activities provided by Community Connectors

Type of education activity	Number of activities	Percentage of activities
Information/awareness raising	708	83.6
Other	45	5.3
Joint planning	38	4.5
Information/awareness raising + joint planning	29	3.4
Information/awareness + skills development	27	3.2
Total	847	100.0

Source: Evaluation Data Collection tool

The largest proportion of education activities delivered by Community Connectors were provided to 'community services' (28%, n=242), 'community groups' (19%, n= 162) and 'CaLD organisations' (18%, n=151). The expectation that CaLD-sector organisations may educate disability sector organisations about cultural issues and disability sector organisations may educate CaLD sector organisations about disability would also appear to have been supported; 33% (n= 277) of education sessions targeted either CaLD, disability, or CaLD and disability organisations.

Figure 13:Types of organisation/networks provided with education by Community Connectors, per cent



Source: Evaluation Data Collection tool

Most education activities were for less than one hour duration (n=277) or between 1 – 2 hours duration (n=231); there were 83 education activities which ran for 2 – 3 hours, and 17 activities between 3 – 10 hours duration. Outcomes of education activities reported by Community Connectors for these events included:

- increased awareness about the NCCP service offer;
- increased LAC and ECEI awareness about the NCCP;
- multiple referrals being received;
- agreement to share information and referrals if relevant;
- agreement to collaborate.

Examples of disability awareness education provided to CaLD community groups included workshops covering knowledge of what constitutes disability, how disability is viewed in the Australian context, and 'myth-busting' community beliefs about disability and the NDIS. Connectors used their knowledge of communities to adapt the information to 'meet people where they were at' in terms of their knowledge of the Australian health system and disability sector. Some community members had low health literacy, such as knowing how to find a general practitioner (GP), and where to seek appropriate medical assistance:

> *[E]ven if they are told that they have a disability, they qualify to be on NDIS, they still need support to plan ... We don't know where to go. Australian health system is complex. …I remember …when I was seeking for health service, I was asked who my GP was but I didn't know what a GP was. I know in my country, if you're not feeling okay, you go to the hospital.* ***(Community stakeholder interview)***

Connectors and their managers reported that community education may be less effective in relation to mental health issues and psycho-social disabilities because of low health literacy and high stigma in regard to these issues. A much longer time frame was therefore likely to be necessary to reduce these barriers.

However, as previously discussed, COVID-19 impacted the ability of some Connectors to undertake outreach such as community education and information sessions because groups were not meeting face to face.

> *A lot of people from diverse CaLD backgrounds prefer to meet and communicate face to face. For our program, we have a COVID19 Policy which allows us to carry out face to face interactions with clients in places they feel comfortable and safe eg their home, a local park, cafe or library. However, for community education and information sessions many CaLD informal groups are not meeting face to face. Therefore, there has been many challenges and delays in building the trust with the grassroot leaders and members to organise such an event. (Reflection survey response)*

4.6.1.1 Revised theory for education activities

Box 3 Revised theory for Education Activies

Where navigators provided information and awareness raising to community groups and community service organisations (C), awareness of the NCCP increased (M), which enabled

collaboration between organisations (O) and enhanced referral pathways for CaLD people with disability (O).

5 Summary and considerations for the future

This evaluation has identified a series of factors which appear to enhance access to the NDIS for CaLD people with disabilities and their carers. Provision of information and support by Connectors with demonstrated understanding of cultural perspectives on disability built sufficient 'initial trust' for (at least some) people with disabilities and carers to disclose the nature of disabilities and engage in the processes necessary to apply to the NDIS. Working in the languages spoken or preferred by community members, or supported by face-to-face interpreters where necessary and acceptable, increased the accuracy and understanding of information. This in turn increased the likelihood of fair assessments and the likelihood of the use of funding once approved. Because there were barriers across all stages of the NDIS participant pathway, the availability of ongoing support is also necessary across all stages.

Differences within CaLD communities and for different disabilities were also confirmed. Working through natural leaders (formal or informal) within cultural groups usually enabled information flow into those groups. However, where stigma was still strong and/or leaders sought to maintain traditional social support structures, leaders sometimes acted as gatekeepers, reducing direct access between Connectors and people with disabilities and carers. At least some cultural groups had existing social support systems which could be tapped to support people with disabilities. Psychosocial disabilities were more stigmatized in some communities than physical disabilities. Small language groups had greater difficulties accessing translated information and those with fewer interpreters faced more significant concerns with privacy and confidentiality. It was harder to find and connect with CaLD people in rural areas than in metropolitan settings because those areas did not have the same social infrastructure. People who were isolated from their cultural communities were the most difficult for Connectors to access.

The project could not demonstrate the effectiveness of long-term strategies to address the stigma of disabilities within communities because it was too short-term, but the impacts of stigma were clearly identified and the ongoing need for work to address it was thus highlighted. The assumption of capacity for self-advocacy is an inherent component of the NDIS, but that capacity is not widespread amongst CaLD people with disabilities and their carers: addressing this issue requires long-term, empowerment-oriented community development.

These findings – while not new or unexpected – support the need for strategies tailored to the particular needs of CaLD people with disabilities and their carers. The recommendations made by the Independent Advisory Council (IAC) to the NDIS titled 'Supporting Local Area Coordinators (LACs) to be LACs' (Independent Advisory Council to the NDIS, 2021) emphasize the importance of LACs undertaking community engagement involving networks, partnerships and community development activities. However, the IAC report does not discuss the need for LACs to meet the needs of culturally and linguistically diverse clients. FECCA, NEDA and the sub-contracted organisations could advocate for this need and for the provision of specialist CaLD connector roles within LACs. The ability to speak languages other than English should be regarded as a significant asset in such positions. FECCA, NEDA and the sub-contracted organisations should also, where feasible, contribute to activities to improve LAC cultural competencies and capacity. Both LACs and the CaLD and disability organisations should be adequately resourced to work collaboratively on programs and activities.

Many of the barriers to accessing the NDIS for CaLD people with disability and their carers are systemic issues. These included General Practitioners not completing Access Request Forms properly, long waiting times for appointments for assessments, inability to cover the costs of private assessments for those on low incomes and lower access to translated materials and interpreters for smaller language

communities. While small-scale problem- solving strategies were used by individual connectors, systemic barriers require ongoing, systems-level strategies. FECCA and NEDA could continue to advocate for this work and where feasible, collaborate with the NDIA and LACs in the implementation of strategies to address them. This could include strategies to improve the supply of interpreters from a wide range of language groups who understand NDIS terminology and processes.

While there are concentrations of some cultural communities in particular locations, cultural and linguistic communities are based on connections not specific to the place. It is important that future strategies to support CaLD people with disabilities and carers are not restricted to specific locations with tight boundaries.

