

Australian Disability Royal Commission
DRCEnquiries@royalcommission.gov.au

Wednesday, 9 June 2021

Dear Commissioners,

drummond street services (ds) are writing in response to the commission's issues paper regarding the Experiences of Culturally and Linguistically Diverse People with Disability. The purpose of this brief submission is:

- to comment and respond to some of the Issues Paper questions and themes and;
- contribute to guiding the design of services responding to the needs of Culturally and Linguistically Diverse People with a disability and their families and carers.

Through our involvement in the *Royal Commission into Institutional Responses to Child Sexual Abuse* and the subsequent National Redress Scheme, **drummond street services** have built substantial practice experience and evidence in service supports that respond to the wholistic needs of people who experience the impacts of complex trauma. We have continued this process in our work as a provider of Disability Royal Commission frontline counselling and support services for people with disabilities, their families, carers and support workers who are affected directly and indirectly (e.g. vicarious trauma) by the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*. Through this work and listening and centring people's stories and experiences, we know that survivors have unique and important insights into what recovery means to them and what supports they (and their families and communities) need.

We welcomed the acknowledgement in point g) of the Terms of Reference of the Royal Commission's inquiry which states "... people with disability have specific needs, priorities and perspectives based on their personal circumstances" and that experiences of violence, abuse, neglect and exploitation are influenced by 'age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of First Nations people and culturally and linguistically diverse people with disability' ¹.

drummond street adopts the definition of people with disability as per Article 1 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). This includes people with '...long-term physical, mental, intellectual or sensory impairments'². People as described in the Convention are contextualized within a social model of disability. Meaning, that 'disability' is the result of the interaction between people living with impairments and environments with physical, attitudinal, communication and social barriers.

drummond street strongly support the implications of the **social model of disability** that physical, attitudinal, and social environments must change to enable people living with disabilities to

¹ Promoting inclusion Issues paper, December 2020 p.2,

² Convention on the Rights of Persons with Disabilities, 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 1; note also art 2 'Definitions'.

<https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-1-purpose.html>

participate in society on an equal basis with others³. We also believe a primary way to improve inclusion is to address broader ranging discrimination, attitudes and disadvantages people experience based on other key identities and characteristics.

We welcomed the *Royal Commission* and its intent to explore and respond to the needs of marginalized groups and those people with disability who face barriers to safety, equitable participation and appropriate services due to intersectional identities. Our agency's Vision includes ensuring our services are safe, trauma-informed, person-centred, community-led and integrate expertise with the lived experiences of our diverse communities. We bring this lens to our support of and participation in the *Royal Commission* processes.

Finally, I would like to take this opportunity to express my appreciation to the Commission for its call to Government for a 17-month extension of the Commission process, and the Chairs successful advocacy for the introduction of legislation to protect the confidentiality of submissions beyond the life of the Royal Commission. drummond street will continue to work with Government throughout the Royal Commission's deliberations, respond to recommendations on behalf of the communities we support, and advocate for equitable outcomes for all people who are impacted by the Commission processes.

I welcome contact regarding queries you may have pertaining to this response.

Regards



Karen Field
Chief Executive Officer

³ People With Disability Australia – Social Model of Disability (website accessed 23.3.21) <https://pwd.org.au/resources/disability-info/social-model-of-disability/>

ABOUT THIS RESPONSE

To inform our response to the issues paper drummond street interviewed two focus groups. One group consisted of Culturally and Linguistically Diverse (CALD) clients and the other of drummond street workers of CALD backgrounds who work closely with CALD communities. Collectively people in these two groups were from Vietnam, Eritrea, Ethiopia, China, Taiwan, Somalia and the Sudan. All of these people either had a disability, or were carers/ family members of a person with a disability, and there were ten people in each group.

