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Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
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Dear Commissioners

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability | Experiences of culturally and linguistically diverse people with disability

Thank you for the opportunity to contribute to the inquiry into the experiences of culturally and linguistically diverse people (**CALD**) with disability. Aged and Disability Advocacy Australia (**ADA**) appreciates being consulted on the issues and questions raised in the issues paper (the **Issues Paper**).

About ADA Australia

ADA is a not for profit, independent, community-based advocacy and education service with nearly 30 years' experience in informing, supporting, representing and advocating in the interests of older people, and persons with disability in Queensland.

ADA also provides legal advocacy through ADA Law, a community legal centre and a division of ADA. ADA Law provides specialized legal advice to older people and people with disability, including those living with cognitive impairments or questioned capacity, on issues associated with human rights, elder abuse, and health and disability legal issues related to decision-making.

Experience and perspectives

In seeking to respond to the questions raised in the Issues Paper, ADA received feedback from ADA advocates whose clients include persons from culturally and linguistically diverse backgrounds with disability, their families and support persons. We provide the following comments for the Commission's consideration.

Diversity amongst the CALD community

ADA acknowledges the Commission's efforts to support and understand the challenges experienced by persons with disability from culturally and linguistically diverse backgrounds.

ADA provides the following observations whilst recognising that persons with disability who identify as being culturally and/or linguistically diverse, are not a homogenous group.

Aside from cultural characteristics, a series of other aspects will impact on which section of the community an individual identifies with – if at all. These include socioeconomic status, education, and religious belief.

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Question 1 - *How is disability understood or described in your family, culture, community or language?*

The concept and understanding of what a disability is, is varied. These include:

- defining disability in medical terms, such as resulting from accidents, genetic disorders or viral infections;
- considering an impairment to be the will of a God;
- attributing to disease or illness.

Blame and superstition are often present. Examples of this include blaming a mother for the birth of a child with a disability, which is a common occurrence in some cultures. For example, she might have touched someone with a disability during the pregnancy, or the child has a disability because their mother has failed. In some cases, presence of a disability is attributed to the woman and the assumption that she is weak and genetically defective.

Blame can be associated with both parents, who may be assumed to have sinned or offended the spirits, or offended the ancestors.

Commonly held superstitions regularly affect behaviours in some communities, including:

- women are encouraged not to touch, look at and hear people with a disability or those who work with them to avoid catching a disability;
- high levels of self-blame prevail among family members; and
- fears related to tarnishing the honour of the family and the future prospects of other members of the family especially younger women who are not married.

These behaviours are founded in ingrained fear and misunderstanding of the causes of disability. Negative and stigmatising connotations reinforce prevailing stereotypes, including viewing disability as a curse or a result of something that the person has done and that they are being punished.

The effects of these stereotypes have significant implications for the person with disability, and for their family. Caring responsibility is usually the obligation of female family members. In some groups, the overall wellbeing of the older members who may have disability is the responsibility of the older son. Practical requirements of this care usually revert to female members.

However, the response to disability is dependent on the educational and socio-economic status of the person and their family. These characteristics may overlap or override social or cultural norms practiced by a particular community.

Religious explanations and beliefs about disability

The notion that disability is a punishment is pervasive in many religions and belief systems and is often linked to moral imperfection and sin with divine retribution in the form of a disability. In some religions a disability is linked to a previous life or to ancestors, and may be seen as punishment for wrongdoings.

Many religious practices teach that a disability is a form of learning for the person with a disability or for those around them. It may be explained by attributing the disability to the will of God who creates everything to the benefit of those who practice the religion.

Some religious texts and practices seem to suggest that a disability is a gift. For example, Christianity suggests that a person with a disability is born so that the work of God might be revealed to them. In some cultures, superstition and informal belief systems also provide explanations of the cause of disability such as, a person with disability is a 'special messenger' or that they have bad blood passed on from their ancestors.

Question 2 - How are the concepts of violence, abuse, neglect and exploitation understood or described in your family, culture, community or language?

Behaviours of violence, abuse, neglect and exploitation of people with disability are typically considered to be unacceptable across the broader CALD community. However, in some instances cultural norms or superstitious beliefs will influence behaviours which are not considered to be inappropriate by the community, though they may be categorised as abusive or neglectful when considered by the mainstream.