The 'natural experiment' in communication and outreach strategies in communities affected by lockdowns for COVID-19 demonstrated the importance of face-to-face communication and relationships in accessing cultural communities. Mass communications strategies, including social media, were attempted during Melbourne's lockdown, and used alongside distance methods for support. These strategies clearly reached some members of the target group. However, the rapid increase in uptake after the lockdown demonstrates equally clearly that distance methods of both information dissemination and of support provision were not sufficient in their own right. It is very likely that those who were most at risk, in equity terms, were least well served by distance methods. The 'hard to reach', digitally disadvantaged and particularly vulnerable people (e.g., those experiencing psycho-social disability and those in communities with strong stigma in relation to disability) may have reduced access to safe transport options, experience housing stress, and be less likely to received appropriate care options when services are delivered virtually rather than face to face. This is consistent with research discussing refugee and migrant communities' barriers to accessing tele-health during COVID-19 (O'Mara et al., 2021).

It is likely that COVID-19 will continue to impact CaLD people with disabilities and their carers. Research should be funded to understand what those impacts are and how they affect access to the NDIS. All parties, including service provision organisations, should participate in the ongoing development of new or alternative outreach practices or collaborations to 'meet people where they are' when face-to-face options are not available and online strategies are less effective.

This evaluation has documented the barriers faced by CaLD communities in obtaining NDIS funding, identified promising practices for addressing barriers and identified differences within CaLD and disability sub-groups that affect the effectiveness of those strategies. Findings could be forwarded to the current review of the NDIS Cultural and Linguistic Diversity Strategy to inform future strategies.

6 Appendices

6.1.1 Appendix 1: A brief introduction to Realist Evaluation

The term 'realist evaluation' is drawn from Pawson and Tilley's seminal work, Realistic Evaluation (1997).[38] It is grounded in realism,[39] a school of philosophy which asserts that both the material and the social worlds are 'real' and can have real effects; and that it is possible to work towards a closer understanding of what causes change. Implications for program evaluation include the following:

- Social programs are an attempt to address an existing social problem – that is, to create some level of social change.
- Programs 'work' by enabling participants to make different choices (although choice-making is always constrained by participants' previous experiences, beliefs and attitudes, opportunities and access to resources).
- Making and sustaining different choices requires a change in participant's reasoning (for example, values, beliefs, attitudes, or the logic they apply to a particular situation) and/or the resources (e.g. information, skills, material resources, support) they have available to them. This combination of 'reasoning and resources' is what enables the program to 'work' and is known as a program 'mechanism'.
- Programs 'work' in different ways for different people (that is, programs can trigger different change mechanisms for different participants).
- The contexts in which programs operate make a difference to the outcomes they achieve. Program contexts include features such as social, economic and political structures, organizational context, program participants, program staffing, geographical and historical context, and so on.
- Some factors in the context may enable particular mechanisms to be triggered. Other aspects of the context may prevent particular mechanisms from being triggered. That is, there is always an interaction between context and mechanism, and that interaction is what creates the program's impacts or outcomes: Context + Mechanism = Outcome.
- Because programs work differently in different contexts and through different change mechanisms, programs cannot simply be replicated from one context to another and automatically achieve the same outcomes. Good understandings about 'what works for whom, in what contexts, and how' are, however, portable.
- Therefore, one of the tasks of evaluation is to learn more about 'what works for whom', 'in which contexts particular programs do and don't work', and 'what mechanisms are triggered by what programs in what contexts'.

A realist approach assumes that programs are "theories incarnate". That is, whenever a program is implemented, it is testing a theory about what 'might cause change', even though that theory may not be explicit. Realist evaluation, therefore, makes the theories within a program explicit, by developing clear hypotheses about how and for whom programs might 'work'. The implementation of the program, and the evaluation of it, then test those hypotheses. This means collecting data, not just about program

[38] Pawson, R. and Tilley, N. (1997) *Realistic Evaluation* Sage
[39] There are many schools of realism. Pawson and Tilley call their approach 'scientific realism'.

impacts or the processes of program implementation, but about the specific aspects of program context that might impact program outcomes and the specific mechanisms that might be creating change.

6.1.2 Appendix 2: Detailed evaluation design and ethics information

6.1.2.1 Developing realist program theory

Realist evaluation is one of the families of theory-based evaluation approaches. The program theory is used to inform decisions about what questions should be asked and what data should be collected. Developing the program theory is therefore a foundation activity for the design of the evaluation. Unlike traditional logic models, realist program theory focuses on how and why outcomes are generated and why they differ across contexts.

The process of developing realist program theory is usually done through one or more workshops involving people who have experience in the sector with knowledge and ideas about *how* program interventions are likely to work. Developing program theory would normally be undertaken in a workshop. However, as this was a national project and many people were unable to travel due to COVID-19 restrictions, the evaluation design used a survey of staff and/or their managers to contribute to the development of program theory.

Community Connectors and/or their managers were invited to participate in the survey with their informed consent (Human Research Ethics Committee approval reference number H20089). The survey was designed to elicit the component elements of an "initial rough" realist program theory, that is:

- For whom (i.e. within the target group for the program, for whom is this likely to 'work' or 'not work'?)
- In what contexts (i.e., what aspects of context are likely to affect how causal processes within the program operate?)
- In what respects (i.e., what specific outcomes are anticipated in the short, medium and longer term)
- How (i.e., what causal mechanisms cause/contribute to the outcomes).

The majority of questions were answerable with Likert-type answer scales, with the option to add explanation or comments. The survey was conducted through Qualtrix (CDU-provided survey software). The survey was constructed in four sections. Section 1 comprised 3 questions about the respondents and the organisations in which they worked. No identifying data was collected about respondents. Section 2 comprised questions about sub-groups of the target population for whom the Community Connectors program may work differently (i.e., better or worse). No data about individual clients was collected. Section 3 comprised questions about the overall approach being taken by the organisation to its role (i.e., more individual service delivery focused, or more community development focused). Section 4 comprised questions about potential causal mechanisms. Sections 2-4 also include options for respondents to refine the elements of program theory described in the survey and suggest missing elements. The data collection implications resulting from the program theory survey were:

- Age of person with disability (in years)
- Age of primary carer (in years)
- Gender of person with disability (M/F/Other)
- Gender of carer (M/F/Other)
- Ethnicity/cultural group
- Nature of disability/disabilities for PWD
- How long resident in Australia
- Visa status
- Refugee status
- Fluency in English (written, spoken) (Whether interpreter required?)
- Whether they or their carer had previously heard about NDIS (Yes/No/Unsure)
- Whether they or their carer had previously tried to access NDIS (Yes/No/Unsure)
- If had heard but had not attempted to access, reasons for not previously seeking NDIS support

The "initial rough" program theories were drafted as context-mechanism-outcome configurations as follows:

