Connecting the dots:

Understanding the domestic and family violence experiences of children and young people with disability within and across sectors

Final report

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to Reduce Violence against Women & their Children

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Acknowledgement of lived experiences of violence
ANROWS acknowledges the lives and experiences of the women and children affected by domestic, family and sexual violence who are represented in this report. We recognise the individual stories of courage, hope and resilience that form the basis of ANROWS research.

ANROWS acknowledges that children and young people living in homes where domestic and family violence (DFV) is present are not simply "exposed" to DFV – they are experiencing it. There are no circumstances in which children and young people are exposed to DFV and are not also being impacted by this violence. Therefore, ANROWS will always default to using "experienced DFV" instead of "were exposed to DFV" or "witnessed DFV". This language aligns with the *National Plan to End Violence Against Women and Children* (due for finalisation in 2022), which recognises that children experience DFV as victims in their own right, and also seeks to honour the voices of victims and survivors who have felt minimised, erased or unacknowledged as childhood survivors.

Please note that in this report, the authors have chosen to use the term "exposed to DFV".

Caution: Some people may find parts of this content confronting or distressing. Recommended support services include 1800RESPECT (1800 737 732), Lifeline (13 11 14) and, for Aboriginal and Torres Strait Islander people, 13YARN (13 92 76).

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Acronyms

ADHD	Attention deficit hyperactivity disorder
ADS	*Australia's Disability Strategy 2021–2031*
CALD	Culturally and linguistically diverse
COAG	Council of Australian Governments
DCP	Department for Child Protection
DFV	Domestic and family violence
ECEI	Early Childhood Early Intervention
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Strategy
OT	Occupational therapy

Definitions and concepts

Children and young people

For the purposes of this research, the term "children and young people" is used to include people below the age of 25 years. The United Nations (UN) defines a "child" as a person below the age of 18 (UN, 1989). There is more variation in the definition of young people. While the United Nations (n.d.) defines "youth" as between the ages of 15 to 24 years, the World Health Organization (WHO, 2022) defines young people as between the ages of 10 and 19, and the Australian Institute of Health and Welfare (AIHW, 2021a) defines young people as aged 12 to 24. We have included both children and young people, as the impacts of trauma in both childhood and the transition into adulthood during youth can be profound on the formation of identity, physical and mental health, cognitive function and learning capacity, wellbeing and independence.

Child-centred approach

A child-centred approach seeks to "expand our focus on children and young people, in or outside of their families, and the development of policies and practices which support this" (Winkworth & McArthur, 2006, p. 14). According to Powell et al. (2020) and Winkworth and McArthur (2006), a child-centred approach:

- recognises critical time frames in childhood and adolescence, including the importance of intervening early in children's lives as well as early in the life of problems
- takes developmental needs of children and young people into account in practice contexts
- provides children and young people with opportunities to participate in decisions about things that affect them
- promotes a collaborative approach to influencing the multiple environments that children and young people engage with, and interactions between these domains.

Disability

As a concept, disability is "complex, dynamic, multidimensional and contested" (WHO, 2011). There is no consensus on how disability is defined, and people differ in how they view or identify their own disability. However, there are models for conceptualising disability in children and young people that inform the collection of data (Patel & Brown, 2017). Historically, the medical model – based on a diagnosis or condition that results in functional impairment – was utilised to define disability. More recently, the International Classification of Functioning (ICF) aims to apply a broader social model. It takes into account the social and environmental context of the disability that may impact the functional ability of a person with a condition (Madden et al., 2014).

In Australia, we have a number of definitions of disability that are used in legislation. The *Disability Discrimination Act 1992* (Cth) defines disability as:

- total or partial loss of the person's bodily or mental functions
- total or partial loss of a part of the body
- the presence in the body of organisms causing disease or illness
- the malfunction, malformation, or disfigurement of a part of the person's body
- a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction
- a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions, or judgement, or that results in disturbed behaviour.

Its definition also includes a disability that presently exists, previously existed but no longer exists or may exist in the future (including because of a genetic predisposition); or is imputed to a person. To avoid doubt, a disability that is otherwise covered by this definition includes behaviour that is a symptom or manifestation of an impairment or condition (*Disability Discrimination Act 1992* [Cth]).

The UN's *Convention on the Rights of Persons with Disabilities* (CRPD), adopted in 2006, applies a broad definition:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. (UN, 2022, Article 1)

For the purposes of quantitative data analysis, our research uses the definition from the *Disability Discrimination Act 1992* (Cth) to include both diagnosed and self-identified disability, including mental illness or psychosocial disability. Our qualitative research relies on people's self-identification with disability, consistent with the CRPD definition.

Domestic and family violence

This research uses the definitions of "domestic violence" and "family violence" that are used in the *National Plan to Reduce Violence Against Women and their Children 2010–2022*. Informed by the United Nations Declaration on the Elimination of Violence Against Women, the definition states:

> Domestic violence refers to acts of violence that occur between people who have, or have had, an intimate relationship. While there is no single definition, the central element of domestic violence is an ongoing pattern of behaviour aimed at controlling a partner through fear, for example by using behaviour which is violent and threatening. In most cases, the violent behaviour is part of a range of tactics to exercise power and control over women and their children, and can be both criminal and non-criminal.
>
> Domestic violence includes physical, sexual, emotional, psychological and financial abuse.
>
> Physical violence can include slaps, shoves, hits, punches, pushes, being thrown downstairs or across the room, kicking, twisting of arms, choking, and being burnt or stabbed.
>
> Sexual assault or sexual violence can include rape, sexual assault with implements, being forced to watch or engage in pornography, enforced prostitution, and being made to have sex with friends of the perpetrator.
>
> Psychological and emotional abuse can include a range of controlling behaviours, such as control of finances, coercive control, stalking, isolation from family and friends, continual humiliation, threats against children, threats and abuse of pets, or being threatened with injury or death.
>
> Family violence is a broader term that refers to violence between family members, as well as violence between intimate partners. It involves the same sorts of behaviours as described for domestic violence. Family violence is the most widely used term to identify the experiences of Indigenous people, because it includes the broad range of marital and kinship relationships in which violence may occur. (Council of Australian Governments, 2011b, p. 2)

This research uses the terms "domestic and family violence" together to ensure a broad range of experiences of violence and abuse within a family or relationship context are included.

Intersectionality

Intersectionality describes the effects on people of living on multiple axes of oppression simultaneously (Shaw et al., 2012; Stubbs, 2015).

Trauma-informed practice

Trauma-informed practice refers to therapeutic approaches that "aim to help a person manage and reduce trauma-related symptoms, and integrate their experiences of trauma so these no longer intrude on the present" (Jackson & Waters, 2015, p. 12).

Situating trauma-informed practice in a wider organisational context is important for building cultures that support and sustain trauma-informed practice:

> A program, organisation, or system that is trauma-informed realises the widespread impact of trauma and understands potential paths for recovery; recognises the signs and symptoms of trauma in clients, families, staff and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatisation. (Jackson & Waters, 2015, p. 12)

Executive summary

This report presents the findings from research that aimed to provide new knowledge on the nature and extent of domestic and family violence (DFV) experienced by children with disability (0 to 18 years), and the experiences of children and young people with disability (8 to 24 years) and their families of using support services.

Background

There are important gaps in policy and knowledge with respect to children and young people with disability who experience DFV, even though they are known to experience it at rates significantly higher than their peers without disability (Jones et al., 2012). When children and young people with disability experience DFV, they are often in contact with a greater range of services than many other children and for a longer period of time (Corr & Santos Milagros, 2015; Maclean et al., 2017). Many of these services are dominated by their own institutional priorities, and struggle to be responsive to the needs of people with disability (Fraser-Barbour et al., 2018; Robinson, Hill et al., 2020).

There is a small but increasing emphasis in research on promoting the lived experience and perspectives of children and young people with disability and their families, and some promising developments in recognising the intersections of disability, violence and children's rights in policy. However, it remains to be seen how this recognition translates into cross-sector collaboration and/or integrated service delivery and practice. Recent research has identified the need for further work to explore opportunities to build child-focused and trauma-informed policy and practice to address gaps and build disability and violence literacy, particularly in DFV, disability service and children's services systems (Flynn, 2020; Maher et al., 2018; Robinson, Hill et al., 2020).

Aim and objectives

This research aimed to provide new knowledge on how children and young people with disability experience DFV. It had the following objectives:

1. Scope and map current data capture of children and young people with disability experiencing DFV, identify gaps and limitations in the data, and map new intersections unique to this population.
2. Develop a new understanding of the support and service needs, priorities and perspectives of children and young people with disability experiencing DFV, and system barriers and enablers.
3. Determine steps to bring service processes into better alignment with the priorities of children and young people with disability.

To achieve these objectives, our research questions were:

> What is known about the nature and extent of DFV experienced by children and young people with disability?
>
> How do children and young people with disability who have experienced DFV and their families experience support from services, and how well does this support meet their needs?

Methods

The study applied intersectionality theory and approaches to children's rights and disability rights. Intersectionality describes the effects on people of living on multiple axes of oppression simultaneously (Shaw et al., 2012; Stubbs, 2015). The research considered the various ways in which disability, age and gender (along with other forms of difference) intersect, and how these influence the ways children and young people with disability experience DFV and the service responses they receive. From the outset, the research centred children and young people as priority voices, establishing a co-researcher position for a young person with disability in team and advisory systems and holding children and young people as the focus point throughout.

The project took a mixed-method approach, conducted across three phases. Phase 1 connected findings from existing datasets in Western Australia and South Australia to form a national picture of prevalence and risk of DFV among children with disability, identifying data limitations and opportunities to improve policy and practice. Please refer to the companion report (Octoman et al., 2022) for full details of the methods and results of Phase 1.

Phase 2 prioritised the voice and lived experiences of children and young people with disability and their supporters through qualitative research identifying their support and service needs in the context of DFV, and their priorities for safety moving forward. The experiences of 36 children and young people with disability are represented in the research. Twelve children and young people participated directly in interviews. Twenty-four children and young people are represented in the research through family members, as they were unable to participate directly due to trauma and/or their high and complex support needs. Fourteen interviews were conducted with family members for their perspectives and 46 practitioners participated in interviews and focus groups, representing a range of sectors.

Phase 3 confirmed and extended findings through workshops and individual consultations with 22 stakeholders from the participant groups and policymakers.

Findings

Phase 1: Data linkage and case study analysis

The data linkage study utilising Western Australian data demonstrated there is a high proportion of children with disabilities exposed to DFV. Some of the findings were as follows:

- Children with disability had double the exposure to DFV (8%) compared to children without disability (4%), measured by mothers hospitalised for assault.
- According to police and hospitalisation data, children with disability made up approximately 30 per cent of children exposed to DFV.
- Children with disability were far more likely than children without disability to have child protection involvement and entry into out-of-home care, with approximately 32 per cent of children with disability involved in child protection and 36 per cent of children with disability in out-of-home care. We note that DFV is not the only reason for children to enter these systems.
- Children with disability who were Aboriginal (36%) and/or from regional and remote areas (36%) were even further over-represented in exposure to DFV compared to children without disability.

Further to these concerning high rates of exposure to DFV, the case study analysis utilising South Australian data demonstrated the effects of DFV on a cohort of children with disability that were reported to child protection authorities:

- Children and young people showed signs of trauma as a result of the DFV.
- The perpetrator of the DFV often directed violence towards children and young people with disability as well as their mothers.
- Violence negatively impacted children's and families' access to services.
- It was harder for protective parents to leave unsafe housing because there were few accessible and safe alternatives suitable for their children's disability support needs.

Phase 1 of the study has built evidence to show that children with disability who experience DFV are present across different systems at disproportionately high rates. It points to the need to better identify the prevalence of DFV and disability in routine data collection; to make better use of administrative data; and to confirm practical support for especially vulnerable groups/families. Children and families who experience DFV face complex challenges and these challenges are increased for children with disability, who may require extra support. The importance of first-response services such as police and hospitals is evident in responding to crisis, but with such a high proportion of children with disability involved in DFV services and the child protection system, workers and organisations across all sectors need the skills and resources to address these additional needs.

Phase 2: Interviews with children and young people, families and practitioners

The children and young people with disability who have been exposed to DFV who were interviewed (or whose families were interviewed on their behalf) for this research are, above all, children first. They are whole people with interests, humour, contributions to make and a sense of fun. They are valued and loved. Most live with their family members in a network of relationships, many of which are complex.

These children and young people understand more about their families' situation than some might think, and expressed

a range of views about what helps them to feel safe. It has been hard for them to have their perspectives and priorities heard – especially those with high support needs – by others but particularly by systems.

DFV has affected these children and young people's sense of security. It has been destabilising and isolating for them. Most children and young people spoke about or showed signs of significant trauma. This trauma was hard to address because they and their families have had little help to escape the violence (e.g. to find safe and accessible accommodation) or to start to recover.

Most of the children and young people and their families were engaged with child- or youth-focused services, disability-related services and family-focused services, but not always in ways that met their needs.

Participants identified that services could better help to meet children and young people's support needs in services through:

- relationships with trusted people, consistency and time to work well with individual practitioners
- capacity in systems to support quality practice
- viewing them as individual people with agency and as able to contribute
- trauma-informed and disability-informed practice
- well-funded and well-organised services
- flexibility to use supports in ways that suit children, and suit them in their family context
- communication and collaboration in/between systems
- clear practice frameworks.

Unfortunately, many of the children and young people and families in this study reported that many of the services and systems with which they interact do not have these characteristics. They have experienced many (often repeated) barriers in receiving reliable, consistent support related to both DFV and disability. These included limited time and resources available to access services and funding; confusing information about eligibility and evidence requirements; limited accessibility and availability. Lack of reliable access to NDIS-related funding and support for children's needs related to both disability and trauma was a persistent and common problem. An overarching finding in this study was that much of the support provided to children and young people seemed to be in place because of the initiative taken by key people in their lives (mothers, mainly) and some individual supportive practitioners, rather than because systems recognised their need and responded systemically or systematically. A significant amount of advocacy and persistence was needed, often over years, for most of the children and young people in this study to receive a reasonable level of support.

This came at a high cost for many parents, and some were not able to provide this level of advocacy, particularly while they were experiencing DFV themselves. Children and young people missed out on needed support if they did not have an advocate – parent, practitioner or systemic advocate – who could continue to negotiate and address repeated barriers to support on their behalf.

Phase 3: Confirming and extending findings with stakeholders

In the third phase of the study, representatives of the stakeholder groups advised the researchers on priorities from the findings for practice and policy. Through the workshops, a series of critical issues were identified which promoted the rights and interests of children and young people with disability who experienced DFV. Four children and young people also provided advice individually about the child-focused elements of the research, building from their own participation in the earlier parts of the project.

What do our findings show about the need to improve support for children and young people with disability experiencing DFV?

Improving support for children and young people

Children and young people's lives will be improved if there are planned, thoughtful ways for their ideas and priorities to be heard and responded to in the services they use. Finding safe places and people to listen to what is important to children and young people can help to build child-informed responses to their needs and preferences. Where children's networks are limited, focused support to identify and sustain relationships with trusted adults is essential to build children and young people's capacity to exercise their voice and agency.

Responses are needed that understand and acknowledge how disability is interwoven with trauma for children and young people with significant support needs, and that therapeutic responses provided by skilled practitioners are needed as a priority to help children and young people begin to recover from DFV.

Improving support to families so they can support their children

The level of complexity in systems, particularly the National Disability Insurance Scheme (NDIS), is too high for these systems to be accessible and appropriate for many people who are experiencing DFV crises. Support coordination and case management are necessary to ensure that DFV and disability systems are available and accessible to children and young people with disability and their families.

