Australia's Disability Strategy
2021–2031

Creating an inclusive community together

Disability and People from Culturally and Linguistically Diverse (CALD) Backgrounds

A qualitative study

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Creating
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community
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Attitudes to Disability Nested Study

People from culturally and linguistically diverse backgrounds

2025

Australian
National
University

Purple Orange

Contents

Executive Summary

The aim of the study was to explore how attitudes held by the general population, different cultural groups and people within systems and services affect people with disability from CALD backgrounds.

The study was supported by a co-design group, with data collected through six focus groups. We thank the members of the co-design group for their valuable input. We also thank the study participants for sharing their stories so openly.

This study was run by researchers from JFA Purple Orange and POLIS: the Centre for Social Policy Research at the Australian National University. The Australian Government Department of Health, Disability and Ageing paid for the study as part of the work for Australia's Disability Strategy 2021-2031.

Key Findings at a Glance

- People with disability and family members from CALD communities experienced both positive and negative attitudes from members of the public and people working in services they use.
- Some individuals within CALD communities had to speak up for themselves, their families and friends. This had both positive and negative impacts and implications.
- Positive attitudes made people from CALD backgrounds with disability feel welcome, listened to and supported. This happened when they were given information about services, were given time to understand the information provided and were able to ask questions.
- People from CALD backgrounds with disability had positive experiences when they had a strong connection with their cultural community and were made to feel welcome in the general community.
- Being from a CALD background and having a disability increased the chances of having a negative experience or interaction.
- Negative attitudes included times when there was obvious disrespect or when incorrect assumptions were made about their abilities. Intimidating or dismissive behaviour such as yelling, ignoring and refusal to accommodate access needs were also experienced as negative.
- Many sectors misunderstood participants' accents, English language skills or complex communication access needs, and made assumptions about their ability to communicate.
- Negative attitudes in health care were very common and increased the chance for wrong diagnosis or treatment.
- Negative attitudes made it harder to settle into their new life in Australia, access support services, and take part in their local community.

- There are negative attitudes towards disability within their cultural communities and this can make people feel isolated and not use disability services.
- The availability of disability support in Australia was higher than their home countries and they were grateful for the support.

Recommendations for Change

Participants suggested changes that would make their lives better, including:

- improving communications in professional and personal settings by making information accessible for people from CALD communities
- meeting their communication access needs, such as using interpreters from the same cultural group
- educating professionals to improve attitudes about CALD people with disability in services like health, public transport and the retail sector
- improving attitudes towards disability in the general community by providing education about disability from when children are very young
- giving people with disability the chance to take part in mainstream and cultural community activities
- making sure that community leaders treat and support CALD people with disability well.

Methodology

Co-design

A co-design group was set up at the beginning of the project to guide the focus group process. This group consisted of two people with disability from CALD backgrounds, two community leaders from different cultural groups, one disability researcher from a CALD background and one staff member of a national organisation that represents people with disability from CALD backgrounds.

The co-design group provided advice on:

- the wording and organisation of the interview guide to ensure it was appropriate
- recruitment strategies, including considerations such as length of time in Australia
- how different cultural groups may respond to questions, for example by telling stories, rather than with quick examples
- the format and set up of focus group sessions
- accessibility, interpreting and cultural considerations in focus groups.

The advice from the co-design group informed the design of the study in several ways, including:

- researchers speaking to people from communities/cultures who don't often engage in research and supporting them to take part
- creating a supportive space with enough time for participants to tell their stories
- providing information about key dates for different communities, such as Ramadan
- not asking directly about experiences in the justice and legal system due its sensitive nature and possible experiences within the groups, particularly for those who were refugees
- rewording questions so they could be easily understood.

Ethical considerations

The study was reviewed and approved by the ANU Human Research Ethics Committee (Protocol 2024/1021). Participants were provided with information about how the focus groups would work before the focus group met. This included an information sheet about the study and a list of questions to start discussions in the focus groups. The information sheet was discussed at the start of each focus group, with hard copies available at face-to-face focus groups. The focus groups were recorded after obtaining consent from all participants.

All data from the focus groups was stored securely in a password-protected electronic file within the JFA Purple Orange office, accessible only to the staff working on the research.

Due to the sensitive nature of the content, each focus group began with a discussion of the services available to support the participants during or after the focus group. This included the option to speak with one of the JFA Purple Orange staff members present at each focus group, with contact details provided. Other services were also discussed and listed in the participant information statement.

Before giving consent to be in the focus group, each participant was told that a $60 gift card would be provided as a thank you for taking part.

Focus groups

The research aims were to explore:

- the attitudes of CALD people towards disability, including the things that affect these attitudes
- the experiences of CALD people with disability when using services, such as health care, education, and personal and community support services
- how CALD people with disability are affected by the attitudes and behaviours of others.

Six focus groups were held over eight weeks during February and March 2025. Three focus groups were held face-to-face, while three focus groups were held online using Zoom. Each focus group was two hours long, with a short break in the middle. The focus groups were run by JFA Purple Orange staff members.

Discussion in each focus group was based on the question guide (see **Attachment A**). The discussions differed between focus groups depending on the views and experiences of participants. Participants decided the direction of the conversations, building on each other's examples. The time spent on specific topics was decided by the participants, and this could be different between focus groups. For example, there were focus groups that spent more time talking about health settings, while others discussed systemic attitudes more than the attitudes of individuals. As a result, not every section of the report contains examples of both positive and negative attitudes.

The facilitators redirected the conversation if it moved away from the central questions. Each participant was given an opportunity to share their experiences, feel heard and respond to others. Some focus group participants had prepared answers to the guide questions, as these were provided the week before.

NAATI (National Accreditation Authority for Translators and Interpreters) qualified interpreters were present at three mono-lingual focus groups to interpret Nepali, Spanish and Vietnamese. The other three focus groups were in English and did not have interpreters as participants spoke a variety of languages. Other ways of communicating included an app on an iPad, Auslan, and written responses. This variety helped people who otherwise may not have had input.

The co-design group discussed the key terms of the research, including the word ‘attitudes’ and how this may be interpreted or understood by different language and culture groups. Based on this discussion, the facilitators often used the word ‘assumptions’ in addition to ‘attitudes’ when explaining the purpose of the research and helping people think of relevant examples.

Participants were told during and after the focus groups that they could contact the researchers for a follow-up conversation if desired, but no one took up this opportunity.

Focus group participants

In total there were 47 participants across six focus groups. Participants were recruited through JFA Purple Orange’s existing connections in South Australia, an online events website, JFA Purple Orange’s regular newsletter, and with the support of several organisations across Australia, such as the National Ethnic Disability Alliance and partner organisations. Participants ranged in age from their early 20s to their 70s.

