



**UNIVERSITY OF
CANBERRA**

BEST PRACTICE IN SUPPORTING INDIGENOUS STUDENTS WITH DISABILITY IN HIGHER EDUCATION

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SECTION 1: INTRODUCTION

This report is the result of a grant awarded by the National Centre for Student Equity in Higher Education to the authors. The purpose of the report is to provide an understanding of the numbers of Aboriginal and Torres Strait Islander students with disability in Australian higher education and the support they currently receive. Further, the report provides a series of recommendations for good-practice in supporting this group of students based on a review of the literature and an understanding of current support practices in the higher education sector.

The report comprises four distinct sections. The first section of the report examines the extant literature pertaining to disability services in higher education, disability support for Aboriginal and Torres Strait Islander people, and the supports available for Indigenous students in higher education. The literature review is extensive, though not exhaustive, and seeks to discern the key factors that affect the experiences of Aboriginal and Torres Strait Islander students with disability.

Secondly, data were obtained from the Australian Government Department of Education and Training regarding the numbers of Aboriginal and Torres Strait Islander students with disability at each Australian university from 2001 to 2013. The data were examined according to students' enrolment status (i.e., full-time vs. part-time); level of degree being undertaken (i.e., undergraduate, postgraduate-coursework or higher degrees by research); and the field of study being pursued.

The third section reports on a study in which current disability advisers throughout the higher education sector were asked about the general and specific supports provided to

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Aboriginal and/or Torres Strait Islander students with disability at their university.

Participating universities demonstrated high consistency regarding generic disability support provided, but some variation in the delivery of these services to Indigenous students. This work also highlighted the variation in training provided to disability advisers with regard to cultural awareness and cultural competence.

The final section of the report combines all these findings and makes recommendations for working with Aboriginal and Torres Strait Islander students with disability at Australian universities.

We would like to acknowledge that this research took place on the land of the Ngunnawal people. Neither author is Aboriginal or Torres Strait Islander and we are aware that Aboriginal and Torres Strait Islander peoples have been over researched and under consulted (Bostock, 2007; Clark, 2008; Dodson, 1995). It was not the goal of the current research to contribute further to this. Thus our report focuses on integrating existing information in order to inform practice. This work has been informed by Aboriginal people and we honour their contributions. We would particularly like to thank the Aboriginal and Torres Strait Islander staff members and students at the University of Canberra who provided us with advice in relation to this report. As a result of the recommendations made in this report, we hope that Aboriginal and Torres Strait Islander people will become key decision makers in how to best support Indigenous students with disability at Australian universities.

SECTION 2: LITERATURE REVIEW

DISABILITY SUPPORT IN HIGHER EDUCATION

In this first section, we examine the literature pertaining to disability support in higher education. We briefly outline the relevant legislation that informs the sector and governs the provision of services. This also provides the background to our more detailed analysis of the experiences of being a student with a disability in higher education. We consider the impact of stigma associated with disability, and the consequences for students who choose to disclose their disability status – including how this may vary at different stages of a student's degree. Our discussion concludes with an examination of the discourse that surrounds disability in higher education and the implications for both individual learners and the wider university context.

Disability standards and the experiences of students with disability in higher education

Disability support for students attending universities in Australia has been informed by legislation including the Disability Discrimination Act 1992, the Disability Discrimination and Other Human Rights Legislation Amendment Act 2009 and the Disability Standards for Education 2005. These legislative instruments clearly outline the legal requirements and obligations of educational institutions to their students with disability in order that students may participate on the same basis as others.

Despite the existing legislation to support people with disability, students with disability often have very different higher education experiences to those without a disability. This is reflected both in attrition rates and in students' reported experiences.

Although reported attrition (or 'drop out') rates vary, they are typically higher for students with disability than for those without (e.g., Megivern, Pellerito & Mowbray, 2003). Australian university students with disability typically have retention rates that are approximately three percentage points lower than other students (Australian Government

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Department of Education and Training, 2015). While there is limited follow-up data available on students who have withdrawn, the reasons for withdrawal can be inferred from reports of students' experiences throughout their degrees.

Students' perspectives

For the majority of students, the transition into higher education – whether from school or other employment – marks a major life change (Dias & Sa, 2014; Lairio, Puukari, & Kouvo, 2013). Associated with finishing secondary education and commencing higher education (in any form) is a range of events including, but not limited to, moving away from home, commencing (or increasing) part-time employment, together with a sense of (at least to some degree) becoming an adult (Mitchell & Syed, 2015). With regard to higher education, decisions concerning whether or not to study – and the choice of institution – are similar for disabled and non-disabled students (Wray, 2012); yet the transition experience itself can be very different (Belch, 2011; Kelepouris, 2014).

For those students with long-standing disabilities, both the amount and types of support available can vary from what they previously received (Stein, 2013). However, the experience as a student can be very different in higher education compared to earlier experiences. Unfortunately, students with disability in primary and secondary schools are frequently the targets of bullying and harassment (Beran, Rinaldi, Bickham, & Rich, 2012), despite the implementation of national frameworks addressing bullying (Cross, Epstein, Hearn, Slee, Shaw & Monks, 2011). Typical of both Australian and international studies is Delfrabbro et al.'s (2006) South Australian study, which revealed approximately 50 percent of secondary students reported some form of bullying from their peers. This was the case for some of the university students in Wray's (2012) UK research. While some had been teased and bullied prior to higher education, all of the students reported having had negative experiences. Although these can continue beyond high school, such experiences are less likely at university (Merilainen, Puhakka, & Sinkkonen, 2015; Young-Jones, Fursa, Byrket, & Sly, 2015).

Disability and stigma

Despite the decreased risk of direct bullying or harassment, students with disability continue to face discrimination in higher education. This is largely related to the stigma surrounding disabilities (Johnstone, 2001; Salzer, 2012). Stigma refers to the negative perceptions – or stereotypes – that surround, in this instance, a person's disability or mental illness (e.g., Corrigan, Watson & Barr, 2006). While eschewing any discussion on the etiology or in/accuracy of these beliefs, stigma has profound effects on both the person with a disability (Corrigan & Matthews, 2003; Reavley & Jorm, 2015) and on those close to the person (Corrigan & Miller, 2004; Reavley & Jorm, 2011), and can even exacerbate the experience of a person's mental illness (Corrigan, 2007). Stigma contributes to social isolation through the person not wanting to engage in social activities and even avoiding health professionals. Similarly, those close to someone with a disability – in particular a mental illness – can experience blame for the person's disability and/or behaviours. Hence, in addition to feeling a sense of responsibility for their loved one, family members can be subjected to the vicarious impact of stigma (Corrigan & Miller, 2004).

Not only does stigma inhibit help-seeking (Wynaden, Wichmann & Murray, 2013; Yap, Wright & Jorm, 2011), it impacts on students' engagement with university and campus life (Salzer, 2012) as students with a disability are much less likely to be involved in extra-curricular activities than are those without (Leake & Stodden, 2014). This is sometimes due to the inaccessibility of the activities (e.g., Shevlin, Kenny, & McNeela, 2004), but is often a result of others' perceptions.

The impact of illness

By far the greatest reported concern, however, is the experience of symptoms, particularly for students who suffer from mental illness (Belch, 2011; Megivern et al., 2003; Schindler & Kientz, 2013; Weiner & Weiner, 1996). The range of symptoms experienced is, of course, extremely varied, and includes, among others, mood swings, an inability to concentrate and psychosis. Not only can such symptoms impact on academic performance,

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they can contribute to relationship and friendship difficulties with those very people whom they rely on for support. For example, in Megivern, et al.'s (2003) study of (US) college student experiences, university support services were rarely utilised. Rather, the students relied on family, friends and community services. Hence the subsequent isolation from friends after a psychiatric episode added further strain to an already stressful situation.

This reliance on 'informal' supports by students with disability is a recurring theme throughout the literature and, as previously mentioned, is often the result of the stigma associated with a disability and/or mental illness. Wynaden et al. (2013) found that students' reasons for not seeking professional help included the potential costs involved, a lack of time/availability, and concerns over the health professionals' capacity to help. However, a greater number of students did not seek help because they believed they should be able to 'deal with their own problems', and even more students did not seek help due to feelings of shame and embarrassment (p. 856). This was exceeded only by the number of students (41 percent) who didn't regard their problem as serious enough – or know if it was serious enough – to consult a health professional (p.855). Thus a large number of students continue to struggle with little outside or ongoing support.

Disclosure and identity

The varied nature of disabilities and the various ways in which they manifest and impact on people's lives makes the issue of disclosure somewhat vexed. For many students – especially those with 'unseen' disabilities – there is no stable pattern to the progression of the illness or the expression of symptoms. Consequently, this leaves the student uncertain as to the full extent of the impact of the disability and/or faced with the decision of whether to tell others (Boyd, 2014).

Inextricably linked to the issue of disclosure is that of identity (Riddell & Weedon, 2014). In order to register for assistance/accommodations, students need to first be diagnosed with a disability or health condition. While the assistance provided by Disability Units (DUs) in higher education has demonstrated significant impact on enabling students to

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graduate (Denhart, 2008), the decision to disclose is nonetheless often difficult. Cole and Cawthorn (2015) investigated the factors involved in this decision process and identified (i) knowledge of (possible) accommodations; (ii) their experiences with university staff and other students; and (iii) students' perceptions of their disability and coping mechanisms. In particular, a lack of knowledge of accommodations was related to the decision to not disclose, while positive experiences with academic staff was related to both the decision to disclose and the depth of disclosure.

The decision to disclose may also differ from undergraduate to postgraduate levels of study (Jacklin, 2011). While the supports available at university are designed to maximise students' opportunities for success, students at higher levels of study and those undergoing work placements may face new levels of discrimination (Riddell & Weedon, 2014; Ryan, 2011). Students with disability sometimes experience negative attitudes in the workplace, which is partially the result of inadequate knowledge of relevant legislations (e.g., Ryan, 2011), but also, potentially, from enduring negative attitudes and misconceptions concerning the abilities of people with disability. One way in which these beliefs become legitimised is through prevailing 'discourses of disability' (Gabel & Miskovic, 2014; Riddell & Weedon, 2014) which are premised on deficit assumptions.

Deficit discourse and disability

Historically, people with disabilities have been separated or excluded from a wide range of education and employment options. While this is no longer the case in Australia, vestiges of these practices remain. Termed 'containment' by Gabel and Miskovic (2014), this individualistic deficit model serves to both silence the person with disability and to justify exclusionary beliefs and practices. A focus on the individual implies that responsibility for his/her disability – and the associated needs and requirements – lies with that person. Unfortunately then, people with disability are often caught in a vicious cycle of having to 'prove' their limitations while simultaneously trying to assert their capabilities (Luna, 2009). In the case of the university student, he or she must provide documentation and even assert

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his/her rights with persons (sometimes staff and other students) whose knowledge and beliefs are either inaccurate or inadequate – and sometimes displayed as resentment (Madriaga, Hanson, Kay & Walker, 2011). At the same time, s/he must go about the ‘normal’ activities of students in fulfilling study obligations and even attempting to engage in university life. The burden this places on individual students should not be underestimated.

Focus on inclusion

More recently, and particularly evident in higher education, there has been a widespread move to a language of ‘inclusion’. Based on a pedagogy of social justice (Madriaga et al., 2010; Madriaga et al., 2011), this approach explicitly recognises both the legal and moral rights of all people to participate in the full range of education and employment opportunities. This approach also helps move the onus for access and assistance away from the individual; instead broadening the responsibility into the wider sphere of all students, staff and the institutions themselves. It presupposes that students with disability have the capacity to succeed and that enabling this to occur is neither onerous nor problematic. It also highlights that universities (and indeed any workplaces) should be ‘safe’ environments for people with disability – environments where disclosure of limitations and help-seeking behaviours are supported and not judged (Claiborne, Cornforth, Gibson & Smith, 2011).

While clearly a step forward, an inclusive approach can ironically overemphasise humanist concerns and burdens of care while minimising students’ efficacy. Claiborne et al. (2011) documented the mismatch that sometimes occurred between a focus on warmth and care by university staff and a desire by students with disability for the provision of more general – and institutional – models of support. Although highlighting the benefits to both students and staff of adopting a more socially inclusive framework, this work serves as a reminder of what can be achieved. For example, both staff and students could be encouraged to challenge their own assumptions of what is meant by inclusion, education and learning (Madriaga et al., 2011).

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This helps shift the focus of ‘disability support’ away from individual learners – and even individual support units – to systemic and institutional-level enablement and empowerment. Changes in this direction are evident throughout the higher education sector and have been well received. However, listening to the voices of those people for whom these policies and frameworks have been devised, suggests there is further work to be done.

DISABILITY SUPPORT FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Aboriginal and Torres Strait Islander people experience ill health and disability at a rate much higher than the Australian population as a whole (Australian Bureau of Statistics [ABS], 2014a; Australian Institute of Health and Welfare [AIHW], 2009). ABS (2014a) data place this figure at almost three times that of the Australian population as a whole; yet alarmingly, these data only include people living in private dwellings. Given the high rates of homelessness among Indigenous people with a disability and a lack of recognition and/or a reluctance to identify as a person with a disability (Griffis, 2014), these figures no doubt underestimate the true extent of the issue. In this section, we examine the support available for Indigenous people with a disability. In doing so, we draw attention to issues that contribute to the underutilisation of existing services while highlighting aspects of service provision that are associated with positive outcomes. Once again, the issue of identity emerges as a central theme throughout.

Disability among Indigenous Australians

The lack of accurate government statistical data on disability among Indigenous Australians has been identified as negatively impacting both the provision of culturally appropriate services and the accessibility of these services (Productivity Commission, 2011). However, even the conservative figure of three times that of the general population (ABS 2014a; AIHW, 2009) is enough to alert us to the severity of the problem. Attempts to break

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down this number by type of disability have also been piecemeal, and show huge variation. For example, AIHW (2011) reported that physical disability was the most common type of disability (82 percent) for Indigenous Australians (aged between 15 and 64 years); however, this must be considered alongside two important issues. First, Indigenous Australians are affected by high rates of non-response (e.g., AIHW, 2008) and second, many find the concept of disability either inappropriate or irrelevant (e.g., AIHW, 2011; O'Neill, Kirov & Thomson, 2004). While this will be discussed in greater detail in the following section, it remains the case that these factors have contributed to the huge underestimation of the number of Indigenous people with disability (Hollinsworth, 2013).

On measures of subjective wellbeing (e.g., frequency of feeling happy/sad) in the Household Income and Labour Dynamics in Australia (HILDA) survey, Indigenous Australians reported fewer occasions of happiness and more occasions of intense sadness than did non-Indigenous Australians (AIHW, 2014a). This reported experience sits in contrast to reported life satisfaction. Using the very same HILDA data, Indigenous people reported significantly higher levels of life-satisfaction than did non-Indigenous Australians (Shields, Wheatley Price & Wooden, 2009). Moreover, and again resulting from the same data set, improvements in self-assessed health led to a rise in happiness for Indigenous and non-Indigenous Australians, but to a decrease in sadness for non-Indigenous Australians only (AIHW, 2014a). These complex relationships between various measures of health and wellbeing serve to highlight the different life experiences of Indigenous and non-Indigenous Australians, providing clues to the difficulties incurred in disability service provision both for and by Indigenous Australians.

