REFUGEES WITH A DISABILITY AND THEIR CARERS

Supplementary Document to the Submission to the Department of Social Services

On the National Disability Strategy

Prepared by the Refugee Support Network Disability Working Group

Context

In the past it was rare for a refugee with a disability to be granted a visa to come to Australia. In July 2012 the policy changed and migration officers were given far greater discretion to grant visas to families in need of resettlement where one or more of the members had complex health needs. This was a very welcome development as it meant that refugee families no longer had to face the impossible choice of whether they should turn down the chance of a safe future to keep the family together or leave the most vulnerable member(s) behind.

The number of visas granted to especially vulnerable refugees was small at first but it has progressively grown, especially in recent years. Since 2017 over 600 refugees with a disability and/or chronic health condition have entered NSW alone.

There are many factors that make this group more vulnerable than others within the community with a disability. These include but are not limited to the following:

- Newly arrived refugees lack of any prior connection to services, thus do not have a documented medical history.
- Typically they little or no understanding that services might be available, let alone how these might be able to assist them. It is unrealistic to expect them to negotiate a support package without assistance.
- Supporting the person with a disability in the family is only one of the many settlement challenges facing the family. They also have to find suitable accommodation, enrol children in school, learn English, find employment and much more.

- All of the above is occurring in an unfamiliar language and culture and at a time when trust has not been established.

- For as long as the carer must take primary responsibility for looking after the person in the family with a disability, this person is not able to actively engage in English classes, vocational training or employment.

- Further complicating things, as recipients of humanitarian visas, the refugees with a disability and their families have been determined to be especially vulnerable and the majority have experienced high levels of trauma and many years of displacement prior to arriving in Australia.

As the caseload grew, the agencies providing support to newly arrived refugees and those from refugee-like backgrounds have been working to build an understanding of the disability sector and the disability sector has had to learn about refugees – from each other and from their clients. And into this came the roll-out of the National Disability Insurance Scheme which has added its own level of complexity.

Despite considerable good will, things are not yet working as smoothly as they should. Recognising this, the Disability Working Group was formed by the Refugee Support Network to focus specifically on the issues facing newly arrived refugees and the impact of these on their settlement and that of their family/carers. Drawing on the experience of service providers, an **Issues Paper** was written. This is presented as **APPENDIX A.**

Having identified the issues, the working group began thinking about the way forward. To this end, a **Five Point Plan** was developed. This is included as **APPENDIX B**. It is believed that this Plan, together with the linked recommendations, addresses the most significant of the identified gaps in the support provided to this vulnerable target group. It is stressed, however, that this is not a comprehensive list but rather something with which to begin what needs to be an ongoing iterative process.

It is noted that the key responsibility for addressing the identified problems lies with the Federal Government. This does not mean that it is not relevant for State Governments because the systemic failures have led to issues that have had to be managed at a local level, not least by the state-based Refugee Health Services, education providers and community-based organisations.

The Impact of COVID-19

The work presented above was largely completed before the arrival of COVID-19. While many of the identified issues remain current, the pandemic has added some new issues, including but not limited to the following.

Since early April the offshore humanitarian program has effectively ceased. Despite holding permanent resident visas, visaed refugees have not been allowed to travel to Australia.[1]

The extended period with no new arrivals is threatening the financial viability of all of the services that have been built around supporting this cohort, not only those with expertise in working with refugees with a disability. The longer the shutdown continues, the greater the impact will be on the sector's ability to meet the needs of this specialised cohort.

Refugees and their carers already in Australia have also faced additional challenges during the pandemic, not least the following:

- The cessation of many face to face medical and allied health appointments has further complicated the process of assessment for NDIS eligibility.
- The lack of technological competency and/or possession of equipment has left some entrants isolated and lacking vital information.
- There have been even more extended delays in getting access to equipment and/or support programs.
- Employment and educational opportunities for refugees with a disability and their primary carers have been further limited.
- Respite and associated services have not been available.
- Any support that could have been provided by extended family and community members has been diminished.
- Families who receive care within the home are constantly afraid of the risk of someone bringing the infection into their home.
- Carers have not been able to participate in support groups, thus leaving them isolated.