34 participants were people with disability. They included no or low sight, no or low hearing and physical, psychosocial, neurological and intellectual disability. There were also people with mental ill health and long-term health conditions. Some participants were born with disability and others acquired disability later in life, and some participants had more than one type of disability and/or health conditions. 13 participants were family members of people with disability.

Many participants – with or without disability – were leaders or active participants within their cultural and/or disability communities. Several participants had work experience with people with disability as support workers, interpreters or staff in the social service, health care and education sectors.

Participants came from variety of cultural backgrounds. Countries of origin included:

Bhutan
Burundi
Chile
Columbia
Democratic Republic of Congo
El Salvador
Ethiopia
Ghana
India
Indonesia
Iran
Kenya
Malaysia
Mexico
Myanmar (Burma)
Paraguay
Sudan
Syria
Venezuela
Vietnam

Limitations

There were some limitations in the research process:

- Focus group participants were from South Australia (SA), Western Australia (WA), Queensland (QLD), and New South Wales (NSW). Participants from metropolitan SA were overrepresented.

- Three focus groups were multilingual and did not use interpreters, which limited participation to people who had some confidence in English.
- Balancing the need to hear from each attendee, the sensitive nature of some of the discussions, the use of interpreters and the two-hour limit of each focus group meant that not every topic was covered in every focus group. There were no discussions about the legal and justice system.

Findings

These findings detail what was heard across six focus groups, with 47 people from 20 countries of origin.

Attitudes in the broader community

Australia is one of the most multicultural societies in the world, where almost half the population was born overseas or has at least one parent born overseas.[1] This means Australian society includes many different cultural communities, languages and histories.

Participants were asked to think about their everyday interactions, such as visiting the shops, talking to their neighbours, and attending community events. The examples given have been separated into contact with the broader community and contact within a person's cultural community.

> In those moments it's hard to get people to understand what it is like – in 2025 attitudes and ableist behaviours we would hope people would understand, be more aware and be more inclusive, but unfortunately we are still having these conversations.

Participants had experienced positive and negative attitudes towards themselves or their family members from members of the public. They talked about different experiences and attitudes based on disability type and whether a person's disability was visible or invisible. Positive experiences were described in general terms, with negative experiences shared in more detail.

This report notes the difference between good intentions and good experiences for a person with disability. Some members of the public try to support people with disability in good faith and with good intention. However, this help was reported as sometimes being unwanted, unasked for, or inappropriate. We want the experience of the person with disability as the focus, rather than the intentions of another person.

Positive experiences and attitudes

Some participants reported having very few negative experiences while out in their local community, noting that they felt supported and respected. Several spoke of offers of help from people and were grateful. One participant said '*it depends on the individual attitude of a person. 70% or so are good. But we don't remember the good people!*'.

Another participant said that no one has been impolite to him in public and he feels that people with disability are respected in public spaces. Several others said that they had not experienced negative attitudes in public spaces, and that it was services and their systems where they had negative experiences.

Negative experiences and attitudes

Participants said people can have good intentions, but do not ask *how* they could help someone, or if they want help at all. A participant with vision impairment described how people will ‘*use words trying to help you but they really don’t. For example, shouting “stop, stop” with no other context. Others will walk with you and want to guide you, but will want to hold your hand … which means I end up deviating from the path and bumping into objects. It can be hard to explain why it needs to be the elbow*’. Another participant who uses an electric wheelchair shared how these experiences made them feel.

> When I am out in public places with peers, such as the shops, library or the park, people always think I need help - even when I don’t. This can annoy me as I don’t think they would do this for someone who isn’t in a wheelchair. I do not think that I am treated the same as another Vietnamese person just because of our culture, but maybe I am treated the same as other people in wheelchairs.

Participants raised the issues caused by stereotypes or assumptions, with one stating that they are ‘*a massive problem in today’s society*’. One participant initially moved to Australia as an international student. She had an accident four years ago and acquired physical and cognitive disability.

> Since that I start to notice how stereotypically people see the people with different abilities…we struggle a lot in the community in general. It’s culture thing but also a stereotype thing. People are sometimes really rude including the people working at shops, treating you like you are not a person, like you are a thing. There is a lot - discrimination is the word.

She also said she had many experiences where staff in shops and other services would speak to her daughter, partner or support worker rather than to her.

Participants noted that attitudes towards people with disability could vary depending on the type of disability. For example, one participant suggested that when socialising with people without disability, people with intellectual disability become invisible, are not introduced into a group and become more isolated.

This was true of other invisible disabilities, such as dementia, psychosocial disability, neurodivergence, hearing and vision impairment, brain injury and others. Participants thought this is most often due to a lack of knowledge about what to do and how to do it. People might meet people with disability in public and, unable to understand their communication or behaviour, speak to them rudely or avoid interacting with them at all. This can also happen with older people with disability. One participant described a time when they took a parent with disability to the hospital and were immediately asked whether the parent had an aged care plan or palliative plan, ‘*in which case it is like she is the bottom of the pile*’.

Neurodegenerative diseases and mental illness were described as ‘silent diseases’ and participants felt they were forgotten. One example of this was when a participant got verbally abused for using a disabled parking spot because they could walk.

Another participant talked about his daily experience of dementia. He described concerns for his own safety as his dementia progresses, including more frequent experiences of becoming lost in public.

> If you don't know me and you see me on the street...It just looks normal or even [the public] will think that you are better than you are. I mean like better in a way that you don't have any issues. But look, we have a lot of issues. Some of us can be proud and not show and not talk.

A participant with vision impairment said that he found it quite hard to interact with others on public transport, or in social settings. He felt more comfortable with peers with disability. He described how he sometimes hears people ask, ‘what happened to your friend’, even though he is standing right there. He has found that the easiest way to meet people is through formal events, at university or work, rather than informal settings such as clubs. He has also encountered systemic issues, such as common leisure activities not being accessible. For example, he has visited a casino but found the gambling machines not accessible for a screen reader, so not accessible to him as a blind person. He strongly felt that people with disability should have the right to engage in leisure activities, including going to zoos, parks and sports.

One participant said that some members of the public are interested in talking to him, but others will just ignore him, which makes him feel rejected. He said he tries his best to socialise, but feels that his social skills are ‘*a bit poor*’. He sometimes finds it difficult to share how he is feeling. When people ignore him, it discourages him from saying hello to others in future.

Another participant related to this story, saying that she is often treated differently based on her disability. In the past she used to use crutches (she is now a wheelchair user), but back then she still felt ignored. At the same time, her English was limited. She said she felt invisible and was treated as though she ‘*wasn’t existing*’.