Children with disability need to be seen in their family context. However, a child-centred approach that responds to the needs of the child and is responsive to their views and wishes is vital. Such approaches recognise the needs of children and young people who are involved with multiple service systems, have intersecting disadvantages and/or who have experienced their own trauma. Trauma-informed practice approaches must take account of this complex and unique context for both children and young people with disability and their families.

Improving systems and structures

By not directly addressing the intersection of disability and DFV, services designed to support children and young people and their families in their particular contexts – either from a child-focused or family-focused vantage point – did not appear to have holistic and flexible approaches available.

The access of children and young people to funding and services to meet their support needs should not be reliant on the capacity of their family members to apply to and negotiate with systems on their behalf. Children and young people with disability have the right to support that meets their needs. Where they and their family members require support to navigate systems due to the impact of DFV, it must be provided proactively to support children and young people to use it well and thoroughly.

Access is needed to funding models that support flexibility and holistic approaches and do not drop or lose children and young people in cross-systems referral. Building the skill level and readiness of practitioners across all sectors working with children exposed to DFV is a priority task. Alongside this, stronger referral pathways and inter-sectoral collaboration between specialist support systems in child protection, youth, mental health, DFV and disability are needed.

Frameworks and processes that support practitioners to take a systematic approach to their work were viewed positively by practitioners and would be helpful for building good practice. Local communities need to bring their expert knowledge to bear on solution-making around these issues, especially First Nations peoples and remote, rural and culturally and linguistically diverse (CALD) communities. Their knowledge needs to be resourced and valued.

Implications for policy

This study sits in the intersection of three new national plans and strategies aiming to promote the safety of children, women and people with disability: the *Australian Disability Strategy (2021–2031)* (ADS); *Safe and Supported: National Framework for Protecting Australia's Children (2021–2031)*; and the *Draft National Plan to End Violence against Women and Children (2022–2032)*. Our study shows children and young people with disability require urgent policy attention and greater investment in early intervention, trauma-informed response and recovery efforts. For such attention to have effect, children and young people with disability and family members need to be included in the action plans for all three frameworks. These action plans must recognise the intersecting nature of children's needs and counter the longstanding problem of people with disability being recognised in statements of principles without concrete strategies articulated in policies to meet their needs. Given the intersecting nature of issues faced by children with disability who experience DFV, these documents need to articulate how policies can be enacted in an integrated way so that children's needs are met and cross-system challenges are resolved.

The increasing complexity of service systems must be addressed for children and young people and families who are not able to navigate them, particularly at times of crisis.

Implications for practice

Children and young people in this research were clear about things that mattered to them. Their priorities have not been well responded to by services and systems. A primary finding in this research was that children and young people with disability often fall between gaps in service systems.

Alongside this were limitations in the skills and capacities of workers from intersecting sectors to provide the supports and services that meet the unique needs of children with disability. It was found that child- and youth-facing services were not always disability- or DFV-literate, while disability services were not always responsive to children's experiences of violence. Across the three sectors, trauma-responsive practices appeared to be lacking. Our findings point to the need for greater investment in staff training, cross-system collaboration and the further integration of trauma-informed practices across each system.

It was encouraging that practitioners in this study were overwhelmingly reflective and open about the need for practice improvement, and eager for guidance about how they could contribute to improving service systems. They readily acknowledged the need for children and young people with disability to have improved access to a baseline level of quality in service provision, across sectors, when they experience DFV.

Our findings point clearly to the need to improve systemic and structural responses to children and young people with disability. We offer some guiding principles that could inform the development of a practice framework, acknowledging that further research needs to be undertaken to build an outcomes- and quality-focused practice framework. These guiding principles are for practice to be:

- child-centred
- rights-focused
- trauma-informed
- disability-informed
- holistic
- investment-oriented.

Conclusion

Through its mixed-method approach, this study has revealed new knowledge about how children and young people with disability and their families experience DFV and related support services in Australia. Phase 1 confirmed that at a population level, there are high numbers of children and young people with disability in families experiencing DFV, and these experiences have a significant impact on them. Practitioners in all sectors working with children need to be ready and skilled to work with children and young people with disability experiencing DFV.

Phase 2 used first-hand accounts of the experience of children and young people, families and practitioners that demonstrate the serious shortfalls in how systems respond to children and young people with disability and their families. A major shortfall is that children and young people have few opportunities to express their wishes about what they want to happen in their lives and how they want things to improve.

In Phase 3, representatives of all of the stakeholder groups assisted the research team in identifying many implications from the research. These represent opportunities to improve policy and practice in ways that would positively shape children and young people's lives. All need to be underpinned by a commitment to seeing children and young people with disability at the centre of their own experience of DFV and as experts in their own lives.

Introduction

Children and young people with disability experience domestic and family violence (DFV) at rates up to three times higher than their peers without disability (Jones et al., 2012; Sullivan & Knutson, 2000). Much of the literature on children's exposure to these forms of violence portrays them as "passive recipients of potentially traumatic experiences" (Överlien, 2017, p. 680). However, there is growing evidence that children and young people are not only witnesses to violence but are often direct victims and take active steps to prevent, intervene or respond to the violence experienced within their families. The impacts of violence at home for children can be significant and enduring. Within this literature, there is little research exploring the perspectives and priorities of children and young people with disability who experience DFV, a significant gap given the increasing call for a more nuanced and child-centred understanding of their experiences and needs (Arai et al., 2021).

Children and young people with disability who have experienced DFV may be in contact with multiple service systems and institutions, including those focused on DFV, disability, child protection, criminal justice, health, housing, youth crisis services and education. Many of these services are not responsive to the needs of people with disability and are instead dominated by their own institutional priorities (Noble-Carr et al., 2020; Robinson et al., 2021). This is compounded by a historical legacy of segregation, where children and young people with disability have been excluded from many services because they are regarded as requiring "special provision" by specialist disability institutions and services (Fawcett, 2016).

Previous research has found that disability services are regularly and notably absent from cross-sector collaborative responses to DFV. They also lack expertise around identifying and responding to violence. Meanwhile, mainstream services have limited understanding and opportunities to learn about disability, which has led to a lack of "disability literacy" (Maher et al., 2018; McDonald & Rosier, 2011). Alongside this, disability services lack expertise around violence (Fraser-Barbour et al., 2018) and are not always child-centred (Ryan & Quinlan, 2018). This presents challenges for both data capture and developing more effective responses that improve access and support disability- and violence-informed practice.

Recent research has identified the need to build child-focused and trauma-informed policy and practice, and to improve disability and violence literacy in DFV services, disability services and children's services and systems (Flynn, 2020; Maher et al., 2018; Robinson, valentine et al., 2020). There is growing recognition in literature focused on adults with disability about the importance of trauma-informed research, and an increasing emphasis in research involving children with disability on methods to include a wider range of children and young people through adapted methods and approaches (Franklin & Smeaton, 2017; Överlien, 2017; Robinson & Graham, 2021). However, this is yet to carry over more broadly into research with children, despite a growing body of research with children at the intersection between DFV and child protection. The priorities and experiences of children and young people have had little impact on the delivery of DFV policy and practice (Moore et al., 2020), and those of children and young people with disability perhaps least of all (Powell et al., 2020).

It is in this context that this report presents the results of our three-phase, mixed-method study. The research aimed to provide new knowledge on the nature and extent of DFV experienced by children with disability, and how these young people and their families experience using support services. Guided by a conceptual framework of intersectionality, children's studies and disability studies, the research centred children and young people as priority voices from the outset. It established a co-researcher position for a young person with disability in team and advisory systems and held children and young people as the focus point throughout.

The research questions guiding the project were as follows:

1. What is known about the nature and extent of the experience of DFV by children and young people with disability?
2. How do children and young people with disability who have experienced DFV and their families experience support from services, and how well does it meet their needs?

This report brings together the findings from the three phases of the research: a large-scale data linkage study in Western Australia (Phase 1A) and a case file analysis based on intake reports from a South Australian child protection jurisdiction (Phase 1B); qualitative research with children and young people with disability and their families (Phase 2); and workshops and individual consultations with practitioners from a range of sectors (Phase 3). A companion report (Octoman et al., 2022) provides a detailed analysis and discussion of the first phase, the data linkage and the case study analysis. This report includes detailed presentation and analysis of the qualitative research, and an analysis of the implications of the full study for policy and practice.

Background

In many families where DFV occurs, children and young people with disability are present (Corr & Santos, 2017; McCarthy, 2019). United States research has established DFV in families with children and young people with disability at three times the rate of other families (Sullivan & Knutson, 2000), but knowledge in the Australian context is scant. The relationship between DFV and disability is complex, and needs to be understood in the context of multi-systemic support delivery (Lapshina & Stewart, 2019) and the limited visibility of women and children (Aini et al., 2020; Didi et al., 2018).

Current national and state datasets indicate that children with disability who have experienced DFV are present in child protection, hospital, emergency department and police data. However, these datasets have not yet been connected to form a national picture of prevalence and risk; data limitations and gaps; and opportunities to improve policy and practice across jurisdictions. There is currently no evidence on the national prevalence of children and young people with disability experiencing DFV as captured in existing national datasets or on the service needs, priorities, and access of children and young people with disability experiencing DFV. Recent research has identified the need for further work to explore opportunities to build child-focused and trauma-informed policy and practice to address gaps and build disability and violence literacy in both DFV and disability service systems (Robinson, valentine et al., 2020; Sutherland et al., 2021).

This project addresses several of the multiple and various ways in which forms of difference influence and compound discrimination and marginalisation. It takes a position of acknowledging and responding to the increased disadvantage experienced by children and young people with disability who are exposed to DFV. These disadvantages can arise from institutional failures to meet their needs, such as in schools and health systems; inappropriate responses from services and agencies, such as child protection; the workforce capacity of various services to respond to their needs with appropriate knowledge and skills; and organisational constraints related to resources, service models and system capacity.

The intersection of childhood and disability is particularly important in the context of poor recognition of the perspectives of children and young people with disability at a national policy level.

The project also challenges the sometimes reductive views of children and young people with disability as inherently risky and vulnerable individuals, as they often appear in policy. Recent scholarship on vulnerability seeks to counter the negative implications of powerlessness, victimhood and pathologising associated with this concept by drawing attention to its unequal distribution (Mackenzie, 2014; Silvers, 2015). Individual children and young people with disability are doubtless in situations of risk at time of DFV in their families. However, their risk of being considered *inherently* vulnerable is greater than other children due to disablist social beliefs, practices and institutions – for example, exclusionary attitudes and discriminatory reforms to programs and welfare systems (Lid, 2015). Therefore, it is important to highlight the contributions and strengths of children and young people, their relationships, and the ways in which they counter and navigate violence and risk in their lives. Alongside this, the systemic and structural conditions in which children and young people are acting may enable or constrain what is possible for them. It is this fulcrum which this project is also very keen to explore for its potential to change the *situational* vulnerability of children and their families. Situational vulnerability is specific to context, "caused or exacerbated by the personal, social, political, economic or environmental situations of individuals or social groups" (Silvers, 2015, p. 7).

Literature review

This section of the review presents the findings from academic and grey literature on the experiences of violence, abuse and neglect by children and young people with disability. At the outset, it should be noted that the evidence base is limited (Sutherland et al., 2021); many of the key statistics reported were produced over a decade ago, so Australian researchers often rely on international studies to estimate the prevalence of violence and abuse against children and young people with disability.

Violence/abuse experienced by children and young people with disability

Prevalence and risk of violence

One of the earliest studies to explore the association between children and young people with disability and violence was

an American study that found that children with disability were 3.4 times more likely to be maltreated than their peers without disability (Sullivan & Knutson, 2000). This study also reported an association between economic distress, maltreatment and neglect, and that younger children with disability are at greater risk of abuse and neglect than older children with disability. Most research about prevalence continues to cite this study.

A World Health Organization–funded study by Jones et al. (2012) provides the most comprehensive analysis of prevalence and risk of violence against children with disability. The study comprised a systematic review and meta-analysis of observational studies published between 1990 and 2010. The report pooled prevalence estimates of 26.7 per cent for combined violence measures, 20.4 per cent for physical violence and 13.7 per cent for sexual violence. On the basis of these estimates, the authors confirmed that children and young people with disability are more likely to be victims of violence than their peers without disability. Jones et al. (2012) concluded by noting the limited data available and the need for more robust data collection. One of the most recent Australian reviews of the extant literature on the experiences of violence and abuse of children with disability was conducted for the Royal Commission into Institutional Responses to Child Sexual Abuse (Child Abuse Royal Commission) by Wayland and colleagues (2016). The report provided estimates of the number of children and young people with disability who were likely to experience abuse (up to 14%), drawing on the Jones et al. (2012) review.

The greater prevalence of violence and abuse perpetrated against children and young people with disability is supported by recent Australian data. It shows that one fifth (20%) of adults with disability reported experiencing abuse before the age of 15 compared to one tenth (11%) of adults without disability (AIHW, 2020). Although the data is retrospective, it suggests even higher rates of violence against children and young people with disability than suggested by Jones et al.'s (2012) study; however, this may be due to methodological differences in the surveys.

One window into the intersection between childhood disability and DFV is out-of-home-care data. In 2019–20, children and young people with disability were over-represented, comprising 15 per cent of children in out-of-home care (AIHW, 2021b). To put this over-representation in context, 7.6 per cent of children aged 0 to14 years have disability and 9.3 per cent of people aged 15 to 24 years have disability (AIHW, 2020). This over-representation of children and young people with disability was interrogated in an earlier Australian study (Maclean et al., 2017). It found that children with disability in the child protection system had a significantly higher proportion of maltreatment allegations and substantiated allegations compared with children without disability. The analysis showed that some disabilities (intellectual disability, mental/behavioural problems and conduct disorder) had a higher risk of having maltreatment allegations and substantiated allegations than others (Maclean et al., 2017). The variations in risk by disability type confirm earlier findings by Sullivan and Knutson (2000).

The experience of violence and abuse by children and young people with disability

There is limited research on the association between mothers' experiences of DFV and the maltreatment of children with disability (Algood et al., 2011; Baldry et al., 2006; Sullivan, 2009). Dababnah and colleagues (2018) undertook a review to examine the relationship between exposure to intimate partner violence and intellectual and developmental disability. They noted the limited research on the topic, but that while it does not provide clear answers regarding directionality, the literature collectively tends towards tentative conclusions that intimate partner violence predicts disability, rather than the other way around.

Koh and colleagues (2021) completed a rapid evidence review for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission). They identified 10 studies examining child maltreatment, which reported that compared to children without disability, children with disability were at increased or higher risk of:

- experiencing sexual and physical abuse before and during care
- being reported and substantiated for any kind of maltreatment including physical, sexual and emotional abuse and neglect

- being at a higher risk for placement instability and entering out-of-home care, experiencing multiple maltreatment incidents
- being abused by more than one perpetrator.

The findings from these studies indicate that much maltreatment of children with disability occurs in a domestic/family context; however, it is unclear whether the maltreatment/violence extends to other family members.

Children and young people with disability can be subjected to abuse by a range of perpetrators – both family and non-family members – and the overlap between DFV and violence against children with and without disability is noted in the literature (Campo, 2015; Corr & Santos Milagros, 2017). Sullivan and Knutson's (2000) analysis of maltreatment against children and young people with disability reported that immediate family members accounted for the vast majority of neglect, physical abuse and emotional abuse, while non-family members were significantly more often the perpetrators of sexual abuse.