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[1] Refugees have been excluded from being able to enter Australia as all other permanent residents have been entitled to do because of a technicality. The Migration Regulations specify that to be a permanent resident you have to be 'resident', which the refugees will only be after they arrive.

In other words, the impact of the COVID-19 pandemic on refugees with their disabilities is significant and is likely to have a lasting detrimental impact on them and on the services on which they depend.

Further reading:

Barriers and Exclusions: the support needs of newly arrived refugees with a disability. FECCA, NEDA, RCOA and SCOA. February 2019: https://fecca.org.au/submission-report/barriers-and-exclusions-the-support-needs-of-newly-arrived-refugees-with-a-disability/

We Need to Raise Our Voices: advice from people of refugee backgrounds and their carers. Foundation House. August 2019: https://foundationhouse.org.au/wp-content/uploads/2020/02/FINAL_FDH0126_DISABILITY-REPORT-2019_A4_online.pdf

APPENDIX A

SUMMARY OF KEY ISSUES RELATING TO PEOPLE FROM REFUGEE BACKGROUNDS WITH A DISABILITY

Convention on the Rights of Persons with a Disability

Article 1: Purpose

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

This document summarises the nature and impact of the challenges facing people from a refugee background with a disability in NSW, in particular those who are newly arrived and/or awaiting permanent residence.

It has been compiled from information provided by members of the Refugee Support Network's Disability Working Group, with demographic information provided by Settlement Services International (SSI), the Australian Red Cross and Ethnic Community Services Co-operative (ECSC).

The information that follows covers the following:

1. Incidence[2]
2. Demographics[3]
3. Issues and Impact.

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[2] The figures included are for NSW based agencies working with newly arrived refugees and were current at the end of 2019.

[3] It is relevant to note that this document was prepared prior to the arrival of COVID-19.

1. Incidence

	SSI[4]	Red Cross	ECSC
Number of refugee clients with a disability seen by agency	499	> 100	4
Period	30/10/2017 – 30/08/2019	Nov 2017 to present	2018-19
Number of current refugee clients with a disability	255	At least 50	4

2. Demographic Information

		SSI	Red Cross	ECSC
Gender	Male	229		35
	Female	270		25
Age	<18	24	Approx. 15	30
	18 - 25	21	Approx. 15	5
	25 - 40	65	Approx. 15	20
	40 - 65	210	Relatively few	5
	>65	179	Few	0

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[4] Note: Numerical data provided by SSI is based on overseas Pre-departure Health Check report for clients arriving to Australia on Humanitarian Settlement Program (HSP). Pre-departure Health Check reports are available through Department of Home Affairs Portal accessible to SSI (HSP) staff but it is not necessarily available for all HSP clients. The information on clients with disability is extracted by HSP case managers from departmental portal and manually entered in SSI's internal database system. In cases where the data on clients' disability is not available on departmental portal, HSP case managers gather the information at the Post-arrival Needs Assessment or through Comprehensive Health Assessment report provided by Refugee Health Services. The numerical data provided captures the number of HSP clients with a disability and the numbers provided on the nature of disability may overlap as there are clients with more than one type of disability.

Location	South West Sydney	480		8
	Western Sydney			2
	Sydney (other)			50
	Regional	Armidale – 6 Coffs – 9 Newcastle – 4	All in Wagga/Albury /Griffith/Leeton	0
Length of residence in Australia	Less than 12 months	199		0
	12 months to 5 years	308	All	3
	More than 5 years	2		47
Visa subclass	200 (Refugee)	123	66%	0
	201 (In Country)	10		0
	202 (Special Humanitarian)	331		3
	203 (Emergency Rescue)	0		0
	204 (Woman at Risk)	28	33%	1
	866 (Permanent Protection Visa – onshore)	1	Very few	0
	785 (TPV)	3	Unknown	0
	790 (SHEV)	13	Unknown	0
	Bridging Visa	NA	Unknown	0
	Long term PR and Citizens			56