Disability services for Aboriginal and Torres Strait Islander peoples

Despite the much recognised need for 'culturally appropriate' services for Aboriginal and Torres Strait Islander people with disability (*see later in this section*), the vast majority of disability service provision takes place in non-specialist systems. Indeed the enormous variation between services across the states (Rosen, 2006) may be greater than between

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services for different stakeholder or client groups. Not surprisingly then, Indigenous Australians access these services at a lower rate than do non-Indigenous people, and report greater difficulties in accessing these services (AIHW, 2011). Moreover, when Aboriginal and Torres Strait Islander people do access these services, it is not uncommon for them to face additional barriers and discrimination from the service providers (Bostock, 2007).

The lack of information available on existing culturally appropriate service provision sits in stark contrast to the abundance of literature detailing what is needed to make services both appropriate and accessible. Central to these recommendations is having Indigenous-specific (disability) support services (Griffis, 2013) with Aboriginal people occupying key positions and involved in key decision-making processes (Disability Services Commission, DSC, 2006; Dudgeon et al., 2014). Aboriginal and Torres Strait Islander people have the right to self-determination (United Nations, 2007) – a view that is inextricably linked to issues of human rights (Hunt, 2013; Tarantola, 2007).

Successful service delivery for Indigenous Australians with disability can also be achieved in the context of partnerships (Isaacs, Pyett, Oakley-Browne, Gruis, & Waples-Crowe, 2010). However, partners and partner organisations need to acknowledge and embrace the cultural diversity of Aboriginal cultures, the depths of Aboriginal knowledges, the strengths of Aboriginal people, and the impact of sustained and systemic racism that has impacted the lives of Aboriginal people for over 200 years. Non-indigenous partners must not only work to achieve cultural competence and create culturally safe places, they need to appreciate – and critically reflect on – the role that white privilege has played in maintaining these systems (Dean, 2001; Hollinsworth, 2013). The diversity of these requirements points to the all-encompassing – or holistic – approach that is recommended in this regard.

Holistic views of health, wellbeing and care

An overriding theme in disability care for Aboriginal and Torres Strait Islander people is the need to adopt a holistic approach – not only to health and healthcare, but to all

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aspects of a person's life. This includes not only physical and emotional health, but other aspects that interact with health and wellbeing. Examples include (i) the substandard housing levels experienced by many Indigenous Australians; (ii) a lack of transport – even to attend basic facilities; (iii) levels of education; (iv) participation in employment; (v) access to legal services; and (vi) the disproportionate incarceration levels of Aboriginal people. It must also include social and cultural factors such as relationships within and between Aboriginal people and groups. Central, too, is the connection to land and country, and the knowledge associated with cultural histories and traditions. Every one of these factors impacts both independently and interdependently to produce the myriad of experiences facing Indigenous Australians. Each one of these can – and many have been – addressed separately, but a more culturally appropriate understanding takes account of all (Calma, 2007; Rosen, 1994).

Adopting a truly holistic approach to health and wellbeing also entails recognition of the impact of the socio-cultural context of Indigenous people. In Australia, this context involves a history of dispossession and dehumanisation (Hollinsworth, 2013). While a full historical account of post-colonial Australia is outside the scope of this report, there are critical aspects that continue to impact on the lives of Aboriginal and Torres Strait Islander people today.

A history of colonisation

British colonisation led to a rapid decline in Aboriginal people's physical health through the introduction of a host of hitherto unknown diseases (Briscoe, 2003; Kunitz, 1994), and via starvation as a result of being dispossessed of their lands (Attwood, 2014). Indigenous Australians were soon removed to reserves and missions, or became victims of deliberate genocide (Harris, 2003; Moses, 2000). Under the guise of 'protectionism', Aboriginal people were placed under state jurisdictions – policies that continued well into the 20th century (Human Rights and Equal Opportunity Commission [HREOC], 1997) with Aboriginal people not fully recognised in the Australian Constitution until 1967 (Attwood & Markus, 2007). At all stages of this history, Aboriginal people were treated as physically and

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mentally inferior to whites (Ford, 2013; Johnston, 1937). Practice and government policies worked in tandem to demean and disempower. In the pursuit of 'science', Indigenous Australians were subjected to appalling experimental regimes (Anderson, 2003). At best, they were treated as objects of curiosity (Hunter, 1997); at worst, with unbridled contempt (Rowley, 1970).

Far from being relics of long-ago history, such practices have continued throughout recent times. Children were forcibly removed and Indigenous families were torn apart as a result of the Stolen Generations which endured until the 1970s (HREOC, 1997). Aboriginal people were exposed to nuclear contamination as a result of British tests in South Australia in the 1950s (Lester, 2000). Even today, Indigenous people suffer from preventable illness and injury at a much greater rate than the non-Indigenous population (AIHW, 2008). An holistic view of Aboriginal and Torres Strait Islander lives includes over 200 years of mistreatment and disrespect.

Racism

High levels of discrimination and racism continue to be experienced by Indigenous Australians (de Plevitz, 2006, 2007). Indeed its enduring and widespread impact means it can be considered a collective stressor for all Indigenous people (Calma, 2007). As with the Stolen Generations, it is not necessary to have been personally removed to experience the ramifications. However, given the high numbers of Indigenous people who were removed during the Stolen Generations, there remain a high number of Indigenous people whose families were and are directly affected. Similarly, there are few Aboriginal and Torres Strait Islander people even today who have not been the direct target of racism (e.g., Ferdinand, Paradies & Kelaher, 2013). Indeed experiencing racism – particularly chronic exposure – leads to poorer physical (Larson, Gillies, Howard & Coffin, 2007; Paradies, Harris & Anderson, 2008) and mental health (Paradies & Cunningham, 2009).

Indigenous and disabled

Adding to the numerous reasons preventing Indigenous people from recognising a disability is that it adds to the layers of disadvantage already faced. Being an Aboriginal person with disability has been described as a 'double disadvantage' (Griffis, quoting Rankine¹ in the Koori Mail, 2015). Hence, Aboriginal and Torres Strait Islander people with a disability experience multiple disadvantage and often multiple layers of racism as a result of their Aboriginality and their disability (Bostock, 2007). This impacts both the time and energy required for the person to devote to these issues, and the degree to which s/he wishes to be exposed to the consequences.

The legacy of Australia's post-colonial history means that Indigenous Australians are disadvantaged across a broad range of areas, when compared to their non-Indigenous counterparts. These include, but are not limited to, education (e.g., Australian Curriculum Assessment and Reporting Authority [ACARA], 2014), employment (e.g., ABS, 2012), income (e.g., Steering Committee for the Review of Government Service Provision [SCRGSP], 2014), housing (e.g., AIHW, 2014b), and incarceration (e.g., ABS, 2014b), along with the wide range of health concerns including significantly shorter life expectancies (ABS, 2013). This means that, at any point in time, Indigenous people face a raft of competing priorities from which they can choose to be involved. Given the number and magnitude of these issues, it is not surprising that some find this overwhelming.

The extent of these issues also highlights the complexity of being an Indigenous Australian. When combined with the all-encompassing approach to Indigenous health and wellbeing (discussed previously), we can begin to appreciate the difficulties inherent in (i) separating specific health issues, and (ii) facing their (multiple) consequences. With regard to being an Indigenous person with a disability, therefore, we can see the difficulties with (i) addressing both Indigeneity and disability, and (ii) meeting the summative and cumulative

¹ Aunty Gayle Rankine, Chairperson of First Peoples' Disability Network.

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challenges of each. Most frequently, people report being Indigenous first and disabled second (e.g., DSC, 2006).

Given the importance of Aboriginal and Torres Strait Islander identity (Dodson, 1994; Paradies, 2006; Wood & Weinman, 2014), this is not surprising. Not only is there huge depth and variation among Indigenous cultures (Garvey, 2008), the consequences of being Indigenous – for example, racism and discrimination – are widely experienced and deeply felt (Calma, 2007; Williams, Neighbors, & Jackson, 2003).

Identifying as an Indigenous person with a disability, therefore, entails the possibility of being perceived as, and experiencing the consequences of, double disadvantage. Hence choosing to disclose becomes problematic. The authors' own experiences indicate that Aboriginal and Torres Strait Islander students often do not wish to disclose their disability and will frequently not seek the assistance and support that is their right. In discussing this report, one Aboriginal student with disability stated that she felt "Indigenous first and a person with disability second". Moreover, she advised that she felt that many Aboriginal and Torres Strait Islander peoples "don't want yet another label" (that of being "disabled").

Culturally appropriate services and culturally safe spaces

Critical to the provision of services for Indigenous people with disability is that these services are culturally respectful and appropriate. Such a claim is easily – and often – stated. It is also so fundamental that, despite appearing in countless papers and reports, it is clear that these goals are not being achieved. We suggest that this is at least partly the result of a lack of understanding of what is meant by cultural safety and what a culturally appropriate service would look like.

The concept of cultural safety originated in the nursing context in New Zealand as health professionals recognised their inability to appropriately address Maori health issues and to communicate effectively with their patients (Papps, 2013; Ramsden, 1990). It began with a recognition that dominant (white cultural) beliefs underpinning medical practice were

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at odds with many Maori concepts of illness and health (Molloy & Grootjans, 2014; Smye & Browne, 2002). Importantly, cultural safety is not about *learning* cultural practices; it is about *understanding* the broad ways in which culture and cultural practices impact on relationships between people. It involves an understanding of one's own culture, and how culture is inextricably linked to social, economic and political positions of different societal groups (Smye & Browne, 2002) and the power relationships between them (Papps & Ramsden, 1996).

Thus cultural safety incorporates all aspects of cultural awareness, cultural sensitivity, cultural knowledge, cultural respect and cultural responsiveness. Critically, cultural safety can only be determined by the person receiving care (or the particular service) (Ramsden, 1995, cited in Papps & Ramsden, 1996). For this reason, we have differentiated cultural safety from 'cultural competence'. Cultural competence, in its very terminology, suggests agency on the part of the carer (or service provider). While recognising the many researchers and practitioners who understand and promote cultural competence in ways that can be described as culturally safe (e.g., Garvey, 2008; Purdie, Dudgeon & Walker, 2010; Ranzijn, McConnochie, Day, Nolan & Wharton, 2008; Walker & Sonn, 2010), there are numerous instances of cultural competence (with reference to multiple cultures) as something that can be learned, achieved, and worn as one would a badge. It is our intention, therefore, to avoid such implications by using alternative terms. 'Cultural safety' is a term understood by all cultural groups (Bin-Sallik, 2003), and it opens an opportunity for the voices of minority groups (Polaschek, 1998).

Adopting the framework of cultural safety allows us to envision what a culturally appropriate service would entail. As previously stated, many of these elements have been outlined in numerous reports and recommendations (e.g., Calma, 2008; Dudgeon et al., 2014; Griffis, 2015; Swan & Raphael, 1995). At the risk of oversimplifying or omitting key aspects, we propose that the many elements can be encapsulated by the following:

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1. Recognition of the history of Aboriginal and Torres Strait Islander people *in relation to* British and European colonisation. This includes recognition of the ongoing effects of dispossession, deprivation and discrimination.
2. Recognition of the rights of Aboriginal and Torres Strait Islander people – as First Nation inhabitants – to self-determination and control.
3. Recognition of the diversity and complexity of Indigenous cultures and their centrality to Indigenous identity.
4. Recognition of the multiple strengths of Indigenous cultures and Indigenous knowledges and that harnessing (and honouring) these strengths provides the key to positive futures.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH AND WELLBEING

In the previous section, we highlighted the mismatch that often exists between disability service provision for, and the needs of, Aboriginal and Torres Strait Islander people. At the heart of this is an appreciation of Indigenous views of mental health and social and emotional wellbeing. In this section we discuss how the different models of health and wellbeing not only inform different models of service delivery, but how those very beliefs can, themselves, impact health and wellbeing. We begin by examining Indigenous perspectives on health and wellbeing before returning to the central issues of identity and place. These factors, in particular, highlight the strengths of Aboriginal and Torres Strait Islander cultures, and we conclude this section by emphasising a strengths-based approach to health and wellbeing.

Understanding health and wellbeing

Western medical approaches have traditionally focused on illness and disease in an attempt to further scientific understanding (Engel, 1977; Fabrega & van Egeren, 1976). Throughout the twentieth century, however, the medical and paramedical professions increasingly shifted their focus to illness and disease *prevention*. This coincided with an

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increased recognition that a comprehensive understanding of illness and health involves incorporating the positive features of what constitutes good health. Ironically, this more widespread notion of health has always been part of Aboriginal and Torres Strait Islander understandings.

An Indigenous holistic concept of health is truly all-encompassing. This is epitomised by the many reports that Indigenous languages do not have words for health and illness as understood in Western terms (Boddington & Raisanen, 2009; Hollinsworth, 2013; O'Neill et al., 2004). Indigenous notions of health incorporate kinship (Ranzijn, McConnochie & Nolan, 2010), connection to land (Guerin, Guerin, Tedmanson & Clark, 2011), and perceptions of safety (Parker, 2010). This latter aspect serves as a reminder of the importance of cultural safety (discussed in the previous section) when working with Indigenous people.

For Indigenous people, the concept of health comprises physical, social, emotional, cultural and spiritual health. It involves a strong sense of identity; being Aboriginal involves knowing what family you belong to. This goes beyond connection and belonging as family and kinship systems indicate one's responsibilities to others (Ranzijn et al., 2010). That these vary according to language and skin groups reflects the diversity of Aboriginal and Torres Strait Islander cultures. Yet for all, the concepts of health and wellbeing are wide-reaching. Although the concept of wellbeing has been described as subjective, this is in fact one of its strengths (Biddle, 2011). A person knows when s/he is well.

Understanding the current poor health status of Indigenous – compared to non-Indigenous – Australians can thus be directly related to the history of dispossession and dehumanisation that has endured since colonisation (Hollinsworth, 2013; Roxbee & Wallace, 2003). While these factors would be related to poorer health outcomes for any group of people, they are particularly significant for Indigenous people, for whom connection to land and to family is fundamental.

Understanding mental health

Making a distinction between physical health and mental health reveals a non-Indigenous view. As stated above, Indigenous views of health are holistic and all-encompassing (Dudgeon et al., 2014; Swan & Raphael, 1995). This poses problems for Indigenous people whose symptoms and behaviours are consistent with contemporary (i.e., white) notions of mental health, particularly in their dealings with the medical system.

Efforts to treat mental health concerns largely occur within a Western framework. Australia's health system is based on the dominant (white cultural) view of illness and health. When a person presents with, or seeks help for, a mental health issue, s/he is generally classified according to the most fitting Diagnostic and Statistical Manual of Mental Disorders (DSM-5) category (American Psychiatric Association, 2013). This classification is then used to inform the 'most appropriate treatment' – a treatment that, almost without exception, will be focused on 'treating' the individual sufferer. Despite some recognition that culture plays a role in the psychotherapy process – even in terms of the DSM-5 (Lewis-Fernandez, Aggarwal, Hinton, Hinton & Kirmayer, 2016; Pomerantz, 2014) – these attempts usually rely on overly simplistic notions of individualistic and collectivistic cultures. Indeed the very tenor of this discourse is, itself, rooted in individualistic beliefs. The idea that mental health can be inextricably linked to, for example, connection to country is anathema to these Westernised (and American-dominated) views in which the individual reigns supreme.