Table 8: CMOs for People with Disabilities and Carers

CMOs for PWD&C		
Context	**Mechanism**	**Outcome**
Sustained engagement with communities and individuals over time Stigma and cultural beliefs about disability addressed Confidence to advocate on own behalf	People with disabilities' and their carers' awareness of their rights and entitlements under the NDIS increases.	People with disabilities or their carers seek access to those entitlements.
Resources and translation based on client needs Sustained 1:1 work between CC and PWD and carers	People with disabilities' and their carers' understanding of how NDIS works increases.	People with disabilities or their carers say and do what's necessary to get their entitlements under an insurance-model system
Relevant and accessible information is provided to clients Organisations are culturally appropriate	People with disabilities' and their carers' knowledge of the disability services sector increases.	People with disabilities or their carers find and access services and supports.
For people with capacity to advocate for themselves Sustained support and capacity building by skilled and knowledgeable staff	People with disabilities and their carers become more able to solve problems that stop them accessing services and supports.	People with disabilities or their carers access relevant services
Long term programs (more than 1 year) Sustained support and capacity building	The skills and confidence of people with disabilities and their carers to speak up	People with disabilities or their carers ask for services and supports or advocate on

Table 9: CMO's for Organisations and Networks

CMOs for Organisations and Networks		
Context	**Mechanism**	**Outcome**
Assertive outreach Consistent education re NDIS; resources in community languages	Organisations and community groups become more aware of the NDIS, what it provides and how it works.	Organisations and community groups support PWD and their carers to access the NDIS
Ongoing cultural awareness education Disability organisations adequately resourced and responsive	The cultural awareness of disability workers and organisations is increased.	Disability workers and organisations provide culturally appropriate services and supports.
Ongoing disability awareness education Cultural organisations and networks adequately resourced and responsive. Low stigma/shame re disability	The disability awareness of culturally diverse organisations and networks is increased.	Culturally diverse organisations and networks provide disability-appropriate services and supports.
	Disability sector organisations and CALD sector organisations reduce barriers to access to their services for CALD people with disabilities and their carers	Access to services improves.
	Coordination or collaboration between disability sector organisations and CALD sector organisations is strengthened.	More, better or better coordinated services.

CMO: Context-Mechanism-Outcome: "In these conditions ('context'), this underlying cause ('mechanism) causes this outcome.

Table 10: CMO's: Relationships (PWD&C)

CMOs: Relationships (PWD&C)		
Context	**Mechanism**	**Outcome**
'Disconnected' people with disabilities or carers have links to cultural networks. Existing relationships between CCs and cultural networks	Community Connectors are able to find and connect with people with disabilities who do not currently access services.	Barriers to connection for "disconnected" people with disabilities and their carers are identified and addressed.
	People with disabilities and their carers establish relationships with other community members.	People with disabilities and their carers have increased social contact and/or informal support.
High levels of expertise of CCs Ethical and professional behaviour by CCs	People with disabilities and their carers trust the Community Connector to support them, or represent them, in accordance with their wishes.	People with disabilities and their carers engage with the Community Connector program.
High levels of expertise of CCs Ethical and professional behaviour by CCs Trust established between CC and people with disabilities and their carers	Increased willingness to follow advice and accept referrals. People with disabilities and their carers establish relationships with new service providers or organisations.	People with disabilities and their carers have ongoing access to support services.
CCs carry official indicators of role (e.g. business cards, NDIS letter)	Acceptance of role by communities	Communities engage with program. People with disabilities and carers accept support from program.

Table 11: Relationships: Organisations – CC's

Relationships: Organisations – CC's

High levels of cultural expertise of CCs Ethical and professional behaviour by CCs	Community groups and organisations respect the Community Connector's **cultural** awareness.	Community groups and organisations engage with Community Connectors and are more likely to follow their advice.
High levels of disability expertise of CCs Ethical and professional behaviour by CCs	Community groups and organisations respect the Community Connector's **disability** awareness.	
Ethical and professional behaviour by CCs	Community groups and organisations respect the Community Connector's **professionalism**.	
Existing networks, community groups or organisations within cultural groups Existing relationships between CCs and networks/groups/organisations	Trust in professional relationship and behaviours	Faster establishment of program within those communities

Table 12:CMO's: Using data to improve services

CMOs: Using data to improve services

Information that Community Connectors receive from people with disabilities and their carers is analysed and the findings are reported to the NDIA. Consistent advocacy over time	Political and organisational willingness to adapt NDIS processes or requirements.	The NDIA amends the system in response to feedback
Information that Community Connectors receive from people with disabilities and their carers is analysed and the findings are reported to other organisations. Organisations are held accountable for service improvement and adequately resourced to introduce changes. Consistent advocacy and support over time Workplace education and support for staff	Organisational and staff commitment to quality of services	Organisations improve the accessibility or quality of their services.
Community Connectors and their employing organisations participate in evaluation. Regular feedback from evaluation to services Organisations are adequately resourced to introduce changes Workplace education and support for staff	Organisational and staff commitment to quality of services Evaluation provides new learning for organisations	Employing organisations improve their services and supports to CALD people with disabilities and their carers.

Table 13:Program Less likely to be effective when...

Program LESS likely to be effective when...		
Context	**Mechanism**	**Outcome**
Conflicts between cultures of CC and PWD&C	People with disabilities and their carers, or their community leaders, are suspicious of, or do not trust, CC	Community groups or people with disabilities and their carers do not engage with the program
Cultural requirements for same-sex worker not met by program	People with disabilities and their carers do not engage or are not open about issues or needs	Linkages to NDIC not formed or range of required services not recognised or provided
Small communities, few interpreters No choice of interpreter Stigma re disability	Conflict of interest or concerns re confidentiality People with disabilities and their carers not willing to be open about issues or needs	People with disabilities and their carers do not engage OR linkages to NDIC not formed OR range of required services not provided
Low skill levels of interpreters	Inadequate or inaccurate information provided to people with disabilities and their carers	Linkages to NDIC not formed OR range of required services not provided
COVID-19 / Social distancing COVID-19 – Economic impacts	Harder to establish relationships, rapport, trust Lower financial resources	Slower or lower levels of engagement Harder to access services

Table 14: Program less likely to be effective when

Program LESS likely to be effective when...		
Context	**Mechanism**	**Outcome**
Other services unwilling or unable to engage	Loss of network for information Lower access to services	Information and services not accessible to PWD and carers
Other services cannot fulfil NDIS requirements properly (E.G. GPs don't complete forms properly)	NDIS rejects 'incorrect' applications	Application unsuccessful Higher demand on CC services to address problems
Costs of services/assessments high People with lower incomes	Unaffordability	Application processes cannot be completed; NDIS not accessible
Institutionalised discrimination	Inequitable treatment	Outcomes poorer for some groups
Cost of assessment Waiting times for public assessment services	Private assessments are unaffordable	NDIS application stalls Loss of momentum in application ("There's a real risk that we can be identifying people who will probably still be on the waiting list for public assessments after the project finishes.")

6.1.2.2 Data

Following the development of the realist program theory for testing, the evaluation sought and received ethics approval to collect data to test the theories (Human Research Ethics Committee approval reference number H20107).

Data collected by Connectors – the Evaluation data collection tool

An online workshop was help with Community Connectors and their managers to provide feedback on the survey results and give an overview of realist evaluation. The workshop also undertook a session on consultation about the data items to be collected by Connectors/ Managers. Breakout discussion sessions were held on the topics of registration data (information that Connectors may want to collect at client registration about the person with disability and or their carers); service delivery data (ie. community engagement/community education, collaboration and partnership); and monthly reflection questions (to determine what was feasible and what would be useful).