Nature of disability	Physical disability with mobility Issues	164		3
	Intellectual and/or Specific Learning Difficulty	43		47
	Mental Health	77		10
	Sensory disability	36		0
	Old Age related	195		0
	Long Term / Chronic Health condition	202		0
NDIS	Successful referrals	Sydney - 135[5] Armidale – 4 Newcastle – 1 Coffs - 6	<5	30
	Outstanding NDIS referrals	Armidale – 2 Newcastle – 3 Coffs - 3	>20	4
	Unsuccessful referrals	Armidale – 0 Newcastle – 0 Coffs - 0	None known	0

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[5] Data provided by NSW Refugee Health Service. Note this not include people living over 65 years with a disability as they are ineligible for NDIS. Children with a disability, or suspected disability under 7 years are likely to have been referred to Early Childhood Early Intervention so may not be included in this data.

3. Issues and Impact

Area	Issue	Impact
Health	Health reports produced overseas are only provided to health services in Australia before or immediately on-arrival if the client has a health alert issued. Clients arriving on visa sub-class 202 (Special Humanitarian Program) may be linked with the local GPs for the initial health assessment on occasions when the Refugee Health Service (RHS) is out of capacity. While those with health needs are usually referred to the Refugee Health Service (RHS), clients living with a disability that is not obvious and/or not disclosed may not get this referral or the referral might be delayed.	Humanitarian Settlement Program (HSP) caseworkers unaware of disability and unable to make suitable preparations prior to arrival and/or make inappropriate provisions e.g. selection of inaccessible on arrival accommodation. Delays in identification of needs. Delays in referral to specialist services. Difficulty and delays in collating medical reports necessary for NDIS, Disability Support Pension (DSP) eligibility. Delays in receiving appropriate care and or access to mobility aids/equipment.
	Private specialists may be unwilling to use fee-free interpreting services. Private allied health providers are not eligible for fee-free interpreters. By way of an example, the occupational therapists who provide the essential functional assessments which help determine access to the NDIS are not eligible for fee-free Translating and Interpreting Service (TIS).	Family members being used to interpret in heath appointments with consequent impact on privacy and accuracy of interpretation. Cancellations or rescheduling of important health appointments. Delay in collating documentary evidence (health reports) necessary for NDIS, DSP eligibility. Entrants having to wait for extended periods for necessary support. Client dissatisfaction and stress. Increased risk of injury if specialist equipment is not used correctly because instructions were not understood.
	Delays in getting specialist appointments as public waiting lists for some specialities can be extensive.	Entrants having to wait for extended periods before they can get medical aids or diagnosis. Risk is that they may be exited from settlement services before complex health needs are identified. A further risk is that they enter into a rental agreement before their equipment is provided and then discover that their accommodation is unsuitable for the equipment, e.g. the doors are too narrow.