This underscores the incongruity between the different views of health and healthcare. A qualitative study by Vicary and Bishop (2005) in Western Australia demonstrated vast differences between traditional (Aboriginal) and Western approaches to mental illness. Incorporating traditional (cultural) understanding, 'treatment' of mental illness included the involvement of other people, and often a time spent 'on country'. The notion that the person would be 'treated' in isolation and asked to 'self-explore' was frustrating (p. 13). Not surprisingly, Western models of psychology have been shown to be inappropriate and

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ineffective in Indigenous contexts (McConnochie, Ranzijn, Hodgson, Nolan & Samson, 2011).

These examples also illustrate how the concept of cultural safety developed within a medical environment. What is less clear, however, is how and why these models of culturally appropriate healthcare delivery are not yet standard practice. This is not to say that one system should be abolished in favour of the other. It is possible to combine Western scientific practices with traditional Indigenous healing practices in ways that both are complemented (Nagel, Hinton & Griffin, 2012; Rosen, 2006).

As stated in the previous section, what is important is *understanding* how culture and cultural practices impact the relations and dealings of different groups. Given the prevailing dominance of Western healthcare practices, it becomes incumbent upon non-Indigenous people to consider the impact of their own beliefs and approaches. This necessarily includes an acknowledgement of the unearned benefits of white privilege (Dean; 2001; Riggs & Augoustinos, 2005; Young & Zubrzycki, 2011) and its ongoing impact. It involves being open to the idea that other worldviews and understandings may be both valid and valuable.

Indigenous strengths and strengths-based views

Many authors refer to the 'spirit-breaking' of Aboriginal people as a result of colonisation (e.g., Cleworth, Smith & Sealey, 2006; Rosen, 2006). Despite its negativity, this term captures the essence of strength that Indigenous people and Indigenous cultures possess. Despite, and in spite of, both individual and collective hardships, Indigenous Australians continue to display extraordinary resilience. This resilience, and the strengths of Aboriginal and Torres Strait Islander people come from those same factors that define Indigenous health and wellbeing, i.e., physical, social, emotional and spiritual health, and a sense of identity that incorporates connection to culture, family and country.

Indigenous Australian cultures involve over 60,000 years of complex practices and traditions. These practices have changed over time as cultures grow and adapt; the process

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of culture is dynamic (Kashima, 2000). Strengths derive, however, from a connection to one's culture (Brough, Bond & Hunt, 2004) and a sense of identity (with that culture). The post-colonial experiences of Aboriginal people, while targeted at their very elimination (Harris, 2003; Moses, 2000), has occurred over a short period of time when compared to the length of time that Aboriginal cultures have endured.

In extensive work with Canadian First Peoples, Chandler and colleagues (Chandler, 2000; Chandler, Lalonde, Sokol & Hallett, 2003; Chandler & Proulx, 2006; Hallett et al., 2008) demonstrate how a narrative sense of self – one that emphasises *continuity* of culture and self (as part of that culture) has the potential to overcome temporary (even 200+ years) setbacks. A sense of self that incorporates past, present and future encourages participation, commitment and further continuity. Their work has even shown how suicide rates are lower in communities that have (re)asserted their own sense of cultural continuity (e.g., Chandler & Proulx, 2006).

It is precisely through this connection to culture – a culture that persists throughout time – that Aboriginal and Torres Strait Islander people have retained a sense of identity and have demonstrated extraordinary resilience. It is these strengths that are being harnessed by educators (e.g., Stronger Smarter Institute; Sarra, 2013; Stronger Smarter Institute Limited, 2014). And it is these very strengths that point the way to positive futures for Indigenous Australians.

SUPPORTING ABORIGINAL AND TORRES STRAIT ISLANDER STUDENTS IN HIGHER EDUCATION

In this final section of the literature review, we examine the range of supports available to assist Aboriginal and Torres Strait Islander students with their higher education studies. We begin by investigating suggested reasons for the ongoing discrepancies in education participation rates. These appear very early in students' lives and continue to widen as education progresses. In the higher education environment, we focus on

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Indigenous-specific supports and see that the delivery of most of these occurs from and within the Indigenous Education Units (IEUs). This leads us to further examination of the notion of cultural safety and the role of deficit discourse in education disparities. As with the previous section, however, we refuse to accept this 'normative' discourse and present alternative models of support in higher education that focus on the strengths of Indigenous people and cultures. Ideal supports include whole of university responsibilities and undertakings.

Participation in higher education

Aboriginal and Torres Strait Islander people are underrepresented at all levels of higher education (Barney, 2013; Centre for the Study of Higher Education [CSHE], 2008; Pechenkina, Kowal & Paradies, 2011). Non-indigenous people are more than four times likely to have a bachelor degree or higher than Indigenous Australians (ABS, 2008), and Aboriginal and Torres Strait Islander retention and completion rates are well below those of non-Indigenous students (CSHE, 2008). For example, retention rates for Aboriginal and Torres Strait Islander students over the period from 2008 to 2013 have consistently remained at between 9.5 to 12.5 percentage points below the rates for non-Indigenous students (Australian Government Department of Education and Training, 2015). A number of reasons for these discrepancies have been suggested.

As early as the preschool years, fewer Indigenous children attend early childhood educational settings compared to non-Indigenous children (ABS, 2008). This may be, at least in part, a result of the early childhood services not being seen as appropriate for and/or welcoming of Indigenous families (Sims, Saggars & Frances, 2012). However, the impact of not attending school (or attending infrequently) can establish a norm for this behaviour well before formal schooling commences (Taylor, 2010).

As children progress to the primary school years, much academic emphasis has been placed on achievement as measured by the National Australian Program in Literacy

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and Numeracy (NAPLAN) since its introduction in 2008. Results from this have consistently demonstrated discrepancies in the performance of Indigenous and non-Indigenous children (Ford, 2013). In addition to receiving criticism for their lack of cultural adaptiveness (Klenowski, 2009; Wigglesworth, Simpson & Loakes, 2011), the use of these tests completely disregards other sources of long-standing inequality and entrenched disadvantage.

By high school, the differences in academic performance persist while discrepancies in school attendance rates (between Indigenous and non-Indigenous children) steadily increase (SCRGSP, 2014). Not surprisingly then, Aboriginal teenagers' engagement with school and self-concept across a variety of domains is lower than their non-Indigenous peers (Yeung, Craven & Ali, 2013). Combined with the racism experienced by many (Ngarritjan Kessar, 2006; Paradies & Cunningham, 2009), it is not surprising that Indigenous Year 12 completion rates are almost half that of non-Indigenous students (SCRCSP, 2014).

Essentially, there often exists a mismatch between the school environment and Aboriginal and Torres Strait Islander cultures and values (Malin, 1990; Osborne & Guenther, 2013). Both academic content and the 'hidden curriculum' in schools (Rahman, 2013) are based on, and emphasise, white culturally dominant beliefs and values. This is evident from the pre-school years, and can contribute to a decreased sense of belonging and increased disengagement as Indigenous students progress through school. This may also help explain why Indigenous students who do enrol at university often doing so at a later age, and often after some form of introductory or enabling course (Behrendt, Larkin, Griew & Kelly, 2012).

Indigenous education units

Almost all Australian universities now have dedicated Indigenous Education Units (IEUs) providing a range of educational and pastoral support to Aboriginal and Torres Strait Islander students. Registration with these units is voluntary and students are free to make use of the unit as little or as much as they choose. These units have generally had

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responsibility for the coordination of Commonwealth funded tutoring support, along with a range of other formal and informal academic and general student supports. Some of these units also have responsibility for Indigenous education programs and for coordinating Indigenous research activities at their university.

A key role of IEUs, however, is to provide a 'safe space' for Aboriginal and Torres Strait Islander students (Helme, 2007; Sharrock & Lockyer, 2008). Universities are not perceived as 'black spaces' (Barney, 2013). This is partly due to the low numbers of Indigenous students in higher education, but also due to the ways in which academic knowledge and academic language is presented (McKay & Devlin, 2014; O'Brien, 2008).

Historically, and throughout the world, academia has been the preserve of the elite and the middle and upper classes. Academic discourse has therefore developed in a way that reflects its own history and values. As a result, it has served to exclude a wide range of groups from 'non-traditional' academic areas (Devlin, 2013; Gale & Tranter, 2011). These include students from low-socioeconomic backgrounds, from non-English speaking backgrounds, from rural and remote areas, and those who are Aboriginal or Torres Strait Islander. Indeed Indigenous Australians have experienced a history of exclusion from education since the beginning of colonisation (Australian Human Rights Commission, 2001; Burrige & Chodkiewicz, 2012) under a system designed to maintain social inequalities (McConaghy, 2000). Sadly, the experience with education mirrors other histories of Aboriginal Australians.

This long history of exclusion has, not surprisingly, led to feelings of uncertainty with regard to higher education. IEUs thus play a critical role in the retention of students in higher education (Helme, 2007; Howlett, Seini, Matthews, Dillon & Hauser, 2008; Sharrock & Lockyer, 2008). These units, or centres, are seen as a place of acceptance and safety (Nakata, Nakata & Chin, 2008), where students can receive advice and assistance, work on

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assignments and projects, or simply meet other students away from the larger university space.

Safe spaces, safe places

The very fact that IEUs are widely known as places of safety is, however, a sad indictment on how the rest of the university is perceived by Indigenous students. As we have seen with regard to health and disability support, the enduring racism and discrimination experienced by Aboriginal people is also evident within educational settings (Bodkin-Andrews, Denson & Bansel, 2012; Howard, 2002). Consequently, the need for cultural safety within educational contexts is just as great as within healthcare settings.

As previously emphasised, cultural safety involves recognition of power relationships between groups (Papps & Ramsden, 1996) and, critically, an understanding of cultures and the extent of their impact on people. This emphasis on *understanding* the impact of cultures – in contrast to learning about cultures as fixed in time – means that cultural safety is, itself, an educational process (Ramsden & Spoonley, 1994). There could be no better place in which to foster this notion than an educational setting itself.

Creating a culturally safe university, however, extends far beyond Indigenous education units. It involves the creation of a whole university in which Aboriginal and Torres Strait Islander people and cultures are respected and valued. It means that responsibility for this is shared throughout the university. As recommended by the Behrendt Review (Behrendt et al., 2012), the support of Aboriginal and Torres Strait Islander students should be the responsibility of all faculties and mainstream support services. Indigenous education should be core business (Andersen, Bunda & Walter, 2008). This includes the provision of not only culturally safe spaces (e.g., IEUs) but culturally safe places (the whole of university).

Deficit discourse in education

Both explicit and implicit exclusionary practices in education have contributed to lower participation (and performance) by Aboriginal and Torres Strait Islander people.

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Devaluing Indigenous knowledges and practices has allowed the propagation and continuation of a deficit discourse in education. Indigenous education becomes a 'problem that needs fixing' (Vass, 2013, p. 85), and Indigenous people are seen as the source of that problem (Gorringer, 2011). The ongoing disparity between Indigenous and non-Indigenous educational achievement (discussed above) is used in support of this argument (Harrison, 2007; Gray & Beresford, 2008).

This is not dissimilar to the separation, exclusion and devaluing of people with disabilities (discussed previously). In the same way that the non-disabled population has excluded and silenced disabled people, so too the non-Indigenous population has excluded and silenced Indigenous people.

Redefining deficits

Acknowledging that educational differences can result from broad social practices, and recognising the interplay between power and culture enables alternative ways of viewing education and educational practice. Already there are examples of how changes to educational practice through the inclusion of Indigenous epistemologies has led to dramatic improvements in students' performance and self-concept (e.g., Bat, Kilgariff & Doe, 2014; Bodkin-Andrews, Dillon & Craven, 2010; Edwards & Hewitson, 2008). Particularly relevant is that academic skills and achievement are not at the centre of these programs. Rather, a focus on cultural identity and cultural strengths has benefits across multiple domains (e.g., the Australian Indigenous Mentoring Experience [AIME]; Harwood, McMahon, O'Shea, Bodkin-Andrews & Priestly, 2015). Indeed, a focus on strengths – rather than deficits – underpins the Stronger Smarter approach that has demonstrated enormous benefits for Indigenous students in primary schools (Sarra, 2013). These same principles have been at the centre of Indigenous success in high schools (Keddie, 2011; Yeung et al, 2013) and in tertiary settings (Edwards & Hewitson, 2008; Williams, 2011).

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Clearly then, the focus on supporting Aboriginal and Torres Strait Islander students to succeed at university involves much more than assistance with academic skills. By default, non-Indigenous students succeed in an educational system that is consistent with, and values, their worldview. Indigenous student success has also been linked to situations and environments that avow and value Indigenous knowledges.

Within the university setting, this happens most often within the context of Indigenous education units. But universities, as a whole, have responsibility for the education of *all* students. Consistent with Behrendt et al. (2012), this involves supporting, and releasing the capabilities of Indigenous students, at all levels of study, in all fields of study, and by all units, faculties and divisions within the universities. At the centre of this is acknowledgement of the educational histories of Indigenous people and the role of non-Indigenous people in perpetuating these inequities. Understanding the relationship between culture and power is an important step in this process, as is a focus on Indigenous strengths (as opposed to deficits). The success of Aboriginal and Torres Strait Islander students relies on a united approach.

SECTION 3: HIGHER EDUCATION STATISTICS 2001-2013

Context

In this section we aim to provide a comprehensive picture of the prevalence and representation of Aboriginal and Torres Strait Islander students with disability in Australian universities. We present these findings over the period 2001 to 2013, as changes throughout this time have implications for policy and practice within the sector.

Data were obtained from the Australian Government Department of Education and Training regarding the numbers of Aboriginal and Torres Strait Islander students with disability at each Australian university² from 2001 to 2013. We were specifically interested in the distribution of students according to enrolment status (i.e., full-time vs. part-time); level of degree being undertaken (i.e., undergraduate vs. postgraduate coursework vs higher degree by research); and the field of study being pursued.

Findings

We first present data on enrolments and completions of the student population as a whole, at all Australian universities from 2001 to 2013. These appear in Figures 1a (total enrolments) and 1b (total completions). These figures are used to compare the enrolments and completions of Aboriginal and Torres Strait Islander students, and students with disability. Given the huge disparity between these groups and total enrolments and completions, these data are presented in separate graphs utilising different scales.

² All Table A and Table B providers are included.

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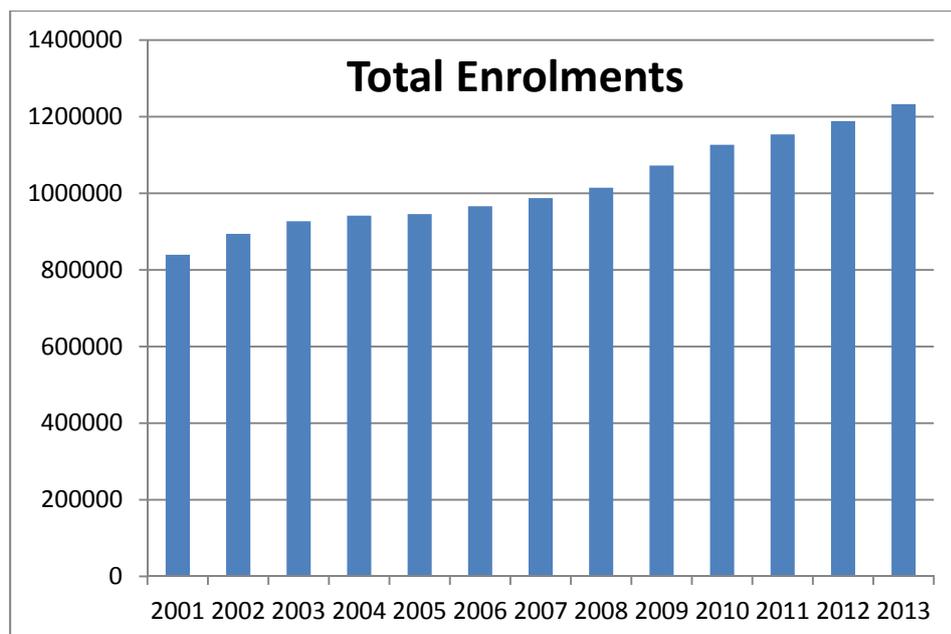


Figure 1a: Total student population across all Australian universities from 2001 to 2013: Enrolments.