Studies reporting children and young people's experiences of violence

Most of the studies reported above are prevalence studies that examine administrative datasets to estimate violence against young people with disability. Clearly, such studies are vital for assessing the scale of the problem and for shaping prevention efforts; however, they provide only a partial insight into how violence affects children and young people with disability. Children and young people with disability have long been excluded from research, with researchers often relying on parents or other adults as proxies for their views. However, over the last two decades there has been growing recognition that children and young people with disability hold and can express views and contribute to research. Inclusive research methods are increasingly used, and researchers have the appropriate expertise to communicate with children and young people to explore their views and perspectives on a range of issues (Franklin & Smeaton, 2017; Sloper & Beresford, 2014). This growing body of research with children and young people with disability has included studies that have aimed to give voice to children and young people with disability about their views on safety (Hollomotz, 2018). This research is critical given the heightened risk of abuse faced by children and young people with disability.

Robinson et al.'s (2017) qualitative study explored what "being safe" meant to young people with disability. They found that four factors were considered as fundamental to a sense of safety: being physically safe, being emotionally safe, having access needs met (physical, social, emotional), and feeling capable. The young people in the study reported several strategies they used to keep themselves safe, including building strong relationships with family and friends; seeking support by confiding in trusted adults; knowing and using help-seeking skills (e.g. calling police); seeking protection through physical and emotional closeness with others; and avoiding potentially harmful situations. The participants also identified a range of actions that others could take to promote their safety, including:

- showing care and respect for children and young people with disability
- promoting young people's capability
- recognising young people's supportive contexts (i.e. family, friends) and identifying alternative supports if required
- taking action if concerned about the young person's safety
- supporting the young person's health and wellbeing, access and communication; providing learning opportunities
- supporting an accessible and inclusive environment.

Australian qualitative research conducted for the Child Abuse Royal Commission extended this approach, and explored how children and young people with disability develop and sustain a sense of safety in institutional contexts (Robinson & Graham, 2021). It identified several contributory factors. While safety is an abstract concept that can be difficult for some young people with disability to describe, the research identified several meanings attached to "being safe". These included feeling safe and secure; having a "go-to" person; not being hurt; not trusting strangers; following formal and tacit rules; and having some control in situations. Facilitators of institutional safety included having a secure foundational space; feeling known and valued; telling someone; having strategies; being educated about safety; and learning from experience. The study also identified barriers to being able to access these facilitators of safety: fears and worries; feeling out

of control; the impact of abuse; under-supported transitions (e.g. geographic, different services, leaving the care system); and complexity in family life.

A study by Jones et al. (2017) reported on the experiences of Deaf and disabled children regarding help-seeking following maltreatment. They identified three enablers of help-seeking: the capacity of adults to detect abuse and respond to disclosures; supportive relationships (with adults or peers) or circumstances which facilitate disclosure; and access to registered interpreters for Deaf children. In many cases, the young people did not disclose that abuse had occurred until long after it began, which highlights the importance of child protection education for children and young people with disability to help them recognise, respond to, and report abusive situations.

A UK study by Franklin and Smeaton (2017) explored service responses to young people with learning disabilities who were at risk of or had experienced child sexual exploitation. The research included in-depth interviews with young people with learning disabilities, in addition to stakeholders/service providers. Although the paper does not refer to DFV, a key finding of relevance to this review is the invisibility of young people with learning disabilities to a range of services. The study found that significant numbers of young people who became known to child sexual exploitation services had mild or moderate learning disabilities, but had no prior contact with other services or supports, disability or otherwise. This invisibility to services was attributed to several factors, including the "high threshold for disability services, lack of alternative provision to meet their needs and a low level of understanding of their impairments and their potential impact on young people's lives" (Franklin & Smeaton, 2017, p. 480). Many of the young people reported that this lack of recognition of their disability led to problems at school, with some ultimately disengaging from education.

These qualitative studies highlight the importance of adopting appropriate and inclusive methods to ensure that the voices of children and young people with disability are heard and that appropriate measures are taken to address their safety concerns.

Services

Despite an increased appreciation of the fact that many children and young people experience DFV, research and inquiries continue to demonstrate that children and young people's unique needs, interests and wishes are often missed in DFV policy and program initiatives (Øverlien, 2010; Överlien, 2017). Approaches to reducing and responding to DFV have often failed to be child-inclusive or responsive. They often operate on assumptions that children and young people are not directly affected by exposure to DFV and are secondary clients and that if the needs of mothers and families are met, then outcomes will improve for children (Noble-Carr et al., 2020). In research conducted in Australia and abroad, children and young people have reported feeling "invisible" and sustained in unsafe environments with little input into assessments of need and minimal influence over how they and their families are supported (Moore et al., 2020).

Over 15 years ago, Baldry et al. (2006) highlighted the lack of an integrated response to women and children with disability who experienced DFV. Despite the passage of time, more recent studies have reaffirmed this finding (Fraser-Barbour et al., 2018; Robinson, Hill et al., 2020). Fraser-Barbour et al. (2018) interviewed staff from disability services and mainstream violence response services. They reported that staff from both services lacked awareness of practical ways in which they could support people with intellectual disability to report and access services outside of disability-specific services. They identified a lack of understanding, resources, awareness of or education about people with intellectual disability as victims of crime. Robinson, valentine et al. (2020) found that despite the very high prevalence of DFV where disability is present, the two are still rarely connected in a policy and service delivery sense. Service providers reported being aware of or recognising the signs that might indicate DFV, but for many, disability was a "bit of a grey area" (Robinson, valentine et al., 2020, p. 59), particularly intellectual disability. In circumstances where both DFV and disability are present in a family, it was noted that the needs of the person with disability can often be overshadowed if the family is presenting primarily due to DFV concerns.

Both studies pointed to the need for resources to guide professional practice across disability and wider violence-

response services. Robinson, Hill et al. (2020) identified the need for a literacy-building resource to assist specialist and mainstream service providers to identify/recognise disability and to identify risks of domestic violence. The critical importance of integrated service responses that are skilled and equipped to recognise the intersections between disability and family violence are critical to keeping children and young people with disability safe (Maclean et al., 2017; Robinson, Hill et al., 2020). Robinson (2015, p. 2) highlighted the need to reconsider the "intersections between specialist and mainstream violence prevention and service provision agencies – disability and child protection, education, domestic violence, family support, and health systems".

Policy review

Campo (2015, p. 2) noted that "policy responses to children exposed to domestic and family violence are complicated by the intersecting policy jurisdictions of child protection, family law and domestic violence sectors". The matter appears to be complicated further where children and young people with disability are concerned, due to the added disability policy domain. A body of scholarship highlights how children and young people with disability have long been poorly represented in policy and how they are not a focus of child protection or DFV policies or frameworks (Hernon et al., 2015; Robinson et al., 2017; Wayland et al., 2016).

In their comprehensive policy analysis for the Child Abuse Royal Commission, Wayland et al. (2016) highlighted that viewing disability as a risk factor for abuse goes against Australia's human rights and disability rights obligations to view children with disability as children first and disabled second. This framing of children with disability in terms of risk rather than in terms of their rights has resulted in them being sidelined in policy. Wayland et al. argued that "if children with disability were regarded as children first, with disability regarded as only one aspect of their lives, they would have a strong presence in policy frameworks designed to keep all Australian children safe" (2016, p. 31). Additionally, they noted that disability legislation, policy and strategy frameworks and implementation plans in Australia are increasingly aligned with international practice in rights, citizenship and social responsibility. However, these documents focus on adults with disability and effectively exclude children and young people with disability. This point was echoed by Powell et al. (2020).

Despite some indications that children and young people with disability are becoming more visible in policymaking, they continue to be overlooked in key policy documents. For example, the Commonwealth of Australia and the Australian Human Rights Commission developed *A Guide for Children and Young People to the National Strategy to Prevent and Respond to Child Sexual Abuse (2021–2030) and its Action Plans* (2021), but the resource makes no reference to disability. Additionally, many DFV research and advocacy documents acknowledge disability, but only in reference to women/mothers with disability, not children and young people with disability (AIHW, 2019; Di Nicola et al., 2019; Our Watch, 2019).

Children and young people have limited opportunities to engage in policy design, and those with disability have even less so (Powell et al., 2020). A policy forum report from Families Australia and Children and Young People with Disability Australia (CYDA) emphasised that more needs to be done to ensure that children and young people with disability have opportunities to participate meaningfully in policy design and the importance of reframing policy discourse about disability from a rights-based perspective instead of a risk/vulnerability/deficit one (Families Australia, 2021).

There have been recurrent calls for the need for improved data collection relating to risk and abuse of children with disability, so as to inform policy (Commonwealth of Australia, 2009; Sutherland et al., 2021; Wayland & Hindmarsh, 2017). Some progress has been made on this front, with fieldwork for the first Australian Child Maltreatment Study – which includes a focus on disability – commencing in 2021 (Mathews et al., 2021).

As children and young people with disability who experience DFV are caught at the intersection of multiple policy domains, the following policy review examines key policies and frameworks at the federal level in the policy areas of DFV, disability and child protection. Table 1 lists the federal policy documents covered in this review. Although they are not policy, documents and reports produced by the Child Abuse Royal

Table 1: Federal policy documents and Royal Commissions

Domestic and family violence (DFV)
National Plan to Reduce Violence against Women and their Children 2010–2022 (including four action plans)
Draft National Plan to End Violence against Women and Children 2022–2032
Disability
National Disability Strategy 2010–2020
Australia's Disability Strategy 2021–2031
Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
National Disability Insurance Scheme
Child protection
Protecting children is everyone's business: National Framework for Protecting Australia's Children 2009–2020
Safe and Supported: The National Framework for Protecting Australia's Children 2021–2031
National Strategy to Prevent and Respond to Child Sexual Abuse (2021–2030) and First Action Plan
Royal Commission into Institutional Responses to Child Sexual Abuse

Commission and the Disability Royal Commission are also included. While the recommendations provided by Royal Commissions are not legally binding, "many are expected to generate findings and recommendations that will lead to policy change" (Mintrom et al., 2021). This section of the review begins by examining DFV policy to ascertain the degree to which children and young people with disability are considered in frameworks and plans. This is followed by an examination of disability and child protection policies.

We note that there are many other policy domains that are important to children and young people with disability – particularly health, education, housing, local community/government, and community services. It is not possible in the scope of this project to review all of these, and for expedience, in this review we focus on the priority domains around disability, childhood and violence.

Domestic and family violence policy

National Plan to Reduce Violence against Women and their Children 2010–2022

In 2009, the Australian Government released the *National Plan to Reduce Violence against Women and their Children 2010–2022* (Council of Australian Governments [COAG], 2011b). The focus of the National Plan was to prevent violence through primary prevention initiatives leading to cultural change. The National Plan outlined a framework for action over a 12-year period, to be implemented through four three-year action plans. The National Plan and the subsequent action plans identify disability as a risk factor for violence, but primarily in reference to women who experience violence. Children with disability are not recognised as requiring specialist support. The action plans progressively include women with disability and mention children. However, they have not resulted in resourced activities or programs for children with disability.

Draft National Plan to End Violence against Women and Children 2022–2032

At the time of writing, the *Draft National Plan to End Violence against Women and Children 2022–2032* (Commonwealth of Australia, Department of Social Services, 2022) has concluded its final consultation period. The Draft National Plan acknowledges children as victims and survivors in their own right. It includes foundation principles to "draw upon the diverse lived experience of victim-survivors to design appropriate and effective policies and solutions" and to take an "intersectional and evidence-informed approach that considers the complexity and diversity of people's lived experiences" (p. 7). The four proposed pillars of the Draft

National Plan are prevention, early intervention, response, and recovery. Action plans are proposed to direct resources and activities to priority groups. This is a promising signal for children and young people with disability, if the policy settings can be brought into alignment with children's and disability policy.

Disability policy

National Disability Strategy 2010–2020

The National Disability Strategy 2010–2020 (NDS) marked "the first time in Australia's history that all governments have committed to a unified, national approach to improving the lives of people with disability, their families and carers, and to providing leadership for a community-wide shift in attitudes" (COAG, 2011a, p. 3). The NDS represented Australia's response to its 2008 ratification of the UN's Convention on the Rights of Persons with Disabilities (CRPD). The NDS covered six policy areas aligned to the principles underpinning the CRPD. One policy area addressed "Rights protection, Justice and Legislation", under which sat five "Policy directions". The fourth policy direction was "People with disability to be safe from violence, exploitation, and neglect". The NDS noted the research that shows that people with disability are more vulnerable to violence, exploitation and neglect; that they fare worse in institutional contexts where violence may be more common; that they are more likely to be victims of crime; and that women with disability face increased risk of violence compared to women without disability.

Australia's Disability Strategy 2021–2031

In December 2021, a new 10-year disability strategy was released, building from the previous NDS. *Australia's Disability Strategy 2021–2031* (ADS) is an important tool, as it is the domestic instrument reflecting Australia's ratification of the UN's CRPD. Alongside the ratification of the United Nations Convention on the Rights of the Child, these ratifications provide a clear human rights framework for protecting the rights of children and young people with disability (Robinson, 2015).

The ADS strengthens the focus of the previous "Rights protection, Justice and Legislation" policy area in the NDS. It has been changed to "Safety, Rights and Justice", and adds a seventh outcome area focused on "Community attitudes" (Commonwealth of Australia, Department of Social Services, 2021a). The emphasis on safety is a new focus that highlights the importance of the conditions in which rights must be respected. Under the "Safety, Rights and Justice" outcome, six policy priorities are listed. The third policy priority explicitly recognises the need for policies, processes and programs for people with disability to recognise and prevent violence against women and their children.

The ADS emphasises the need for cross-sector collaboration in violence prevention efforts and highlights the need to consider this new disability strategy in conjunction with the National Plan (COAG, 2011b) and the *National Framework for Protecting Australia's Children 2021–2031.* It calls for ensuring that actions taken to deliver on policy priorities are implemented using an intersectional and diversity lens. This represents a significant step forward from the NDS, which did not explicitly consider the issue of intersectionality.

The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) was introduced in 2012 and was implemented from 2013 to change the way disability supports were being provided to people with disability. The aim of the NDIS is to "provide support to eligible people with intellectual, physical, sensory, cognitive and psychosocial disability. Early intervention supports can also be provided for eligible people with disability or children with developmental delay. The NDIS gives all Australians peace of mind if they, their child or loved one is born with or acquires a permanent and significant disability, they will get the support they need." (NDIS, 2021). It provides eligible individuals with a funding package to buy the supports identified in their individualised plan, with the intention of giving them more choice and control over their lives. To access the Scheme, people need to contact local Partners in Community agencies (mainly non-government organisations) or the National Disability Insurance Agency (NDIA) and complete a series of eligibility processes, which often involve assessment.

In 2016, the NDIA, responsible for implementing the NDIS, introduced the Early Childhood Early Intervention (ECEI) approach for children aged 0 to 6 years. The ECEI is intended

to provide early intervention support for children who may have developmental delay or other possible disability but may not have a formal diagnosis and may be eligible for funding under the NDIS. Children aged over 7 are eligible for NDIS support if they meet either the disability or early intervention criteria.

"Support coordination" is the term used in the NDIS for "capacity building support which helps you to understand and use your NDIS plan to pursue your goals; connect you with NDIS providers, community, mainstream and other government service providers; [and] build your confidence and skills to use and coordinate your supports" (NDIS, 2021). There are three levels of support coordination which can be funded, each of which provide progressively higher levels of assistance: support connection, support coordination, and specialist support coordination. Specialist support coordination

> is for people whose situations are more complex and who need specialist support. A specialist Support Coordinator will assist you to manage challenges in your support environment and ensure consistent delivery of service. (NDIS, 2021)

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

The Disability Royal Commission was established in April 2019 "in response to community concern about widespread reports of violence against, and the neglect, abuse and exploitation of, people with disability" (Public Advocate, 2022). Children with disability are included in the remit of the Disability Royal Commission.