Data was collected by Connectors/Connector Managers using an Excel Spreadsheet referred to as the 'Evaluation data collection tool'. Clients informed consent was sought prior to information being entered into the Evaluation data collection tool. Organisations provided monthly updates of the tool for the evaluation between January and June 2021. The data dictionary for the Evaluation data collection tool provides detail of the items collected for the evaluation by Connectors. Data items in the evaluation data collection tool included categorical and numerical data. A copy of the Evaluation Data Collection Tool is embedded, and the data dictionary is provided to show the nature of information collected in the tool

Table 15: Data dictionary for the Evaluation Data Collection tool

	Data item	Data input	Description
Client data	Random Unique Client Number	Using the random number generator at	This is a unique code for the client you are entering data about. It means that the evaluator will not know any identification details about the person with disability or their carer. This is to protect privacy.
	Age	number	In years
	Suburb or town	free text	If the person lives in a metropolitan area, write the suburb. If the person lives in a regional or rural area, write the nearest town.
	Gender	Male/ Female/ Other	Does the person identify as male, female or other (they may prefer not to state gender).
	Does the person identify with a cultural or ethnic group?	Yes/No	
	If yes, please specify	free text	
	What language(s) does the person prefer to use at home?	free text	This is to understand which language(s) the person prefers to use at home in their day-to-day life. It does not need to be a long list of all the languages the person is able to use.
	Does the person require an interpreter?	Yes/No/For complex matters	
	Visa status	Australian Citizen/ Permanent Visa/ Temporary Visa/ Status not determined	Provide response if known. When unknown do not provide response.
	Approximately how long has the person lived in Australia?	Less than 2 years; 2-5 years; 6 – 10 years; more than 10 years	

	Type of impairment [categories for type of impairment are consistent with the Convention on the Rights of Persons with Disabilities (CRPD)[40]: "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."] [categories for type of impairment are consistent with the Convention on the Rights of Persons with Disabilities (CRPD): "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."]	Select type of impairment(s): [select all that apply] Physical Mental Intellectual Sensory	FECCA, NEDA and CDU acknowledge the complexities involved in categorizing disability status. The response may be based on observations made by the community connector (if the person does not wish to identify as having a disability, or does not wish to, or cannot, name the nature of their impairment). The purpose of this information is to better understand how client outcomes in the community connectors program are influenced by type of impairment.
	Did the person already know about the NDIS before your organisation worked with them?	Yes/No/Unsure	
	Has the person previously attempted to access the NDIS?	Yes/No/Unsure	

[40] The evaluation used the CPRD following advice provided by NEDA and FECCA during consultation in the development of the data collection tool.

	If not, why not? (What were the barriers)?		For those who were previously aware of the NDIS, why did they not pursue it before?
	Is the person already registered with the NDIS?	Yes/No/Unsure	
	What stage is the person in connecting with the NDIS?	Pre-planning/ Access/[41] Planning/ Plan Implementation/ Plan Review	
	Has your organisation linked the person to the NDIS PIC?	Yes/No	
	Has your organisation provided information about the NDIS to the person?	Yes/No	
	Has your organisation referred the person to a service which is not NDIS? (eg. homelessness service)	Yes/No	
	Has the NDIA approved the person's eligibility for the NDIS?	Yes/No	
	Is the person now claiming NDIS entitlements (purchasing items on their plan)?	Yes/No	This is a yes/no item to find out whether there are barriers once a plan is in place.
-	Barriers encountered this period	Free text	What are the barriers?
-	At what stage of the NDIS process were these barriers experienced?	Free text	At what stages of the NDIS process are clients striking barriers?

[41] The term 'pre-planning' was intended to capture those working with a Community Connector prior to an application to NDIS. However pre-planning is used in NDIS to refer to preparation for a planning meeting. The term 'pre-access' has been used in the report to refer to the former, for clarity.

-	Support provided to overcome barriers What support has been provided to overcome these barriers?	Free text	What support is required to overcome barriers?
-	What was the outcome of actions taken to address barriers?	Free text	
-	Where did they find out about the CC program?	Free text	
-	Total number of sessions your organisation has spent with the person to date	Number	this is a free text option
Education activities	Name of organisation/community group/network you have worked with	Free text	In terms of education activities, these are for projects and get recorded once (ie. It is not necessary to record every meeting)
	Nature of organisation/network	Select from dropdown • CaLD • Disability • CaLD/Disability • Community Service • Community Group • Government Department • Other (new column for other)	This is to provide information about which sectors you are working with to deliver education activities.
	"Other" type of organisation/network. Please specify…	free text	If the categories in the drop down list do not apply, please specify here.
	Type of activity	Select from dropdown • Information/awareness raising • Skills development • Joint planning • Other (new column)	Select all that apply
	Other type of activity	free text	If the categories in the drop down list do not apply, please specify here.

	Topic of activity (if appropriate)	free text	
	Duration of activity	free text	How many hours did the activity run for?
	Number of people attending	free text	
	Gender distribution of participants	Mostly male Mostly female Even mix of gender	This is to understand target groups for education activities.
	Outcomes of activity	free text	(e.g. referrals received, agreement to work on joint activity)
Joint collaboration work	Name of network / name(s) of partnership organisation(s)	free text	In terms of collaboration activities, these are for projects you are working on with others and get recorded once (ie. it is not necessary to record every meeting)
	Brief description of activity		
	Type of partnership activity	Select all that apply from dropdown • Skills dev • Joint planning • Joint service delivery • Advocacy • Other	Select all that apply
	Other type of activity, please specify…	free text	If the categories in the drop down list do not apply, please specify here.
	Outcome of partnership activity at time of report	free text	

Analysis of client data included:

- Frequencies for client characteristics: Total number of PWD, total number of carers, and breakdowns by age group; gender; cultural identification; preferred language(s); whether interpreter required.
- Proportions of clients who had and had not previously heard of, tried to access or accessed the NDIS. This is to provide an estimate of the extent to which 'new' clients were accessed by the program and the extent to which it provided services to those not new to NDIS.
- Frequencies of barriers to accessing the NDIS reported by clients. This may be of relevance to service provider organisations, some of which may adapt their services in response to the data, and to the NDIA, which has overall policy responsibility for access to the program.
- Correlations between characteristics and outcomes achieved within the period (noting that some outcomes were expected to take longer than was available in the program).

Analysis of community development activities included:

- Frequencies of types of activities and frequencies of interim outcomes of activities, noting that community development is generally a long-term approach.
- Activities data was analysed against data from the Quarterly Reports to the Commonwealth which collected some qualitative data on community development activities and their outcomes.

Quarterly Reports to the NDIA

All organisations employing Community Connectors were required to provide a quarterly report on activities and outcomes to the Commonwealth Government. Permission was sought from the organisations and the Commonwealth for copies of these reports to be provided to the evaluation team. This provided information about the project period prior to January 1 (albeit lesser data), and helped to fill gaps in data provided by organisations. Reports were analysed using Maxqda software, coded against the program theory.