For example, in some languages other than English the description of disability may involve the use of negative terminology which inevitably has adverse outcomes. This may include descriptions which associate disability with inability, deficiency, incompetence and even failure.

In some situations, shame and superstition will impact the visibility of the person with disability and adversely affect their opportunity to participate in their community. This may be driven by the person with disability attempting to hide the disability, or family members hiding the person away, causing isolation and other harmful impacts.

Question 3 - How are autonomy, safety, inclusion and belonging understood or described in your family, culture, community or language?

Autonomy is a western concept and is not understood in the same way among non-English speaking groups and in the context of caring of a family member with a disability. Some groups are communal in nature and prefer to support one another. These groups may facilitate safety, inclusion and belonging, but autonomy is not prioritised.

Among some families and groups negative connotations associated with disability prevail which can result in experiences of isolation and exclusion for the person with disability and their family. This is particularly noticeable where there is misunderstanding of disability and causes.

Question 4 - What can you tell us about the experiences of violence, abuse, neglect and exploitation for culturally and linguistically diverse people with disability?

ADA advocates have provided examples of observing these behaviours whilst supporting CALD community members with disability. In one example, an advocate supported a Vietnamese client

with an acquired brain injury [REDACTED]. The client's wife appeared to be neglectful, and on occasions was verbally abusive towards the person with disability. The wife was the client's only informal support [REDACTED]. The client would describe feeling upset by his wife's actions, particularly being excluded from participating in decisions that affected the family, [REDACTED]. These are duties that are typically considered to be the husband's role in Vietnamese culture, and exclusion left him feeling devalued and isolated. [REDACTED]

[REDACTED] Increasingly isolated and without a broader support network, our advocate became concerned that the person was vulnerable to abuse.

People with disability who are dependent on others are at risk of suffering from neglect. Neglectful behaviours have a variety of causative factors, including:

- lack of understanding of the services system by non-English speaking people with disability and their carers, including what services may be available, how to navigate the system and how to access the most appropriate services;
- services and staff who do not understand the needs of people from non-English speaking backgrounds or culturally diverse backgrounds with disability; and
- lack of cultural competence of services and staff in delivery or availability of services.

Targeted community education campaigns, as well as upskilling services and staff in cultural understanding of CALD persons with disability would be beneficial. This should include a recommendation that service providers review mechanisms intended to reach people with disability who may need support, and reflect upon how a system accommodates cultural and/or language characteristics of a person with disability, and how services may provide long term support for person whose family members are no longer able to assist in providing care.

Question 5 - How are people with disability included, supported and welcomed by your cultural community? Are there any ways in which your cultural community excludes (for example, ignores or stigmatises) people with disability?

We refer to our response to question 1, particularly the impacts of shame and superstition which can negatively affect a person with disability and their family. Shame and honour beliefs amongst some non-English speaking groups exacerbate social stigmas in relation to the treatment of persons with disability.

These embedded beliefs can lead to self-blame and negatively affect the mental health of a person with disability.

An advocate recalled a client who had experienced torture in his country of origin, and who declined psychology services to treat his post-traumatic stress disorder because of stigma associated with mental health conditions in his culture. The client knew that he would require a translator who may be known in his community and was concerned that he would suffer reputational damage as a result of seeking treatment for a mental health condition.

Exclusion and isolation of persons with disability is prevalent. We refer to the example provided in response to question 4, where the exclusion of the person with disability from involvement in family decisions was particularly hurtful because the person with disability was unable to fulfil their culturally normative role in the family.

Observed effects of stigma, stereotyping, social exclusion and unequal treatment of persons with disability led to entrenching discriminatory attitudes, and increased barriers to care. These in turn led to poorer health and wellbeing outcomes.

Discriminatory effects were also observed in relation to decreased opportunities in employment and secure housing, and consequential impacts upon a person's overall quality of life.

Question 6 - What barriers do culturally and linguistically diverse people with disability face when reporting violence, abuse, neglect or exploitation or making a complaint? What might help address these barriers?