Collectively languages spoken in the focus groups included Arabic, Tigrinya, Amharic, Somali, Cantonese, Vietnamese and Mandarin and Urdu. The types of disability discussed in the groups included physical disabilities, chronic degenerative illnesses, mental illness/or psychosocial disability, learning disabilities such as ADHD, Autism as well as vision impairments and deafness. Language support was provided in Arabic and Vietnamese, Somali and Tigrinia during the focus group with clients. drummond street greatly appreciates the participants time and would like to acknowledge the wisdom of their lived experience.

drummond street notes the barriers to inclusion listed on page three of the Disability Royal Commission Issues paper on Promoting Inclusion ⁴, and the position that an inclusive society for people with disability *values* difference and *respects* the dignity and equality of all human beings ⁵. However, we view 'inclusion' as *more* than the belief all people have equal social, economic and cultural rights regardless of their 'race', ethnicity, class, gender, age, religion, gender or sexual identity and/or disability. *Rather* the concept of inclusion requires demonstrative action to ensure all people are free from discrimination and can exercise their rights.

We also note the Committee on the Rights of Persons with Disabilities highlighted inclusion as it may exist in different areas of life ⁶. We strongly agree with the Committee that 'inclusion is the result of a process and commitment to eliminating barriers' ⁷. **drummond street believe this requires sincere efforts by Governments, institutions and the Community to dismantle systems and structures which constrain the resources, opportunities and power available to people; and that enables discrimination which results in the abuse, neglect and exploitation of them.**

This view corresponds with those of our focus group participants who believed poor system engagement of CALD clients was directly driven by a lack of engagement of CALD communities in system co-design, co-decision making and co-implementation/co-production of crucial services.

Our focus group participants all raised the barriers as outlined (and referenced) ⁸ in the Experiences of Culturally and Linguistically Diverse People with Disability Issues paper, these being:

⁴ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2021 'Promoting Inclusion' Issues paper, (p 3)

⁵ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2021 'Promoting Inclusion' Issues paper, (p 4) cites Gerard Quinn and Theresia Degener, Human Rights and Disability: The current use and future potential of United Nations human rights instruments in the context of disability, United Nations Press, Geneva, (2002), p 15.

⁶ Promoting inclusion Issues Paper December 2020 p. 5

⁷ Promoting inclusion Issues Paper December 2020 p. 5

⁸ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2021 The experiences of culturally and linguistically diverse people with disability Issues paper, (p 4)

- lack of information and interpreters
- language barriers
- lack of culturally appropriate services
- negative stereotypes in the general community
- cultural stigmas around disability
- distrust of government agencies

The participants agreed these issues resulted in poor inclusion and service access for people with a disability from their communities, and that these issues were influential factors to poor mental health and wellbeing outcomes for CALD populations over all.

Both focus groups we spoke with said these listed barriers can also combine rather than work in isolation and that this is particularly the case for people who live in public housing estates, who have sought asylum, and for those who have fled conflict or authoritarian regimes.

HOW IS DISABILITY UNDERSTOOD OR DESCRIBED IN YOUR FAMILY, CULTURE, COMMUNITY OR LANGUAGE?

The focus groups were unanimous in noting isolation for people with disabilities and their families was a significant issue in their communities, and indeed disabilities were associated with being less connected to the community making isolation both *a cause and effect* of stigma.

Group participants (both those with disabilities and carers/family) said stigma relating to disability also depended on the type of disability involved. While people agreed there was some understanding about physical disability - other 'invisible' disabilities faced unique community stigmas such as sensory disabilities, intellectual disabilities, autism and mental illness. Focus group participants said that people's actions were often put down to 'poor behaviour' and 'acting out', particularly among children where assumptions about 'poor parenting' were made, that the family was of 'bad' character or that parents were being punished for something.