Between October 2019 and March 2021, the Disability Royal Commission produced 12 issues papers. One paper particularly relevant to this review focused on violence and abuse of people with disability at home (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2020). This issues paper recognised "home" could include many types of accommodation, including:

- private and family homes
- specialist disability accommodation
- out-of-home care
- boarding and rooming houses and hostels
- domestic and family violence shelters, homeless shelters and refuges. (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2020, p. 1)

It considered all forms of violence and abuse in the home, noting that it is often referred to as "DFV" and that there are many potential perpetrators of violence and abuse. The issues paper included a brief section on children with disability, which recognises that they:

- experience abuse in all types of homes, including out-of-home care
- may be exposed to family violence, which can have an adverse effect on their development. (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2020, p. 5)

Child protection policy

Protecting children is everybody's business: National Framework for Protecting Australia's Children 2009–2020

Protecting children is everybody's business: National Framework for Protecting Australia's Children 2009–2020 outlined how the Commonwealth, state and territory governments and non-government organisations should work together to protect Australia's children. Childhood disability was only mentioned in reference to being one of several "known risk factors for abuse and neglect" (Commonwealth of Australia, 2009, p. 50).

Safe and supported: National Framework for Protecting Australia's Children 2021–2031

In December 2021, *Safe and Supported: National Framework for Protecting Australia's Children 2021–2031* (Commonwealth of Australia, Department of Social Services, 2021b) was released. "The bests interests of the child" are placed at the heart of the Framework, which asserts that "listening to the voices of children will be key to our success" (p. 2). The Framework will be delivered by two five-year action plans, with a specific action plan for First Nations peoples. The Framework aligns and interacts with other national initiatives "to support systemic change for children, young people and families". These include the National Plan (COAG, 2011b), the *National Strategy to Prevent and Respond to Child Sexual*

Abuse 2021–2030 (Commonwealth of Australia, Department of the Prime Minister and Cabinet, 2021), and the *National Aboriginal and Torres Strait Islander Early Childhood Strategy* (National Indigenous Australians Agency, 2021).

Among the priority groups, the Framework lists "children and young people and/or parents/carers with disability experiencing disadvantage or who are vulnerable" (Commonwealth of Australia, Department of Social Services, 2021b, p. 22). This is a significant development in recognising the increased risk of violence and abuse that children and young people with disability face. The Framework emphasises the need for a whole-of-government approach and includes focus areas targeting early intervention and targeted support. Principles are directed towards building evidence and data to support quality practice, giving primacy to "the knowledge, insights and experiences" of the four priority groups, and developing trauma-informed responses and systems (p. 36).

National Strategy to Prevent and Respond to Child Sexual Abuse (2021–2030)

The development of the *National Strategy to Prevent and Respond to Child Sexual Abuse (2021–2030)* (Commonwealth of Australia, Department of the Prime Minister and Cabinet, 2021) and its First Action Plan was a key recommendation from the Child Abuse Royal Commission. It focuses on child sexual abuse in all settings, including in organisations, online, within families, and by people known and unknown to the child or young person. The National Strategy "is a whole-of-nation policy approach that provides the strategic framework for increasing our understanding of, better responses to, and prevention of child sexual abuse over the next 10 years" (Commonwealth of Australia, Department of the Prime Minister and Cabinet, 2021). Action plans will outline how the strategy can be implemented in practice. The First Action Plan has five themes focused on building child-safe cultures, supporting victims and survivors, improving responses to children with harmful sexual behaviours, offender prevention and intervention, and improving the evidence base.

The First Action Plan acknowledges "people with disability" as one of six priority groups and notes that there are gaps in the data about the experiences of children and young people with disability. The Plan emphasises the role of organisations in providing services and supports to children and young people in a child-safe way. It notes that they have mandatory reporting obligations which means they must report suspicions of child sexual abuse. In addition to schools, sporting and other organisations, disability support services are listed.

The Royal Commission into Institutional Responses to Child Sexual Abuse

The Child Abuse Royal Commission was conducted between 2013 and 2017. Alongside hearings and a series of issues papers, the Child Abuse Royal Commission developed a research program to answer key questions and identify gaps in the Australian and international evidence base.

In December 2017, the Child Abuse Royal Commission released its final report, comprising 17 volumes and 409 recommendations. The 12-page fact sheet *A brief guide to the final report: Disability* (Royal Commission into Institutional Responses to Child Sexual Abuse, 2017) highlighted the sections of the final report that focus on disability issues. It began by noting that while all children are vulnerable to sexual abuse in institutional contexts, children and young people with disability are at greater risk. The guide described how people with disability were supported to participate in and contribute to the Child Abuse Royal Commission, including through private sessions. Additionally, it noted the research it commissioned concerning children and young people with disability (Robinson, 2016; Wayland et al., 2016). It presented the key themes that emerged from accounts provided by survivors with disability in private sessions: experiences of abuse, wellbeing, and disclosing the abuse. The guide summarised key issues concerning how to make institutions safer for children; advocacy, support and therapeutic treatment; children's harmful sexual behaviours; and different types of institutions. It also referred to several recommendations relevant to disability, which relate to the following:

- accounting for equity and diversity needs in child-safe standards
- ensuring that reportable conduct schemes include organisations supporting children with disability

- funding therapeutic and trauma support services for people with disability who have experienced child sexual assault
- improving police responses
- accessing to redress.

Summary

Children and young people with disability who experience DFV are caught at the intersection of multiple policy domains (DFV policy, disability, child protection), and integrated policy and service responses are lacking. When families experiencing DFV come to the attention of services, it is often due to the need for a DFV service response. Specialist DFV services are not always attuned to working with children and young people, particularly those with disability. Similarly, specialist disability services may not be equipped to respond to DFV matters. Additionally, many mainstream services do not have the expertise to recognise disability or signs of DFV.

The research literature shows that people with disability are at more risk of experiencing violence, exploitation and neglect than people without disability. However, perhaps the most striking finding from the review of the research literature is the fact that the research base and extant knowledge about children and young people with disability who experience DFV is limited and largely reliant on international and dated data. This highlights the lack of recognition afforded to children and young people with disability who experience DFV. Nevertheless, there are encouraging signs that the need to improve data collection has prompted action, with the Australian Child Maltreatment Study currently being undertaken in the field, which aims to capture representative data for people with disability. Additionally, the emerging body of research giving voice to children and young people with disability and examining their perspectives on safety is encouraging.

There are reassuring signs that national policies are beginning to acknowledge the intersecting nature of disability, violence and children's rights. However, limited attention to cross-jurisdictional resourcing and action is also evident. Policy often continues to be developed in a fractured manner, with limited recognition of the need for integrated responses to address the needs of children and young people with disability who experience DFV.

In summary, this review points to gaps in policy and knowledge with respect to children and young people with disability who experience DFV. At the same time, it indicates some promising developments with respect to recognising the intersecting nature of disability, violence and children's rights in policy. A small but increasing emphasis on promoting the lived experience and perspectives of children with disability and their families is evident. It remains to be seen how this recognition translates into cross-sector collaboration and/or integrated service delivery and practice.

Methods

Aim and objectives

This research aimed to provide new knowledge on how children and young people with disability experience DFV. It had the following objectives:

1. Scope and map current data capture of children and young people with disability experiencing DFV; identify gaps and limitations in the data; and map new intersections unique to this population.
2. Develop a new understanding of the support and service needs, priorities and perspectives of children and young people with disability experiencing DFV, and the system barriers and enablers they encounter.
3. Determine steps to bring service processes into better alignment with the priorities of children and young people with disability.

Research questions

To achieve these objectives, our research questions were as follows:

- What is known about the nature and extent of the experience of DFV by children and young people with disability?
- How do children and young people with disability who have experienced DFV and their families experience support from services, and how well does this support meet their needs?

The project took a mixed-method approach, conducted across three phases. The methods of Phase 1, data linkage and case study analysis, are detailed in the companion report. This report details the methodology for the overall study and the research design for Phases 2 and 3.

Theoretical framework

Children and young people who are exposed to DFV are present in various current jurisdictional datasets, including health, police and child protection. These datasets provide a significant untapped opportunity for understanding the prevalence and extent of DFV experienced by children and young people with disability across sectors, as well as early intervention and prevention responses and potential for data linkage. Alongside these, child- and disability-rights approaches can guide qualitative inquiry. These approaches centre the views of children and young people with disability and their families, and the ways that their experiences impact their lives and can shape more responsive policy and service practice.

The project applied intersectionality theory and approaches to children's rights and disability rights. It considered the various ways in which disability, age and gender (along with other forms of difference) intersect and how these influence the ways children and young people with disability experience DFV and the service responses they receive.

Intersectionality

Intersectionality emerged as an analysis of power and oppression and a critique of feminist analyses that neglected forms of difference other than sex/gender, including race, class, sexuality, age and disability (Cho et al., 2013). Intersectionality describes the effects on people of living on multiple axes of oppression simultaneously (Shaw et al., 2012; Stubbs, 2015). According to Stubbs (2015), these disadvantages can arise from:

- institutional failures to meet people's needs, such as discriminatory schools and health systems
- inappropriate responses from services and agencies, such as child protection
- inadequate capacity of various services to respond to people's needs with appropriate knowledge and skills
- organisational constraints related to resources, service models and system capacity.

Intersectionality was central to our research design. It considered the multiple and compounding intersections of disability with youth and DFV, with consideration also given to Indigeneity, cultural and linguistic diversity, and rural and remote residence.

Children's rights and agency

Drawing on scholarship from childhood studies and from critical disability studies, the perspectives of children and

young people with disability are explicitly addressed in the project. We recognise that children and young people have needs, preferences and priorities that may or may not align with their mothers and respects children and young people as expert informants on and decision-makers in their own lives (Curran & Runswick-Cole, 2014 ; James et al., 1998). An approach that opens multiple ways to participate counters the silencing of children and young people with disability that often occurs in research on sensitive subjects, while still respecting that for some children and young people, participation in research such as this is not possible for many reasons (particularly relating to trauma).

Children and young people have been, and to some extent still are, viewed and labelled as "witnesses" of DFV. This can focus attention of service providers solely on the physical presence of children during episodes of violence, or on children being "exposed" to violence, which can minimise the impact of their experience and reduce or remove consideration of their agency (Callaghan et al., 2018; Noble-Carr et al., 2020). Alongside this, a focus in policy and practice on the "inherent risks" associated with disability in children and young people has failed to alleviate or address their vulnerability or safety, and has not adequately considered how situational or environmental vulnerability might have a significant part to play in understanding the importance of context (Hall & Bates, 2019; Hollomotz, 2011). Rather, this individualistic focus places responsibility for such vulnerability with the child or young person, and in so doing, locks in disability as a deficit within the child rather than a combination of individual experience and social and structural relations (Curran & Runswick-Cole, 2014).

In broader research with and about children's lives, children and young people are increasingly recognised as individuals, with their own priorities and perspectives, distinct from their parents. However, there is a need for a more nuanced and child-centred understanding of their experiences and needs in research on sensitive issues (Arai et al., 2021). Elliffe et al. (2020) argue that there is growing concern in the DFV literature about ascertaining children's views "in order to develop more child-centred responses", but there remain significant challenges to including their voices in research. This includes a lack of understanding of children's agency, and an "invisibility" of children in research and practice. Emerging DFV research informed by childhood studies is finding that children living in DFV situations wish to take an active role in decision-making and are more active in supporting themselves and others than previously thought (Katz, 2015).

Children's involvement in research, particularly on sensitive topics such as DFV, can be challenging. Firstly, it requires a commitment by researchers to engage children and young people in safe and ethical ways and to have the skills to be responsive to their unique needs and wishes. Secondly, it requires researchers to negotiate with a series of "gatekeepers" such as ethics committees, service providers and families. These gatekeepers may question the value and right of children to participate in research and/or have concerns about the safety of children in discussing sensitive topics (Taplin et al., 2022). Finally, it requires partnership with organisations and staff to find often-hard-to-reach children and to facilitate their engagement (Martins & Sani, 2020). Researchers have reflected that gatekeepers can often be risk averse and need encouragement to balance children's right to participate in research with their right to protection (Cater & Øverlien, 2014).

Recent approaches to undertake research with children who experience DFV have involved triangulating their voices with the perspectives of others, situating their experience in the context of their family, the violence, their actions and resiliency, and their interactions with services and professionals (Elliffe & Holt, 2019 ; Katz, 2019). A strengths-based approach to this recent research also balances researching children's negative life experiences with researching the ways they experience safety and resiliency, and their experience as active agents in their world, including their acts of resistance (Morris et al., 2020).

Recent research with mothers and children with disability found that children's priorities are rarely directly responded to within the frameworks of DFV prevention and response services (Robinson, valentine et al., 2020). This research identified the need for further work to explore opportunities to build trauma-informed collaborative practice across service systems, which includes a child-focused approach.

Table 2: Research design of project

Phase 1	Phase 2
Analyses of administrative linked datasets across sectors Case study analysis	Qualitative research with children and young people, families/carers & practitioners
Phase 3	
Workshops to generate collaborative priorities from the results of Phases 1 & 2 to bring service processes into better alignment with children and young people's priorities	

Violence against women and children

Feminist analysis of gendered violence and the social model of disability are integrated in a conceptual approach first developed by Mays (2006; see also Baranti & Yuen, 2008) of feminist disability theory. This is a helpful theoretical standpoint for our research. It emphasises the intersections of gendered and ableist norms that work to produce and reinforce the environments in which violence against women with disability occur, and what is needed for services and responses to be effective and accessible. Our research extends this to children with disability.

Research design

This research project responds to the identified priority gaps in population-level data and understandings of lived experience. It uses a mixed-method approach to build a scaffolded understanding of the experience of DFV and service responses for children and young people with disability and their families. The three-phase design (Table 2) connects findings from existing datasets to form a national picture of prevalence and risk, identifying data limitations and opportunities to improve policy and practice. It also prioritises the voice of children and young people with disability through qualitative and co-design activities that identify their support and service needs in the context of DFV, and their priorities for safety and for moving forward.

Phase 1: Quantitative analysis

The first component of Phase 1 (Phase 1A) was the quantitative analysis of Western Australian administrative linked datasets containing information about disability and/or DFV. We accessed a range of datasets (police, hospital morbidity, emergency department, and child protection). The second component of Phase 1 (Phase 1B) was undertaking a child protection case file analysis of intake forms from a South Australian child protection jurisdiction to understand the nature and experience of DFV by children and young people with disability.

The methods and findings of this phase are detailed in the companion report (Octoman et al., 2022).

Phase 2: Qualitative analysis

A qualitative study was conducted in parallel to Phase 1. Informed by the domains and emerging findings of the data analysis in Phase 1, this phase identified the support and service needs and priorities of children and young people with disability and their families, and enablers and barriers to violence-responsive services across a range of service sectors.

Interviews and focus groups were conducted with each of the key participant groups:

- children and young people with disability (aged eight to 24 years): interviews focused on everyday life and priorities; support and service needs; priorities for generating safety; advice to other children and young people
- families/carers of children and young people with disability: interviews focused on perspectives on support and service needs of children and young people; what helps their child prevent and mitigate effects of exposure to DFV
- practitioners across service types: interviews and focus groups focused on opportunities and barriers to violence-responsive practice; system features to identify, prevent and mitigate effects of exposure to DFV for children and young people with disability.

The initial project design included participants from the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands, with the aim of capturing the perspectives of First Nations children, families and practitioners. However, early in the project it became clear that it would not be possible to proceed with this part of the fieldwork (see "Limitations" section).

Phase 3: Triangulation

The final phase triangulated the results of the first two phases to build evidence for policy and practice. Working with a subset of participants, stakeholders and the advisory group, workshops generated collaborative priorities and recommendations for how we can bring practice and policy into better alignment with young people's priorities for support.