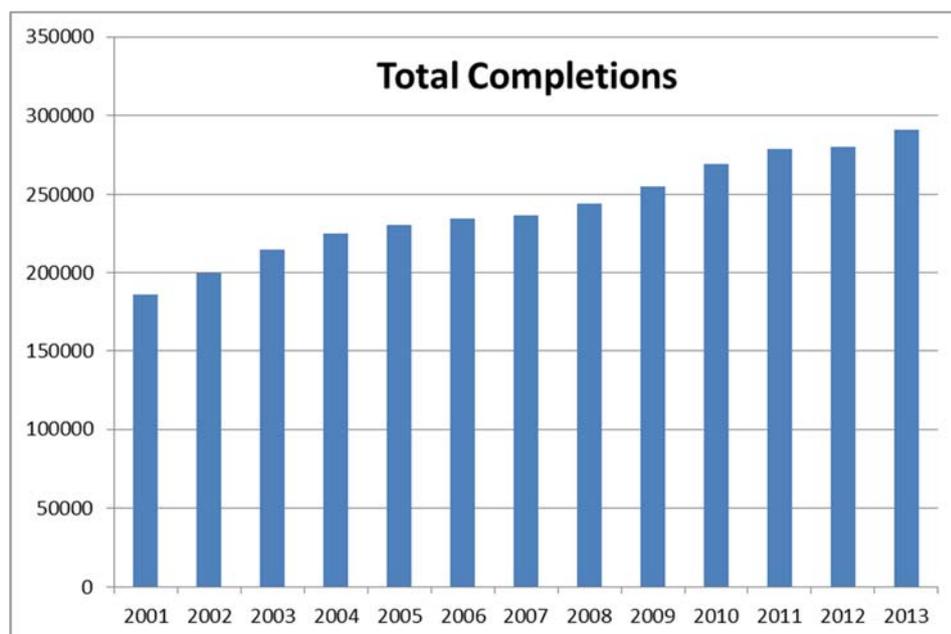


Figure 1b: Total student population across all Australian universities from 2001 to 2013: Completions.

Next we look at the numbers of Aboriginal and Torres Strait Islander students at all Australian universities from 2001 to 2013. Enrolments of Indigenous students have remained relatively stable from 0.93 percent of the student population as a whole in 2001, to 1.09 percent in 2013. This can be seen in Figure 2a.

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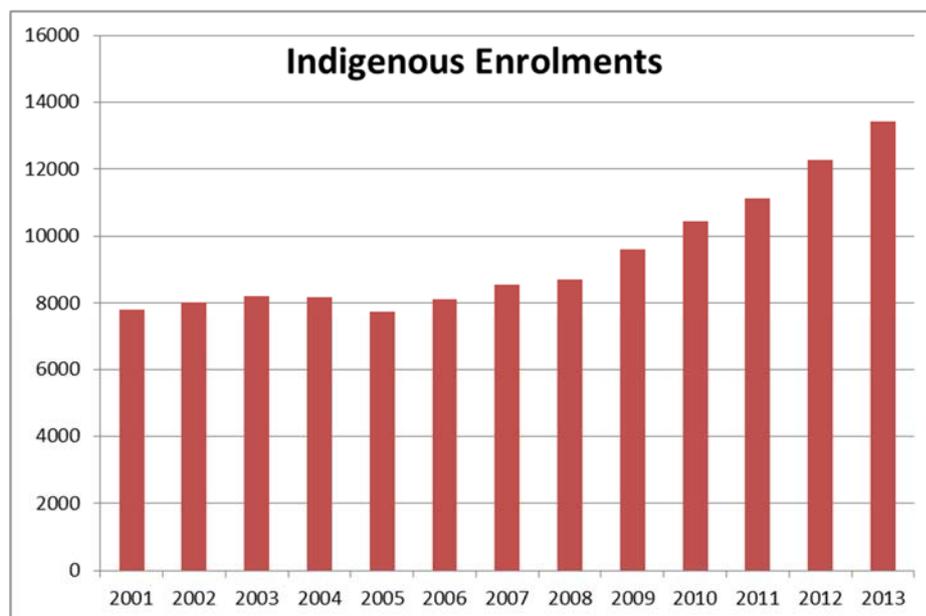


Figure 2a: Aboriginal and Torres Strait Islander student population across all Australian universities from 2001 to 2013: Enrolments.

Similarly (see Figure 2b), Indigenous university completions have remained relatively stable – relative to the university student population as a whole – from 2001 to 2013.

Aboriginal and Torres Strait Islander students completing degrees comprised 0.53 percent of the total student population in 2001 and 0.63 percent of the total student population in 2013.

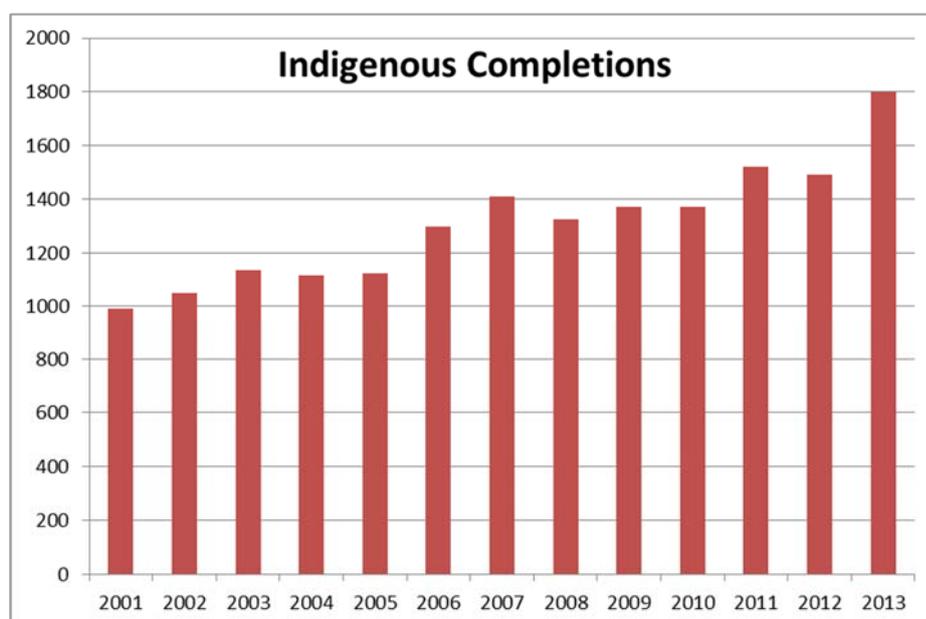


Figure 2b: Aboriginal and Torres Strait Islander student population across all Australian universities from 2001 to 2013: Completions.

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From 2001 to 2013, however, there has been an increase in both enrolments and completions of students with a disability. Enrolments of students with disability have risen substantially from 2.68 percent of total enrolments in 2001 to 4.18 percent of total enrolments in 2013 (see Figure 3a). During this time period, degree completions by students with a disability have increased, but only slightly, from 2.29 percent of all students completing degrees in 2001, to 3.24 percent of total completions in 2013 (shown in Figure 3b).

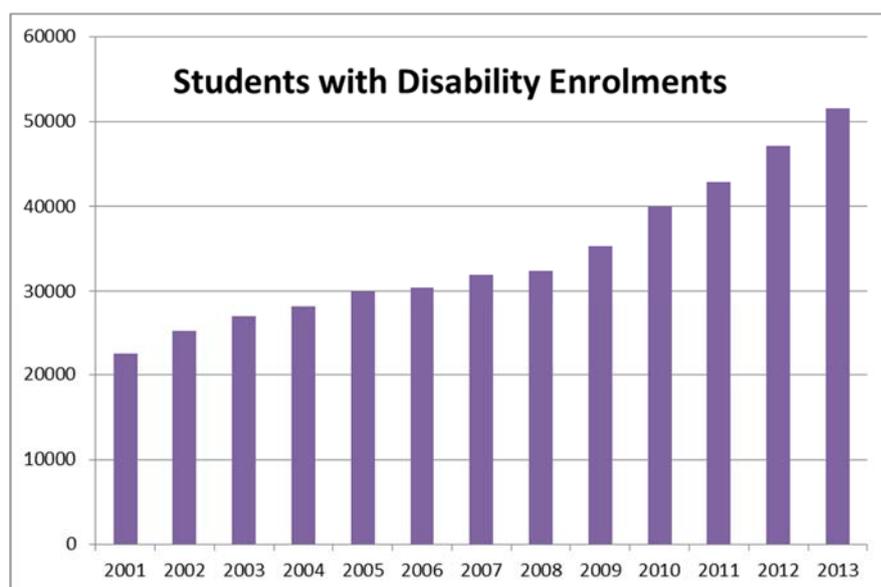


Figure 3a: Students with disability across all Australian universities from 2001 to 2013: Enrolments.

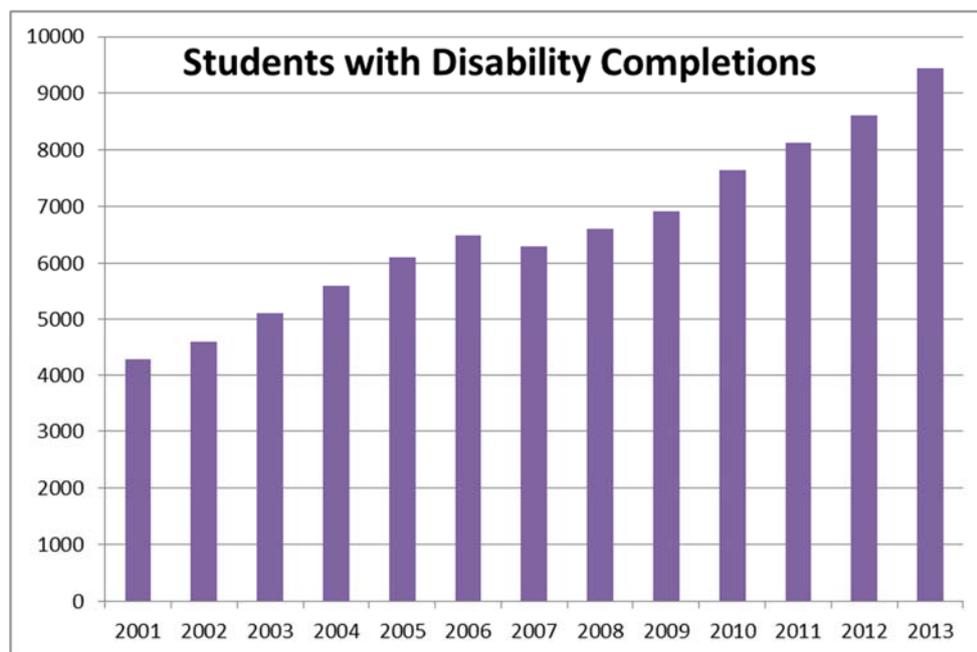


Figure 3b: Students with disability across all Australian universities from 2001 to 2013: Completions.

We also present data on degree enrolments and completions by Indigenous students with a disability. Percentages of these students are presented relative to the total student population, relative to all Indigenous students, and relative to all students with disability over this period of time.

Figures 4a and 4b provide a broad picture of how the proportion of these students – though still very small relative to the student population as a whole – is increasing, particularly regarding enrolments. Indigenous students with a disability represented only 0.06 percent of all student enrolments in 2001 but 0.10 percent of all students by 2013. Completion rates, however, remain lower; these were 0.03 percent of all completions in 2001 and 0.05 percent in 2013. Again, given the huge discrepancy between these figures, the tables utilise different scales in order to visually represent the data.

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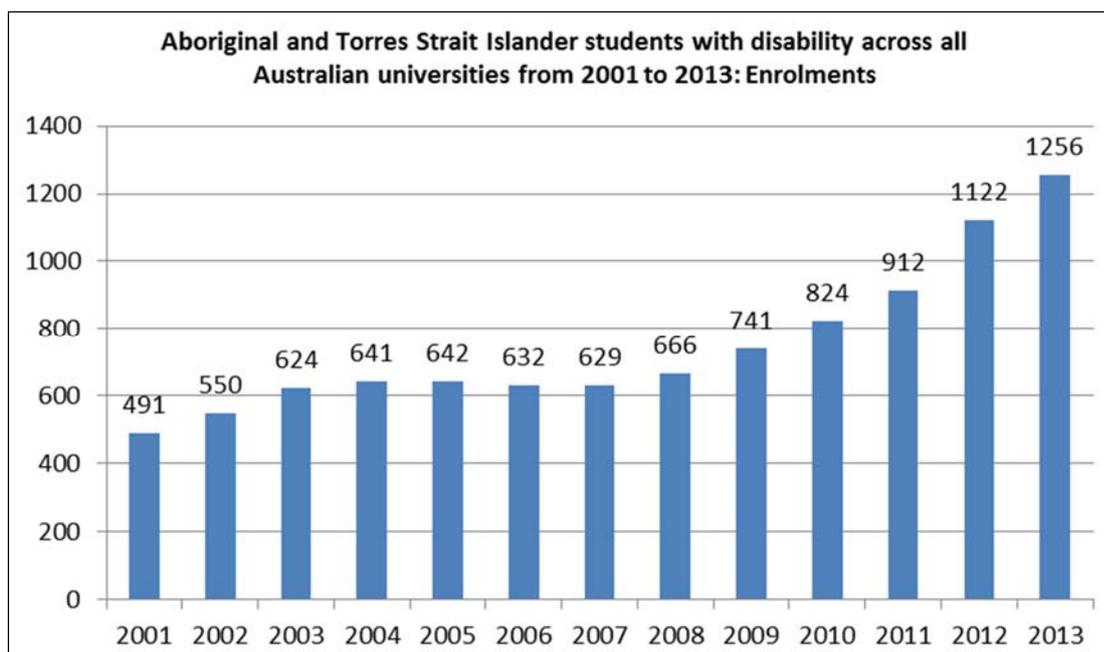


Figure 4a: Aboriginal and Torres Strait Islander students with disability across all Australian universities from 2001 to 2013: Enrolments.