	Fear or shame of disclosure of disability (by the person and/or by the family), or fear of jeopardising visa status /citizenship eligibility.	Delays in receiving appropriate care and support, particularly for people with intellectual or developmental delay. Risk is that they might be exited from initial settlement support before additional needs are identified.
	Lack of client knowledge and understanding of the private versus public health system.	Client dissatisfaction due to the long waiting period through public health sector. Cost associated with private health service creating financial stress.
	Clients with formal diagnosis from overseas still need to go through specialists for reviews and onshore formal diagnosis which is considered recognised for eligibility screening for NDIS.	Delays in identification of needs. Despite a formal diagnosis from overseas, the process of getting one onshore takes longer than just one or two sessions. Delays in accessing specialist services and cost associated with it puts clients on financial stress
Humanitarian Settlement Program (HSP)/ Specialised and Intensive Services (SIS)	Mobility aids such as rented wheelchairs are only provided to new entrants for the first 28 days after arrival and it is expected that they rent their own aids thereafter (in most cases prior to their eligibility for DSP being established). Lengthy waiting periods before the clients can access mobility aids through the state equipment provider, Enable NSW, particularly if specialist equipment is required. Referral requires a prescription from an occupational therapist recognised prescriber which might need to be purchased privately (Tier3 purchased service) as there is long waiting period through the public health service. There is a high degree of need prior to NDIS access that the HSP case management team must address for the client in their initial settlement.	Risk of injury to the clients living with disability / mobility issue. Limitation to their mobility creates isolation for people living with disability and their carer. Logistical challenges for the HSP case management team when transporting the clients to the specialist health appointments necessary for the NDIS, DSP or mobility aid applications eligibility. Great deal of strain on resources within HSP team, e.g. coordinating multiple trips to various health appointments, linking with other necessary services like housing, school, AMEP, community linkage, local area orientation, DHS etc.
	The HSP/SIS teams do not exclusively support clients with disability. They also look after clients with many other complex social, financial, legal and medical needs. They therefore do not necessarily have specialist disability	HSP/SIS teams do not have enough funded hours or staff to provide the intensive support that NDIS access requires, often resulting in staff and resources being over stretched.

	knowledge/skills.	The lack of specialist knowledge within HSP/SIS teams can result in relevant issues being overlooked or connections to necessary supports not being made.
	Clients do not have access to community transport service for the pre-NDIS health appointments.	Clients with severe disability have difficulty accessing public transport. They are thus dependent on HSP/SIS support which might terminate before other affordable transport options become available to them.
	Clients not engaging in orientation training covering various settlement outcome domains due to mobility issues.	Delay in orientation outcomes and clients left with a lack of information.
	Lack of free special interpreting service for clients with sensory disability until NDIS support commences.	HSP providers are required to seek DHA approval each time they need to contact a client who requires a special interpreting service (such as sign language) and this approval is not always obtained.
	Difficulty obtaining assisted communication technologies for refugees with visual or hearing impairments. These are being classified as ‘educational needs’ rather than as ‘life enabling’. Perceived dispute about who should provide such technology: Education (State) or NDIS (National).	Refugees (especially young refugees) not receiving the technological aids that will enable them to learn English and engage with the wider community.
	Arrangement of assessments and approval of quotes and payment in support of NDIS application, combined with the high cost associated with use of accredited therapists.	Delays in getting HSP clients assessed for NDIS. This is further complicated in regional areas by the reluctance of assessors to use telephone interpreting and the transport costs associated with getting clients to appointments.
	HSP/SIS is a time limited service – usually 3 to 6 months. The time needed to get access to services through the NDIS may be close to a year.	Services are required to exit clients prior to services being in place. Justifying extending services is difficult as it is unknown when NDIS processes will progress.
NDIS	Failure to engage with CALD communities and CALD people with a disability.	Many CALD families are still unaware that the NDIS even exists let alone what it does. Many new arrivals therefore miss out on receiving some or all services or supports.

	Ineligibility of asylum seekers with a disability for NDIS. By extension, as almost all disability services are now structured through NDIS, few public therapeutic options exist for asylum seekers. Many public health services provide assessments but the therapy is provided by NDIS services	Risk of deterioration of functioning without therapy. Risk that the person is not able to live at their capacity due to lack of therapy and early intervention. Burden of care wholly on carer with limited service options, and related risk to carer of injury and burn-out. Limited opportunity for the carer to engage in employment to purchase private therapies required. Increased risk of neglect and cost of residential care if carer is not able to cope. Cost of care transferred from federal government to health services or schools, particularly without access to early intervention services.
	Absence of cultural competency amongst some LACs, service providers and many agencies involved in the NDIS.	NDIS CALD Strategy document needs to be communicated with people with disabilities in a meaningful way. The CALD Strategy cannot be an ‘add-on’ to the NDIS. Rather, access and equity must be considered at all stages of the participant. While a CALD Advisory group was set-up, the sector has not been informed about the outcomes of the consultations and what changes, if any, were made. The CALD Advisory Group was dissolved in 2019 with many questions still unanswered about improvements to be made.
	Limited CALD Data and Statistics.	Limited data and statistics being kept on CALD participants and NDIS, little to no data collection by NDIA and difficult to understand outcomes of transition to new system for CALD individuals. No knowledge of unmet needs within the community.
	Clients not understanding the various roles played by the different services involved in NDIS. This is exacerbated by language barriers and the complexity of the application process.	Clients and their carers undergo significant additional stress while they are in their initial stage of settlement.