Our advocates reported a number of observed barriers experienced by CALD persons with disability. These include:

- lack of knowledge and general absence of knowledge/awareness of how to make a complaint and to whom to report;
- lack of knowledge and access to information and/or expertise and the mechanisms to facilitate reporting of issues;
- fear of reporting problems and fear of consequences if they complained about anyone or a service;
- unavailability of or access to multilingual information about how to report and/or complain and about the available complaints' mechanism;
- lack of specialised multicultural advocacy services or lack of visibility of such services that could lend culturally competent support to the person and in their own language if required;
- stigma and discrimination within the community and/or fear that the stigma will worsen if issues of violence, abuse, neglect or exploitation are disclosed;
- socio-economic disadvantage and reliance on the social services sector for information and support and fear that this would be affected if they complained; and
- isolation and burn out of families and carers means that they continue to manage and deal with issues privately and on their own.

As mentioned, a lack of cultural knowledge by service providers and staff imposes additional challenges. Services are typically conventional, mainstream and general, and rarely cater for the cultural and linguistic needs of people from non-English speaking backgrounds with a disability and their families.

ADA advocates report that clients from non-English speaking backgrounds regularly encounter challenges with translating and interpreting services (**TIS**), particularly that translators with adequate skill and experience in the required language are not readily available. For example, a client who spoke Armenian would often struggle to use TIS as a translator was not available. As a result, the client would be required to call back multiple times, until one could be allocated. Challenges with written communication were also observed. ADA has represented clients who spoke Arabic and

struggled to read emails which were translated using Google translate – often, this translation would be inaccurate, and the message became incoherent.

Additional funding for CALD inclusive NDIS planners and resources will be effective in breaking down some of these barriers to access and understanding for people from non-English speaking backgrounds.

Question 7 - What should governments, institutions and the community do to encourage reporting and ensure effective investigations of violence against, and abuse, neglect and exploitation of culturally and linguistically diverse people with disability?

Funding and development of resources to implement culturally appropriate (and diverse, to reflect the diversity of the CALD community) education programs, to target both service providers and the community, should be prioritised.

These programs should be developed in consultation with persons from different sections of the CALD community, and include education and resources about the causes of disability for communities, as well as providing an understanding of how cultural norms affect management of disability within a particular community.

Review of existing services to ensure that care provision is of a high quality for culturally and linguistically diverse people with disability will be important component in securing better outcomes for individuals. This in turn, will positively impact stigma associated with disability diagnosis.

ADA recommends that fact sheets should be developed by service providers, to translate provider information to non-English speaking participants about the service and other issues that may affect them. Early intervention programs that include strategies to target families and children from non-English speaking backgrounds with disability are needed.

Linguistically diverse community hubs with gendered and culturally diverse hiring practices should be introduced, to offer a safe space to provide culturally appropriate support. Hub services should include culturally competent interpreter services who are trained in disability support, education and de-stigmatising programs, as well as counselling and support for carers and women affected by challenges associated with stereotypes about disability in their community. Although clients (both persons with disability, as well as carers) may acknowledge that some behaviours influenced by cultural norms constitute abuse, they may feel trapped in their home or by the carer that they rely on. Staff with an understanding of trauma informed practice interlocked with culturally sensitive practice will be key when supporting persons from CALD communities to discuss abuse.

Services improvement should include funding for specialised bilingual support services that can provide aid in a timely manner. Advocacy services and reporting requirements should also be significantly expanded to support persons with disability navigate these services. Funding levels should reflect the level of CALD representation across the Australian community.

Question 8 - What are the experiences of children and young people with disability from culturally and linguistically diverse backgrounds? What are the main issues and concerns they face? What do culturally and linguistically diverse children and young people with disability identify as being important in their lives?

A lack of access to early intervention services results in children from culturally and linguistically diverse communities being left without opportunity to reach their full potential, especially children with learning and/or behavioural difficulties, and early mental health challenges.

Lack of understanding about the NDIS and eligibility to access early intervention programs persists in CALD communities. In addition to an outreach program targeted at reaching the communities to raise awareness about the NDIS and early intervention, children's services and staff should undergo training in culturally competent care and education for clients and families.