Overall, many participants had experienced stigma and discrimination from members of the public. Participants felt that this was often based on negative attitudes towards disability and made worse by cultural differences. They felt that their negative experiences were more common and more complex because of their intersecting experiences of disability and cultural difference.

> We’re supposed to be humans and have the same rights, but actually [it] is not real. In the real situation the rights are not taken account of...we are still human beings who want to live life, we want to study, we want to work, we want to have a family, we want to be accepted in the community, we want to have kind of normal life, whatever a normal life means for us.

Attitudes towards disability within CALD communities

There are many reasons why someone may choose to come to Australia, including seeking asylum, employment and education opportunities, working holidays and migrating in search of a better life. The participants of this study included new arrivals to Australia, people who had emigrated as adults and lived here for many years, people who had been born overseas but had migrated to Australia as children, and second-generation Australians whose parents were born overseas.

We heard from participants that staying connected to their culture(s) through shared community was very important to them, and that for people with disability it can be more difficult to keep their cultural identity and be part of their cultural community.

Positive experiences and attitudes

We heard many positive stories of informal support arrangements within families, the most common of which were parents caring for their children, and adult children caring for their parents. We also heard many examples of community support where friends and neighbours looked out for each other, advocated for disability within the community and helped each other to access support. We heard how friends of participants would help by driving them to appointments, sitting with them in doctor's appointments to translate and advocate for them, sharing resources, information and skills and providing emotional support. Examples of this are detailed in other sections of the report.

Connection with community was important in each focus group. Support ranged from typical 'settling in' support for new arrivals, to daily and systemic disability-specific support.

Participants discussed the importance of knowing community members who had moved to Australia before them. The Bhutanese community discussed the hardship experienced when there were only a few newly arrived people from their country and they were placed in different suburbs. As more members of the community arrived, they began to live nearer to each other and meet up more frequently, sharing experiences, services, advice and support. When people arrive now, they '*have a community that will support them, that already knows the system and it is much easier for them now*'.

Such support can come from established communities who have been in Australia for some time, or from individuals with particular skills to offer, whenever they arrived. These could include a higher level of English, experience navigating services, a driver's licence, technological skills or simply the confidence and desire to support others in their community. Some of these people had taken on leadership roles and actively advocate for people with disability in their cultural community.

One participant described how her role as a parent also became an educational and advocacy role for members of her community. When her daughter was born with Down Syndrome, the participant was depressed and found it hard learning how to support her.

Disability in her community appeared to be rare, but after talking more about her daughter and her experiences, she realised that people were hiding their own experiences of disability. ‘*People can know that they have a disability, but it is not easy for them to accept it*’. This encouraged her to talk about disability more and share resources and opportunities to support others in her community.

Negative experiences and attitudes

People also had negative experiences within their cultural community. Some shared culturally specific experiences that could help to promote understanding and inform future programs, support and communication across different cultural groups.

Participants felt that many members of their community assumed that people with disability were limited in what they could do. Some members of their communities treated people with disability like they weren’t human beings or didn’t have the same rights as people without disability. Some people from their own cultural community viewed disability as a disease, and either over- or under-estimated the amount and type of support that different people needed. One participant said, ‘*there are narrow minded people in my community too*’.

Many participants from different cultures said their culture was ‘shy’ when talking about health and disability, which affected their willingness to seek and/or accept support services. Discomfort when asking for help was common across many of the cultural communities in the focus groups. One participant from Southeast Asia said that, while members of their community might accept what is directly offered to them, they would think it rude to ask for more.

A participant of Indian background explained that she does not seek community within her own cultural group as she doesn’t feel accommodated or included. She prefers to join church groups and similar where she can meet people who take the time to know her and understand her circumstances.

> Most people from India are highly educated professionals and just don’t have the time for you. They might come and greet you at a group, but they don’t want to get to know you. There might be a class element but more likely they don’t know how to deal with disability, even if they [are] educated as doctors or lawyers.

Participants often felt that uncertainty and discrimination were linked to cultural norms and assumptions. A participant who worked at an international school with 58 nationalities described how the stigma around disability remained for many communities. She said many students do not want to talk about or have the label of disability, even if they could be eligible for more support. She said, ‘*it's really hard for people to face their biases and prejudices, especially if they are culturally linked.*’ Another participant explained that her son’s behaviour and body language may look a little different from other people. She had seen people giving them ‘*unusual or dirty looks*’, which makes her feel sad. This was from both the general community and within their extended family, including close and distant relatives.

A participant from the Bhutanese community felt that some families kept their family member with disability hidden from the community. They assumed that the family was trying to protect the person with disability.

> They don't want people talking about the person negatively either and want to protect them from attitudes, so they don't want them visible. That then means that these families are taking on huge amounts of responsibility caring for people with disability on their own, rather than openly expressing a need for external support.

It was also hard when community members did not see or understand the amount of support that was provided to a person, and the effort that family members put in to support them. One participant described how her family member has complex and diverse needs. Visitors to her home would say '*oh, your sister is good*' without fully understanding how much work she did to support her. She felt that people judged her sister's condition based on what they saw but don't understand the invisible work that goes into supporting her.

A lack of understanding about disability and the role of carers meant that some participants felt undervalued and their efforts to support their family member were not appreciated.

Different understandings of disability in CALD communities

The examples shared by participants in this research clearly showed how the understanding of and attitudes towards disability varied between CALD communities.

Several participants discussed the complexities of being the first in their family to have and openly acknowledge a disability diagnosis, either for themselves or for their children. An autistic parent with a Malaysian background explained that disability was not a common topic for her family and culture, so her child's 'bad behaviours' were blamed on her parenting, rather than being understood as related to the child's disability. This is common in her culture. She received '*a lot of what seems like negative judgement without understanding*'. Her son was the first member of the family to be diagnosed as autistic, after which she was also diagnosed. She found it hard to tell her family and was worried about the shame that it might bring to her family. '*It's been a lot of education along the years. We are a Catholic family so when he was diagnosed, we got an "I'll pray for you" card in the mail.*' She is trying to educate her family by sharing articles and talking openly with them about disability. Her family do not always understand because of the language and cultural barriers, and they often talk about 'how to fix' the disability. They also don't like using labels as this goes against their culture and religion. The participant explained that now that more members of the family, such as her cousins, are also getting diagnosed with autism and ADHD, the older generations are starting to understand.

We heard from other participants how religious beliefs influenced their cultural community's perception and understanding of disability. A Kenyan participant said that in his religious community, many people don't understand disability. He said he was not invited to religious community events for many years because they didn't know how to approach him and didn't want to bother him, which isolated him from his own community. This participant is blind and said some members of his community believe blind people have a sixth sense and that they are '*magical*' or '*a miracle man*'. He also said someone once said to him, '*I thought all blind people are very religious*'.