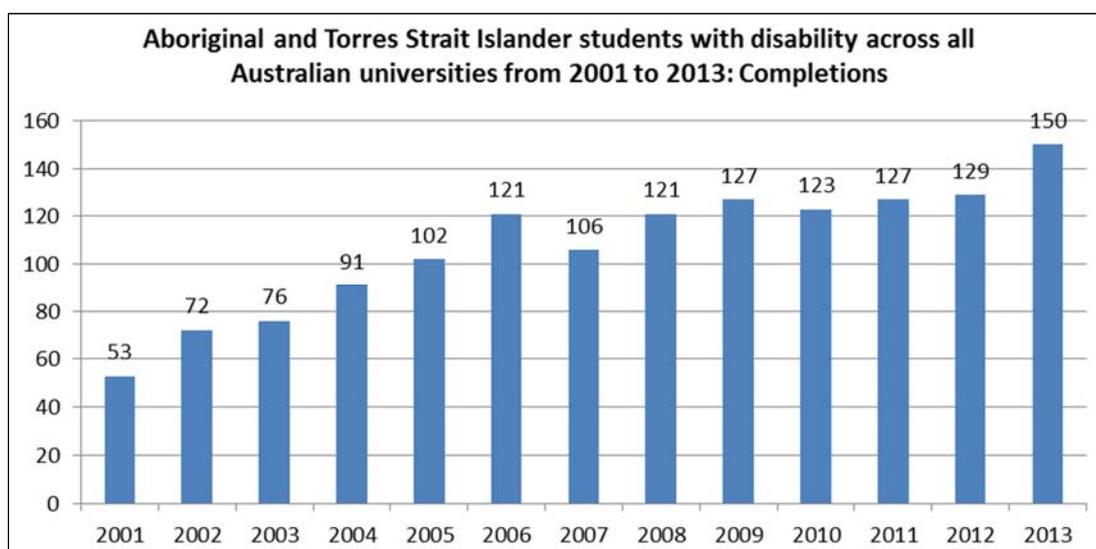


Figure 4b: Aboriginal and Torres Strait Islander students with disability across all Australian universities from 2001 to 2013: Completions.

Next, in Figures 5a (enrolments) and 5b (completions) we see the numbers of Aboriginal and Torres Strait Islander students with disability *compared to* Aboriginal and Torres Strait Islander students overall. In 2001, 6.29 percent of Indigenous students commencing university also had a disability; in 2013, this had risen to 9.36 percent.

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This increase followed through into university completions. In 2001, 5.35 percent of Indigenous students completing their degrees had a disability whereas in 2013 this figure was 8.33 percent.

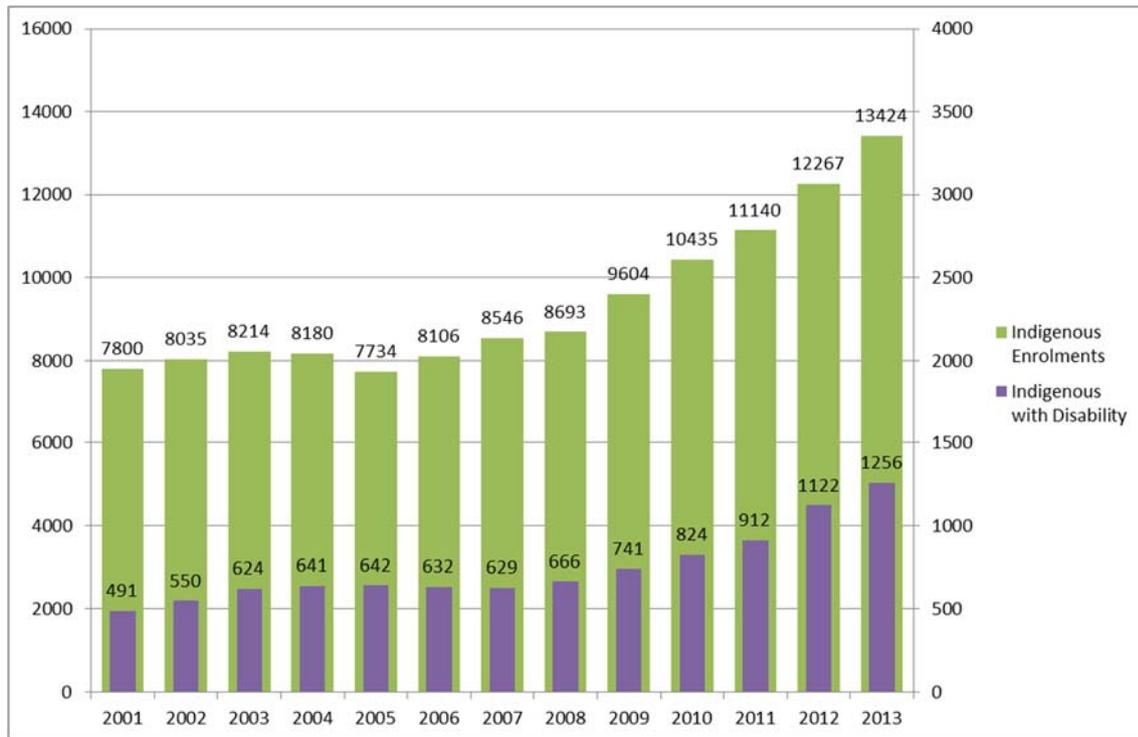


Figure 5a: Aboriginal and Torres Strait Islander students with disability and total Aboriginal and Torres Strait Islander student population across all Australian universities from 2001 to 2013: Enrolments.

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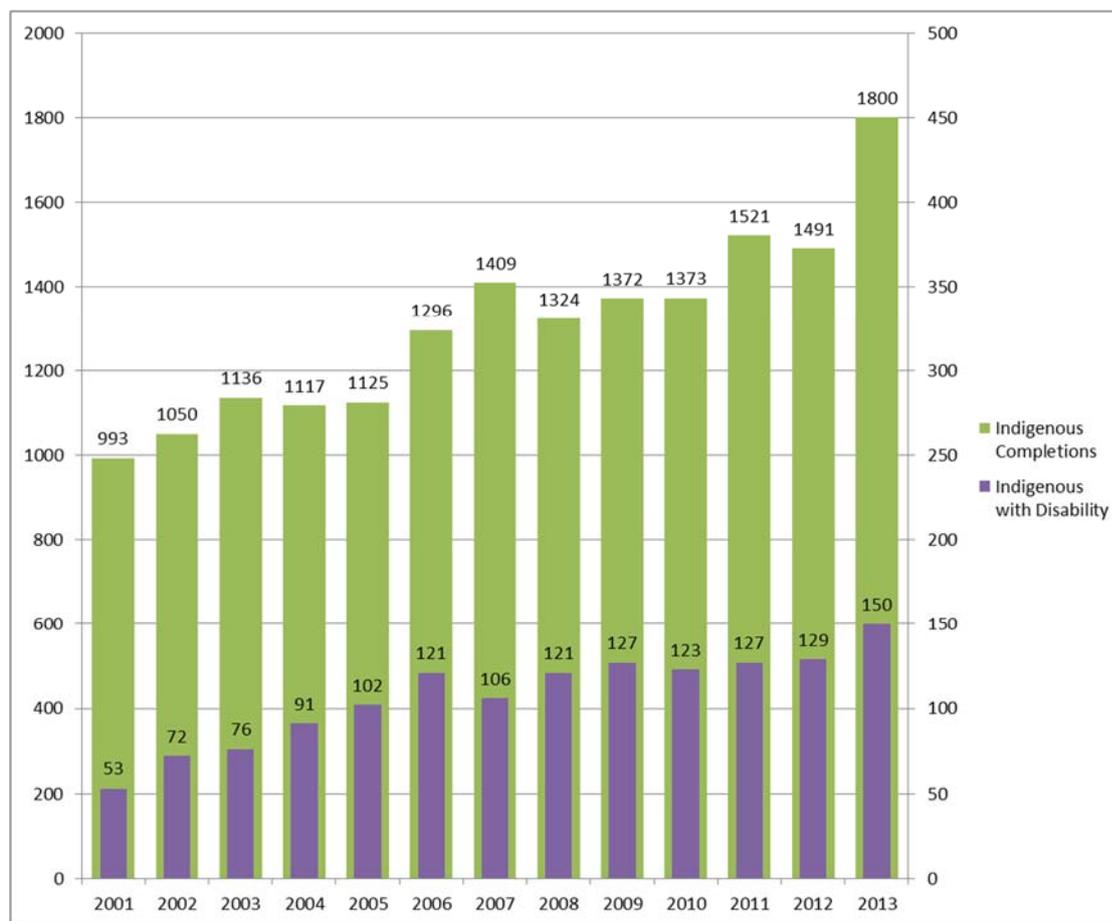


Figure 5b: Aboriginal and Torres Strait Islander students with disability and total Aboriginal and Torres Strait Islander student population across all Australian universities from 2001 to 2013: Completions.

To complete the picture, we examine enrolments and completions of Indigenous students with disability *relative to* all students with a disability in higher education. (See Figure 6a for enrolments and 6b for completions.) Despite the substantial increases overall in students with a disability at university, the proportions of Indigenous students with disability remain low. These were 2.18 percent of all students with a disability enrolled in a degree in 2001, and 2.44 percent in 2013. Completion rates remain lower with only 1.24 percent of all students with a disability being Indigenous in 2001 and 1.59 percent in 2013.

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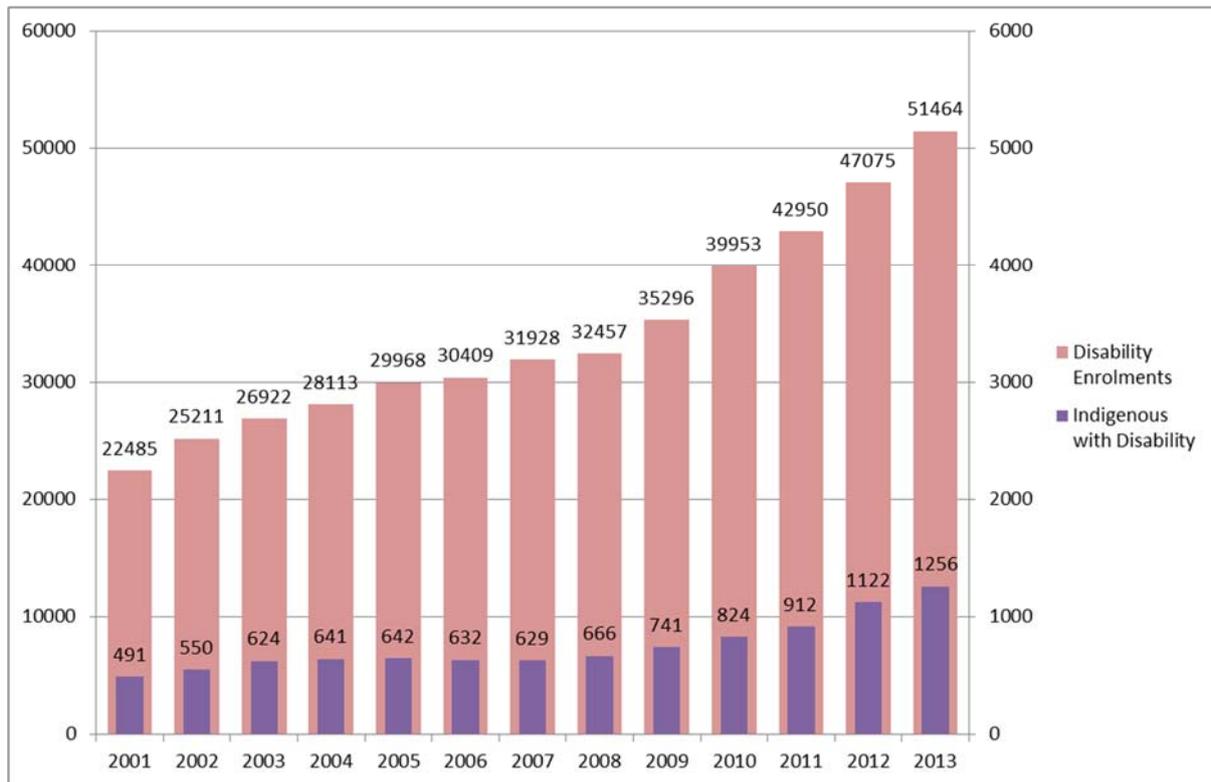


Figure 6a: Aboriginal and Torres Strait Islander students with disability and total students with disability across all Australian universities from 2001 to 2013: Enrolments.

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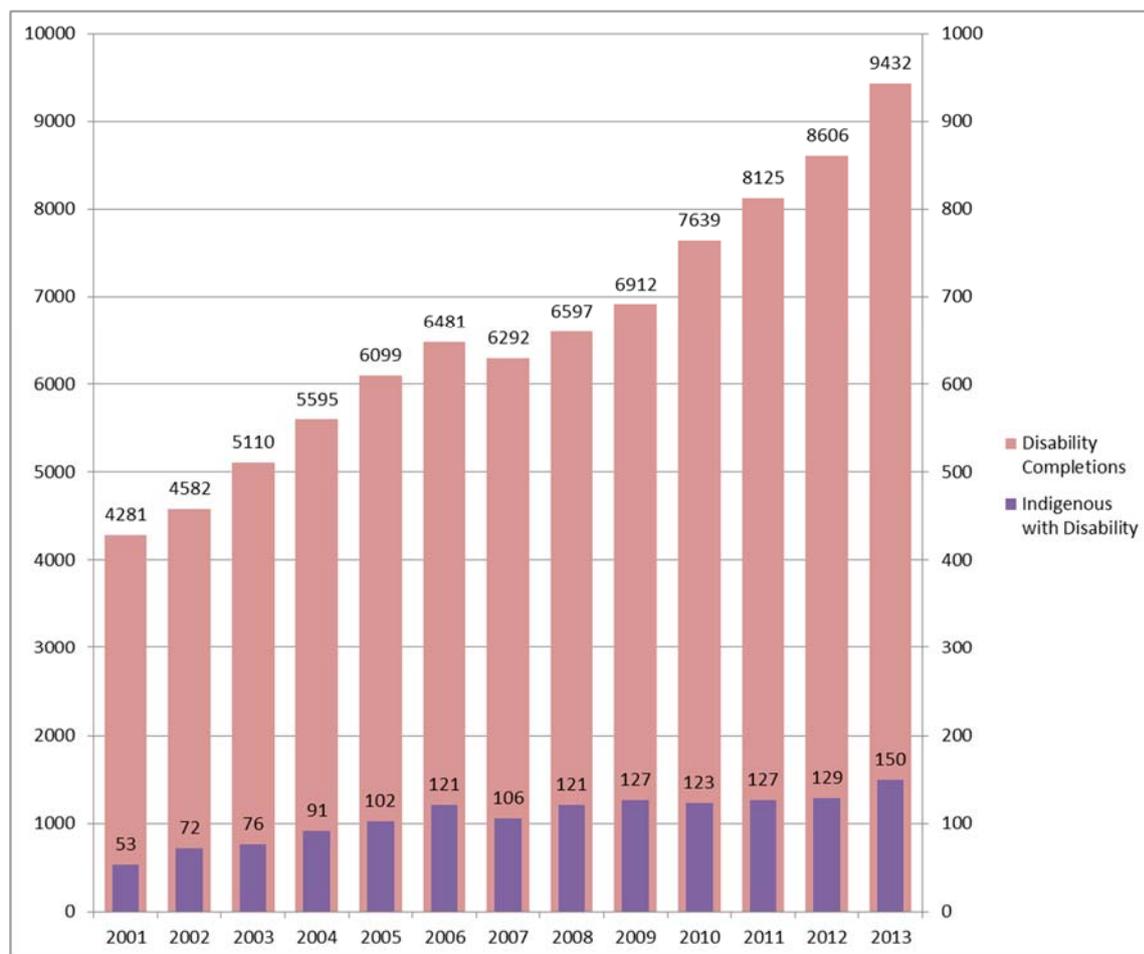


Figure 6b: Aboriginal and Torres Strait Islander students with disability and total students with disability across all Australian universities from 2001 to 2013: Completions.