	Complexity of some of the technical aspects involved in NDIS such as getting an access request granted by NDIS and registering on the NDIS portal.	Majority of clients are not technologically savvy and do not have the language proficiency to understand such complex process so miss out on critical steps.
	Newly arrived clients with no English and no experience with disability services not being granted Support Coordination post-NDIS access to assist them find services and negotiate delivery. Clients need to coordinate their own support, sometimes with more than one agency. The clients need to sign up for agreements with each provider as well as liaise with the staff coming to provide the service. After a year, the Plan must be reviewed requiring them to redo the process. Many clients believe that it is good not to ‘spend’ all of their NDIS allocation, thinking that this is ‘saving’.	Carers become overwhelmed with their responsibilities resulting in burning out. Risk that NDIS funded services are not provided because family is unable to find and negotiate contracts with various service providers. For people who have had no access to disability specialist therapies this may result in delayed recovery in some or continued deterioration in others. When plan is reviewed the following year it is likely to be reduced if funds were not spent, even if the lack of spending was not due to lack of need but a reflection of the family’s capacity to coordinate services. Even if Specialist and Intensive Services are available soon after arrival in recognition of complex needs, the limited time frame of support means that they are likely to be exited before NDIS Plan is issued. Clients are vulnerable to fraud as they are dependent on their contracted providers as the only link to the NDIS.
	Long waiting list for occupational therapist assessments and early intervention service delays. NDIS access and Centrelink entitlements.	The longer an OT assessment is delayed, the longer the wait will be for services and equipment, and the higher the health risk for the person and their carer. Delays in approval of carers’ payments. In a rental market with limited options for some people with disabilities, the underestimate of income means significant differences in the quality and appropriateness of accommodation.
	Although NDIS is provided for those clients with mental health issues, there are more clients who have been denied NDIS than those approved due to the nature of the disability. NDIS needs a proof that client’s disability is permanent and cannot be improved with treatment. Such a diagnosis of mental illness can take in excess of a year.	While waiting for a diagnosis to putting in an NDIS application and then waiting for approval, clients are ineligible for relevant services. This puts extreme pressure on clients and their carers.

	Transcultural Mental Health referral process has been changed. Direct referrals from frontline workers are not accepted and it has to go through GPs.	Delays in accessing relevant services. Clients funnelled towards mainstream mental health services that may or may not pose multiple cultural barriers to access.
	Access to interpreters and delays in accessing interpreters. Lack of / use of interpreters by NDIS providers.	Complications at every stage of the process of applying for NDIS and receiving all other forms of support. Misinterpretation of relevant information.
	Lack of translated materials. Failure to recognise the complexities associated with varying cultural perceptions of disability as well the role of government, family and community. Barriers to access and participation in the NDIS by CALD Australians include both linguistic and cultural aspects. Failure to meet access and equity obligations.	Translated materials are very limited and it is a major barrier in assisting CALD participants to understand and access new system. Plans are written in English and require a high-level of English language understanding that may not exist in all families. Information about consumer rights not translated thereby impacting on clients' ability to make complaints and change services. Risk of exploitation of clients who do not know their rights.
	Information, Linkages and Capacity building (ILC) funding is time-limited and project-based funding.	The one-off funding for ILC is not a sustainable solution. Capacity building of CALD communities involves many layers of support services including building trust, understanding cultural practices and religious beliefs, perception of 'disability' within cultural context etc. In order to engage CALD communities in NDIS in a meaningful way there must be a genuine commitment to ongoing resources.
	Low levels of participation by people from CALD backgrounds at a National and State level in the NDIS reflects that the system is failing CALD communities.	CALD people with disability are falling through the gaps. ECSC's Ethnic People with Disability Advocacy Program has shown many are missing out or going without vital services and support.
	Support Coordination is limited/transitional.	Initially funded as a transition support under NDIS, only accessed by a handful of participants, this has become an essential part of supporting CALD NDIS participants to navigate this new system and bridge the gaps in service provision, appeals, plan reviews, budgeting and better outcomes. This funding was, however, intended to be time limited and phased out.