A Vietnamese participant also said, '*I think Vietnamese families are learning more about disability, but years ago it was really bad for anyone with a disability. Sometimes they think disability is caused by family curse or karma*'.

Participants felt that although attitudes were changing, there was still a lot of stigma around the word 'disability'.

> As soon as you say it in front of a young or old person, there's a 'cringing' effect, and some people don't want to be told they have a disability. You might be trying to get them NDIS support or get them to have a more positive view, but it's very hard to hear that word.

One participant said that negative attitudes to disability are deep-seated in some cultures which have clear views of what a 'normal' person is. Any difference from those means that '*it is very hard to get them to be seen as a person*'. The cultural stigma around disability can mean that people do not use services that may be helpful, especially services like the NDIS which need a diagnosis and ongoing engagement.

Participants also said the understanding of disability in their cultures is different from the understanding in Australia, including language differences. A participant from Kenya said, '*when it comes to the culture again, quite a number of communities, they don't have the word for disability*'. In his community there is a word for physical disability, but there is no word for any other type of disability. He explained that because there is no word for invisible disability, people with invisible disabilities are misunderstood and left out.

A Burmese participant said that they use an umbrella word for disability, which translates as '*person living with difficulty/problem*'. This means that people with disability are seen as needing help or as being a problem. Another participant said that in Indonesia they do not have words that go with disability, such as 'carer', and therefore it is very important that people have access to interpreters familiar with their culture and linguistic nuances.

Participants from Bhutan shared that there is no common word for disability in Nepali. Instead, people are described by their appearance, for example 'one leg man'. Deaf people in Bhutan used to be described in a way that translates as 'mute', 'deaf mute' or 'deaf and dumb'. Most of the Bhutanese community in Australia no longer use 'mute', but some people still do. Older community members now know what the English word 'disability' means and have accepted it (in its English form) into their Bhutanese Nepali dialect.

People with disability from CALD backgrounds experience negative attitudes both from within their cultural group and from the broader community. In CALD communities, being treated unfairly is due to poor understanding of disability. Some individuals expressed fear or shame about disability in their families and communities.

Participants seemed to be less affected by negative attitudes within their own communities, because they understood where those attitudes came from. However, the negative attitudes of the broader community were more obvious and left participants feeling they were treated unfairly. These feelings were made worse by language barriers and cultural differences. The unfairness was felt most by the more at-risk participants - the newly arrived migrants, refugees or those with complex disabilities.

Attitudes experienced in services

All Australians, with or without disability, use federal, state and local government and non-government services such as public transport, social services and healthcare. Anyone who is using these services for the first time may find them hard to find and understand. For many of the participants from CALD backgrounds who have a disability or care for someone with disability, the barriers to finding and using the same services were even greater.

Participants were asked about their experiences understanding and using services. They talked about the attitudes they had noticed when using services, and how this made them feel. They shared examples of federal government services such as Centrelink, and state-run services, like transport.

Participants in all groups described accessing services as very complicated, overwhelming and hard to understand. The direct barriers to services and lack of information about services suggest that support service systems neglect people from CALD backgrounds and people with disability. Most participants found out about important support services through friends, their cultural community or other people with disability, rather than through settlement services or government services. This suggests that such services could do more to provide information about disability services and supports to newly arrived migrants.

Participants said there were almost always communication barriers when using face-to-face services. These could be language barriers and communication access needs. Even participants with good English skills who were comfortable meeting in person still found it hard to use computer systems and found the resources that services gave them too long and complicated.

The ways services work with each other is difficult for most people. For participants, this is made worse by language barriers and limited knowledge about how the system should be working. Government services such as Centrelink and identification services are some of the first services new arrivals to Australia meet, so it is important that these services are welcoming, inclusive and user-friendly.

Participants said that positive first impressions are important, noting that first meetings with people and services set the tone for the future. Some participants felt that their experiences in Australia had improved over the years, but they still pause before they engage with services or speak to strangers based on early experiences.

Positive experiences and attitudes

Participants often spoke about the lack of services in their home countries, saying how grateful they were for the range of services in Australia. One said that transport providers were very understanding, saying '*they are always accommodating for my needs and helping me work through challenges I face*'. Participants were grateful for the increased opportunities that these services gave them and their families, although the services should be easier to find and use.

Negative experiences and attitudes

Experiences with government services can be greatly affected by both the structure of the system and the people who run it. Participants said systems and services were confusing, with some participants asking why services were there when they were so hard to find that they seemed to be 'hidden'.

Participants spoke about interactions which made it easier or harder when using services. One participant described a visit to a Centrelink office near where she lived. A staff member told her that she had to go to a different office and 'threw' her forms back to her, causing her to cry in the Centrelink office. Participants from this focus group were from the same cultural community and agreed that one of the Centrelink offices in the region seemed to have kinder staff than the other offices.

Another participant had a similar experience at a social services office, where she did not know how to answer the staff in English, but handed over her paperwork. In response, the employee's speech and body language became stressed. The participant then showed her proof of her citizenship, after which the staff member's attitude changed. The participant said she felt judged and discriminated against, only being treated with respect when she had proved that she was an Australian citizen.

A blind participant described a time when he was travelling alone and asked ground staff to help him fill in a required form. They said no. He was then pulled to a counter by another member of staff who was angry with him for not filling in the form, which he was unable to do by himself due to his disability.

Similar experiences were mentioned in other focus groups, where participants had experienced negative attitudes. For example, when staff had raised their voice at participants or used embarrassing language. Many participants said that these times left them feeling sad, frustrated and in tears.

Participants said service staff do not always understand their access needs when their disability, such as hearing or sight, affects their communication. They report that service staff often incorrectly assumed their needs were for English language support, rather than a hearing or sight need.

> It is about communication and awareness and trying to reduce cultural bias. So, about the cultural balance, just asking for clear speech doesn't mean I don't understand English. It is about a [disability] requirement and not the language. So, if people can stop making assumptions about language ability, I think it will help treat customers equally.

These attitudes seem to show both a lack of understanding about the access needs of people with disability and negative assumptions about people who speak languages other than English.

Attitudes underpinning system design

One participant thought services were built without thinking about people with disability, noting that people working in public services are often unhelpful. The issues described in the sections above show that services do not always suit people who speak a language other than English or have communication access needs. This is made worse when many staff are not trained in language and communication differences, resulting in people with disability from a CALD background feeling even more isolated.

> It is not easy to live in Australia without family to support. [We] find that you are asked to sign contracts or access medicine without being able to understand the system. It is both the system and the people you have to talk to that are really challenging.

Attitudes in disability services

Almost all participants had used disability services, including the NDIS, disability services and support workers. We heard from many participants who rely on these support services that they would feel 'stuck' and isolated without them and would need family members to support them.