With some variation, the proportions of Indigenous students with a disability at university are increasing, some at a substantial rate. Below we more closely examine how these particular students are undertaking their degrees. In terms of both enrolments and completions, we look at how and what they are studying. It is important to bear in mind, however, that while these students remain a numerical minority, as a group they represent a growing sub-section of students.

In the following figures, we examine the levels of study undertaken by these students. Figures 7a and 7b show that, in both enrolments and completions, Aboriginal and Torres Strait Islander students with disability are demonstrating numerical increases at all levels of study, with the greatest increase in postgraduate by coursework degrees.

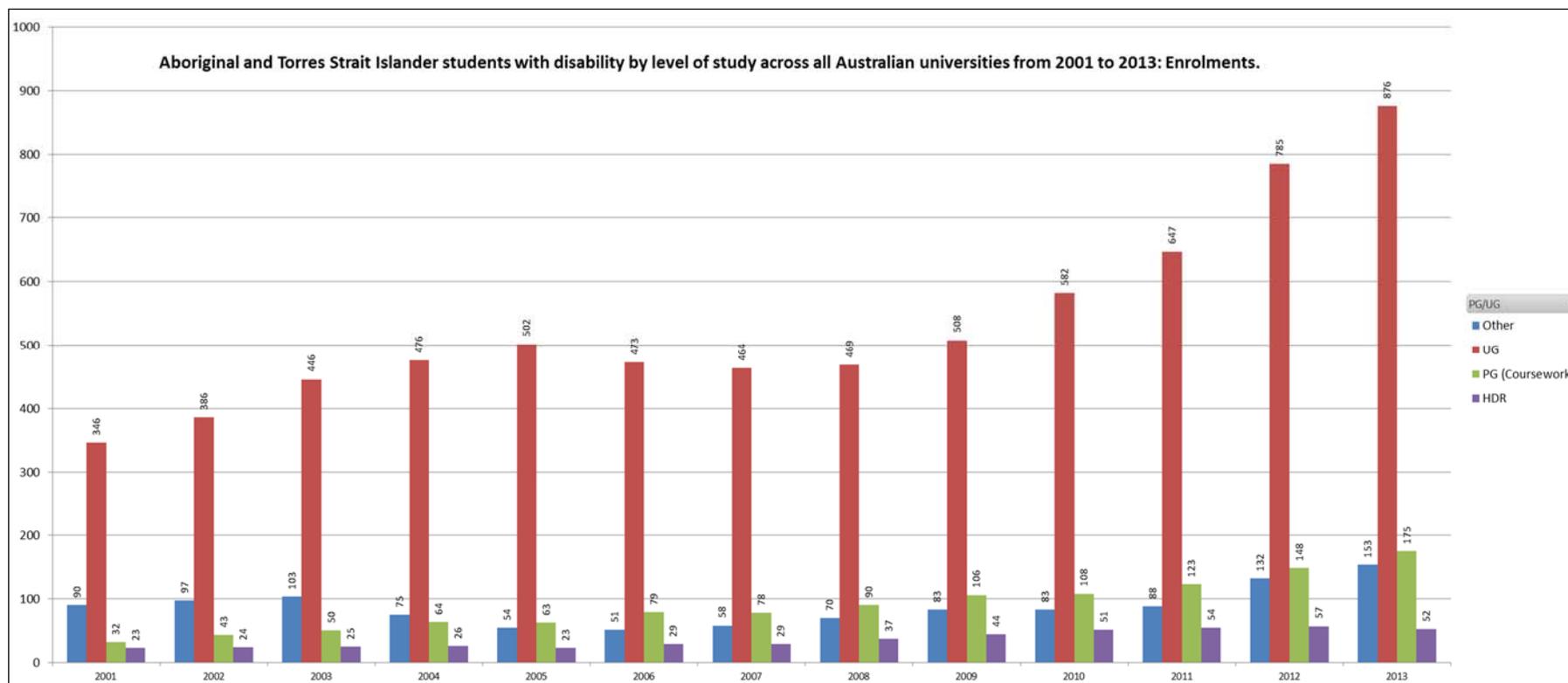


Figure 7a: Aboriginal and Torres Strait Islander students with a disability by level of study across all Australian universities from 2001 to 2013: Enrolments.

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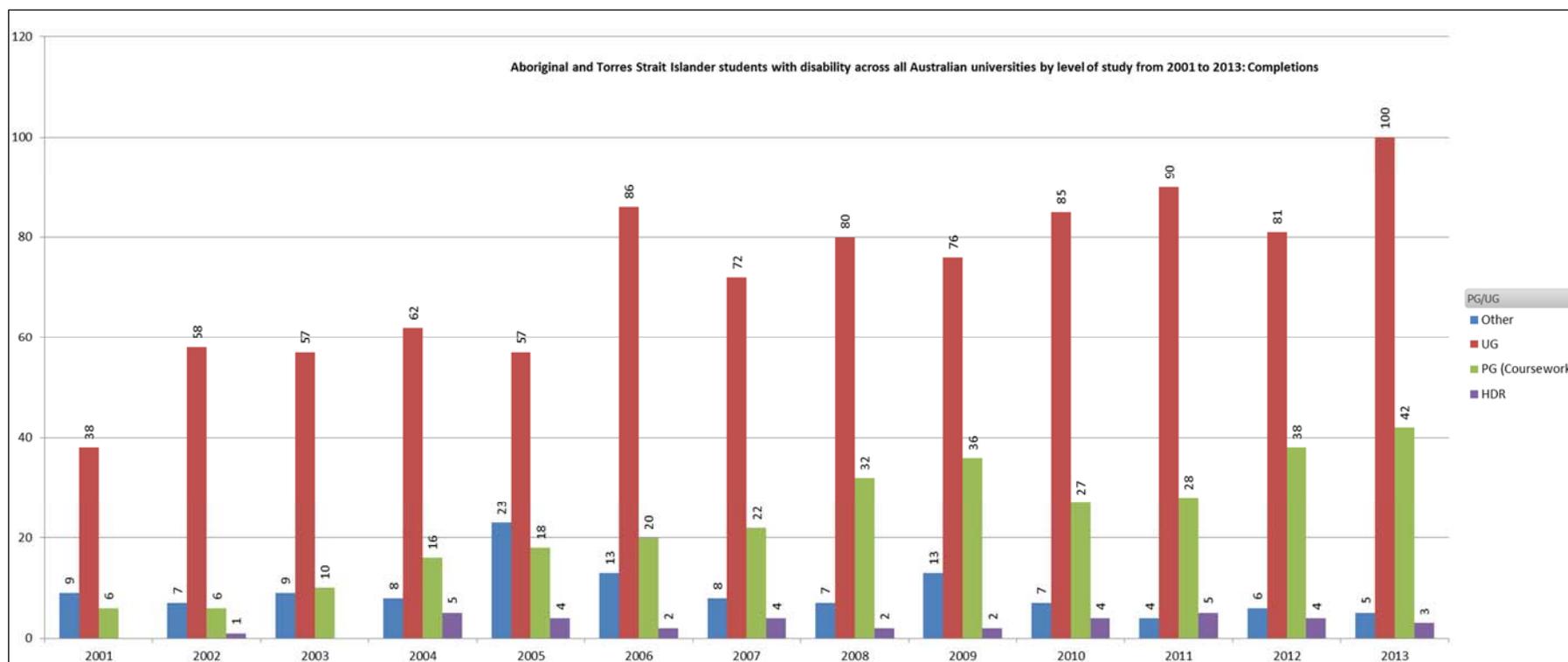


Figure 7b: Aboriginal and Torres Strait Islander students with a disability by level of study across all Australian universities from 2001 to 2013: Completions.

For our purposes, the category 'Other' captures a variety of non-degree courses but in most instances refers to some type of university enabling course. The total numbers of students undertaking the different levels of degree also appear in Tables 1a and 1b.

Table 1a: Aboriginal and Torres Strait Islander students with a disability by level of study across all Australian universities from 2001 to 2013: Enrolments.

	Other	UG	PG (Coursework)	HDR	Total
2001	90	346	32	23	491
2002	97	386	43	24	550
2003	103	446	50	25	624
2004	75	476	64	26	641
2005	54	502	63	23	642
2006	51	473	79	29	632
2007	58	464	78	29	629
2008	70	469	90	37	666
2009	83	508	106	44	741
2010	83	582	108	51	824
2011	88	647	123	54	912
2012	132	785	148	57	1122
2013	153	876	175	52	1256

Table 1b: Aboriginal and Torres Strait Islander students with a disability by level of study across all Australian universities from 2001 to 2013: Completions.

	Other	UG	PG (Coursework)	HDR	Total
2001	9	38	6	0	53
2002	7	58	6	1	72
2003	9	57	10	0	76
2004	8	62	16	5	91
2005	23	57	18	4	102
2006	13	86	20	2	121
2007	8	72	22	4	106
2008	7	80	32	2	121
2009	13	76	36	2	127
2010	7	85	27	4	123
2011	4	90	28	5	127
2012	6	81	38	4	129
2013	5	100	42	3	150

Figures 8a and 8b show the enrolments and completions of Aboriginal and Torres Strait Islander students with disability by enrolment status.

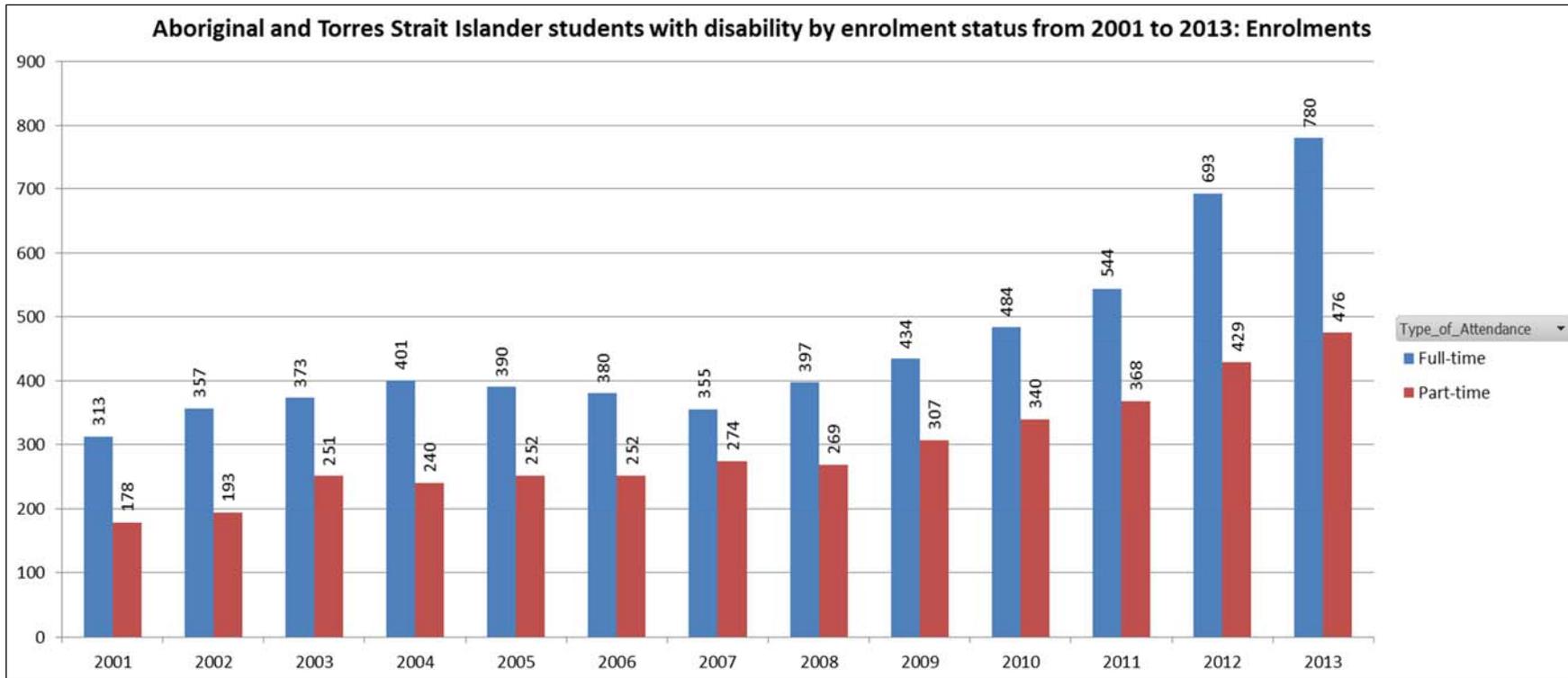


Figure 8a: Aboriginal and Torres Strait Islander students with a disability by enrolment status across all Australian universities from 2001 to 2013: Enrolments.

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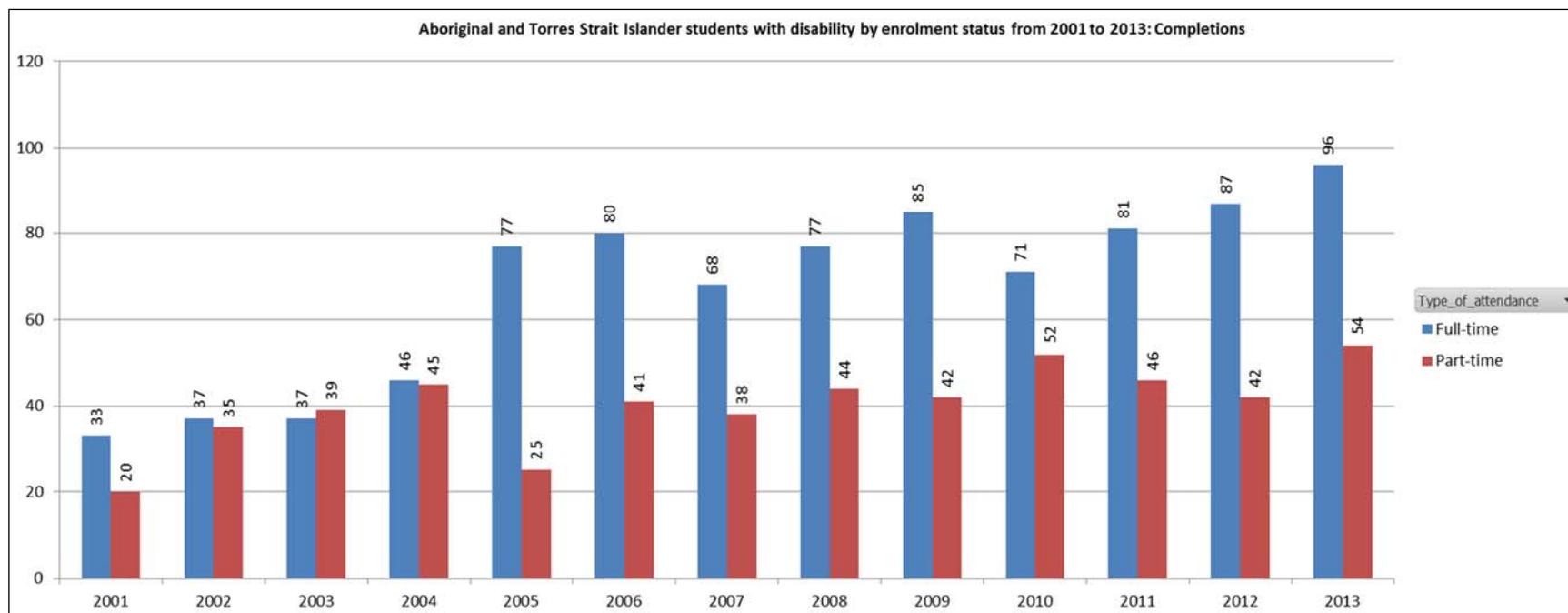


Figure 8b: Aboriginal and Torres Strait Islander students with a disability by enrolment status across all Australian universities from 2001 to 2013: Completions.