		Support Coordination should be made available to CALD participants who can demonstrate a need for it and not phased out.
	Inadequate funding received does not match level of services required.	Inadequate services provided to clients.
	Price guide and Temporary Transformation Payment (TTP).	The TPP, which was introduced with the new 2019 Price Guide, has been problematic. Initially the loading of 7.5% was introduced to assist organisations with additional costs in their first two years of business in the NDIS. Understanding that plan budget would increase to support this price change without costing the participant. Better communication and transparency is needed from NDIA. They are penalising small organisations and risk losing specialist, expertise, grassroots organisations from the disability sector as a result.
	Transport.	Limited transport options and the high costs of transport impacts on the ability of people with a disability to connect to their own community and the wider community and access vital services. Newly arrived refugees rarely have access to a car so are not able to transport disabled family members to appointments or community activities. This results in service deficits and isolation.
	Clients placing greater weight placed on (often inaccurate) information received from community members than on information from HSP case managers and RHS disability support team.	Delays in identification of needs and in accessing specialist services. The status of the NDIS application is hard to track and clients are not able to communicate this information with the case managers. Delay in accessing appropriate service and funding.
Education	Children with a special need waiting for a long time to be enrolled in a public school as the school is waiting for the funds to support those children.	Delay in educational outcomes. Parents may also delay enrolling siblings until they know what school will take the child with a disability. Parents’ enrolment in English classes/employment delayed until child is in school.

	Access to appropriate supports – this includes SLSOs for school, AUSLAN training etc.	Many refugees arrive with no formal documentation of their disabilities so this must be generated before supports can be put in place. They have typically also missed out on medical care, e.g. receiving cochlear implants. This in turn delays access to education.
	Lack of specialist schooling options and/or teacher aids	Clients might be in mainstream schooling that does not meet their educational requirements until diagnosis is confirmed and funding approved.
Accommodation	For some Tier 3 clients on TPV / SHEV visas, affordability of private rental property is an ongoing problem as they are not eligible for rental or bond assistance.	Risk of homelessness.
	Access to affordable and suitable housing for clients with mobility issues.	Clients' special needs are not met, ability to perform activities of daily living, and/or ability to be mobile within the home further limited.
	Lack of supported accommodation options.	Clients with intellectual or mental health associated disabilities who wish to find assisted living and supported accommodation are unable to access this so find themselves in unsuitable/precarious accommodation.
	Evidence required for priority listing is too challenging.	Clients struggle to provide enough evidence to support their claims for priority listing for accommodation. Even when they transition to NDIS they face barriers for lack of 'evidence' especially when coming from overseas where such 'evidence' is difficult to come by as many arrive without a diagnosis and supporting medical evidence.
Employment	Clients not engaging with employment services due to lack of mobility aids, correct diagnosis	Delay in employment outcomes.
	Difficulty for clients to attain recognition of prior learning and education in home country.	This has an impact on their ability to find and maintain work especially when coupled with their disability. This in turn greatly affects their confidence and ability to participate in community, i.e. leads to further social isolation and sometimes exploitation.