Positive experiences and attitudes

We heard from some participants that life is easier now with the NDIS and more support workers. The availability of disability support is very important. Many participants recognised that their home countries do not have the same sort of disability support, if any, and that they were grateful to have these 'beautiful' systems here in Australia.

> Vietnamese people with a disability in Australia have a happy and resourceful life. Sometimes you face issues but there are lots of services to assist you and your family. I believe a person with a disability living in Vietnam would have a hard life. The accessibility for wheelchairs is not good. Lots of the people in public, the doctors and also family members don't treat you the same as everyone else.

Negative experiences and attitudes

However, there were also many examples of negative experiences. These were mostly about the design of disability services and systems, rather than the attitudes of individuals.

Many participants shared the problems they had when trying to use the NDIS. One felt that disability services are not developed for people from other cultures. We heard from many people that they relied on the backing of family members and sometimes professional support to try to access NDIS services.

> NDIS is supposed to be available for many people, but it is so difficult to access, so many people are denied services because the system is not actually ready to understand the needs of the person.

Some participants did not receive the support that they needed, even after contacting the NDIS. One Bhutanese participant who arrived as a refugee when he was a teenager, said he met with NDIS coordinators and was told he would have an occupational therapist come to his house and assess his needs. He was excited to know he was 'going to be safe' with changes at home. However, he waited several years, and no one came for the assessment. At the time, he was underage and needed his mother to speak up for him, but she was worried that if they 'went up against' the NDIS that they would lose their support services.

Another participant who arrived as a refugee with his family from Syria, was caring for his sick and elderly father in Australia for five years before he learned he could apply for the Carer Payment. His doctors, case managers and friends had not told him about it. After enquiring, he was told a person would come to visit their home. They waited over a year for this visit, after which they waited many months to hear whether he had been approved to receive the payment. The Carer Payment was approved one month after his father died.

Other participants talked about the hard relationship and cultural management that was needed between families and service providers. For one participant's family and culture, it was common for adult children to care for ageing or sick parents, as she was doing. She found that some service providers assumed that she, as the daughter, would provide the care, rather than supporting her to hand over certain tasks to them.

These examples show how hard it can be for people to access the support they need, even if it is available. These problems are greater for those new to Australia as they often don't understand what support they could or should be getting.

Positive experiences with support workers

Many study participants use support workers to help with their day-to-day activities, including home care, health care, and going to service appointments. It was clear that having a good support worker let participants with disability to be more independent and find more opportunities. One participant said that face-to-face contact is easier when they can bring a support person, and where they have done so, their support worker '*made sure I was listened to*'.

Some participants said that having a support worker from the same cultural background can be very helpful, making communication between the person and support worker better and acting as a mediator with other support services. Sharing language and culture reduced the effort for participants explaining their situation, their family and why they need support. They understand cultural issues as well as the needs of a person with disability.

Negative experiences with support workers

Issues with support services were raised in most focus groups. Some participants or their family members had been taken advantage of or abused by support workers.

Participants gave examples of negative attitudes and dehumanising behaviour towards people with disability, saying they felt that support workers thought they were 'silly' or 'stupid'. One participant said a support worker spoke badly of another person with disability to him, and said, even the support worker doesn't understand about disability and their attitude is very wrong.

Some of these negative attitudes and actions led to participants feeling that support workers were taking advantage them. One participant said she had once fainted in her own home. While she was unconscious, her daughter overheard her support worker saying, '*you can treat them however you want because they can't say anything*'. Her daughter also noticed bruises on her arms after this and was worried about her mother being handled physically while unconscious. The participant said that this is especially concerning for people who 'don't have a voice' because they are not able to communicate orally.

> They hit people, they steal from them, don't give them food – and there's no one else to look after you and to protect you, it is just you and them.

Participants in two focus groups spoke of support workers not maintaining the confidentiality of the individual and sharing information about their health with the person's family or the wider community. A Bhutanese participant gave an example of when they had a Nepali speaking support worker come to their home to look after a family member. The worker would then go to another house and relay information about her sister or mother's health to another family in the Bhutanese community. She now knows that she can speak up if that happens.

One participant had a negative experience with a support worker who supported her and her three daughters at home. The support worker shared information and told different stories to each of the daughters, causing conflict within the family and resulting in family members leaving the home. The participant said that the support worker did not help with her personal care and cleaning as she was meant to and instead spoke to her daughters and ignored her. She said, ‘*it felt like she was coming to stir trouble*’.

Other support workers seemed to put the family’s needs over the needs of the person they were there to support. This can happen when the family misunderstands or takes advantage of the support worker’s presence and asks them to do tasks outside of the individual’s support plan, such as gardening or cleaning. Although the family may cause this, support workers are required to provide support which is directly related to a person’s disability and which aligns with their plan.[2] If helping in the family home is part of the person’s plan, support workers should involve the participant in the process, offering support to build skills within the home.

> Instead of helping them to learn the skills and gain independence, they are instead making them more dependent on them. It doesn’t make sense that a support worker does it all for them, instead they should support people with disability to be able to do it themselves.

If the person with disability is unable to do household tasks, families in some cultures expect that the support worker will do the work that the person with disability cannot do. Where support workers are from the same cultural community, they are likely to understand the cultural context and be able to balance that with meeting the needs of the person with disability.

Attitudes in health care systems

When asked about services, almost all participants gave examples that related to their healthcare, or the health of someone else within their community. These examples included a variety of settings including GP offices, specialists and mental health services.

Most focus groups agreed that language barriers for people from CALD backgrounds are worse in medical settings. Medical terms are often difficult for English speakers, and this is much worse for people whose first language is not English. The way medical staff respond to communication barriers is key to whether the interaction is a positive or negative experience.

In all their examples, participants stressed that it is important that people with disability and people from a CALD background are treated in a way that makes them feel heard, understood and respected. Otherwise, there is a very real risk that people will not get the medical care they need.

Positive experiences and attitudes

Positive experiences were when participants felt heard and had their needs respected and met. One participant said he feels hospital staff are professional and know how to treat patients.

Another participant said there were lots of helpful moments at the doctor's clinic, as the doctor answers all his questions and gives helpful feedback. A participant with hearing loss said she has positive experiences in medical settings where people take the time to face her directly when speaking to her, they take off their mask when speaking and explain things in a different way if she doesn't understand. She said that when people slow down and make sure she understands everything, she feels more included.

Negative experiences and attitudes

Many participants said they had negative experiences when engaging with medical services. These were often communication problems, but sometimes reached the point where participants felt treated as less than human. Many participants talked about healthcare staff using complex language or speaking too fast. However, asking for someone to explain again or speak more slowly, often led to:

- people just speaking louder and repeating the same thing
- assuming the participant was being difficult on purpose
- getting annoyed and frustrated
- cutting them off when they were speaking
- assuming that they cannot speak any English at all.