Co-design

Co-design was important across the life of the project. Engaging and involving a broad array of stakeholders in "co-designed" research projects has become an increasingly popular methodological approach (Palumbo, 2016; Slattery et al., 2020). Central to the concept of co-design is an intention to meaningfully include relevant stakeholders or end-users in the various aspects of project design and implementation, with a goal of strengthening the research project that is being considered, thereby increasing relevance and acceptability (Green et al., 2020; Slattery et al., 2020). Co-design methods hold particular promise for research that focuses on groups whose voices are often marginalised and who are often disempowered. Providing the conditions for service users and providers to work together can be transformative in creating better systems and services and for meeting diverse needs and priorities (Mulvale et al., 2019). However, this is not without challenges. The participation of groups experiencing intersectional disadvantage in co-design research may be restricted due to issues with initial engagement; power differentials; accessibility; and health, economic and social circumstances affecting participation (Mullins et al., 2021).

In keeping with the principles of inclusive research and co-design, the project proposal was built in consultation with organisations for people with disability and key advisors with disability. We established a policy and practice advisory group and employed a co-researcher who was a young person with lived experience of disability once the project was funded. The advisory group was formed at the commencement of the project and met on a semi-regular basis according to the project's key milestones. It provided advice and input, particularly about the recruitment and dissemination strategies and interpretation and presentation of the findings. The co-researcher worked from the outset of the project and contributed significantly to all aspects of the project, including the design of the project information and recruitment materials, the development and refinement of the interview questions and process, the design and running of the Phase 3 workshops, and the analysis and writing of both project reports. We were unable to successfully develop an intended young people's advisory group, despite several attempts to recruit through direct contacts, service providers and peak organisations.

We were able to involve young people in a secondary advisory layer in the project in Phase 3. Here we took a flexible approach to checking in with them about how their own contributions and those of other young people had influenced the project results. A small group anticipate remaining in contact as the project enters the knowledge exchange phase and we develop a summary for children and young people.

Information, consent and interview design

Tailored sets of information and consent materials and interview guides were designed for each of our three groups (children and young people, family members, and practitioners). We developed advertisements inviting participation for children, young people and family members, and sent letters and emails of invitation to practitioners. In the later stages of the project, social media advertisements were also shared with families and young people.

We developed an information pack for practitioners who were supporting recruitment to share with families and young people. This included an invitation flyer, information sheet and consent form with an easy-English alternative and a pictorial social story. These materials were also used directly by the researchers in recruiting children and young people with disability. Materials were developed in English, but funds for translating them into other languages were available. Appendices A to C provide examples of the adapted project recruitment materials.

Flexibility was built into the approach to interviewing the participants so the research team could respond to the preferences and circumstances of participants. An iterative approach to consent and assent was built into the interview process for researchers to check for any reluctance to participate, particularly in children. All interviews were

completed in person or by video call or phone call (interstate participants were only able to participate via video or phone call). All children and young people and family members were offered the opportunity to have a support person with them during their participation. Alternative and accessible methods were also offered to children and young people as well as their family members, including pictorial mapping, walk-along interviews and game or sensory activities. Interpreters (Auslan and other languages) were made available and assistive communication support was encouraged.

Individual interviews with children and young people with disability were designed to be very brief to keep children engaged, and simple so that younger children could understand, and they explicitly avoided discussing the violence they had experienced unless the child or young person raised it themselves. Young people's assent/consent was established at the outset of the interview. This was separate to their parent's consent, using a verbal script or an easy-English consent form. We asked four main questions, but were very much guided by how the children and young people wanted to take the conversation:

- Can you tell me a bit about yourself and your family?
- What is important to you?
- What helps you and your family to be safe and happy?
- What do you think would help other kids who have the same kinds of experience as you to be safe and happy?

This research team has used multiple alternative and accessible methods with young people and adults with diverse support needs and preferences in previous studies, finding pictorial mapping to be particularly helpful for those who preferred an alternative way to express themselves beyond speaking (Robinson, 2014; Robinson, Hill et al., 2020). Pictorial mapping was popular among the children and young people who were interviewed in person, and many of the children who were either interviewed or present during a family member interview engaged strongly with the games and sensory activities. All child and family participants were offered $40 gift vouchers to thank them for their expertise, time and contribution.

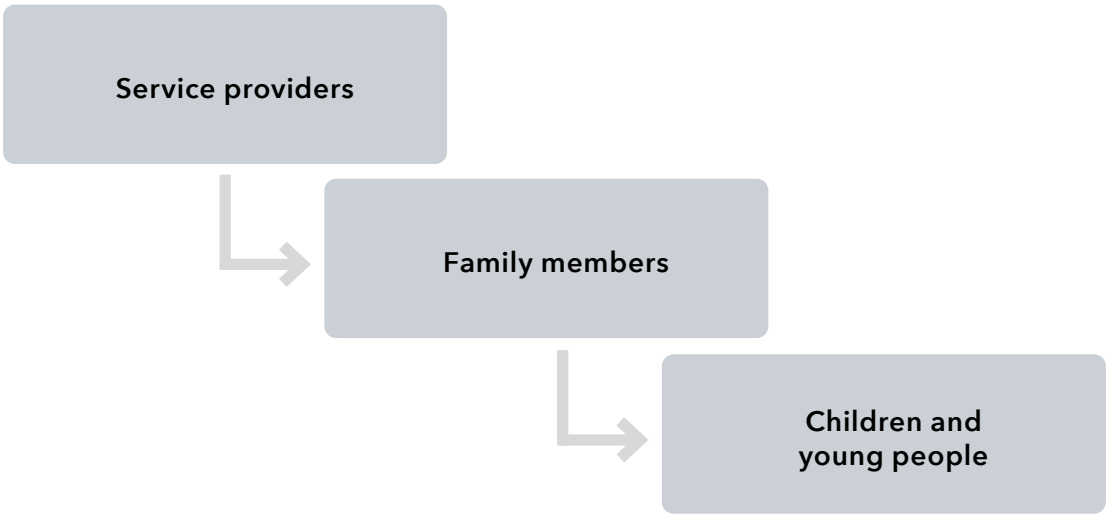
Individual interviews with family members were designed to support participants to critically reflect on the service needs and experiences of the children and young people with disability in their family, during or after experiencing DFV. We took a strengths-based approach by focusing particularly on what helped. This interview guide (Appendix D) included questions about the general family context, which services and supports the family accesses, what is most important to them and their child, and advice for other families in their situation.

The interview schedule of practitioners was designed as a single interaction that could be used in either a focus group setting or individual interview depending on the preferences and availability of practitioners. This interview guide (Appendix E) included questions about the general service context, recognising and responding to disability and DFV, service barriers and enablers, and ideas for improvement.

Recruitment

Recruitment was conceived as an iterative process (Figure 1) whereby practitioners would be recruited through participating services, who would then invite family members they worked with to participate, who would then support their children to participate. This iterative design was informed by the importance of trusting relationships and getting to know the research team before the next participant group is invited to participate. Parents who have been subjected to DFV are often vigilant about who their child meets (and rightly so). Previous experience has shown us how difficult it is to directly recruit children and young people with disability to research on sensitive topics. Without parental engagement with the researchers, families can be reluctant to trust that the process will be safe for their children. Interviewing families first allowed them to build confidence that we were trustworthy, and to make more informed consent about their child's participation. It also allowed us to establish a sense of any potential coercion from families for their children to participate. In keeping with ethical requirements, this recruitment process kept the researchers at "arm's length", with practitioners passing on information about the project and contact details for family members and young people to contact the research team directly if they wished to participate or to seek further information.

Figure 1: Iterative recruitment



Participant eligibility was purposefully broad, particularly regarding disability. Our approach took a non-diagnostic approach and relied on people's self-identification as having disability, in recognition of the fact that many people with disability may not have a formal diagnosis while others may not identify as people with disability. With regards to experience of DFV, we were similarly non-prescriptive, as it manifests in different ways. Practitioner participants were eligible if they provided any type of support or service to children and young people with disability and/or their family members during or after they had experienced DFV. This included disability services, DFV services, advocacy services, health services, justice services, and community and housing services. Family member participants were eligible if they were a caregiver for a child or young person with disability of any type under the age of 25, and their family had experienced DFV but were not currently in crisis. Children and young people were eligible if they were aged between eight and 24, lived with disability of any type, and their family had experienced DFV but were not currently in crisis.

The initial research design included metropolitan Adelaide, two regional centres in South Australia, and the APY Lands. The APY Lands was withdrawn as a fieldwork site early in the project (see amendments, below), apart from remote interviews with practitioners.

Services that operated in the fieldwork areas were identified and contacted by the research team with an invitation to participate. Once services indicated they were willing to participate, communication between the research team and the service identified potential participants within the organisation, and interview/focus group times were arranged according to the preferences and circumstances of the service. Invitations to services commenced in May 2021, and services were continually recruited as they were identified until November 2021.

Amendments to design

An amendment to the ethics approval from Flinders University was sought in August 2021 to expand the age range of children and young people included in the project. Initial approval was sought for participants aged between 12 and 18 years. However, upon commencing data collection with practitioners and family members, it became apparent that this would be too restrictive and exclude child participants under the age of 12 and older participants aged between 18 and 25 years who would be able to bring valuable reflections on their earlier experiences. The non-invasive approach we used in interviews with children and young people with disability on this sensitive topic (Robinson & Graham, 2021) adapted methods to support participation (Hollomotz, 2018; Robinson, Hill et al., 2020), and demonstration in related studies that both younger and older children and young people had contributed to sensitive research (Franklin & Smeaton, 2017; Jones et al., 2017) all supported our rationale to extend the age range. No young participants reported distress or discomfort from their participation in the interviews.

We experienced several recruitment difficulties. These were mainly due to the impacts of COVID-19 (discussed below under "Limitations") and the reticence of many services in our target regional areas to participate. When recruitment slowed, ethics approval was sought and granted from Flinders University (October 2021) to include additional methods of recruitment. These new recruitment methods utilised social media to distribute short advertisements aimed at family members and young people with disability, inviting them to

contact the research team directly for more information if they were interested in participating (Appendices A and B). These were distributed on Twitter, Facebook and LinkedIn by the research team and shared by multiple disability, advocacy and research organisations and individuals. This also enabled the recruitment of child and family participants from interstate.

The study originally aimed to recruit in three regional/rural/remote South Australian communities. However, COVID-19 made travel to these communities impossible, and practitioners made it clear that recruitment in this context was not possible. Our remote site in the APY Lands was facing particular shortages of staff in child and youth services, which made service provision in an already under-served region even more precarious, and after consultation with key stakeholders it was deemed unethical to try to conduct sensitive fieldwork with children in the current context there. Online interviews with practitioners and families in regional, rural and remote communities were conducted.

Sample

We conducted interviews with a range of people with expertise about the service needs and priorities of children and young people with disability who experience DFV. Interviews were conducted between July 2021 and January 2022.

Children and young people with disability and their family members were located across South Australia, Victoria and New South Wales. All practitioner participants were located across metropolitan and regional locations in South Australia.

The experiences of 36 children and young people with disability are represented in the study. Twelve children and young people with a range of disabilities took part in interviews with the researchers, where they expressed their views about their own experiences and ideas directly. These children and young people were aged between eight and 20 years. Interviews were either in person or via video call. The experiences of a further 24 children and young people with disability aged between six and 24 years who were not able to participate directly for a range of reasons (including trauma, complex support needs, and child removal) are also represented in the report through the perspectives of their family members. Data presented in the findings is drawn from the whole group of 36, making clear where children and young people are expressing their views directly.

Children and young people and family members were not asked to provide information about their disability as part of the data collection. Most children and young people in this study spoke about or were referred to by family members as having cognitive disability – intellectual disability, autism, and developmental disability. Some young people spoke about their identity as disabled people and as Deaf and autistic people. Several people referred to the effects of living with multiple disabilities, including cerebral palsy, attention deficit hyperactivity disorder (ADHD), post-traumatic stress disorder, epilepsy, sensory impairments, particular syndromes, and mental health conditions including anxiety and depression.

Fourteen family members participated in interviews, which were individual conversations focused on the experiences of their children and support services around DFV. Thirteen mothers and one father took part in these interviews. These interviews were a mix of in-person, video call and phone call interviews. Although only 14 family members participated, data saturation was still achieved quickly due to very consistent service experiences and priorities across all participants.

Of the 14 family members who took part, six spoke about their own disability as well as that of their children. Of these six parents, most spoke about having anxiety and depression, two were autistic, and one family member had intellectual disability. In six families, both children and young people and their parent participated in interviews. These generated rich datasets with multiple perspectives on the experiences of different family members.

Forty-six practitioners participated in interviews or focus groups that focused on the services they provided and the perceived barriers and enablers to delivering services that meet the needs of children and young people with disability. Eighteen worked in disability services, 13 worked in health and family support services (including youth services), eight worked in advocacy organisations and seven worked in DFV services. These were a mix of in-person, video call and phone call interviews.

Table 3: Interview participant sample

Participant group	n=
Children/young people	12 interviews
Family members	14
Disability practitioners	18
Advocacy practitioners	8
DFV practitioners	7
Health and family support practitioners	13
Total practitioners	**46**

Data analysis

A coding framework was developed based on the key questions asked in each cohort of interviews (children and young people, family members and practitioners). The interview transcripts were coded using NVivo software. Data was coded according to the framework, with additional codes added inductively according to emerging themes (Braun & Clarke, 2021). These emerging themes were then progressively integrated into the framework, which were then discussed and refined by the research team.

Phase 3: Stakeholder workshops

The last phase of this project involved consultation with a selection of participants from the research along with policymakers to hone and strengthen the findings. The aim of this phase was to ensure the results of the project were responsive to young people's priorities and were useful for policy and practice.

Eighteen participants took part in workshops, with three separate workshop sessions held. They responded to the findings emerging from the data analysis and provided advice on their resonance to lived experience, fit with current practice, and appropriateness for national policy. Through the workshops, a series of critical issues were identified which promoted the rights and interests of children and young people with disability who experienced DFV.

Four children and young people also provided advice individually about the child-focused elements of the research, building from their own participation in the earlier parts of the project.

The critical commentary and advice from stakeholder groups has been incorporated into the final section of the report, honing the implications for policy and practice.

Ethical considerations

Ethics approval for the research was obtained through the Human Research Ethics Committee at Flinders University (HEG-4131). Further ethics approvals for Phase 2 were obtained from two of the participating organisations and from the South Australian Department for Child Protection (DCP). For Phase 1 of the study, researchers had existing ethical approval from the University of Western Australia, University of South Australia, and the Western Australian Aboriginal Health Research Ethics Committee.

The risk of harm or discomfort was present for participants due to the nature of the topic: there was a risk of causing further complex trauma and distress for children and young people with disability who have experienced trauma by reprising difficult topics and memories. Psychological harm was possible for participants due to their lived experience of DFV or caring for children and young people who have experienced DFV. In our work across multiple research projects on abuse and neglect, we have found that people are often relieved to speak about sensitive issues; however, the need to manage potential distress and feelings of shame due to the discrimination and stigma related to the intersections of violence, family and disability was present and real. There were also legal risks for participants if allegations of violence or abuse were made during interviews, and potential invasion of families' privacy by children sharing information that family members may prefer left private.

These risks were minimised through a number of careful and deliberate decisions, actions and resources. Risks of distress to any participants were mitigated by the strengths-based approach of the project and trauma-informed interview questions. Our approach draws on participants as experts in their own lives, asking them to provide expertise and knowledge for others, including service providers. To safeguard parents and children involved in this project, we worked with each individual as they commenced their involvement to identify any areas of safety concern and facilitate any ethical action (see Moore et al., 2020).