Our advocates reported concerning examples of children who were unable access early interventions because of the lack of evidence/documentation from a formal service who could support their application. These included:

- a Serbian speaking mother whose son with Cerebral Palsy did not receive any assistance for ■ years, such as early intervention support, because she was not able to provide evidence of need supported by doctors or other practitioners deemed acceptable by NDIS policy and processes;
- a Japanese speaking boy who did not receive an NDIS package as his mother who cared for him was unable to provide the evidence, largely due to difficulty when communicating in English. The general practitioner accessed by the family was not appropriately trained in use of TIS or culturally appropriate practices;
- a woman experiencing psychosocial impairment who had moved several times in association with her experiencing domestic violence, was not able to access support from the NDIS. The reason was that she could not provide evidence of any engagement with services or a practitioner that has treated her for the last ■ months and/or provide an assessment of her functional capacity.

Question 9 - What are the experiences of women, refugees and asylum seekers, people in immigration detention, and temporary visa holders with disability from culturally and linguistically diverse backgrounds? What are the main issues and concerns they face?

Persons with disability who have not been granted refugee status, or where status is pending, are particularly vulnerable.

Australia's immigration policies and practices continue to exempt decisions made under the *Migration Act* (1958), such as the application of the health assessment requirements when assessing

at the immigration visa eligibility of a person. Such practices are inconsistent with Australia's commitment to the United Nations Convention on the Rights of people with disability (UNCRPD).

To maintain Australia's commitments to the UNCRPD, ADA recommends that positive steps should be taken to ensure that women, refugees and asylum seekers and temporary visa holders with disability from CALD backgrounds are not further disadvantaged by immigration laws and policies.

Question 10 - How do culturally and linguistically diverse people with disability access support? What pathways do they follow to ask for assistance? (For example, do they reach out for direct help when experiencing violence, abuse, neglect or exploitation, or do they indirectly seek support through other channels such as seeking visa assistance, migration advice etc.).

Help-seeking behaviours are often looked down upon in many cultures. As a result, persons from CALD communities may try to find alternative pathways to seek help. An ADA client from a [REDACTED] background was experiencing domestic abuse, and began discussing her experience with her [REDACTED] who noticed a bruise on the client's neck. The discussions included ways to protect herself, and future planning. The client found this very shameful at first, but slowly became comfortable enough to seek formal help.

Question 11 - How accessible are services for culturally and linguistically diverse people with disability in different settings, for example, justice, health, education. What sorts of culturally-appropriate supports and services should be made available?

Translation services and cultural awareness education needs significant improvement across all sectors. The lack of understanding about disability in the criminal justice system, particularly by police who are not appropriately trained to recognise behaviours associated with neurological or psycho-social impairment are well known. This deficit is especially acute in cases where the person with disability is from a culturally or linguistically diverse background, and where the person's cultural, language, or disability hinders communication.

Question 13 - What else should we know about?

The impacts of psychosocial issues include loneliness, anxiety, fear, grief, depression, neglect, abuse, self-care issues, loss of confidence, and lack of social and support networks. There is a need for greater understanding of these issues in the context of persons with disability from culturally diverse and non-English speaking backgrounds. Greater depth of understanding should include prevalence and perceptions of psychosocial issues and disabilities by different sections within the CALD community.

The role of carers needs to be recognised and supported. Specialised programs tailored for supporting carers from culturally and linguistically diverse backgrounds should be readily available, including counselling supports.

Role of General Practitioners (GPs)

Some GPs lack cultural understanding and competency, particularly when working with newly arrived immigrants and refugee groups. There is a lack of understanding of stigma in non-English speaking

communities and other cultural issues that impact the person with disability and their support persons.

GPs are a critical group that would benefit from a targeted education campaign, perhaps utilising the Primary Health Networks, as they are more likely to have involvement with a CALD person with disability and will be a key referring practitioner in relation to a person accessing specialist care and the NDIS.

Thank you again for the opportunity to comment. ADA would be pleased to further assist the Commission with its inquiry. Should you wish to discuss this submission, please do not hesitate to contact Vanessa Krulin, Solicitor and Senior Policy and Research Officer on [REDACTED] or via [REDACTED]

Yours faithfully

[REDACTED]

Geoff Rowe

Chief Executive Officer