Community of Practice

The evaluator regularly attended Community of Practice meetings as a participant-observer. This served two functions: i) to provide feedback to organisations about the evaluation ii) to observe what issues were emerging during program implementation. The evaluator took notes of issues to inform the development of questions for focus groups and interviews.

Focus groups and interviews

Using maximum variability sampling, select community Connectors/their managers and other stakeholders with whom Community Connectors worked (eg NDIA Local Area Coordinators, local CaLD, disability and community services groups and organisations) were invited to participate in interviews/focus groups to provide qualitative data. Sampling was intended to draw out differences in implementation approaches (those organisations which were more individual service delivery focused, or those that were more community development focused). The selection of organisations to approach for focus group participation was determined through consultation with FECCA and NEDA. During this consultation process the program theory was prioritized to test the CMOs detailed in Appendix 3.

Connectors and their Managers participated in peer focus groups with 4-6 participants. Stakeholders (from Community groups or Partners in the Community) were invited to participate in interviews. The interview and focus group questions used semi-structured realist evaluation interviewing to ask about the outcomes of program, how the outcomes were achieved, whether the outcomes worked in the same way or different ways for different groups, and whether the interview/focus group participant would change anything about the program to make it work more effectively. Interviews/focus groups were undertaken online, with participants from all states and territories. These were recorded and transcribed for analysis in Maxqda software to be coded against the program theory.

Reflective surveys

Reflective surveys were administered monthly using a link to Qualtrix provided via email to Connectors via their manager/main contact for evaluation correspondence. The response rate to the reflective surveys was low, ranging from 12 to 17 responses. One question was asked for each reflection survey and the questions were open-ended to allow for a length to be determined by the respondent. Individuals could not be identified and informed consent was sought from the respondent in the preliminary question. Some respondents chose to not provide consent and exited the survey prior to the question being asked. This suggests some reticence about providing information for the evaluation. Responses to the reflection surveys were analysed in Maxqda against the program theory.

6.1.2.3 Ethics

Ethics information sheet and consent form:

Evaluation of the National Community Connectors Program - INFORMATION SHEET

This information sheet is yours to keep.

The Community Connectors program has been funded by the Australian Government. It aims to support eligible people with disabilities and their carers from other countries and cultures to access the National Disability Insurance Scheme.

Who is involved in the evaluation?

The evaluation will be conducted by Professor Gill Westhorp and Dr Ruth Nicholls from Charles Darwin University. The purpose of the evaluation is to help understand how the program works, who it helps (or does not help), and what things affect that. The evaluation will make proposals to improve the design and delivery of similar programs in future. This evaluation has ethical approval from Charles Darwin University Human Research Ethics Committee (REF: H20107).

What will the evaluation team do, and when?

A member of the evaluation team will interview you over the phone or by other remote technology (e.g. skype or zoom) to ask you questions about your experiences with the Community Connectors program. The time will be negotiated with you. Individual interviews may last up to an hour. Focus group interviews may last up to one and a half hours. With your permission, this interview will be audio recorded for transcription.

What will the evaluation team do with the information they collect?

The information you provide will be used to create an evaluation report. Your identity will be anonymous, and you will not be identified in the report.

What will happen to the results of the evaluation?

The evaluation report will be given to the organisations providing the Community Connectors program, the two organisations coordinating the program (the Federated Ethnic Communities Council of Australia and the National Ethnic Disability Alliance) and the Australian Government. The evaluation results may be used to improve the program or to improve other programs like it in the future.

Evaluation of Community Connectors Program - INFORMED CONSENT FORM

- I have read (or had read to me) the Plain English Information Sheet which explains what this research project is about and I understand it.
- I understand that the evaluation is being undertaken by Professor Gill Westhorp and Dr Ruth Nicholls from Charles Darwin University.
- I have had a chance to ask questions about the project, and I am comfortable with the answers that I have been given. I know that I can ask more questions whenever I like.
- I have volunteered to participate in the research. I know that I do not have to participate in it if I don't want to. I agree to talk to the researcher and I know this will take up to an hour.
- I understand that I will be audio recorded and I consent to this recording being transcribed for analysis purposes.
- If I do not want to answer a question, I know I only have to say so and the interview will progress to the next question.
- If I want the interview to stop at any time, or for the recording to stop, I know I only have to ask and that will happen without any penalty against me.
- I know that I am free to withdraw at any time. If I do withdraw there will be no bad consequences for me.
- If I withdraw, none of the information I have given can be used in the research, unless the interview was a group interview in which case the words I spoke would not be used.
- I know that the researchers will keep my information confidential and my identity anonymous so far as the law allows.
- I understand that we won't talk about anything of a personal nature, or about my own private life. If I tell the researcher these kinds of things, they will try to stop me and will try not to record them.
- I know that I won't get paid for participating in the research project.

I have read this Informed Consent Form and I agree with it [OR appropriate format for oral consent].

Signed by the research participant_____

Name of the research participant_____

Date_____

I agree to having an audio tape made of the interview.

Signed [or orally confirmed] by the research participant_____

6.1.3 Appendix 3: Detail of initial program theory and data sources used for analysis

6.1.3.1 CMO 1.1

	Context	Mechanism	Outcome
Initial PT	'Disconnected' people with disabilities or carers have links to cultural networks. Existing relationships between CCs and cultural networks.	Community Connectors are able to find and connect with people with disabilities who do not currently access services	Barriers to connection for "disconnected" people with disabilities and their carers are identified and addressed.
Data sources	Evaluation data collection: client & carer data sample MAXQDA summary: 236 coded segments from 68 documents, 7 document groups: 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers 7. Reflection survey responses		

6.1.3.2 CMO 1.2

	Context	Mechanism	Outcome
Initial PT	Sustained support and capacity building by skilled and knowledgeable staff	The skills and confidence of people with disabilities and their carers to speak up	People with disabilities or their carers ask for services or advocate on
Data sources	MAXQDA summary: 103 coded segments from 48 documents, 7 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers 7. Reflection survey responses		

6.1.3.3 CMO 1.3

	Context	Mechanism	Outcome
Initial PT	Sustained engagement with communities and individuals over time Stigma and cultural beliefs about disability addressed Confidence to advocate on own behalf	People with disabilities' and their carers' awareness of their rights and entitlements under the NDIS increases	People with disabilities or their carers seek access to those entitlements
Data sources	MAXQDA summary: 66 coded segments from 36 documents, 6 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers		

6.1.3.4 CMO 1.4

	Context	Mechanism	Outcome
Initial PT	Resources and translation based on client needs Sustained 1:1 work between CC and PWD and carers	People with disabilities' and their carers' understanding of how NDIS works increases	People with disabilities or their carers say and do what's necessary to get their entitlements under an insurance-model system
Data sources	MAXQDA summary: 146 coded segments from 59 documents, 6 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Focus groups with Connectors and Connector managers 6. Reflection survey responses		