The drivers of this stigma were cited as (in part) due to different conditions remaining misunderstood. All participants said key contributing factors to a lack of understanding were:

- a lack of detailed information in languages they understood
- a lack of community discussion about disabilities
- conditions remaining undiagnosed or diagnosed too late and;
- disability services that focussed on physical disability being the most visible services in their communities.
- A lack of literacy in languages spoken (particularly among refugees from the Horn of Africa and North Africa)

One woman with a deaf daughter spoke of the stigma her family experienced,

“Disability is seen as shameful. We have deaf nephews, our daughter is not the only one with a hearing disability in our family, yet still it was difficult to discuss, people saw it as a punishment to us. There needs to be support for communities to discuss disability, understand disabilities/different conditions and reduce stigma so we have more support in

our community.”

Community assumptions about ‘poor behaviour’ and ‘acting out’ were not assisted by situations where young people with learning, intellectual disabilities and mental illness had conflict or contact with police and the justice system. One parent of a child with ADHD among other learning disabilities said the older her child got, the ‘more worried’ she became. She was concerned her child would act out in frustration of the lack of support available to them to achieve similar things to other kids at school. She said her situation would be a lot better if she could have been able to get a diagnosis when her child was younger, and thereby receive the early intervention she needed. Focus group participants (both ds staff and clients) spoke also of children with autism being underdiagnosed in particular.

‘Burden’ and the perception of ‘deficit’

Participants highlighted negative views of disability not only impacted families with a disabled child, but it impacted other people in CALD communities with disabilities broadly. Some people in the group with disabilities said they would try and hide their disabilities or needs because of stigma they would be seen as a ‘burden’. This negative internalised view was also closely related to the high levels of interdependency, rates of kinship care and informal support within communities that is present in absence of a wide range of accessible formal services. One Vietnamese woman of refugee background, who was a carer with her own lived experience of chronic illness and poor mental health said,

“In my culture, disability is understood as a significant loss in life. People are scared to have disabled children, or being disabled as the view is that it is a burden to others... We look after each other and our extended families in the community as a way of life. While my family would look after me as much as possible if I need help, having a disability would make me feel like a burden, because people wouldn’t see me as being able to do the same back or help them...”

Another older Eritrean man with a degenerative visual impairment said,

‘In my community the word ‘disability’ refers to people who are not complete. My condition will worsen, so the thought I will become dependent on others causes me to be very depressed.’

The participants also believed stigma can arise due to not being eligible for services or being able to access them. This creates ambiguity in the community about people’s capacity, because they were not seen as having a disability and questions could arise as to why a person was not working or doing things others could do.

This was also an issue that could substantially deplete a person’s resources whereby they could slip into poverty. For example, if they could not access disability support payments or receive carer payments, people’s ability to participate in the community was further eroded and could subsequently impact their confidence, views of themselves and their capabilities to be useful in their communities.

Participants also identified when a person is not properly supported or provided services this impacts whole families, and risks rejection of a child or person, or creates blame within families. One mother used the example of conflict among siblings as a result of her child’s autism and

behaviour associated with ADHD. The focus required to support the child with a disability in the absence of formal services imbued the child's siblings view of disability, thus marginalising the child with a disability within their own family, impacting capacity for building and maintaining healthy sibling relationships.

Support for whole families in CALD communities and easing the strain on relationships was viewed as a key ingredient to addressing stigma around disability by all the focus group participants. One woman who is also a mother of nine children said,

'I love and accept my daughter, but the community response to her is a test for my husband and I as they treat her differently and with pity...'

Another women participant raised the importance of questioning others and her own view of her disability:

'I don't want to depend on anyone. But people think I need support and I'm incapable of doing things or looking after myself. I was questioning this attitude more often from others and myself.'

Language barriers between people and services were identified as an absolutely crucial issue to address stigma relating disability. For people who needed services provided in language, many existing 'CALD services' were not viewed as 'accessible' as they were not ethno-specific, specific to cultural needs, values or identities and some interpreters used to provide detailed information spoke different language dialects to the clients.