Risks specific to First Nations peoples and their communities were addressed through consultation with communities, including high rates of violence experienced by children with disability, collective trauma in communities, staff shortages and current disruptions to service continuity in communities. This resulted in the decision to only conduct interviews with practitioners working with First Nations communities in this study.

Care has been taken to de-identify the data to protect the privacy of participants and to minimise the risk of reputational harm to any parties accused of perpetrating DFV and any services or practitioners that are named as providers of poor quality. All children and young people and family members have been assigned a pseudonym and some other identifying details have been removed or altered. Children's ages have been clustered into ranges. Practitioners have been referred to by their role and identifying details of services have been removed. All participants were informed that the researchers would have an obligation to report any harm not already being addressed.

Finally, there was a risk of psychological distress to the research team, particularly those conducting fieldwork. A researcher wellbeing plan – an initiative of the University of South Australia Centre for Child Protection – was used as a proactive support strategy to minimise the risk of vicarious trauma to researchers. This included limiting the researchers' exposure to distressing content, providing access to regular debriefing, and ensuring all fieldworkers received appropriate training and support from supervising staff. Supervising staff were appropriately trained in trauma and supervision.

Findings

Phase 1 – Data linkage and case study analysis

Phase 1 of the project used analysis of administrative datasets from two Australian jurisdictions to identify how common DFV is for children and young people with disability, and to determine the nature of DFV exposure for children and young people with disability. This phase was split into two sections: Phase 1A, a quantitative analysis of population-level Western Australian linked datasets; and Phase 1B, a qualitative analysis of a random sample of families reported to South Australian child protection authorities. The companion report (Octoman et al., 2022) details this phase of the research.

Utilising linked population-level data (police, hospital morbidity, emergency department, and child protection) has enabled us to ascertain the prevalence of children with disability exposed to DFV.

This study found that 16 per cent of children born in Western Australia between 1990 and 2009 had disability. For First Nations children with disability, prevalence rates were 22 per cent. It is difficult to compare this prevalence to other studies due to the differences in identification of disability; however, this is higher than the Australian prevalence found in the Survey of Disability, Ageing and Carers (SDAC), which collects information about people with disability, older people, and carers who assist people with disability (ABS, 2019). In 2020, SDAC estimated that 7.7 per cent of children aged 0 to 14 had some level of disability (AIHW, 2020a). It is lower than the Nationally Consistent Collection of Data on School Students with Disability figure of almost 19 per cent (Education Council, 2016).

By linking administrative data, we were able to identify that 4 per cent of all children in the cohort had a mother hospitalised for assault, and children with disability had double the prevalence at 8 per cent. This would be an underestimate as it was limited to mothers who were hospitalised for assault. Importantly, of the children whose mother had a hospitalisation for assault, almost 30 percent were children with disability.

First Nations children with disability were disproportionately exposed to DFV. Thirty-six per cent of First Nations children with disability were exposed to DFV (mother hospitalised for assault). Given that First Nations children make up 8 per cent of our population cohort, this is a significant over-representation and is consistent with previous findings from survey data (ABS, 2019).

Children with disability were more than twice as likely to be involved in child protection and out-of-home care (5.8 per cent) as children without disability. We note that involvement in child protection does not equate to DFV exposure. Children with disability were significantly over-represented in the child protection system. Children with disability made up 32 per cent of maltreatment allegations, 36 per cent of those with substantiated maltreatment and 36 per cent of placement into out-of-home care. This is similar to the estimates of previous international studies (Dion et al., 2018; Sullivan & Knutson, 2000). Our findings have significant policy and practice implications for the resource and support needs of children with disability, both in terms of prevention and response to abuse and violence through the child protection system.

This study has also been able to describe what is known about the nature and extent of the experience of DFV by children and young people with disability reported to child protection. However, this analysis only concerns children and families who come to the attention of the child protection system. As a result, this is a more limited sample of children and families who would be considered higher risk due to their contact with the child protection system. Reports made by notifiers can be utilised to form a picture of concerns raised about the abuse and neglect of children over the course of their childhood. Details about children's exposure to DFV are reported to child protection from a range of notifiers, including police who attend such matters. Unit-record fixed-field administrative data was extracted by the South Australian DCP for all concerns reported to child protection for children in the families (intake reports). Through analysis of a sample of intake reports on 280 families, this study found that 62 families (22%) were identified as including children and young people with disability, with 45 of these family groups (16%) experiencing DFV.

The case study analysis demonstrated the following effects of DFV on this cohort of children with disability in the context of the intake reports to the DCP:

- Children and young people showed signs of trauma as a result of the DFV.
- The perpetrator of the DFV directed violence towards the children and young people with disability as well as their mothers.
- Violence negatively impacted children's and families' access to services.
- It was harder for protective parents to leave unsafe housing because there were few accessible and safe alternatives suitable for their children's disability support needs.

Overall, this shows a picture of highly complex contexts of abuse and neglect, of which DFV is one feature, and the obstacles to services and supports experienced by children and young people with disability and their families.

Summary

Phase 1 of the study has built evidence to show that children with disability exposed to DFV are present across different systems at disproportionately high rates. It points to the need to better identify the prevalence of DFV and disability in routine data collection; to make better use of administrative data; and to confirm practical support for especially vulnerable groups/families. Children and families who are subjected to DFV face complex challenges and these challenges are increased for children with disability, who may require extra support. The importance of first-response services such as police and hospitals in responding to crisis is evident, but with such a high proportion of children with disability involved in DFV services and the child protection system, workers and organisations across all sectors need the skills and resources to address these additional needs.

There is a need to consider in policy and practice how to better support children and young people with disability and their parents/caregivers. Access to services and supports to ensure children and young people with disability feel safe and supported is vital. Support for parents and caregivers is also an important consideration. Parents and caregivers need access to resources, services and supports to enable appropriate and safe housing for families and mental health supports that also take into consideration the additional needs of families with children and young people with disability. The first research report identified other issues to be addressed in policy and practice such as promoting flexibility in practice; addressing barriers to effective multidisciplinary practice; addressing structural disadvantage such as homelessness; and workforce development.

Phase 2 – Qualitative research

Phase 1 of the study answered our first research question: What is known about the nature and extent of the experience of DFV by children and young people with disability? In doing so, Phase 1 identified critical issues for the qualitative study to explore further. These included the high rates of children and young people with disability present across various service domains at times of DFV crisis, and the disproportionately high rates of children and young people in families in high-risk situations (such as mothers hospitalised due to assault, and children reported to child protection). DFV has multiple impacts on children and young people with disability, including trauma and a lack of access to services. Their families can also have difficulties escaping the violence, due to a lack of safe and accessible housing alternatives for people with disability.

Informed by this context, our research question for Phase 2 of the study was:

> How do children and young people with disability who have experienced DFV, and their families, experience support from services, and how well does it meet their needs?

The next section of the report describes the findings according to the themes drawn from the qualitative data analysed from the interviews with children and young people with disability, family members, and practitioners.

What did we find out about children and young people?

Interviews with children and young people aimed to explore how they understand their general family life, the things

that they enjoy (and don't enjoy) in their everyday lives, and their ideas about what helps their families to stay safe and happy. Alongside this, family members were interviewed separately for their own perspectives about the responses of service systems to support their child and family around the time of DFV crisis, things that had helped, and their ideas for improvement. Practitioners shared their views about their experience in supporting children and families, and of the systems in which they work.

As noted above, while 12 children and young people took part in interviews with the researchers, the experiences of 36 children and young people with disability are represented in the report. There were many reasons why it was not possible for some children and young people to participate directly in the project. Several suffer from complex and severe trauma, which precluded their involvement in the study. Some have been removed from their family of origin, so we were unable to interview them. Others have significant complex disability, so their family members quite reasonably felt the nature and topic of the study was too abstract and likely to be distressing for their child, although accessible methods were offered. However, participating family members were motivated by the aims of the study to promote the rights and interests of children and young people with disability. They were keen to ensure that their children's experiences and priorities were heard and included.

Children first

It was clear in all the interviews that children and young people with disability who have been exposed to DFV are, first and foremost, children. Their interests and enthusiasm, energy and ideas reflect their age, life stage and opportunities, as for any child. Children spoke about toys, games and pets. Young people spoke about school, the internet and gaming. The children and young people we interviewed are loving, bright and thoughtful individuals.

> I'm a good person. I care for others and try to make things better for others … I'm very emotional with things … If someone says something bad or keeps a secret, it makes me very worried and then I just don't like that. (Aadi, aged 8 to 11)

The children and young people who were described to us by their family members were also relayed as whole people – sons and daughters, siblings and much-loved family members. Among them were students, gamers, high-energy exercisers, craft-makers and movie buffs. Regardless of their support needs, children and young people were portrayed as people with interests, relationships and worth. Parents were keen to make sure we saw the positive and loving sides of their children as well as their complexity, as Mandy's reflection on her daughter Yvette (aged 8 to 11) shows:

> She just asked me yesterday. She's like, "Hey Mum, do you think I'm going to age well?" [laughs] … She's pretty mature for her age in that regard. So, she's on the autism spectrum, and she also has ADHD. Her ADHD is severe, quite severe. So that's why I'm spending my first child-free time cleaning her room. Because we've had a lot of meltdowns and aggressive outbursts over the last 10 days that she's been home. (Mandy, mother)

Practitioners spoke respectfully about the children and young people they supported. There were a small number who spoke about children and young people in clinical ways, but in the main, practitioners across different fields viewed children as having inherent dignity and value.

Home and family life

In response to the first question in the interview, "Tell me a bit about yourself and your family", young people generally began the interviews by speaking about their family. Most children talked about the number and age range of siblings, the parent they live with and their pets. Children and young people in this study were part of families ranging from one to seven siblings, with several in blended families. All spoke to varying degrees (or showed us how they felt) about their relationships with family members.

> Well, I'm quite a creative person so I've been told; also, apparently witty. My family is the same. Mum is also quite creative, really, and very nice, kind. [My brother] is quite a nice caring person kind of like me and well, let's just say he is always there. (Daniel, aged 8 to 11)

Figure 2: Isaac's self-portrait, with cat and kittens

These early descriptions provided a window into how comfortable children and young people felt about their immediate circumstances. Several spoke about things they value, particularly their relationships, and also things they would like to change in their home lives:

> My mum and dad says it's hard to keep pets right now. Especially in a small household. We'll just do it as soon as we figure out something. (Aadi, aged 8 to 11)

> So, I need a new [bed] … my bed is just a mattress on the floor. And do you think that's comfortable? (Sam, aged 8 to 11)

Feeling safe

When asked what helps them to feel safe and happy, the children and young people focused primarily on the interpersonal relationships and interactions that help or make it hard for them to feel this way. In addition to gaming consoles and pets, almost all children and young people spoke about the support they receive from their families and other adults they feel safe with:

> All of the advice mum and [my brother] have given me is all right in here [taps head]; all my common sense comes from both of them. It's good to make sure that people on my level of spectrum have a good sense of common sense. (Daniel, aged 8 to 11)

Some children were able to name people in a wider circle as trusted people. Only a few of the children named people outside of family members.

> My family makes me feel safe. Also, teachers and principals as well and Kids Help Line. (Aadi, aged 8 to 11)

Two young people said they would speak to friends about concerns rather than to adults. One young person noted the importance of having access to both friends and adults in a range of roles, for different reasons:

> I do feel that sometimes friends do mean well, but at the same time, they misinterpret the question, and so that will often result in misleading advice … I would also recommend seeing probably a counsellor as well, to deal with more private matters … So, I would see a friend, and then perhaps also see a counsellor as well … Speaking to your teachers, it's quite weird … when it comes to personal life, I personally … I know there's one or two people with disabilities who voiced out that, they do not really feel comfortable talking to teachers. They feel some sort of embarrassment, given that they might not have done necessarily well in school, and then they are speaking to their teachers about their family problems at home. Most of the time they would seek help from the teachers solely because of academic help. (Jason, aged 17 to 21)

Figure 3: Olivia's drawing of the mean girl

Most of the children and young people interviewed spoke about worry and anxiety, or showed us in the interviews how this influences their interactions. Their parents spoke at length about how anxiety and stress have disrupted school for many children, as they felt unable to attend regularly. Five children had stopped attending school for extended periods due to extreme anxiety and trauma (see "Trauma" section). As Jessie (aged 8 to 11) shared with us, this could be pervasive:

Researcher: Do you worry a lot?

Jessie: Yes! You know the tiniest things, I worry about them.

Researcher: What helps you to stop worrying?

Jessie: Not really anything, I just wait until I stop worrying.

Some of the things that worried children and young people were interpersonal, such as difficulties with other children, feelings of isolation and relationships with siblings. Some children spoke about discord in their relationships with siblings, and the impact of this on their daily life. The following exchange shows how disability was enmeshed in the politics of sibling relations for two brothers who both have disability:

Sam: Being treated as a human punching bag [by sibling] isn't fun.

Researcher: What do you do when that happens?

Sam: Guess what I do, use them as a human punching bag back. He deserves it. If he does it, then he deserves it. For some reason he thinks he can do anything and it's fine but when I do it to him it's like, "Hey! I'm the king, that's illegal!"

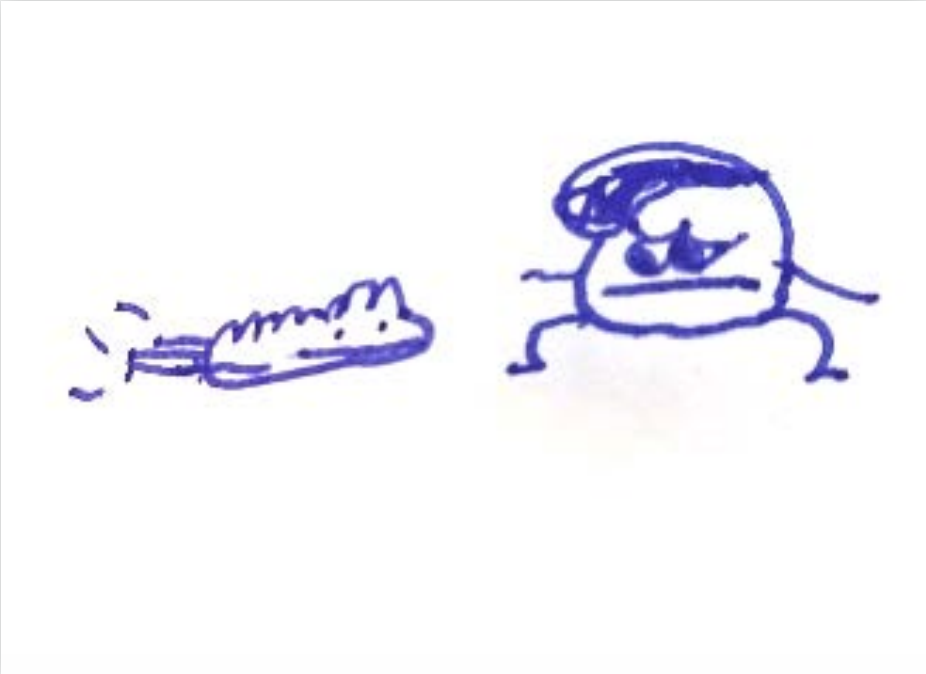
Researcher: Why do you think he does that?

Sam: He has autism, but he's not even trying to get better.

(Sam, aged 8 to 11)

Olivia (aged 8 to 11) drew a series of pictures about a girl who spoke in a mean way to her at school, talking about how this made her unhappy. She said, "My friend, she said she didn't like me. She was angry at me." It was hard to get a clear picture of what happened in these interactions, apart from unhappiness about school.

Figure 4: Patrick's drawing of the animal in his room at the hostel



How did the children and young people experience DFV?