6.1.3.5 CMO 1.5

	Context	Mechanism	Outcome
Initial PT	Relevant and accessible information is provided to clients. Organisations are culturally appropriate	People with disabilities' and their carers' knowledge of the disability service sector increases	People with disabilities or their carers find or access services and supports
Data sources	MAXQDA summary: 115 coded segments from 42 documents, 6 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Focus groups with Connectors and Connector managers 6. Reflection survey responses		

6.1.3.6 CMO 1.6

	Context	Mechanism	Outcome
Initial PT	Conflicts between cultures of CC and PWD&C	People with disabilities and their carers or their community leaders, are suspicious of, or do not trust, CC	Community groups or people with disabilities and their carers do not engage with the program
Data sources	MAXQDA summary: 91 coded segments from 44 documents, 5 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Focus groups with Connectors and Connector managers		

6.1.3.7 CMO 1.7

	Context	Mechanism	Outcome
Initial PT	COVID-19 social distancing	Harder to establish relationships, rapport, trust	Slower or lower levels of engagement
Data sources	MAXQDA summary: 98 coded segments from 47 documents, 7 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers 7. Reflection survey responses		

6.1.3.8 CMO 1.8

	Context	Mechanism	Outcome
Initial PT	Cultural requirements for same sex worker not met by program	PWD&C do not engage or are not open about issues or needs	Linkages to NDIS are not formed or range of required services not recognized or provided
Data sources	MAXQDA summary: 8 coded segments from 5 documents, 5 document groups 1. Quarterly reports October to December 2020 2. Quarterly reports January to March 2021 3. Quarterly reports April to June 2021 4. Stakeholder interviews 5. Focus groups with Connectors and Connector managers		

6.1.3.9 CMO 1.9

	Context	Mechanism	Outcome
Initial PT	Low skill levels of interpreters	Inadequate or inaccurate information provided to PWD&C	Linkages to NDIS not formed or range or required services not provided
Data sources	MAXQDA summary: 99 coded segments from 47 documents, 7 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers 7. Reflection survey responses		

6.1.3.10 CMO 2.1

	Context	Mechanism	Outcome
Initial PT	Assertive outreach Consistent education re. NDIS; resources in community languages	Organisations and community groups become more aware of the NDIS, what it provides and how it works.	Organisations and community groups support PWD and their carers to access the NDIS.
Data sources	MAXQDA summary: 126 coded segments from 42 documents, 7 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers 7. Reflection survey responses		

6.1.3.11 CMO 2.2

	Context	Mechanism	Outcome
Initial PT	Ongoing cultural awareness education Disability organisations adequately resourced and responsive	The cultural awareness of disability workers and organisations is increased.	Disability workers and organisations provide culturally appropriate services and supports.
Data sources	MAXQDA summary: 31 coded segments from 22 documents, 5 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Focus groups with Connectors and Connector managers		

6.1.3.12 CMO 2.3

	Context	Mechanism	Outcome
Initial PT	Ongoing disability awareness education Cultural organisations and networks adequately resourced and responsive. Low stigma/shame re. disability	The disability awareness of culturally diverse organisations and networks is increased.	Culturally diverse organisations and networks provide disability- appropriate services and supports.
Data sources	MAXQDA summary: 107 coded segments from 32 documents, 6 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers		

6.1.3.13 CMO 2.4

	Context	Mechanism	Outcome
Initial PT	Private assessments are unaffordable Shortage of specialists/GPs available to do assessments leads to long waiting times	Loss of momentum in application	NDIS application stalls ("there's a real risk we will be identifying people who will probably still be on the waiting list for public assessments after the project finishes")
Data sources	MAXQDA summary: 40 coded segments from 26 documents, 6 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Focus groups with Connectors and Connector managers 6. Reflection survey responses		

6.1.3.14 CMO 2.5

	Context	Mechanism	Outcome
Initial PT	Other services cannot fulfil NDIS requirements properly (eg. GPs don't complete forms properly)	NDIS reject 'incorrect' applications	Application unsuccessful Higher demand on CC services to address problems
Data sources	MAXQDA summary: 129 coded segments from 51 documents, 7 document groups 1. Quarterly reports July to September 2020 2. Quarterly reports October to December 2020 3. Quarterly reports January to March 2021 4. Quarterly reports April to June 2021 5. Stakeholder interviews 6. Focus groups with Connectors and Connector managers 7. Reflection survey responses		

6.1.4 Appendix 4: Detailed quantitative findings

Barriers were reported by Community Connectors using free text responses in the Evaluation Client Data tool. Connectors described the barriers in their own words, based on what they knew of the person's situation. Responses to the question were grouped according to similar types of barrier. Some clients were reported to experience multiple types of barriers, while information was not provided for some clients. The types of barriers are presented as frequency of barriers; the data does not represent a proportion of clients who experienced types of barriers.

Table 16: Frequency of barriers encountered by people with disability who knew about the NDIS, but had not previously applied

Common reasons given for why person did not previously apply	n
Lack of information/knowledge	52
Language/communication barrier	47
Lack of evidence/diagnosis of disability	23
Did not know how to apply	16
Less common reasons	
Lack of support	7
Not eligible (visa status)	6
Did not need NDIS until now	6
Family relocated	5
Carer struggling with lack of support and stigma	4
Never heard back from NDIS	3
Financial issues	2
Access denied	5

Source: Evaluation client data

Table 17: Frequency of barriers encountered by people with disability at pre-access and access stages of engaging with the NDIS

Common barriers at pre-access/access stages	n
Needs help gathering evidence	66
Language barriers	43
Lack of knowledge of how NDIS works	22
Difficulty navigating NDIS due to lack of support	13
Less common barriers at pre-access/access stages	
Not eligible	10
Anxiety/complexity of process	8
Application unsuccessful	8
GPs lack of experience with NDIS/GP reluctant or refused to complete ARF	7
Psychological issues/ psycho-social disability	7
Delay from LAC/NDIS	7
Needs help to find occupational therapist for functional assessment	6
Transport	5
Needs help meeting with LAC	4
Waiting on medical evidence	4
Influence on decision from family - unlikely to proceed	3
Difficulty completing NDIS access request form	3
All treatments not exhausted	3
Recently moved, no local support networks	1

Cannot afford appointments to obtain evidence	1

Source: Evaluation client data

Table 18: Frequency of barriers encountered by people with disability at implementation and plan review stages of engaging with the NDIS

Common barriers at implementation and review stage	n
Did not understand how to use plan, support coordinator did not explain	19
Breakdown in communication with support coordinator	11
Needed to have NDIS processes (re)explained	10
Language /needed interpreter	9
Plan funding insufficient	8
Difficulty getting access to services/therapy	8
Less common barriers at implementation and review stage	
Services are not helpful/needed referrals to other services	7
Breakdown in communication between client and PITC	6
Transport	4
Carer load too high to access therapy	3
Recently moved and disengaged from local services	3
Inadequate funding for support coordination	3
Unaware had a plan	2
Communication challenges with NDIS	2
Housing issues, family breakdown	2
Inaccurate goals in plan	1
6 month-plus wait for services	1
Exploitation from services	1
Services do not meet cultural needs	1
Visa restrictions	1