One participant said that in health services, many staff make assumptions based on a person's appearance or how they present.

> As a person from a lower-income background I face assumptions that they are less likely to adhere to treatment plans, or that the person I am caring for's health concerns are less complex.

Communication challenges and solutions

One participant shared that when he visits the doctor for a check-up, he often can't understand what the doctor says, despite asking him to explain in simple terms. In response, he has experienced doctors getting angry, not being sympathetic, and saying '*you should understand English properly*'. When this happens, he has had to return with a translator, after which he might leave feeling a bit more satisfied

Another participant said that it is often hard for people with disability to explain their pain during medical episodes or speak up for themselves, especially when they are anxious. They gave the example of being dismissed too soon from an emergency room because they could not describe the level of pain they were experiencing, compared to their usual (high) level of pain. This can put people with disability from CALD backgrounds at risk of being triaged incorrectly, waiting longer for admission or treatment and making their health problem worse.

Getting interpreters in health settings is also a problem. Several participants noted that every medical service should have them, including hospitals, doctors, physiotherapists and psychologists. Not only is medical language especially hard, but not all languages have specific words for ‘disability’ or related terms like ‘carer’.

Participants had different understandings of services, with one stating that they did not know if, when or where free interpreters were available. The extra cost of language interpreters was another barrier to access, both for languages others than English and sign languages, with one participant being quoted $300-400 for a medical appointment. One focus group noted that there is a certain level of English needed to be able to book the interpreter in the first place, and therefore non-English speakers still rely on support to access interpreting services.

One participant said she felt that her experiences with doctors changed after she had an accident causing physical, psychological and cognitive disabilities.

> Because I had a traumatic brain injury I lost my speaking English, I was not able to communicate properly my needs and my requests and for my treatment. So many times I was not able to have interpreter services that can help me to communicate it.

Most participants felt that medical staff do not understand the extra time, money and mental labour it takes for people with disability and their families to ensure that medical appointments are accessible. Participants felt that medical staff could have helped them in this process.

To deal with language barriers, people with disability said they would often bring another person to support them during medical appointments. This may include support workers, friends or family members. The roles that these individuals took varied. Some acted as translators, others spoke up for the person with disability, by helping them to understand their illness and treatment options and to make informed healthcare choices. These support people also helped the person with disability outside the appointment by helping them to book appointments, talk to staff, look up diagnoses or treatment, and give health support, like medicines, at home. For participants with disability without access to formal support, having support from community members was key to getting and understanding their healthcare.

These examples show important gaps that can limit access to basic medical care. Having to use informal interpreters, or none at all, could increase the risk of people with disability not getting key information about their health. Stressful contact with medical professionals can make people with disability from CALD backgrounds less likely to seek medical care, putting their health at even greater risk.

Systemic attitudes in medical services

Participants described negative attitudes towards disability in health services as an ongoing, sector-wide issue. Poor attitudes towards disability can lead to long wait times, poor attitudes from medical staff, and the need for family members to be very involved so that proper care is provided. While these attitudes may also be experienced by people who are not from CALD backgrounds, language barriers and using new systems can increase their negative impact.

One participant who works in the health sector felt that many of their highly educated colleagues don't have empathy and compassion and '*disapprove*' of disability. We also heard how the negative attitudes of medical staff reinforced their approach to their patient's medical care. Participants gave examples of how doctors' misunderstanding of, or bias towards, disability led to poor diagnosis or treatment choices.

One participant, who cares for a parent with disability, described how she had to speak up for her mother after she was placed on a one-year waitlist for surgery she needed. Her mother was too ashamed to talk about the problem, which was shameful in her culture, and she couldn't share enough information or explain her pain clearly enough for staff to understand her condition.

If the need for interpreters or communication access needs are not taken into account or if they do not have a chance to explain their symptoms or pain, people may get the wrong diagnosis or poor treatment.

One participant has a daughter with physical and intellectual disability and complex communication access needs. When her parents sought treatment for a gastric complication, the doctor recommended invasive surgery that would have left her more dependent on her parents' care and increased their responsibilities. They sought a second opinion and were recommended a non-invasive treatment, which was successful. The participant said that he and his wife felt that the first doctor '*didn't have empathy that their daughter could progress*'. The doctor's negative attitudes and low expectations of their daughter's capabilities meant he did not recognise the difference that a major physical surgery with lifelong care requirements would make to her independence and quality of life. He also did not consider how placing additional physical needs onto their daughter would impact their family unit.

Many participants in the study felt that medical staff lacked empathy. In the final focus group, participants discussed the systemic negative attitudes towards disability and said that attitudes towards people with disability within the hospital system especially need to be changed. One participant suggested that hospitals should have both the awareness and budget to train staff in disability inclusion.

Attitudes in education systems

Of those participants who had received formal education in Australia, we heard how both schools and universities provide support to students with disability or refer students to external services to support their development.

Positive experiences and attitudes

A deaf participant had arrived in Australia as a young child and received good support during his school years, both in learning and in broader connections to services. His primary school teachers told him and his mother about NDIS services and connected him with an organisation where he learnt Auslan (his first sign language) and made strong connections with the deaf community. The primary school had both hearing and deaf students integrated in mixed classes. This meant that other students learned Auslan too, and he was able to communicate with many of his peers for the first time. The school also provided a School Services Officer (SSO) and a bilingual (Auslan) support officer who was able to sign for them, which helped him understand what the teacher was saying. For him, attending a school that understood disability played a significant role in him settling into Australian school and community.

Another participant who came to Australia as an international university student also experienced positive attitudes and support from the university. Although he found the university services hard to use at first, once he learned what support was available, he felt very welcome and used those resources. He found out he could ask lecturers for accessible content for screen reader use, have an access plan, and request extensions based on this plan. As a result, he has continued his studies in Australia, and he has found community and friendship with other international students with disability.

Another participant said her daughter’s school supports her daughter’s access needs. She said that as a parent she felt depressed when her daughter was young, and she did not know how to support her. She is now confident in her knowledge and skills and has taught her daughter’s school how to understand and support her best. They know how to give instructions to her daughter and how to help her engage with lessons. She now shares her skills with other members of her community, which has not recognised disability before. She feels proud seeing her daughter in school.

These examples show that education can not only support an individual’s learning, but support and drive their overall wellbeing. With the right supports and better integration, people with disability from a CALD background can build confidence, find their own community and receive a quality education alongside their peers.