	Exploitation at work.	Many face exploitation in the workplace, often from members of their own community who may be involved in illegal practices or employ them illegally or underpay them.
	Lack of translated information about their rights as workers and safety at work.	Lack of understanding of their rights as workers.
Language Training (including signing)	Clients not engaging in English language study(AMEP, school).	Delay in English language acquisition, education, employment and social participation.
	Access to professional service to assist with language acquisition and clear direction on how to address.	As many clients with sensory disabilities have not had access to supports in the past, they have developed various communication strategies that are vastly different to anything that is commonplace. This requires re-learning all communication. Those who are illiterate in their own language find this especially difficult as written language as a mode of communication is also not possible in their own language or English.
	Lack of understanding that free English lessons are available.	Delays in English language acquisition.
	Lack of transport/geographical isolation.	Depending on their location and transport options, some clients struggle to access services that provide them with language training.
Translating and Interpreting	Shortage of interpreters in emerging languages.	Delay in clients accessing services in a timely manner.
	Cultural appropriateness of the interpreter is not always understood by service providers when they are requesting them.	Failed communication and erosion of trust in the service.
	Lack of understanding about right to access interpreter	Many clients are unaware that they can ask for an interpreter to assist them with services. They struggle to ask/request this from many providers due to communication and language barriers. They might also be embarrassed or ashamed to ask for an interpreter.

	Psychiatrists and other medical specialists not providing interpreting service and expecting HSP case managers to arrange the service, despite being eligible for fee-free TIS.	Clients not being able to access the service as HSP staff cannot do medical/health interpreting.
Regional Settlement	Access to specialists: there are few or no specialist services available in some of the primary settlement locations and arranging travel to major centres is complex and expensive.	Strain on HSP staff to support attendance. Time and effort of person and carer to attend. Financial cost of attendance once they have exited HSP.
	Knowledge of interpreting: most services in regional areas have had little experience in dealing with language barriers so this presents an additional hurdle that must be crossed in education and supporting services to use these facilities appropriately.	Unfamiliarity with how to use interpreters can result in reluctance to use interpreters If interpreters are not used, minimal trust is built, and it's less likely that families attend. This in turn results in less education opportunities and poorer management of conditions.
Knowledge and Skills of Service Providers	Lack of cultural awareness and/or lack of culturally responsive practice, generally and in the context of cultural understanding of disability.	Inappropriate services provided to clients. Failure to understand the cultural stigma associated with disability and the way this impacts on the way the person and their family members engage with 'others' (people in their community, health professionals and service providers).
	Mainstream providers failing to use interpreters.	Despite interpreter service being widely available and, in many cases, free for services to utilise, they often choose not to use interpreters or to encourage family members or friends to be brought along for interpreter services, which is inappropriate and can be harmful for the client.
	Lack of community consultation with specific communities.	Many services fail to form good relationships with new and emerging ethnic communities and lack of interest in understanding the importance of culture and language or understanding and ensuring needs are met. This impedes their ability to provide a culturally responsive service.
	Support services do not have enough information about local services to effectively refer families.	Inadequate or inappropriate referrals.
	Lack of trauma informed practice.	Failure to meet clients' needs.

Support for Carers	Delays in approval of carers’ payments.	Financial hardship.
	Lack of awareness of respite services.	High risk of isolation.
	Lack of culturally appropriate carers support groups.	Most carers are in desperate need of support and respite but struggle with the supports they are offered often because they cannot express themselves in language and do not understand or struggle to connect with other participants due to culture and language barrier. Many will stop attending after the first session because they experience this and it leads to more social isolation.
	Lack of translated information for capacity building of carers.	Many carers struggle to advocate for their children and families as the process to appeal, complain or advocate requires a good command of English and high-level of competency in writing and reading in English. They also fear public institutions and government agencies because of trauma associated with incidents in their home countries and fear of retribution. As a consequence people may accept inappropriate Plans and withdraw from inappropriate services, rather than organising advocating for a better service.
	Too much versus not enough.	This is a very complex aspect for some new arrivals, especially those in regional areas. Some families have been greatly supported by individuals in the community, so much so that there is a complete dependency on them for daily operations, travel and interacting with any service. While this serves the immediate purpose, it does not solve the problem or equip the family to manage individually into the future. This also creates some division as some families perceive that their HSP provider not giving them the same level of support as other families.
Citizenship	Refugees with a disability face many barriers applying for citizenship, especially if their capacity to learn English is compromised and/or they do not have the resources to pay for specialist medical reports.	The refugee, who by definition has not other citizenship, is unable to access the rights of a citizen of Australia.