Source: Evaluation client data

Table 19: Frequency of barriers encountered by carers engaging with the NDIS

Common barriers experienced by carers	n
Lack of information about NDIS	17
Did not know how to apply for the NDIS	11
Insufficient evidence/no diagnosis	11
Needed support to find services	9
Language	8
Less common barriers experienced by carers	
Previously declined access	6
Breakdown in communication with PITC	6
Fear/stigma	3
Did not understand NDIS supports in place	2
Had plan but did not know	2
Recently relocated	1
Financial barrier to obtain assessment	1
Domestic violence, housing issues	1
Visa rejected due to having child with disability	1

Source: Evaluation client data

Table 20: Specific ethnicities people with disabilities identified with

	%	n
Vietnamese	10.3%	36
Bhutanese/Nepalese/Nepali	9.5%	33
Karen/ Karenni / Karrani	6.6%	23
Arab/Middle Eastern	6.0%	21
Congolese	3.7%	13
Iranian	3.7%	13
Filipino	3.2%	11
Iraqi	2.9%	10
Afghani	2.6	9
Burmese	2.6	9
Chinese	2.0	7
Lebanese	2.0	7
Turkish	2.0	7
Syrian	1.7	6
Burundian	1.7	6
African	1.7	6
Asian	1.7	6
Persian	1.4	5
Sudanese	1.4	5
Other	28.9	101
Unknown	4.3	15
Total	**100**	**349**

Table 21: Preferred language(s) spoken at home by people with disability

	%	n
English	16.0	56
Arabic	14.0	49
Vietnamese	9.2	32
Nepali	8.3	29
Karen/Karenni	6.6	23
Swahili	3.4	12
Farsi	2.6	9
Mandarin	2.3	8
Persian	2.3	8
Kinyarwanda	1.4	5
Turkish	1.4	5
Other	30.9	108
Unknown	1.4	5
Total	**100**	**349**

Source: Evaluation Client Data

Notes:
Table 20: **'**Other' cultures (where n=<5) for people with disability were: Bangladeshi, Argentinian, Armenian, Bosnia and Herzegovina, Brasilian , Burmese, Chin Hakka, Chinese and Indonesian, Chinese-Malaysian/Chinese, Croatian, Cyprian, Egyptian, Egyptian Coptic Orthodox, El Salvador, English, Eritrean, Ethiopian, Hazara, Oromo, Falam Chin, Fijian, Fijian-Indian, French, Greek, Hare Krishna, Hazaragi, Indian/Hindu, Indonesian, Italian, Japanese, Khmer, Korean, Latin American, Libanis, Macedonian/Bulgarian, Maori, Mauritian, Middle East, Moroccan, Nigerian, Pakistani, Persian, Peru/Chile/Aus, Peruvian, Polish, Russian, Russian-Jewish, Rwandese, Samoan, Samoan/Tongan, LGBTI, Scottish, Serbian, Somalian, South Sudanese, Spanish/Arab, Sri Lankan, Tamil, Thai, Tibetan, Timorese, Ukrainian, Zomi Chin.

Table 21: **'**Other' languages (where n=<5) for people with disability were: Afghani, Amharic, Arabic/Spanish, Arabic-Armenian, Bangladeshi, Bengali, Bhutanese, Tedim Chin, Chaldean, Chinese, Cong, Creole, Dari, Dinka, Hindi, Cyprian, Falam Chin, Filipino, French, Greek, Gujarati , Haka Chin, Hazaragi, Hindi, Indonesian, Iran, Japanese, Khmer , Kirundi, Korean, Kurdish/Arabic, Malayalam, Mizo Chin, Myanmar, non-verbal, Oromo, Pashto, Polish, Portuguese, Russian, Sakaw, Samoan, Samoan/Tongan, Serbian, Shan, Somali, Spanish, Sri Lankan, , Swahili/French, Tagalog, Tamil, Thai, Tibetan, Tigrinya, Urdu/Urdi.

Table 22: Specific ethnicities carers identified with

	%	n
Vietnamese	11.3	21
Karenni	9.1	17
Bhutanese/Nepalese	7.5	14
Iraqi Arabic	5.4	10
Filipino	4.8	9
Chinese	4.3	8
Iranian	4.3	8
Burundian	2.7	5
Afghan	2.7	5
Arabic / Middle Eastern	2.7	5
Congolese	2.7	5
Other	37.6	70
unknown/ does not identify	4.8	9
Total	**100**	**186**

Table 23: Preferred language(s) spoken at home by carers

	%	n
Arabic	14.5	27
Vietnamese	11.3	21
Karen/Karenni	9.7	18
Nepali	7.5	14
English	7.5	14
Farsi	5.4	10
Mandarin/ Cantonese	3.2	6
Cebuano and/or Tagalog	2.7	5
Other*	37.1	69
unknown	1.1	2
Total	**100**	**186**

Source: Evaluation Client Data

Notes:

Table 22: 'Other' cultures (where n=<5) for carers were: African, Agentinian, Armenian, Asian, Bangladesh, Burmese, Chin Hakha, Cook Island, Cyprian, Dinka, Egyptian, Eritrean, Ethiopia, Falam Chin, Fiji-Indian, Greek, Hazara, Hindi, Indian, Indonesian, Kayaw, Lebanese, Malaysian-Chinese, Oromo, Pakistani, Persian, Peruvian, Russian, Samoan, Scottish, Serbian, Somalian, South Sudanese, Syrian, Tibetan, Turkish, Zomi Chin.

Table 23: 'Other' languages (where n=<5) for carers were: Amharic, Bengali, Burmese, Chaldean, Congolese, Dari, Dinka, Falam Chin, Filipino, Greek, Gujarati, Hazaragi, Hindi/English, Indonesian, Japanese, Khmer, Kinyarwanda, Malayalam, Mizo Chin, Maori, Oromo/ sign language, Serbian, Somali, Tibetan, Tigrinya, Turkish, Bangladesh, Chinese, Pashto, Persian, Russian, Tedim Chin, Kirundi, Samoan, Swahili, Urdu/Urdi.