The impacts of DFV on children and young people's home and family life were significant. Most of the children and young people had experience of moving house following DFV crises, sometimes multiple times. Half of the children and young people lived with their mothers in single-parent families after experiencing DFV. Others had experienced violence from other family members, which had disrupted their living arrangements and relationships. Children in most of the families taking part in the study had been involved at some point with child protection authorities, with several mothers mentioning care and protection orders. Children in three families had been removed from their family of origin into state care, and two children had been reunited with their families. No children or young people who were under guardianship were interviewed. Children in four families had been placed under public guardianship, at least in part as a consequence of long-term DFV experienced by their mothers.

Children and young people's recollections of DFV

Children and young people were not asked questions about DFV or pressed to discuss violence in any way. If they offered comments, researchers gently extended opportunities for them to continue the conversation. Few mentioned violence directly, although it featured indirectly in their conversations in several ways, such as discussing frequent house-moving or why they went to school far from home. One child did discuss his memory of DFV and the differences between his siblings' feelings about their father and his own:

Sam:	We left home because of someone that was our dad at the time … and Isaac [brother] somehow misses that piece of poo. How can you miss a piece of poo?
Researcher:	How do you feel about it?
Sam:	It was terrible. Honestly terrible. Who in their right mind would not think that guy's terrible if you knew what he did?

While Sam distanced himself from his father, his younger brother Isaac drew his dad in his pictorial map. Their mum felt that their father's influence was also evident in the family dynamic and relationship between the siblings, as Sam's brother Isaac used behaviour which was very similar to his father's DFV when he felt stressed and overwhelmed. This

caused physical and emotional conflict which was traumatic for the whole family. The boys' older brother responded by withdrawing, locking himself in his room for extended periods.

Five children remembered moving from place to place after leaving their family home due to DFV. Olivia said she and her sibling Patrick (aged 8 to 11) lived in "a hotel and we went to the different ones. We go to the hotel, and the hotel, and the hotel, and the hotel house. We go to four of them." They spoke at length about how disturbed they were about the lack of cleanliness in crisis accommodation. They found pests such as cockroaches, a rat, and an unknown animal in the night distressing, and described the incidents both verbally and through pictures. Patrick was particularly frightened. The family was provided with two separate rooms in one of the hotels, and he had to go out into the main body of the hotel to reach his mother during the night when he heard the noise.

Five children talked about going to school a long distance from their home after moving to escape DFV. They did not like the long travel time, but did appreciate the continued connection to their friends and having a familiar school community. Their mothers spoke about how they had tried to maintain school as a familiar environment while so much else was changing in their children's lives. This was particularly important for children receiving therapy and specialist supports in school, which are not easily transferable. It was also seen by mothers as a necessary safety precaution to live a considerable distance from school.

Effect of DFV on children and young people's sense of security

Family members spoke at length about how they felt DFV had affected their children's home and family life. Several parents spoke about how their child's sense of personal security had been affected by the violence, as well as by physical and social dislocation. This included moving house and school, changing relationships with other family members and losing access to friends. This was pronounced for children who were still in contact with parents who used violence through access visits. Two children in the research had been injured by parents on access visits. Their mothers spoke about the heightened risk to children with disability in this situation:

> We talk about DV as if it's something that happens, but there's actually a person doing it and that person's behaviour, character, personality doesn't change because you leave, but what does change is that your children are alone with them and you are not able to be a buffer or run any interference … I totally get why women stay and there were certainly times when I thought, "I have gotten myself to safety, but my children are actually worse off than they were." (Eliza, mother)

Trauma caused by DFV

Several family members spoke in detail about their own experiences of DFV, with the aim of describing how closely connected the experiences of children and young people are with their parents'. Most of the families had survived severe, sometimes extreme, violence. For some, DFV had continued for many years, and for others it was still ongoing. A small number had experienced DFV from extended family members. However, the majority of parents experienced intimate partner violence that extended, in most cases, to the children through verbal, emotional/psychological, physical and (in a small number of cases) sexual violence. A number of women described staying in violent relationships longer than they felt was safe for them or their children and had returned to DFV situations because of a lack of safe and accessible alternatives.

> Throughout my marriage, I experienced domestic violence and I tried to leave many, many times and the world isn't set up for single mothers to rent a place that is accessible. I would go back because … just the inability to care for Rani. I had lots of little part-time jobs, but my main role was caring for Rani. So, I relied on his [the father's] income to support our family. Yeah, it was terrible. Absolutely terrible. (Patricia, mother)

Through families, we heard about the distress and trauma that children and young people experience. Parents said that the effects of DFV on their children are significant and evident in multiple ways. Most parents spoke about the ongoing effects of their child's psychological trauma, which among the participating children and young people included severe anxiety, post-traumatic stress disorder, significant "conduct disorders" and behaviour problems.

> She has crippling separation anxiety … because as much as she doesn't want me to go anywhere, she tests that with her behaviour … what's driving a lot of her negative

> behaviour is fear of abandonment and separation from me. (Mandy, mother)

Children had problems with school attendance, either feeling unable to go to school, or being suspended from school due to their behaviour. Several families mentioned that their children struggled to sleep well. Some spoke about how their children halted in their development or regressed in key developmental milestones. For example, one child had been toilet trained at two. Through different crisis accommodation they stayed continent, but when the family moved into their own new home, they stopped using the toilet and developed scatolia (faecal smearing). This has continued for three years, and their mother said, "we can't get [them] to even look at a toilet, go on a toilet". This child's siblings have also been affected, with the school notifying the mother that all the children needed better hygiene due to the smell, which was humiliating for them all. Other parents were anxious about the temporary nature of their accommodation and associated safety issues:

> She [daughter] knows that this house is only a short period of time, so she's forever asking me "When are we getting our new house?" and I don't think that's really any service's fault, it's the fact that we are in a rental crisis and it's just really hard to move on. But I also feel like housing and stuff should have more services available in our situation, especially when there's children with needs. She's asking me every week, so it's very much on her mind. (Nerissa, mother)

In some cases, conditions related to children and young people's trauma had been formally diagnosed. In other instances, no formal diagnosis had been received. There were many reasons for this – including expense, waiting lists, lack of access to practitioners and uncertainty about the merits of diagnosis. For some children, disability and trauma were closely linked, such as in families where DFV has manifested in part as parental conflict about the child's disability:

> His dad was very against having him diagnosed with autism … his dad decided that I wanted there to be something wrong with him, and that the problems that he was having was because I wasn't a good enough parent, and so he sort of blocked me from having Daniel diagnosed. Anytime, usually they interviewed the parents, his dad would voice concerns that I was mentally ill and there was nothing wrong with Daniel. And it gave me a lot of self-esteem issues with getting Daniel diagnosed, so I sort of wanted to wait and see how his school felt. And his first two years at school was with the same teacher, and because we were going through a marriage breakup, she felt that Daniel's problems might just be from being from a broken home. (Frances, mother)

The effects of intergenerational trauma were noted by some family members who had themselves experienced child abuse or DFV as children. Several mothers spoke about their own trauma as children and adults, and how strongly it has propelled them to change their children's trajectories. One parent, Hathai, spoke about how she has recognised through her own therapy that she has lived with anxiety and depression all her life, and she is extremely fearful that her own children will experience the same.

Social isolation following DFV crisis

Several family members spoke about how deeply they and their children have been affected by the consequences of DFV, including social isolation. Some of the children and young people also noted that they had only one friend, or wished they had more friends.

> Well, at least I have a friend that gives me Legos. I'm his only friend and his family's nice to me … I repeat no one hangs out with him but me. (Sam, aged 8 to 11)

One child mentioned that they aren't able to go to friends' houses because they have to stay safe – their mother spoke in her interview about the extensive safety precautions she needs to take following criminal charges against the perpetrator. Family members noted that the intersection of disability and DFV increases the social isolation for children and young people, leaving them at heightened risk emotionally and developmentally. It also means that others do not benefit from their contributions.

> For three years we've been isolated in a home like this – roller shutters, gate, don't go out the front, I don't want people seeing you. They haven't had a chance to go out in society, to get their community, their recreation, social inclusion. It's probably 10 times worse [with their] disability, that they don't get invited to birthday parties. They hardly

> have friends. And I've even noticed with, we started with a pack of the DV mums – we all fled at the same time. And we were all in a group, even they alienated me in the end because none of them had kids with disability and they were like, "They [my children] are so extreme for my children, we've got to stay away from you." (Tracy, mother)

This isolation could be very stark in rural and remote communities. Practitioners spoke about children and young people with disability being at higher risk of multiple forms of violence than other children due to their social isolation and their increased difficulties in telling safe adults about harm they experienced:

> But when I think of a few kids who you know do have intellectual disabilities … other kids really recognise that they're different and they're much, much more vulnerable in the community because they tend to wander … All the kids wander but they're wandering in little groups, where these kids are floating between groups or not with anybody, in terms of kids when they're out playing.
>
> And so, they're just more vulnerable to any of the negative things and you see that over and over again … I can think of three kids that really stand out to me who have got very profound intellectual disabilities. All of them can speak, but often don't speak … I've seen them sometimes in such a state that you just think, "Gosh, what's happened?" But they're not telling you. They're more curled up in a ball on the front veranda. But that's been incredibly hard. We know they've been hurt, and they've been hurt sexually. (Remote youth practitioner)

Stigma and discrimination due to disability had been experienced by several mothers, which has affected them deeply and made them reluctant to trust providers because of previous negative experiences:

> The more honest I am about my lived experience, the more open and out loud and proud I am about my disabilities, the more that they think it's okay to disrespect me, to disregard me, to treat me as if I don't know what my own reality is, let alone my child's … No wonder my child doesn't want to be autistic or to identify as autistic. (Lindsay, mother)

One mother talked about the stigma of disability in her CALD community and how fear of ostracism has led her family to hide both her child's disability and DFV from community members.

Children and young people's voice and agency

Children and young people with disability interviewed for the study understood a lot about their family situations, perhaps more than their families relayed to us. Their comments about housing, school and the material circumstances of their families showed how they are aware of at least some of the circumstances and pressures facing their families and the impacts that this has on their lives:

> The main thing we need is, my mum needs financial support … I do feel like more could have been done. Because my mum's having trouble with NDIS funding. (Leigh, aged 12 to 16)

Some children and young people expressed how difficult it has been to have their perspectives and priorities heard and responded to by adults in positions of authority. This included their views about important issues such as court-ordered contact with the DFV perpetrator; health and medical issues; and where they wanted to live following DFV crises. This was particularly evident for children and young people with high and complex support needs who did not use conventional speech. Two young people had court orders made for unsupervised contact with fathers, although their mothers reported they were unwilling. In one family, different court orders were established for a young person with disability and his siblings:

> The other [siblings] never [had] to see their father because they went to the court counsellors, et cetera. But because my second son couldn't speak, couldn't voice, he had to see his father. So, what it provided was an opportunity for my ex-husband to continue to hurt me, and he could do that through my son. He actually weaponised his disability because my son couldn't speak out. (Emily, mother)

For two young people, public guardianship had been invoked because of intractable difficulties in making decisions about health and medical care and daily living issues. For both of these young people, serious abuse from both service

providers and the abusive parent had occurred alongside other wellbeing concerns while under public guardianship. Another was under threat of guardianship as part of a pattern of family violence.

Consideration of how children and young people experience and reflect on DFV was less evident in the practitioners' interviews. They spoke in a more general way about children and young people with disability who experience DFV and the effects they have observed. Across all types of participating services, practitioners described a climate in which children and young people with disability have little agency or authority and where their needs and preferences are not often prioritised, particularly in times of crisis.

What support is provided for DFV to children and young people with disability and their families?

In this section, findings are presented about the support that participants described as being provided to children and young people and their families following DFV crises. To prioritise the experiences of children and young people with disability, we turn first to findings about child-focused support, including disability-focused and youth-focused support. Following this, we consider the findings about family-focused support for families that include children and young people with disability.

Sitting over the discussion of the themes in this section is an overarching finding that much of the support provided to children and young people seemed to be in place because of the initiative taken by key people in their lives (mothers, mainly) and some individual supportive practitioners – not because systems recognised their needs and responded systemically or systematically. A great deal of advocacy and persistence was needed, often over years, for most of the children and young people in this study to receive a reasonable level of support.

Child- and youth-focused support related to DFV

Children and young people generally did not remember being directly provided with support from services or particular people after their families left their homes following DFV crises. Younger children reported feeling confused by the people coming and going, and did not understand the different roles that people played in crisis services, mistaking cleaners with social workers, for example.

In youth services, children's workers and case managers reported that many young people with disability use their services, particularly young people with support needs related to mental health, autism and cognitive disability. They relayed very complex family situations, including DFV. They also noted patterns of young men using violent behaviour in their family home and the intersecting and compounding disadvantage that many young people face due to poverty, social isolation and intergenerational violence.

> [Recently we have seen] a very big trend of violence of young men towards mothers in particular … previously the family was in a DV relationship where the father was the perpetrator, and now they no longer see the father, but now the young man started to show some similar behaviours. (Youth services practitioner)

Youth services practitioners spoke about conversations they have had with children and young people with disability in this context, where they sought to find out from them how they felt they were faring and where they might need help to respond to issues:

> [I spoke to them about] … their experiences, how their relationships are with siblings and just really about life domains I guess for children. School. Bullying. Mental health. Self-harm. All those kind of areas … What they've experienced that's good and what's bad and what they'd like more of that's good. (Youth services practitioner)

Youth social workers discussed examples where they have worked with young people with disability who experienced DFV, with an emphasis on building capacity and agency through group processes:

> We ran a basketball group for children that were in the child protection space who had NDIS plans. And for a lot of them, there was trauma, there was domestic violence involved. That whole boys' group, we kept asking them for decision-making, they named the group, and we had

> some behavioural strategies, and they were very much involved in all of that. I think we did that, made sure that the boys came up with group norms and that worked really, really well. (Social worker)

Disability and community services practitioners worked with considerable numbers of children and young people who had experienced DFV. They felt that they had little time to engage in ways that might help them learn more about the trauma needs of the children and young people, particularly when this would require more than conversation.

> I don't have too many [clients] that are able to verbalise what they want. And for me that's hard to find out from my direct clients' perspective or what they need or the impacts of the DV around them and how it's impacting them, other than through engaging behaviours of concern to express their emotions. (Disability practitioner)

Some practice in services was oriented more heavily towards keeping children and young people safe and, where necessary, referring them to other services, relying primarily on views of professionals and family members about need. To do this, some practitioners foregrounded a "best interests" approach, relying on family members as proxy voices for children.

> What are the child's priorities? Sometimes it's hard to really determine, because when we're working with the child, he has very high complex needs and he's non-verbal and has very limited communication. So, for us to understand what his priorities are, yes, he has a basic way of communicating his needs but really his priorities are articulated by his mother, who we trust, that what she wants for him is in his best interests. (Disability practitioner)

Others talked about how they work with both parents and children together, engaging the children in conversation and asking their views and opinions throughout. They used strategies such as building on the work that children did with other professionals to help them express their views and preferences:

> I've got a client who has a psychologist, and they do a lot of drawing, and she brings them to our meetings. (Disability practitioner)

Disability-related support for children and young people

NDIS-funded services

Family members interviewed for the study were not asked specifically about the NDIS. However, most talked about it as the gateway to the services their children need. Many of the supports and services provided directly to children and young people who experience DFV are funded through the NDIS, such as therapies (speech, occupational, equine and art therapies), behaviour support, counselling and psychology (for a few), support workers and assessments. Support coordination had been made available to some of the children and families, which assisted them in finding and using these services.