While showing some variation over the years, many more of these students are studying full-time than are studying part-time. This pattern holds for both enrolments and completions of degrees.

When it comes to field of study, a substantial majority of Aboriginal and Torres Strait Islander students with disability are undertaking degrees in the broad field of Society and Culture. Indeed, the numbers of students in these fields are consistently more than double that of the next popular field of study. In 2001, the next most popular field of study was Education; however, since then there has been a consistent increase in Health-related degrees. These have now overtaken Education in both degree enrolments and completions. Broad fields of study that could be classified as STEM (science, technology, engineering and mathematics) subjects retain low enrolment and completion numbers. (See Figure 9a for enrolments and Figure 9b for completions by field of study.)

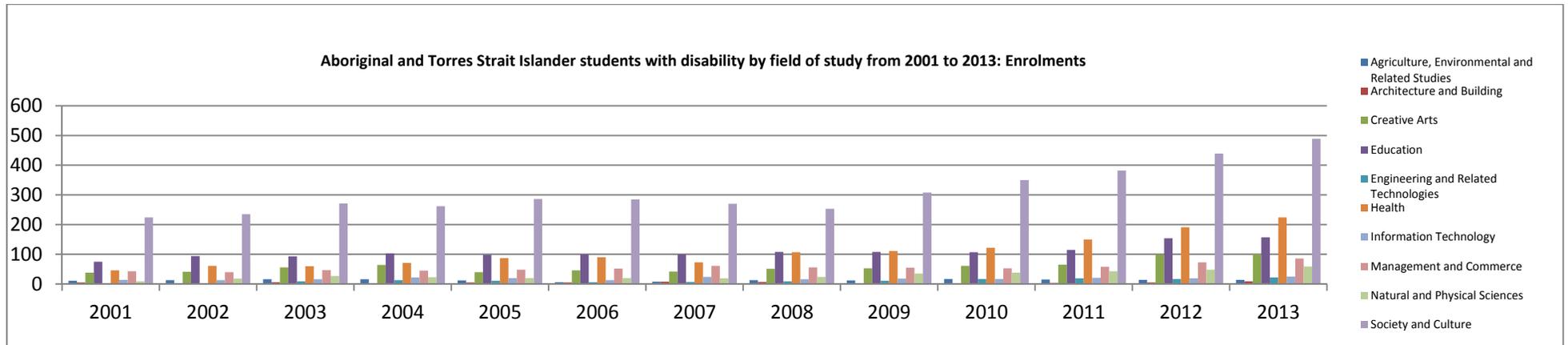


Figure 9a: Aboriginal and Torres Strait Islander students with a disability by field of study across all Australian universities from 2001 to 2013: Enrolments.

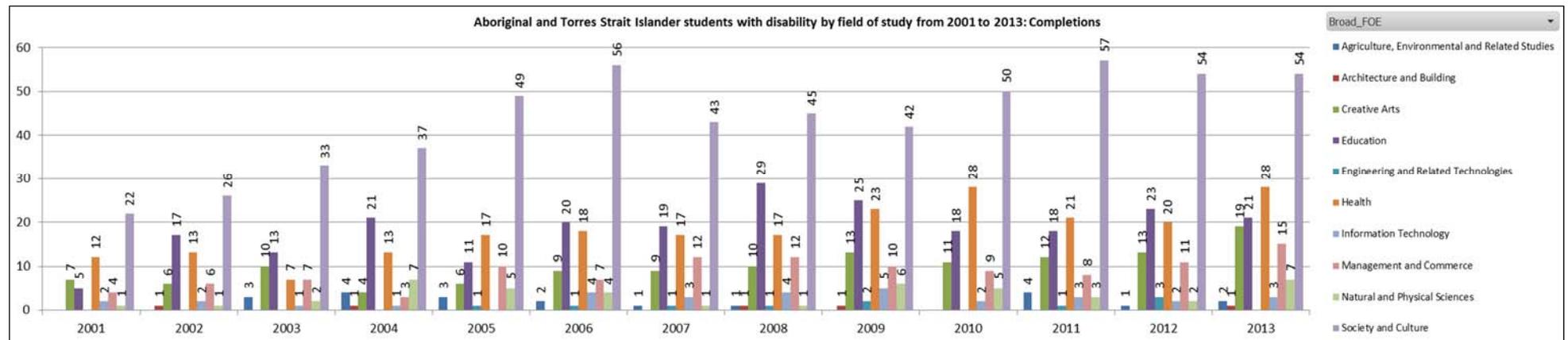


Figure 9b: Aboriginal and Torres Strait Islander students with a disability by field of study across all Australian universities from 2001 to 2013: Completions.

The mode by which degrees are undertaken (i.e., internal, external, multi-modal) is important when considering student supports. Despite the growing number of online courses offered by all universities, the majority of Indigenous students with a disability continue to study on campus (internal mode). Figures 10a and 10b show the total numbers of enrolments and completions, while these data are displayed in percentages in Figures 11a and 11b. Particularly striking are degree completions by these students. Despite some variation, degree completions by these students studying internally are consistently more than double the completions of these students studying externally, and between four and ten times more than when the students study in multi-modal manner. It may be the case that this particular subset of students may benefit from on campus (internal) study modes.

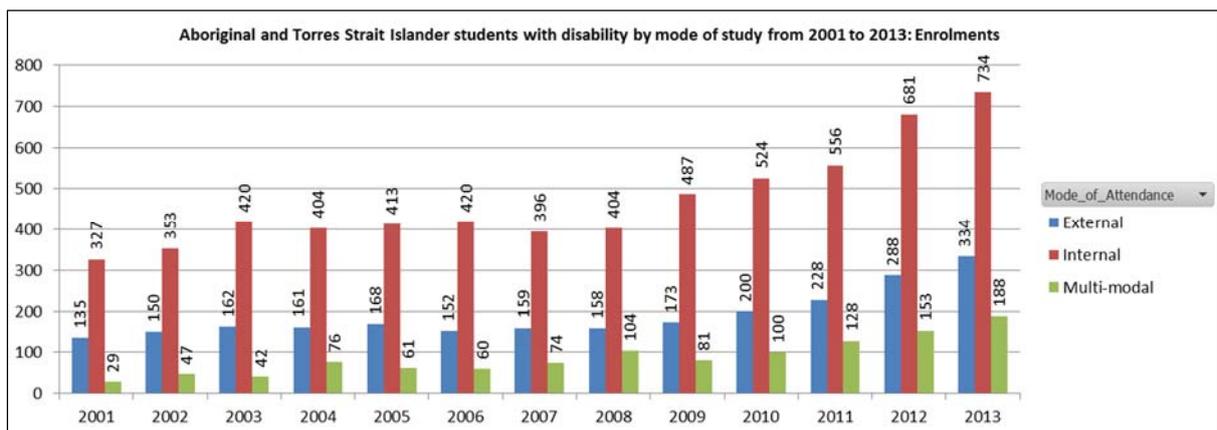


Figure 10a: Aboriginal and Torres Strait Islander students with a disability by mode of study across all Australian universities from 2001 to 2013: Enrolments.

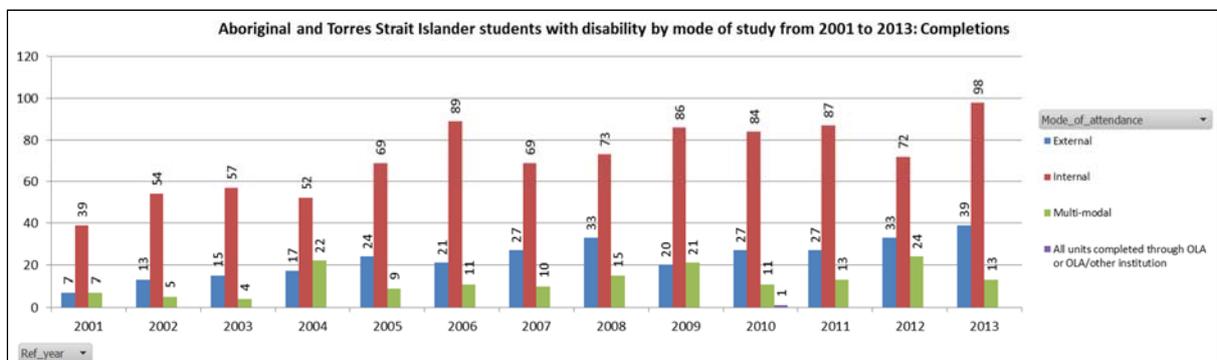


Figure 10b: Aboriginal and Torres Strait Islander students with a disability by mode of study across all Australian universities from 2001 to 2013: Completions.

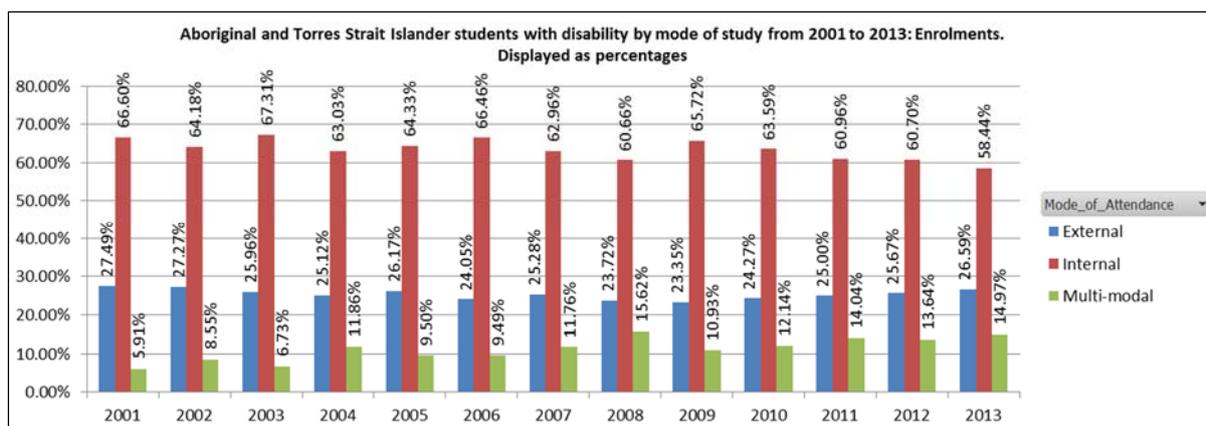


Figure 11a: Aboriginal and Torres Strait Islander students with a disability by mode of study across all Australian universities from 2001 to 2013: Enrolments: Displayed as percentages.

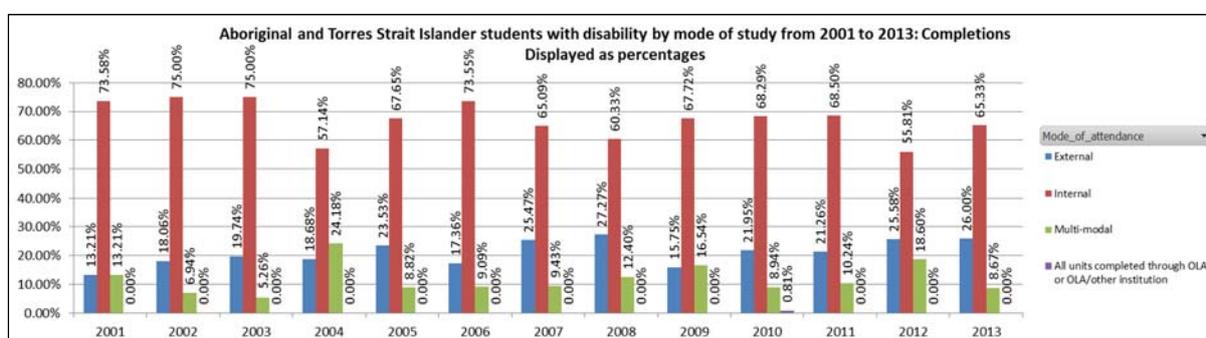


Figure 11b: Aboriginal and Torres Strait Islander students with a disability by mode of study across all Australian universities from 2001 to 2013: Completions: Displayed as percentages.

Conclusions

Aboriginal and Torres Strait Islander students with disability are a numerically small, but increasing, subset of students in higher education. While they represent a growing proportion of Indigenous students at university, they remain a relatively small proportion of all students with a disability. Put another way, the total numbers of students with a disability in universities is growing at a faster rate than is the total numbers of Indigenous students. However, the participation of both of these groups at all levels of education remains an important focus, not only for equity practitioners, but as part of broader moral and socially inclusive imperatives. Our current focus on the subset of students who are both Indigenous and have a disability have, on the one hand, a double disadvantage. On the other hand,

however, they comprise a group of students with enormous strengths and abilities, and it is our goal to see how we can best assist them to succeed.

The majority of these students are undertaking undergraduate degrees. An increasing number of these students are also pursuing (and graduating with) postgraduate degrees by coursework. This may reflect their preferred fields of study – most commonly involving studies of culture and society. It is also consistent with the next most common (though by a considerable margin) fields of study of health and education. Very few of these students are engaged in STEM degrees or business degrees.

A large majority of these students is undertaking, and importantly completing, degrees that are delivered on campus (i.e., internal mode). This has important implications when considered alongside the growing number of university courses and degrees being offered online. Students with disability are entitled to, and regularly utilise, forms of adjustment to their study. These reasonable adjustments comprise a broad range of supports from additional time allowed in exams to the provision of complex assisted technologies. Importantly, it is these students' *right* to these accommodations.

Aboriginal and Torres Strait Islander students are also entitled to a range of study supports. They, too, have a *right* to these supports. For students who are both Indigenous and have a disability, then, this range of available supports is increased. However, the ways in which these supports are delivered can have a huge impact on the students' experience of university and their ability to succeed in their studies.

SECTION 4: DISABILITY SUPPORT UNITS IN HIGHER EDUCATION

Context

In this section, we report on research conducted across Australia in an attempt to obtain a current picture on the types of support provided to Aboriginal and Torres Strait Islander students with disabilities in Australian higher education. All Disability Units (DUs) are governed by disability and human rights legislation but all units are not staffed and resourced equally. Given the lack of guidelines specific to Indigenous students with disability, we wanted to find out exactly what supports were being provided and by whom.

Prior to conducting the research, ethics approval was sought and obtained through the University of Canberra's Ethics Committee for Human Research (Protocol No: HREC 15-163).

An email survey was distributed to disability support units in all Australian universities. A copy of the survey appears as Appendix 1. Information was collected on: (i) the types of support provided; (ii) who provided the support; and (iii) the training that disability advisers have. Respondents were also asked to estimate the percentage of Aboriginal and Torres Strait Islander students with disabilities according to eight disability types/health conditions.

Findings

Despite being distributed to all universities (using multiple postings) throughout Australia, responses were only received from 17 disability units. These did, however, cover most Australian states and territories, and included both Group of Eight (Go8) and non Go8, as well as urban and regional universities. Below we report on the services provided by the DUs (Table 2) in tandem with the more detailed free text answers provided by respondents.

Table 2: Higher Education Disability Unit service provision for Indigenous students with disability.