Furthermore, it was highlighted that for people with enough English skills to obtain information without interpreters, there remained important cultural nuance they wanted to communicate with service providers and social workers but couldn't. Participants noted for those who can read in their language – they still need resources that use language and a vocabulary to describe disability issues in ways they can relate to. One participant with a disability said,

"I find it's hard to use services because they don't understand where I'm coming from.... if these support services could understand my cultural values, I guess I would feel much comfortable".

Literacy was also highlighted as an issue for people who face challenges reading and writing in their own language due to learning, intellectual disabilities, memory issues or simply inadequate opportunity and resources to learn English later in life. In these instances, people need information via an interpreter and to be supported in ways to record or remember the information. Many said duty services where people could book half an hour to an hour with a community worker who could relay information in their language or via an interpreter were very useful, but access to these services were limited.

Stigma, abuse and intersectional forms of discrimination

As drummond street wrote in our response to the Promoting Inclusion paper, exclusion and marginalisation processes can be complex, multidimensional or intergenerational, where 'risks' and 'vulnerabilities' manifest as discrete and connecting forms of exclusion. These processes can also occur in specific geographic locations, neighbourhoods and/or be experienced by specific social groups and cohorts that can remain or shift over time. Social determinants of health remain heavily influenced by division and exclusion practices of discrimination and marginalisation, negative stereotypes and socio-economic disadvantages.

drummond street recognises intersectionality as intersecting social and legal systems which produce discrimination and disadvantage for people who, by virtue of belonging to particular and multiple groups, fail to be recognized⁹. In a human services context, intersectionality can be a useful way of thinking and practicing that produces inclusion and safety for consumers and staff and; can inform practice by linking systemic factors to the effects on individual well-being, taking a whole-of-person approach to client work. Intersectional perspectives enable a full range of 'issues' to be identified as they arise, rather than focusing on a siloed 'cohort need', or a specific 'illness' or 'problem'.

While it is important to recognise disadvantages due to disability, it is also important to recognise some people with disabilities contend with more marginalisation than others. People raised the stigma associated with disabilities was compounded by people's experiences of racism or the stigma of being a refugee or asylum seeker.

"if a person with darker skin also has a disability, society looks at them as an unwanted person to society.... that's the experience I've had. People think I came to this country because the system supports disabled people, but that's not the truth. When I first arrived in Australia, I was fully able. The disability happened after I started living here. I went through many heartbroken situations and challenges because I came as an asylum seeker. Some people mock me, saying I was an asylum seeker back then and now have been a burden to the system. I always feel racism is still there."

This racism was raised alongside challenges seeking work as a person with a disability.

"The advertisements say they welcome people of every type, but that's not the truth. I have seen disabled people get jobs, but they were low paid because we need time to think, time to react and extra attention for treatments, and maybe extra consideration of our working space arrangements, most companies don't want to hire us."

Focus group participants noted other examples of intersectional discrimination, such as how women bore the brunt of assumptions about poor parenting in relation to children's behavior. Youth with intellectual and learning disabilities as well as mental illness were identified in the focus group as increasingly vulnerable to contact with the justice system or conflict with police. People identified over surveillance driven by media and community stereotypes regarding youth, but in particular youth of colour living in poorer communities as being a concern.

In conclusion, the two focus groups raised it is important not only understand how different CALD communities view disabilities but also how they come to these views. Participants believed while some views are shaped by cultural beliefs within their communities, others are perpetuated directly from poor and inappropriate service environments and the intersection of different kinds of discrimination. The two groups summarised the following as **key drivers of stigma** related to disability:

- a lack of access to diagnostic services for disability conditions among CALD populations
 - including a lack of language and ethnic specific services

⁹ Crenshaw, Kimberle, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics," University of Chicago Legal Forum: Vol. 1989: Iss. 1, Article 8. Available at: <http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8>

- a lack of information on disabilities and how people with disabilities and families/carers can be supported to live healthy lives and participate in community
- A lack of local support groups to normalise the experiences of disability and care roles
- the high rates poverty and isolation attached to having a disability
- a lack of service access or confusing eligibility criteria preventing access to the disability pension, the NDIS or other services thus impacting people's participation and perception of living with a disability
- A 'one size fits all' approach to all CALD disability service provision/information
- Intersectional forms of discrimination as well as racial, gender and other stereotypes

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?