Negative experiences and attitudes

Participants had mixed experiences attending primary and high school when newly arrived. One participant said he was bullied in school. He felt this was because he did not know how to make friends due to the language barrier and being new to the country. He also felt that, because of his disability, other people treated him as though he was not mature enough to make friends or understand how strangers were treating him. They treated him '*like nothing*'. Having come to Australia as a refugee, he did not own a mobile phone or computer, which most of his classmates did. He would use his friends' phones or go to the library, but this still meant he was excluded from a form of communication which he felt could have made things better. The digital divide is particularly bad for people with disability from non-English speaking backgrounds.[3]

Having moved to Australia to study before she acquired her disability, another participant was able to compare her experiences before and after becoming disabled. She said that her school had treated her differently at the outset, because she was an immigrant. Once she had acquired her disability, she experienced even more discrimination at university and from the general public. She lost her English language skills due to a brain injury, meaning she was unable to communicate her needs or request treatment, yet she wasn't always offered an interpreter. She described discrimination based on her physical access needs too, including being denied access into taxis because she is a wheelchair user. She described how people hit into her when going into the elevator and reached across her face to push the button. She said that, while she felt some discrimination before acquiring disability, '*after the disability it's worse*'.

Attitudes in employment settings and services

Discussions about attitudes in employment settings were limited and were mostly negative.

Negative experiences and attitudes

Some participants talked about language barriers leading to stress at work, and others noted that ageing can also make it hard for people with disability to find employment. One participant said a lack of employment affected his peers, leading them to rely on the Disability Support Pension or Age Pension. Therefore, some members of the community did not expect a person with disability to try to find work.

> There are then attitudes that is if you are older and have a disability, you'd get more money from the government – why would you work? The system is rotten from the inside – the attitudes then mean the system reinforces the stereotype that people with disability are lazy and don't want to work.

One participant with vision impairment said that he found it hard to find part-time employment during and after his studies. While his peers without disability could find jobs in supermarkets or in retail, he tried and could not. He has been able to find a job, but only within the disability sector where his access needs are understood. He felt that in general it is hard to find employment if you are from a CALD background, especially if you have a disability.

Another participant who worked in a hospital described how she witnessed negative attitudes towards a colleague, who is a wheelchair user. The participant said that other staff did not treat this woman well, claiming that she didn't work and criticising what they saw as a lack of productivity, because it took her longer to complete work-related tasks or go to the bathroom. The participant described how senior staff did not intervene or support her colleague and instead offered her a severance package, resulting in her resignation. The participant was shocked by this experience.

> Although these policies exist in theory, workers don't always follow them. As human beings we sometimes tend to be evil because they are not educated. Supervisors turn a blind eye to these situations as they don't want to be seen as problematic but then those people are not protected or supported.

These examples show the connections between disability, language, culture, age and the attitudes and expectations of employers and co-workers. One participant said the broader community needs to know that employment is not just about '*getting people money*'. It is also about them having a fulfilling life and the freedom to work if they want to. For new arrivals especially, participants felt that employment gave people the chance to meet people and build community.

What might help to improve attitudes?

When asked how people's attitudes towards people with disability could be improved, participants had suggestions ranging from simple changes to major reform. They discussed improving communication, both between individuals and within services and systems. They also suggested improving education and awareness of disability, building advocacy skills and giving opportunities to people with disability and people from CALD backgrounds.

Improving communication

Feedback from participants was that the general community, services and systems need to allow people with disability to take the time they need to speak for themselves and be understood. People should not make it hard for people with disability and/or from a CALD background because they have communication differences, cannot speak English well or speak with an accent.

Participants said they were not comfortable in Australia until they learned English and found out how to interact with systems. The responsibility for understanding and change should be put onto the systems and services and their leaders, because people with disability from a CALD background may have one or more communication access needs that should be met. One participant explained that reforming attitudes should be the responsibility of leaders of organisations or governments, and not individuals. These responses reflect the social model of disability, where the responsibility for change sits with the whole community, not just the affected group.

Accessible information

Participants said information could be made more accessible to support their communication access needs:

- Services should provide shorter documents and documents in Easy Read, with images to support the text.
- Different documents within the same service should be consolidated, so that people have fewer documents to read about one issue.
- Resources should be accessible and screen-reader friendly for people with no or low vision, with image descriptions in clear language and large font.
- For people with no or low hearing, hearing aids such as speakers and microphones should be available for face-to-face interactions.
- Options other than automated telephone systems should be made available. Phone calls and automated systems are challenging for people with disability or from a CALD background, as they cannot always hear or understand. They are not able to ask the system to speak slower or repeat itself, and automated systems often can't meet access needs.
- During face-to-face appointments, organisations should arrange interpreters (language and/or sign language), explain things in as simple terms as possible, or take the time to write things down on paper and share them with the person - they may be able to read it or take it away and get help from a family member or friend.
- Service resources such as websites and brochures and staff should be kept up-to-date to reflect the current service offerings.
- Each service provider should have one central website with all their resources and explanations of the different services so people can more easily understand which services are available and how to access them.
- Specifically in medical settings, service providers should keep information about the patient, including if they have any communication access or other support needs. They should also provide a visual pain scale for patients who experience regular pain, to help explain their pain at a given time.

Asking the right questions

Participants explained that during face-to-face contact with services, there could be a lack of understanding about what was being said, what they needed to do or what the service was offering. This sometimes led to conflict or meant that people with disability or their families were not able to get the support they needed.

Services should begin by asking individuals which language they use and what their cultural background is. This can reduce bias and make communication better. For example, when supplying an interpreter, matching both the language and the cultural background can help the individual feel comfortable and culturally safe and understand the information better.

Services should also ask people with disability before meetings or appointments about their access needs, and do their best to meet them. Where people with disability have support mechanisms already in place, these too should be included. Examples include having enough space for a wheelchair, or allowing a patient's support worker to come with them to a medical appointment.

Participants said that *how* they are asked questions can make a big difference to understanding them. Many participants explained that their home countries did not offer disability or other social services. This meant they did not know what support they needed or could be available to them. Therefore, they may not know how to answer general questions like 'what support do you need?', meaning that some of their support needs are not detected and they do not receive full support.

Due to cultural norms, such as the expectation to care for one's own family and not rely on others, participants often answered 'no' when asked if they needed help. Some families may have been providing support for so long that they no longer see it as an extra activity. Instead, participants suggested asking specific questions, such as 'how many people live in your home? How does your family member get ready for the day? Are you able to cook for yourself? Do you often feel tired?' This will tell service providers about the baseline support that someone may be providing. It will also identify areas where support is needed, explain to the person that support is available and what it might look like and understand if it would be helpful.