APPENDIX B:

5 POINT PLAN
Charting the Way Forward

POINT 1: The delivery of quality services to newly arrived refugees with a disability depends on the National Disability Insurance Agency (NDIA) having in place mechanisms to capture information from relevant sectors and monitor the quality of service delivery.

To this end, the following recommendations are made:

1.1. NDIA reinstate their CALD Advisory Group to support the delivery of their CALD Strategy and that included in its terms of reference is specific reference to ensuring that the needs of newly arrived refugees are identified and met.

1.2. NDIA develop a Performance Framework for NDIA service providers that includes, *inter alia*, measures of the provider's knowledge of and responsiveness to the specific challenges faced by newly arrived refugees and the effectiveness of their engagement with refugee communities.

1.3. NDIA collect and publish disaggregated data on participation of CALD clients to demonstrate the implementation of the NDIA CALD Strategy. This data include, at a minimum, arrival date, country of birth, ethnicity, LGA of residence, age, sex, language spoken and nature of disability.

POINT 2: Good preparation is the key to quality service delivery.

To enhance the prospect of this occurring, the following recommendations are made:

2.1. The Department of Home Affairs (DHA) work with representatives from Refugee Health Services and Humanitarian Settlement Program (HSP) providers to design and implement a system that ensures comprehensive, accurate and timely health information transfers from assessments offshore to health and HSP providers.

2.2. NDIA, in consultation with the CALD Advisory Group and those with subject expertise in working with newly arrived refugees, develop a strategy to ensure that those designing plans and those working with newly arrived refugees in both the settlement and disability sectors have the knowledge and skills to provide quality and culturally sensitive support to the new entrants and their carers.

POINT 3: Newly arrived refugees with a disability have needs over and above those of other newly arrived refugees and they also face challenges over and above Australian born people with a disability. Until such time as they begin receiving specialised support through the National Disability Insurance Scheme (NDIS), other services must deliver the essential support required to meet these needs.

The following recommendations are therefore made:

3.1. DHA extend eligibility for Specialised and Intensive Services (SIS) to humanitarian entrants with a disability until their NDIS package commences.

3.2. DHA extend fee free access to TIS for the appointments with allied health services that are required to assess eligibility for NDIS.

3.3. DHA extend funding for hire of disability support aids until people have access to Enable or the NDIS.

POINT 4: For some refugees with a disability, the complexity of their needs, their past experiences and their prolonged periods without support will mean that specialised support will be required after their NDIS package commences.

The following is therefore recommended:

4.1. NDIA expand eligibility for Complex Support Needs Pathways to newly arrived refugees with a disability.

POINT 5: Newly arrived refugees do not exist in isolation. They are part of a family and a community. It is essential to understand the complex inter-relationship between these three and work to educate, support and empower all stakeholders.

To this end, the following recommendations are made:

5.1. NDIA recognise the complex challenges faced by carers who are themselves newly arrived refugees and ensure availability of programs that help them to understand NDIS, support them to be effective carers and enable them to address their own settlement needs.

5.2. Through its CALD Advisory Group and other means, NDIA ensure it has a good understanding of the cultural context of disability in new and emerging refugee communities.

5.3. Through its CALD Advisory Group and other means, NDIA actively support community leaders and influencers to educate those within these communities about the importance of inclusion of people with a disability and provide them with culturally-suitable information so that they can provide guidance about how the available services can help them better care for their family members with disability.