For those in the focus groups the primary issue above all else that needed addressing to ensure an effective response to violence, abuse, neglect and exploitation of people with a disability was **increasing the provision of sensitive, culturally capable mainstream services alongside a strong and resourced ethno-specific disability (and health/human) services sector.**

The primary issue remained for all that disability services (and health and human services) remain woefully inadequate to meet the needs of diverse communities – particularly communities of racial, ethnic, language and cultural diversity. People stressed that more hours and support for language barriers was essential and the absence of this is a direct source of risk for people.

"I cannot reach out to anyone to get any information for me in a crisis. Even for me to report I need to use an interpreter. Interpreters are booked hourly and sometimes they leave when there are long waiting periods at service reception. Another person someone may trust to speak to about abuse is a GP, but some GP's refuse interpreters because they don't want the consultation to go too long. People then rely on family members to interpret, if they had experienced control or violence from that family member then of course they won't reach out to GP's"

The culturally diverse drummond street staff focus group said many CALD clients had not reported incidents of abuse or neglect prior to contact with the agency because they simply did not know where to go.

Another client focus group participant who lives with chronic illness and mobility issues identified how poor service access in her community increased a fear of losing the few services she was eligible for. Her comments also demonstrated how little CALD service users know of their rights to report and use complaint processes. She stated,

'Some service staff don't treat me well – they have disrespected me and some have been mean – but I don't report it. I just stay with my worries. I also don't want to upset the service and lose what is offered by reporting the staff or because I am frightened the staff will find out it was me'.

Participants highlighted as a shared theme the importance to provide interpreting services that are meaningful for both the clients and the services themselves. In other words, that the information must go both ways to improve the connection services have with clients and to their communities. This was viewed as a way to improve the quality and nuance of information about the issues impacting people's lives, as well as build trust and encourage more people with disabilities and their families raise concerns about personal safety or their rights as service users. One client, from the Sudan who was a carer for her daughter said,

“You cannot put people all in the same basket. You need to look at each person's needs. Knowing language is a huge a barrier, isolation is a problem and people require understanding... not just of the language we speak but also of the experience of disability, what it is like to live with disability or care for a loved one...”

Issues of gender too, remained an additional barrier to reporting violence and abuse. One of the male CALD drummond street Parent Coaches working in the family support program identified community attitudes continue to limit women and girls reaching out. He said women experiencing violence from partners or adolescent children in particular would be shamed by views about women's status or roles as mothers, and that this would prevent them from seeking help whether or not they had a disability.

He noted additional risks to safety existed for women with disabilities who experienced family or partner violence. Primarily due to the combined stigma related to disability, as well as that directed towards women who leave abusive partners in communities where men are assumed to have particular rights over them. A client participant reiterated this theme:

“I come from a man dominant culture. Even elder sons dominate mothers sometimes. I have people in my extended families and friends who had been victims of family violence but never wanted to speak. They think society would laugh at them. Most of these victims are women. Men take sexual advantage of their female partners (disabled female partners included) to fulfil their desires. And still, women prefer to suffer than seek support because they feel shame.”

Those present strongly agreed leadership needs to be fostered within CALD communities to address not only violence against people with disabilities but also violence against women, and other cohorts such as LGBTIQ people.

The two focus groups also highlighted service system staff simply assume people know how to access services because they are told they exist. However, all the participants highlighted there is little understanding of eligibility requirements and how to navigate system pathways for key disability services let alone services to address violence they were experiencing.