Table 24: Types of disability and engagement with the NDIS

No. of People with Disability				
	NDIS approved eligibility	**Eligibility not approved by NDIS**	**Unknown**	**Total**
Physical	26	70	7	103
Mental	16	49	6	71
Intellectual	33	26	4	63
Mental + Physical	6	23	4	33
Sensory	13	17		30
Intellectual + Mental	4	9	2	15
Intellectual + Physical	6	7		13
Intellectual + Sensory	3	3		6
Other (incl unknown)	3	12		15
Total	**110**	**216**		**349**
Per cent of People with Disability				
	NDIS approved eligibility	**Eligibility not approved by NDIS**	**Unknown**	**Total**
Physical	7	20	2	30
Mental	5	14	2	20
intellectual	9	7	1	18
Mental + Physical	2	7	1	9
Sensory	4	5		9
Intellectual + Mental	1	3	1	4
Intellectual + Physical	2	2		4
Intellectual + Sensory	1	1		2
Other (incl unknown)	1	3		4
Total	**32**	**62**	**7**	**100**

Source: Evaluation Client Data

Table 25: Provision of information and referrals

	People with disability n=349	
	%	n
Organisation linked the person to the NDIS PIC		
Yes	47	163
No	46	161
unknown	7	25
Total	**100**	**349**
Organisation provided information about the NDIS to the person	%	n
Yes	90	314
No	4	15
unknown	6	20
Total	**100**	**349**
Organisation referred the person to a service which is not NDIS (eg. homelessness service)	%	n
Yes	33	115
No	60	208
unknown	7	26
Total	**100**	**349**

Source: Evaluation data collection tool

6.1.5 Appendix 5: Detailed description of the CaLD Community Connectors Program

Source: FECCA/NEDA program materials

Project Background

The National Ethnic Disability Alliance (NEDA) and the Federation of Ethnic Communities Councils (FECCA) have been engaged by the National Disability Insurance Agency (NDIA) to deliver the culturally and linguistically diverse (CaLD) component of the National Community Connector Program (NCCP). This program aims to provide active outreach to support CaLD people with disabilities to understand and engage with the National Disability Insurance Scheme (NDIS).

NEDA and FECCA will each select, and fund experienced organisations to provide these outreach services. NEDA will require up to 40 FTE "Community Connector" staff that will operate across 18 identified priority Local Government Areas (LGAs) in New South Wales, Western Australia, and the Australian Capital Territory. FECCA will require up to 42.5 FTE "Community Connector" staff that will operate across 27 identified priority Local Government Areas (LGAs) in Queensland, Victoria, South Australia, and the Northern Territory.

Community Connectors will receive training and resources on navigating the NDIS and provide education and access support to people in their region who would benefit from but otherwise have difficulty participating in the NDIS. Funded organisations will ensure Community Connector services are delivered in accordance with NDIA quality and safety requirements and provide performance reports to NEDA or FECCA.

Project Objectives

1. Support CaLD people with disabilities living in the specified LGAs to engage with the NDIS
2. Increase community members understanding and awareness of the NDIS
3. Soundly monitor and evaluate the program
4. Engage with community members and program participants in a respectful and satisfactory way.

Role of Community Connectors

1. Implement engagement activities, including:

i. providing Assertive Outreach to CaLD communities in a culturally sensitive manner, including breaking down barriers to accessing the NDIS and developing trust and rapport;

ii. providing education and awareness about disability to CaLD communities in a culturally sensitive manner;

iii. linking potential Participants to their PITC and/or the NDIS including through the use of online platforms and resources; and

iv. supporting potential Participants and their representatives to attend appointments to get functional assessments and other evidence (e.g. Psychiatrist reports).

2. Implement connection activities, including:

i. linking potential Participants to their PITC or NDIS to help complete Access Request Forms (ARF), Verbal Access Request (VAR) and psychosocial disability evidence forms and supporting these potential Participants in obtaining updates with respect to submitted forms from the relevant PITC and/or NDIS;

ii. linking CaLD people who are not eligible for NDIS to community mainstream supports and/or refer them to their PITC to support linkages to the community and mainstream supports;

iii. supporting Participant handover to PITC and/or NDIS by:

a. assisting Participants or potential Participants build a positive relationship with local PITC and/or the NDIS;

b. supporting local PITC and/or the NDIS to understand the needs and circumstances of Participants or potential Participants; and

c. working together with PITC and/or the NDIS to develop trust and rapport with the Participants or potential Participants.

iv. supporting CaLD Participants and their representatives to link positively with PITC and/or the NDIS.

3. Implement collaboration activities, including:

i. working collaboratively with already existing NDIA community engagement activities, including but not limited to:

a. community and mainstream engagement activities;

b. ILC grant recipients;

c. Health Liaison Officers;

d. Justice Liaison Officers;

e. remote Community Connectors; and

f. Partners in the Community;

ii. supporting CaLD Participants and their representatives to understand the processes required to set goals, to understand their Plans, ensure the Plan is culturally appropriate and link positively with PITC and/or NDIS and/or a culturally capable Support Coordinator;

iii. supporting CaLD Participants and their representatives during planning and review meetings (if required) by providing non-biased, cultural support;

iv. supporting CaLD Participants and their representatives to connect with NDIS Complaints and/or NDIS Participant Critical Incident processes (if required); and

v. assisting CaLD Participants and their representatives with submitting a request for a Plan review (if they don't have a Support Coordinator).

4. Provide advice to the NDIA staff and PITC regarding:

    i. access to language services and culturally appropriate services;

    ii. shared knowledge on barriers to accessing the NDIS for CaLD Participants as well as barriers to implementing and utilising the Plans of CaLD Participants; and

    iii. shared cultural knowledge and strategies to overcome barriers.

Key Deliverables

1. Engagement of Community Connector staff in agreed location(s)

2. Monthly reports on engagement of Community Connector staff

3. Quarterly reports on Community Connector Services provided for CaLD people with disabilities

Service locations

Community Connectors will operate in the following Local Government Areas (LGAs):

FECCA		
State	Local Government Area	Indicative # of CCs to be engaged
QLD	Brisbane	6
QLD	Gold Coast	2
QLD	Logan	2
QLD	Moreton Bay	1
QLD	Ipswich	1
QLD	Cairns	1
QLD	Townsville	1
QLD	Sunshine Coast	1
QLD	Toowoomba	1
QLD	Rockhampton	0.5
QLD	Mackay	0.5
VIC	Brimbank	4
VIC	Greater Dandenong	3
VIC	Casey	2
VIC	Hume	2
VIC	Moreland	2
VIC	Whittlesea	2
VIC	Whitehorse	1.5
VIC	Darebin	2
VIC	Monash	0.5
VIC	Melton	1
VIC	Wyndham	1
VIC	Greater Shepparton	0.5
NT	Darwin	1
SA	Port Adelaide Enfield	1
SA	Salisbury	1
TAS	Glenorchy	1

NEDA		
State	Local Government Area	Indicative # of CCs to be engaged
NSW	Canterbury-Bankstown and Georges River	4
NSW	Fairfield	3.5
NSW	Blacktown	2
NSW	Liverpool	2
NSW	Cumberland	2
NSW	Parramatta	2
NSW	Hornsby	1
NSW	Penrith and Mount Druitt	1
NSW	Bayside Council and Randwick	1
NSW	Campbelltown	1
NSW	Wollongong	1
NSW	Newcastle	2
NSW	Central Coast	1
NSW	Coffs Harbor	0.5
NSW	Albury/Wodonga	1
WA	Sterling	1.5
WA	Gosnells	1
WA	Wanneroo	1.5
WA	Perth and surrounding (Cockburn, Kwinana, Freemantle and Rockingham)	2
ACT	Canberra and Queanbeyan	2

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