	Yes	No	No response
Collection of information on Aboriginal or Torres Strait Islander status when registering for disability support	8	9	0
Provision of additional supports for Indigenous students	6	9	2
Work with Indigenous education unit	13	3	1
Specific case management practices for Indigenous students	2	15	0
Follow-up/tracking procedures for students	14	3	0
Dedicated Aboriginal/Torres Strait Islander Adviser	1	15	1
Disability staff trained in Indigenous Cultural Competency	13	3	1

Responses

Along with the collection of quantitative data, the survey contained a number of questions that allowed participants to provide greater detail on many of the questions. These free text responses were categorised based on repetitions of responses. There were discernible variations in the types of support available for Aboriginal and Torres Strait Islander students with disability. Due to the small sample size, however, we present our quantitative and qualitative findings together, allowing us to gain a more complete picture of the services provided.

Disability units were asked whether they collected data on whether a student was Aboriginal and/or Torres Strait Islander upon registration with the disability unit. Not quite half of the units collected these data. Two of those that did not, however, added notes in their responses that this seemed a good idea and that they would do begin to do so from now on. DUs were also asked to provide details on the types of supports provided to students with a disability.

They were also asked whether there were additional supports provided for Indigenous students with a disability, and to describe these supports. While more than a third of the units reported providing some form of additional support to the students, the free-text responses revealed that the 'additional' support was overwhelmingly referral to or liaison with the University's Indigenous Education Unit (IEU) and referral for tutoring.

All participating universities advised that it was the DU that provided the necessary support for Aboriginal and Torres Strait Islander students with disability. Only three of the participating universities advised that this was done in collaboration with their IEU. DUs described their collaboration with IEUs as mostly 'referral and liaison'. One participant university mentioned that Aboriginal and Torres Strait Islander students 'would be treated as any other student' and this sentiment came across quite often in the free-text comments. Indeed, the separation between disability support provided by DUs and Indigenous support (broadly defined) provided by IEUs was implied in many of the responses and explicit in others.

Although the majority of the disability units reported working with the IEUs, the free text responses revealed that this was minimal and often limited to complex cases. Very few had specific case management practices for Indigenous students with a disability. Follow-up practices also showed huge variation, largely as a result of the many different (university wide) systems in place. Again, a distinction between students with disability and Indigenous students was apparent in follow-up/tracking procedures.

We also attempted to gain a picture of the types of disability/ health conditions affecting Indigenous students with disability. Respondents were asked to estimate the percentage of these students with (i) mental health condition, (ii) chronic medical condition, (iii) hearing impairment, (iv) neurological condition, (v) learning disability, (vi) vision impairment, (vii) physical disability, and (viii) other. Only two DUs provided responses to this

question and their estimates varied greatly. Consequently, we are unable to provide this information.

DU staff, themselves, came from a range of backgrounds and training, although social work, psychology, allied health and education were the most common. The majority of disability advisers reported received some form of cultural competency training, and this mostly took place in the context of generic university cultural training. These ranged from a few hours to two full days of compulsory training. Some training was only available online.

There was considerable variation in the staffing of DUs. Again, we are unable to accurately report on this data given that responses included both total numbers of staff and full-time equivalent, with most not specifying within their response. None of these, however, identified as Aboriginal and/or Torres Strait Islander themselves. Only one unit had a dedicated Indigenous disability adviser.

Apart from the three DUs that mentioned working collaboratively with IEUs to support Aboriginal and Torres Strait Islander students with disability, only one other referred to a difference in the way Aboriginal and Torres Strait Islander students with disability were treated by the DU. This DU referred to consultations being 'more personal and narrative (as opposed to clinical/professional) with Indigenous clients'.

Conclusions

There were discernible differences in the types of support available for Aboriginal and Torres Strait Islander students with disabilities. Less than half of the units collected data on Aboriginal or Torres Strait Islander status upon registration, while a third of the units provided some form of additional support to these students. Over two thirds of the units reported working with the IEUs but this was revealed to be in very limited ways. Specific case management practices for Indigenous students with a disability were uncommon.

While most disability advisers received cultural competency training, only one unit had a dedicated Indigenous disability adviser. Importantly, there were no Indigenous staff at any of the responding DUs.

Indigenous Education Units

At the same time that DUs throughout Australia were invited to participate in this research, so too were IEUs at all Australian universities. A copy of the survey sent to IEUs appears in Appendix 2.

The request for participation was sent out by the University of Canberra's IEU; however, only two responses were received and, given the low number, we have not presented this information. However, the issue as to *why* IEUs may have chosen not to participate is of particular concern. In the absence of data in this regard, our suggestions are speculative, but informed by the broader university contexts.

As stated in the introduction to this report, we are all too aware of the burden placed on Indigenous peoples, and on IEUs specifically – a burden that extends to frequently being asked to participate in research. Some suggestions for why the IEUs chose not to report might be because they did not see the research as relevant to them; they did not have the resources to take the time to participate; and they may have felt a sense that 'nothing would change' even if they did participate. We hope that this report *will* create change and that DUs and IEUs can work more closely together to support Aboriginal and Torres Strait Islander students with disability.

SECTION 5: DISCUSSION AND RECOMMENDATIONS

The panel that undertook the *Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People Final Report* (Behrendt et al., 2012, p. 12)

stated:

The Panel proposes a fundamental shift from often marginalised Indigenous Education Units bearing responsibility for supporting Aboriginal and Torres Strait Islander students, to a whole-of-university effort. Indigenous Education Units are currently the main source of cultural, and often academic, support for Aboriginal and Torres Strait Islander students. Students have said Indigenous Education Units are important to them as supportive environments that enhance their university experience and the Panel believes that they should continue to play this supportive role for students. However, they cannot be expected to drive whole-of-university strategies because they simply do not have the reach, resources or discipline-specific knowledge to do so.

As has been demonstrated within the current report, there is clearly more that must be done in order to provide the best possible support for Aboriginal and Torres Strait Islander students with disability attending Australian universities. This is a whole-of-university responsibility and cannot simply be left to universities' Indigenous Education Units. Institutional level support to ensure enablement and empowerment of Aboriginal and Torres Strait Islander students is essential. For Indigenous students with disability, support needs to be provided by DUs, IEs and faculties. If students obtain their primary health care within the University, then medical and/or counselling units may also need to be involved in case management.

Recommendation 1

That a whole-of-university approach to supporting Aboriginal and Torres Strait Islander students with disability is taken, such that Indigenous Education Units, Disability Units and Faculties work together to support Indigenous students with disability, subject to permission being sought and received from the students themselves.

Although our research found that the majority of university staff in DUs had participated in Indigenous cultural awareness training, this was not always the case. Moreover, the depth of training for disability advisers varied considerably. As stated in the Behrendt et al. review (2012), a key challenge to building professional pathways for

Aboriginal and Torres Strait Islander students and responding to community need is 'fully grounding academic staff in Aboriginal and Torres Strait Islander cultural protocols (p. 189)'. This grounding of course needs to apply to all staff and particularly those staff who are dealing with Aboriginal and Torres Strait Islander students with disability. As mentioned previously, cultural safety is not about *learning* cultural practices, it is about *understanding* the broad ways in which culture and cultural practices impact on relationships between people. University staff members need to have a much deeper understanding than currently exists regarding how to respond to the needs of Aboriginal and Torres Strait Islander students, particularly those with disability, and how to provide culturally appropriate services.

Recommendation 2

That more extensive cultural awareness training be made available for staff in Disability Units at Australian universities.

Although it is clear that Indigenous Education Units are highly supportive of Aboriginal and Torres Strait Islander students, IEU staff members are generally not trained to provide the necessary supports to Aboriginal and Torres Strait Islander students with disability *within the university context*. Many staff members within IEUs clearly understand the need to adopt a holistic approach in supporting Indigenous students but they may not be aware of the specific details of how to best support students with, for example, ongoing mental health issues. Moreover, they are unlikely to have the resources to provide this support. And nor should they. It is the disability units not the Indigenous education units that provide information and recommendations to academic staff on reasonable adjustments for students with disability. More training for IEU staff to understand the supports available to Aboriginal and/or Torres Strait Islander students with disability and the requirement for universities to provide reasonable accommodations to allow students to participate on the same basis as others may ensure closer links between DUs and IEUs to the benefit of students.

Recommendation 3

That Disability Units share with Indigenous Education Units the reasons why referring Aboriginal and Torres Strait Islander students with disability for support by Disability Units will benefit the students in the university context.

As Griffis (2014) states, Aboriginal people must occupy key positions and be involved in key decision-making processes in relation to disability support services for Indigenous people. This applies as much in the university sector as it does in the community sector. The responses from Disability Units across the sector indicated that the relationship between DUs and IEUs was generally one of cross referral rather than of true collaboration. The free text comments from DU staff indicated there was little close collaboration between DUs and IEUs at most (but not all) universities. This must change. Aboriginal and Torres Strait Islander people must be brought into the decision making processes and must be consulted regarding the types of reasonable adjustments that might suit an Indigenous student with disability, according to their particular health and other needs. This could be achieved through employing more Aboriginal and Torres Strait Islander staff in DUs and/or by greater consultation by DUs with IEUs and the local Indigenous community.

Recommendation 4

That Aboriginal and/or Torres Strait Islander people play a key role in decision making processes in relation to disability support services for Indigenous students at Australian universities.

In addition to Aboriginal and Torres Strait Islander peoples' involvement in decision-making regarding disability support service for Indigenous students with disability, greater collaboration between DUs, IEUs and Indigenous communities is needed. These partnerships may involve Indigenous health care providers as well as university units or departments. Joint case management, where the student has provided consent, could

ensure a more informed and holistic approach to supporting the students. The feedback from the majority (88 percent) of DUs in the current research was that they had no specific case management practices for Indigenous students. Moreover, in the free text comments most DUs described collaboration between DUs and IEUs as simply one of cross-referral. From the comments provided, there was no sense that the sector is providing real collaboration between DUs and IEUs to ensure the best outcomes for Aboriginal and Torres Strait Islander students with disability.

Recommendation 5

That Disability Units form close partnerships with Indigenous Education Units to ensure that Aboriginal and Torres Strait Islander students with disability are fully and appropriately supported, and that where appropriate joint case-management is provided.

The majority of Aboriginal and Torres Strait Islander students with disability at universities are studying full-time. In both 2009 and 2010, 59 percent were studying full-time and in both 2012 and 2013, 62 percent were studying full-time. Moreover, the majority of Aboriginal and Torres Strait Islander students with disability continue to study via 'on-campus' mode, although there has been a slight drop in the percentage of 'on campus' Indigenous students with disability over the past 5 years (from 66 percent in 2009 to 58 percent in 2013). However, this has not been due to an increase in the number of students studying 'externally'; this has remained relatively stable across the period 2001 to 2013 (figures remain constant at between 23 and 27 percent over these years), but rather due to an increase in the number of Indigenous students with disability studying flexibly via multiple modalities. Given these study patterns, it is important that universities continue to offer support to Aboriginal and Torres Strait Islander students with disability via various modalities. Continued face-to-face support is needed, as well as opportunities for advice and support offered and provided through a variety of media, such as online and via teleconferencing.

Recommendation 6

That support for Aboriginal and/or Torres Strait Islander students with disability is provided both face-to face and through various other media to ensure that the needs of all students are met, no matter what their mode of study.

Finally, the Disability Standards for Education 2005 (the Standards) specify how education and training are to be made accessible to students with disabilities. The Standards are not solely about participation but include requirements for 'enrolment; participation; curriculum development, accreditation and delivery; student support services; and elimination of harassment and victimisation' (p. 4). Aboriginal and Torres Strait Islander students with disability have the *right* to reasonable adjustments in all these areas in order to ensure that they can participate on the same basis as others. This is their due, and it is all of our responsibility.

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APPENDICES

APPENDIX 1: Survey distributed to disability units



Best Practice in Supporting Indigenous Students with Disability in Higher Education

In order to gain an accurate picture of how Aboriginal and Torres Strait Islander students with disability currently receive assistance, the following questions concern your role and the practices in your institution. Thank you.

1. When students register for Disability support, do you collect information on Aboriginal and Torres Strait Islander status? Yes No

2. What types of support do you provide to students with a disability? _____

3. Are there additional supports you provide for Indigenous students with disability?
Yes No

If Yes, please describe these supports: _____

4. Who provides the support for Indigenous students with disability? _____

5. Do you work with your university's Aboriginal and Torres Strait Islander Education Unit?
Yes No

If Yes, please describe this work (e.g., shared case management; special projects etc.):

6. Do you have specific case management practices for Aboriginal and Torres Strait Islander students with disability? Yes No

If Yes, please describe these practices: _____

7. Do you have follow-up/tracking procedures for students? Yes No

If Yes, please describe these procedures: _____

8. Do you have a dedicated Aboriginal and Torres Strait Islander Adviser? Yes No

If Yes, is this person/s Aboriginal or Torres Strait Islander? Yes No

9. Please provide an estimate of the percentage of Aboriginal and Torres Strait Islander students who are registered with your services, according to disability type/health condition.

Mental health % of all registered Aboriginal and Torres Strait Islander students

Chronic medical condition % of all registered Aboriginal and Torres Strait Islander students

Hearing impairment % of all registered Aboriginal and Torres Strait Islander students

Neurological % of all registered Aboriginal and Torres Strait Islander students

Learning disability % of all registered Aboriginal and Torres Strait Islander students

Vision impairment % of all registered Aboriginal and Torres Strait Islander students

Physical disability % of all registered Aboriginal and Torres Strait Islander students

Other % of all registered Aboriginal and Torres Strait Islander students

About your Support Unit:

1. How many Disability Advisers do you have in your institution? _____

2. How many of these identify as Aboriginal or Torres Strait Islander? _____

3. What training do your Disability Advisers have? _____

4. Are your staff trained in cultural competency/proficiency with regard to Aboriginal and Torres Strait Islander people? Yes No

5. What training is available to your staff? _____

6. If you have any additional information/comments you wish to provide, please do so:

Thank you so much for your assistance; it is greatly appreciated.

APPENDIX 2: Survey distributed to Indigenous education units



Best Practice in Supporting Indigenous Students with Disability in Higher Education

In order to gain an accurate picture of how Aboriginal and Torres Strait Islander students with disability currently receive assistance, the following questions concern your role and the practices in your institution. Thank you.

1. When students register with your unit, do you collect other information such as disability status? Yes No

2. Do you receive referrals from your university's Disability support unit? Yes No

If Yes, what is the nature of these referrals? _____

3. Do you provide specific support to students with a disability? Yes No

If Yes, please describe these supports: _____

4. Who provides the support for Indigenous students with disability? _____

5. Do you work with your university's Disability Support Unit? Yes No

If Yes, please describe this work (e.g., shared case management; special projects etc.):

6. Do you have specific case management practices for Aboriginal and Torres Strait Islander students with disability? Yes No

If Yes, please describe these practices: _____

7. Do you have follow-up/tracking procedures for students? Yes No

If Yes, please describe these procedures: _____

About your Education Unit:

1. How many staff do you have in your Indigenous Education Unit? _____

2. How many of these identify as Aboriginal or Torres Strait Islander? _____

3. Please describe their roles: _____

4. Do your staff have training with regard to students with disability? Yes No

5. What training is available to your staff? _____

6. If you have any additional information/comments you wish to provide, please do so:

Thank you so much for your assistance; it is greatly appreciated.