> I want to be treated with respect and shown that they are open to helping me. To help me feel this way, they can show an effort to communicate with me and ask me follow up questions to reinforce my needs. You might have to ask me a couple times for an answer but let me think before assuming or moving on.

Community inclusion

> I want to become the best version of myself in this country by using all the opportunities in front of me. I think having a strong mind, advocating for myself and learning about new cultures will make me more accepted in Australia.

This participant wanted people with disability to be able to create a life for themselves that is self-sustainable, where they have access to technology, their finances, the community and appropriate support and can live independently if they want to. If this support is in place, they will depend less on family members and others.

Participants said people with disability from CALD backgrounds, their family members and cultural community leaders need to have a strong understanding of the available services and how to access them, and to develop advocacy skills. This will help people with disability to become more independent.

One way to share knowledge about services and improve individuals' advocacy skills is through cultural and disability peer networks. Participants of four focus groups had been, or were currently involved in, peer networks. They said these networks were important to their understanding of Australian systems, supporting them to develop their social networks, language skills and confidence.

> Lots of communities and cultures should run peer cafes. Either learning from someone with a disability and hearing their own stories and accomplishments or breaking down stereotypes by sharing stories of people's lived experiences. This will make people more aware.

Education and employment

Participants said people should be educated about disability inclusion, both in school and later in employment settings. Many of the groups agreed this inclusive approach should be developed early in children's lives, from kindergarten or primary school age. One participant, a teacher at an international school, said that teaching disability inclusion to primary school students can help to change negative assumptions and stereotypes.

Participants talked about the part that parents play in the way their children think about disability. They said some parents don't explain disability to children, so the next generation thinks that disability is shameful and something to be hidden. However, they do believe that the younger generations know better than older people how to approach people with disability and how to respect them.

> We need to dismantle the view that people with disability cannot live without support but also acknowledge that everyone needs support. Young people are more accepting of this because they grow up talking about this and normalise it.

Most participants discussed training and education for people working in health, government, disability and other services. They stressed that staff need more training to improve communication and to understand the needs of people with disability. Participants also felt that services should be overseen by a group of people with lived experience and should have processes in place '*to ensure that service staff get trained in disability awareness, and oversight to ensure that funding of services is used effectively*'. Some participants noted that, while some organisations have disability representatives at higher levels, the staff providing the services often do not have the right training. One group said many employers give their staff basic online training, but that can be clicked through quickly, and is often forgotten after a week. Participants said training should enable employees to understand the real-life experiences of people with disability and to meet the needs of people with different types of disability, including invisible disabilities.

One focus group talked about the negative attitudes they hear from political figures in Australia, particularly about keeping people out of Australia. Although not formal 'education', participants felt that political leaders have a lot of influence on how the

Australian public feels about disability and people from CALD backgrounds. One participant said, '*you fix government, please, you fix that root.*'

What Australians see on traditional media and social media can strongly influence their views. Participants suggested that media, advertising, film and television should be used to change people's minds and perspectives, by showing role models, providing informal education and encouraging understanding and supportive attitudes towards disability.

Conclusion

This study describes how attitudes towards people with disability from CALD backgrounds can affect and shape their lives. The intersections of disability, cultural differences, settling in a new country and age create different barriers and opportunities for each person. While it is not always possible to tell whether unfair behaviours have occurred due to a person's cultural background, disability or both, the patterns of behaviour described show that they often experience negative attitudes. This leaves them feeling like outsiders and less than human. These negative attitudes also underpin the following issues described by the participants:

- discriminatory and dismissive behaviours due to communication and cultural differences
- issues finding out about and engaging with services, both public and private
- different cultural understandings and expectations of disability
- a lack of cultural awareness and understanding from staff working in services
- negative biases towards disability within different cultural groups

Participants said that they want to feel heard, understood and welcome. We heard many examples of how both cultural and disability communities have come together to provide practical and emotional support and speak up for their members. Participants suggested ways to improve attitudes within the broader community, particularly through awareness-raising.

Attachment A
Question guide

Attitudes towards disability research – participant questions

Section 1: Interacting with services

To begin, we will be talking about what attitudes you experience when you access the public services that you need. This could be visiting the doctor, attending school or university, visiting the bank, using public transport.

Questions

1. How do you feel trying to get the help you need from services?

Follow up questions:

- How does the way that people treat you during this service make you feel? What attitudes do you experience?
- How would you like to feel and be treated when you get help from services? What would help you to feel this way?
- What makes it easier/harder to ask for help from services?

2. When you try to access services, what assumptions do people make about you/ people with disability?

Follow up questions:

- Before you meet with services do you think they will make assumptions about you or treat you differently because of your culture or community?

3. Can you give an example of a time where you had a very good or very bad experience with public services?

Follow up questions:

- What attitudes did you experience? How did this make you feel?
- Did you have a support person or carer with you? How did that change your experience? Did they make sure you were listened to? Did the service only want to talk to them?
- Are there any services that are easier or harder to access?

BREAK (10 minutes)

Section 2: Disability and culture

Next, we would like you to think about the things you do every day where you meet and talk to people. For example, going to the shops, passing your neighbours, or spending time in public spaces like the park, beach, public transport or library, or at your workplace. What attitudes do you experience during these interactions?

Questions

4. How do you feel you (as a person with disability) are treated during the time you spend with people from other cultures or communities?

Follow up questions:

- Is this different to how people with disability are treated within your culture/community?
- Do you feel more discriminated against because of your culture/community?

5. How are people with a disability treated within your culture/community?

Follow up questions:

- Do you feel people with disability are treated differently from people without disability?
- [If speaking to someone who identifies as living with disability] Do you feel accepted in the same way as other members of your community?
- Does that change with the type of disability?
- Do you think attitudes towards disability differ across generations within your culture?

Section 3: How do we make things better?

6. How can we improve people's attitudes towards people with disability from different cultures/communities?
7. What assumptions would you like people to have about disability?

Follow up questions:

- How can we make this change?

8. What do you need to feel more accepted in your [cultural group] community?

Follow up questions:

- What would improve the experiences and outcomes for people with disability in your [cultural group] community?

9. What do you need to feel more accepted in the wider Australian community?

Endnotes

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1 Australian Government (n.d.), ‘Multicultural Australia’, *Department of Home Affairs.* https://www.homeaffairs.gov.au/mca/Statements/english-multicultural-statement.pdf

2 National Disability Insurance Agency (2025). ‘Your rights and responsibilities’, *NDIS*. https://www.ndis.gov.au/participants/your-rights-and-responsibilities

3 Australian Institute of Health and Welfare (2025). ‘Disability Inclusion Gap’, *Australia’s Disability Strategy Outcomes Framework.* https://www.aihw.gov.au/australias-disability-strategy/outcomes/inclusive-homes-and-communities/digital-inclusion