COVID: increased needs Vs increased reluctance to seek support

Another concern raised in relation to safety was that community reluctance to access services had exacerbated during COVID-19, yet also corresponded with increased service needs. For those within the public housing estates specifically, responses to COVID-19 such as the hard lockdown reduced already low levels of trust in government and services.

drummond street services also examined the emerging impacts of COVID-19 on our clients as captured through organisational data, practitioner insights and client feedback, resulting in two reports. These reports identified cohorts most vulnerable to the impacts of COVID-19; and the

specific ways in which these cohorts are being impacted. As part of this process service Risk Alerts were compared from the 30th of March to 14th of August 2020 to the same period in 2019.

Financial distress, social isolation, the inability to access support, and physical and mental health impacted people disproportionately from CALD populations who featured across a variety of these risks. When considered across an intersection of diverse characteristics CALD people were particularly vulnerable.

<p>Clients at risk financially</p> <ul style="list-style-type: none"> » Individuals or families with restricted visas » Out of work asylum seekers » International students » Public and private renters » New arrivals in Australia » Carers of people with disability » Single mothers - particularly those who have experienced family violence » Those who already had limited resources » LGBTIQ+ and QTPOC young people » LGBTIQ+ and QTPOC young people living with queerphobic family/housemates » Clients experiencing/who have experienced family violence » New parents 	<p>Clients at risk of not being able to access supports</p> <ul style="list-style-type: none"> » People with disability » New parents » New arrivals in Australia » Families who have children with special needs » Young people » People with anxiety » People with mental illness with no carer
<p>Clients at risk in terms of physical and/or mental health</p> <ul style="list-style-type: none"> » Immunocompromised individuals and their family members » Public housing residents » Young people with histories of being targeted by police » Clients with suicidal ideation » People with limited resources » International students » Single mothers » New parents » Parents of school aged children » Stepfamilies » Clients who are at risk financially » Clients who are at risk socially 	<p>Clients at risk of experiencing excessive social isolation</p> <ul style="list-style-type: none"> » People with lack of digital resources » New parents » Young people » People with low literacy » People with pre-existing mental health concerns

Furthermore, analysis of data identified a fear of police prevented many clients from doing permitted activities within COVID-19 restrictions. Some did not even go outdoors or undertake physical exercise for the permitted one hour per day, primarily out of fear of police confrontation. Many of these clients were people of colour, who were already overpoliced as a result of profiling systemically embedded in policing practices.

For people of colour, asylum seekers and newly arrived migrant communities, the police and military presence provoked anxiety, and in some cases reminded them of traumatising past experiences of government persecution. Many choose not to leave the house to avoid needing to explain what they are doing out if stopped. This environment was extremely uncondusive to meeting the needs of people with a range of disabilities where they relied wholly in informal

community support – but also particularly for those who already experienced disabling mental and trauma related illness.

Concerns remain for people with disabilities and their families from CALD communities as the exacerbation of risk and already poor outcomes to due COVID-19 reverberate. Particularly after further lockdowns in Victoria this year and as ongoing socio-economic impacts ripple across more vulnerable populations.

A KEY SOLUTION: LIVED EXPERIENCE WORKFORCE MODELS

Focus group participants were unanimous in the view that things would only change for people with a disability and their families when sensitive, culturally capable mainstream services were provided alongside a strong and resourced ethno-specific disability services sector. All participants believed this requires:

- the voices of CALD people with disabilities (across all age groups) to be raised and included in co-design of services that target them
- CALD people – including those with disabilities – to be promoted into community leadership roles
- a workforce that reflects the diversity of communities, including the application of mandatory affirmative employment policies within funded agencies
- the creation of education, employment and sector programs designed to grow diverse workforces within the disability and other health and human services sectors (e.g. family violence, parenting and family programs and youth programs)
- The employment of people from CALD communities not only in personal care roles but in high level decision-making roles. (e.g. senior management, systems and governance)

Participants believed achieving the above would:

- *improve messaging about disabilities within communities and reduce stigma about them*
- *achieve earlier access to services and diagnosis of conditions*
- *increase service sensitivity to CALD people's needs and create better services*
- *improve community trust in services and increase help seeking*
- *better support service navigation*
- *support communities to build trust with services*

drummond street strongly supports the view that diverse voices are needed in decision-making, service design and delivery, including dedicated governance and leadership positions for people of lived experience in organisations and government agencies. Specifically, there is a lack of health and human services sector employees of diverse backgrounds who experience multiple, compounding forms of discrimination and health and wellbeing inequalities. Poor workforce diversity impedes efficient or appropriate engagement with many culturally and linguistically diverse people, despite greater support needs, further entrenching disadvantage.

In recognition of this, **drummond street** has built innovative lived experience workforce models through our Youth Services, Parenting Support, Family Violence and Survivors of Institutional Abuse programs and is leading evidence building in this area. Our lived experience models were

developed in recognition of the place of peer work in supporting recovery from complex trauma and adversities. All of our lived experience workforce models target marginalised groups, including the unique intersectional experiences of individuals who identify with multiple populations including:

- people living with a disability
- people from culturally diverse communities (particularly of migrant/refugee experiences)
- people of colour

Building emergent evidence in lived experience practice is also vital. Particularly where these strategies increase workforce diversity to reflect that of communities who need services, and also where program outcomes are enhanced. Government funders, policy makers and sector leaders (both public and private) should prioritise the implementation, evaluation, review and refinement of lived experience workforce models with demonstrated capacity to:

- *engage culturally diverse communities who face barriers to support services*
- *promote job opportunities for people with disabilities from CALD communities (particularly of migrant/refugee experiences) and who face barriers to employment and/or further education*
- *increase disability and human services sector workforce diversity and organisational competencies to work with people from CALD communities*
- *build knowledge and use evidence*
- *be developed using holistic co-production models*

There is great potential through workforce innovation to increase inclusion for people with disabilities from diverse communities (particularly of CALD/refugee experiences) in service delivery, socioeconomic participation and the broader community.

drummond street believe it would be both ethical and cost effective to offer additional funds to community organisations specifically to invest in the development of CALD lived experience workforces and reduce barriers to economic participation for the same community members who can improve service engagement and system responses to highly marginalised groups.

A diverse intersectional lived experience workforce could be bolstered through initiatives across the disability and health and human services sector and include the following examples:

- Fully funded ethno-specific peer-leadership and community development positions
- Supported traineeships targeting CALD community members with additional barriers to tertiary study and employment: e.g. youth who have been homeless, CALD people from LGBTIQ populations, people living in public housing etc. Traineeships could provide vocational and transferable qualifications alongside community specific components.
- The incorporation of the lived experience workforces in COVID-19 recovery programs, prevention and early intervention programs
- Fully funded, CALD community targeted partnerships between the health and human services organisations and universities
- Funds for organisations to incorporate CALD leadership initiatives in governance and senior leadership models in partnership with CALD peak agencies/groups

CONCLUSION

drummond street welcomes the *Royal Commission's* focus on inclusion and the impacts of discrimination and barriers related to intersectional characteristics such as colour and cultural and linguistic diversity. However, crucial to the goal of increasing inclusion is not only looking at the impacts of structural and systemic barriers, but actively removing them in collaboration with communities, particularly those that are most marginalised within culturally diverse communities.

This includes going beyond considering the 'inclusion' of CALD population needs. It requires commitment to initiatives which engage CALD communities in co-design right through to co-production of a range of disability and human services. Government also needs to prioritise the enabling of an increase in the number and capacity of peer/lived experience workers from a range of cultural, language and ethnic backgrounds. Finally, the health and human services sectors should also take meaningful steps to support equity for CALD populations and dismantle systemic forms of racial discrimination.