Participants reported that access to NDIS support for children and young people who were not already in the Scheme was not straightforward when families sought access following DFV crises. Several families applied for NDIS funding with support from DFV and advocacy services. Family members and practitioners raised several issues hindering prompt and helpful access to the Scheme. These included the time and resources required to support families to apply to the Scheme, confusing information about eligibility and evidence requirements, and difficulties in obtaining assessments:

> So we can support the family to apply for NDIS, that's not a problem. It's trying to get enough evidence for him to be eligible to get some support … [Another] one is on hold because I can't get a paediatrician referral. The mum is on a Centrelink payment so she can't afford to get an autism assessment through [provider]. He's been excluded from school. (Social worker)

While being positive about the benefits of the Scheme, workers outside of the disability field reported their struggle with understanding its requirements, and found meeting them complicated and time consuming. Many felt that within the boundaries of their roles, they do not have adequate time available to support families in applying for funding. They noted that they often work with families with limited literacy and numeracy, and this affects how much family members can take on of the application process themselves.

> I think there is multiple issues there around the complexity,

> the number of rules, the amount of time it takes and the amount of evidence that you need. (DFV practitioner)

Most families described experiencing extensive delays in receiving assessments, reports and services using NDIS funding. A small number of families had been able to make positive gains through flexible use of funding (see next section). It was more common that delays affected children's progress. For example, following his diagnosis with autism, Daniel's mother Frances was advised to contact a large disability support provider in their local area. They assisted her to prepare for the first NDIS meeting, and he was placed on a waiting list for psychological, occupational and behavioural therapy through the service. In the first NDIS meeting, Frances felt "under-heard, under-listened-to, and not really given an opportunity to speak". The planner did not accept the information Frances had gathered from the family's child psychologist, speech therapist or paediatrician. They were told no funding was available to support Daniel and his family in responding to the very disruptive behaviour changes brought about by puberty. Tracy had similar problems in trying to obtain funding for trauma-informed behaviour support and skilled counselling to help Isaac with severe challenging behaviour as part of their family's experience of severe DFV:

> I've had to be very strategic with my NDIS goals to not mention trauma or disability. It's just, this is my goal for my son, and that then becomes his funded goal. So, I don't say, "He's got these behaviours because of trauma." It's, "These are the behaviours he displays. This is my goal for this year." So, I changed it to that. But now, I'm finding there's a two-year waitlist for [children's therapy service]. DHS [Department of Human Services] is trying to fast-track me through [service], just for the extreme of Isaac. If they can do it on his NDIS funding it might get us through quicker. (Tracy, mother)

Four parents described problems with the nominee system in NDIS, as the perpetrators had access to information and were in some cases actively involved in negotiating the child's NDIS plan. Without a court order banning perpetrators, the protective parents had little control over how this was managed. Some children and young people found this highly distressing, and had no authority over how their own information was managed. One young person responded to the risk of his father finding out information about him and his mother through services by withdrawing from all services, and also from school. Several families and practitioners suggested that the NDIA needed to consider new approaches to assist families experiencing DFV and those with intractable conflict. One mother had requested funding for an independent advocate for her child, concerned about his welfare amid continuing high conflict, but this was rejected. She said:

> I think a social worker would make a huge difference because if we're meant to work together, then how do we do that? How do we do it for [my child]'s sake? (Emily)

Many examples were provided by families and practitioners of inadequate plans and families having to initiate appeals and plan reviews, sometimes multiple times, in order for their child to receive adequate support. This had a significant cost to families experiencing DFV where there is little energy to spare. After three rounds of review and appeal and three years of fighting poor quality service provision, Daniel's mother Frances spoke with satisfaction about the result:

> Now [his funding is] quite huge. From the $5,000 he got the first year, it went up to $8,000 the next year, and so now he's gotten another eight. In total, he's got about $13,000 sitting there now in his NDIS. (Frances, mother)

Cost-shifting by government departments was also mentioned by practitioners as common for children and young people who receive supports through more than one jurisdiction:

> There's often that pull between Department for Child Protection [DCP] and NDIS and who's going to pay for what. It's quite a common occurrence with a lot of kids under guardianship is "Well, that can come out of their NDIS funding" and then NDIS are "Actually, no, DCP can pay for that". So, then there's that constant battle of "Well, we need the service. Someone just pay." (Therapy practitioner)

The following case study highlights a number of the elements raised by parents in the study about eligibility criteria, the impact of delays, inadequate responses to demonstrated need, and the need for persistent advocacy. In this case study, Mandy spoke in detail about her experience of negotiating what she considered an adequate NDIS plan for her daughter Yvette, now aged 8 to 11.

Table 4: Case study of Mandy and Yvette

Mandy and her daughter Yvette moved interstate to escape DFV. Yvette was not on the NDIS before moving. Mandy said:

> And before moving, I had called [planning organisation] to try and see, what do I have to do just to get advice and information? And they were like, "Oh no, that's fine. She'll just trickle onto the system." And then I got here and that wasn't true. So, we were without any services or therapy for six months or so.

As both Mandy and Yvette were struggling to cope and Yvette was using some violent and aggressive behaviour, Mandy kept contacting the planner.

> And she just said to me, "Mandy, if you are not coping, you're going to have to relinquish her." And I was so mortified by that. It just put me off ever seeking help, because I thought, "The only reason why I'm not coping is because you are taking so long to draft her plan."

Yvette's first plan came through after several months, with just one hour of respite per week for six months. Mandy applied for a review, but never heard back. At the time of Yvette's second plan, Mandy requested they look at the submitted review, but it was subsumed into the second plan, which again was inadequate to meet Yvette's needs for support.

> And we had a support coordinator funded, and she used up the whole three and a half grand within six weeks and then dropped off the face of the planet. She wouldn't return calls or emails or anything, because there was no money left for her to do it. And so, I ended up having to do all the calling around anyway, to see what she had spoken about and who to. And all that sort of thing, and essentially doing her job [in finding therapy services] … They had waitlists of nearly a year long. So, what are you supposed to do? And then they turn around and say, "Why haven't you spent your funds?"

In an attempt to compensate for the initial lack of support, Mandy organised intensive therapy for Yvette, which quickly used up the allocated funds. Mandy applied for a change of circumstance, but it was rejected.

> I had to go through this whole thing, it took a couple of months where I had a guy who handles the money side of things from NDIS call me. And he was so arrogant and very patronising. And I just got fed up with him and I straight out told him, I was like, "You know what? I haven't always been a carer. I was self-employed. I ran my own business, and you are treating me like I'm some kind of a dole bludger. The money isn't even for me, it's for my child, because I don't want her to have to navigate this system on her own later on in life. It's difficult for me. And I'm a neurotypical person. I want her to get the help now so that she doesn't have to deal with all of this later."
>
> And I just had a rebuttal for everything, and he finally just went, "Oh, I'm not going to be able to push this lady over." And we finally got the plan that Yvette should have had in the beginning.

Mandy's relief was evident as she described the new planner as "fantastic" – they have managed to roll over the same funding level for the next two years – "So, I don't even have to deal with it."

Public guardians

States and territories have slightly different public guardianship systems, but all are government statutory bodies. A guardian can be appointed by a court or tribunal to make decisions for a person who does not have the capacity to make their own decisions about their lifestyle, healthcare, accommodation and the services they receive. The guardian can be appointed by a court order or by mediation. In two families we interviewed who were experiencing protracted DFV, public guardians had taken decision-making roles for young people, one through court action and one through mediation. In a third situation, a mother was described as threatening her young adult child with guardianship as a form of family violence.

Two mothers said that public guardianship has had poor outcomes for their children. This was due to Public Guardian staff not knowing the young people; lengthy delays in approval for decisions; lack of information about critical incidents and medical incidents shared between services, the Public Guardian and families; and, for one young person, ongoing violence in supported accommodation which remained unaddressed for a long period.

> [The Public Guardian] made a decision that I was no longer able to get any medical information for my son. And I wasn't allowed to accompany him to his medical appointments. This is after years. So, Wayne had no support. And what my biggest fear was, and it happened, his psychotropic medication started really increasing. And you're not given any choices … as his mum, I no longer had any say at all in his medications. And this was related to his father, them not wanting to give it [information] to his father, but if they don't give it to his father, they don't give to the mother. (Emily, mother)

The young people under guardianship did not have opportunities to contribute their perspectives about what they wanted to happen in choices and decisions about their lives. It was reported that guardians did not meet or know the people on whose behalf they were making decisions. Although there were some sporadic attempts to capture young people's priorities, these were not systematic. One young person in our study had a communication system in place that fell into disuse. There was discussion by their family, service providers and the public guardian about reprising it, but this did not occur. When a medical decision was made that had very serious implications for their wellbeing, the young person was not consulted, despite being close to 18 and able to express views and preferences.

Family-focused support

Some families had received support through crisis DFV services, including accommodation in hotels, refuges and temporary/transitional housing, as well as financial assistance for food, fuel and other essentials. Short-term case management was provided to some family members. This assisted them in locating housing and other essential services such as Centrelink, healthcare, childcare and NDIS support for children. Mothers felt that the support from DFV services was helpful and resourced them in caring for their children. Some mothers were not too sure about what was provided through case management:

> Oh, and I met up with Domestic Violence … I had a case manager or something, and I met up with her once a week. And it was like compulsory or something … I think I had two case managers. One was at the hotel, one was at [suburb]. (Katie, mother)

All of the parents spoke about how their experience of DFV has affected their parenting, particularly of their children with disability. Some of the changes related to the children's needs associated with disability. However, many more related to the ways family members were required to deal with systems and structures to receive support.

> Having been through a lot of domestic and family violence stuff, we're still dealing with the consequences … And my repeated experience is that however well intended the people in the services are, that because of these issues of ableism and stigma and lacking a trauma-informed approach – you need all of them sorted, not just one. Many of these services have actually actively retraumatised us. (Lindsay, mother)

Both families and practitioners spoke about the wider community perception that the NDIS meets all the needs of people with disability, and how false this is. This point was brought home strongly in discussing the ways that parents receive support (or don't) when they need it in parenting their children with disability. One practitioner noted:

> In fact, there haven't been paid supports for parents … before the NDIS came in. When the NDIS rolled out, they [NDIA staff] said, "No, that's not our responsibility. The responsibility lies with family services", and the only family services that exist are Child Protection. (Advocate)

Child protection and child safety

Several children whose family members engaged in this study were living in out-of-home care, in foster care and in residential care environments. We were not able to interview many of these children and young people for ethical reasons, and we did not press the care-experienced young people we spoke with who were over 18 years old to talk about this part of their lives. In the main, this section of the report relies on parents' and practitioners' perspectives about the child protection system. Parents who had children with disability in care were actively involved in their lives. They spoke about access visits and negotiating time and conditions; activities that helped them to connect with their children during visits together; and negotiated supports and equipment that they had been provided with to improve the quality of their children's lives.

The experiences of parents in this project with statutory child protection and child safety departments located in different states were mixed. Three had experienced involuntary removal of their children, both with and without disability. One family had experienced distinct improvement when their case changed offices and the culture of support shifted. This family found renewed positivity, opportunities for new activities and increased time together, and are now planning for reunification when their DFV-related crisis housing is resolved.

Rachel and her partner both have intellectual disability. She has a complex and difficult history, having experienced child abuse and institutionalisation herself. She spoke at length about her experience of DFV growing up and as an adult. Rachel has several children, and talked about how all of them had been removed from her care in their first few months of life. She is able to communicate with her older children now that they are over 18, but contact was restricted when they were younger to just one hour a month or less. She felt strongly that both practical support and respect was lacking from child protection services towards her and her partner as parents with intellectual disability:

> [Child services in this state] just treated us with no respect, didn't help us at all. They made it worse, and treated us like we're nothing, and took our children … What they did is treated us like we were criminals instead of helping us with our relationship.

One of Rachel's children returned to live with her as a toddler, and lived with her until age six, when she had to relinquish care of him due to his high and complex behaviour support needs. She spoke about how distressing they both found his residential care arrangement and limited access:

> He's very close to me … And I just feel that sometimes he gets angry and frustrated because they're not listening to him, he wants me to live with him and all that. And he doesn't understand … He's already run away trying to look for me. They've given him less and less because of that, and it shouldn't be that; it should be more … It used to be once a fortnight and now it's once a month. It's not enough time for him and me … He plays up, shockingly, five minutes before I have to leave … I feel so sorry for him. I never wanted him to go through what I went through in [institution] and he's going through it. That's not what I wanted.

Advocates also spoke about their experience of supporting parents with disability to negotiate contact with children with disability who have been removed from their care. They found it much more common that contact would be reduced than increased in response to children's expressed wishes.

Some practitioners spoke about how they have been required to respond to children disclosing harm as mandated reporters of abuse. Some providers spoke about clear guidelines and support from managers for staff to receive direction and support. One senior practitioner spoke about their service playing an important role because of their regular contact with children and their families and their capacity to monitor children's safety and to act as a bridge to other services:

> We've perhaps got more eyes on the ground, so to speak. So, there's a little bit more surveillance to ensure that child's safety, I guess probably working with other services. (Disability practitioner)

Child safety was also de-prioritised for some children and young people in legal settings. During family court proceedings, a Family Report Writer (a child psychologist) advised the court that because Eliza's child was "young and disabled, he would be unlikely to be affected by domestic violence". Eliza said:

> I don't claim to be an expert, but I'm actually fairly certain that having a disability and being young actually compounds the trauma. (Eliza, parent)

Eliza's son was injured due to DFV. Because he does not show pain in typical ways, his injury was not diagnosed for several months, despite several trips to hospital to explain his increasingly severe symptoms. They travelled to another region for a diagnosis. When finally diagnosed, his injury had progressed to the point it required surgery. Another young person was ordered by the family court to spend access visits with his father after DFV, despite his indications to his family of distress. His siblings were able to articulate their unwillingness to the court and did not have the same access orders made.

How well does this support meet their needs?

Relationships, consistency and time to work well

Children and young people spoke about the importance of having people in the system they trust and with whom they have established relationships. This allows them to share issues that they are finding difficult to resolve (such as conflicts with siblings and friends) and to negotiate to have services provided in ways that best suit them. For example, Olivia's regular case worker knew that she thrived on routine and found the lack of it disruptive and difficult to navigate. Therefore, they have devised well-developed strategies which help Olivia manage when things are not as organised as she would prefer.

Particular individual practitioners who "go the extra mile" were mentioned by several family members as making a real difference. These were people in a range of different professions – a doctor, a youth worker, an advocate – who were personally interested in and concerned by the circumstances of the families and who took action to support family members. These people helped to make things happen that improved families', and children's, living situations.

Most of the families believed that the quality of individual practitioners was more effective than systemic responses. This is not unique to this study. However, practitioners consistently emphasised the need to work beyond the limits of available resources to support families in complex situations, and voiced their frustrations with unresponsive or obstructive systems. Youth practitioners emphasised how important it is to have strategies in place to find alternative ways to support young people when their personal connection to their workers is not strong:

> I would say probably 60 to 70 per cent of them didn't have a great experience [with youth mental health] just because they haven't connected well with their workers. And that's such a huge thing for young people in particular. My question has been "What was it that you didn't get out of it?" It's just always been the connection with the workers, because if they click – and they use the word "vibe" – if they haven't vibed with their workers, they just refuse attending and they will just delay, cancel their sessions. (Youth services practitioner)

Several practitioners and family members identified practices that disregard children's experiences and noted that this was not challenged systematically.

> In an ideal world, it would be great to have a child-focused response to [emergency] situations like that, where the children do feel empowered to actually have a voice, because it's a very adult world. (Advocate and youth services practitioner)

While individual practitioners showed strong commitment to their work, and were dedicated to providing individual children and young people with the support that they need in particular circumstances, they also pointed to concerning gaps in collective practice:

> [Disability support workers] don't know if they need to put an incident report or how to approach the information they get from kids. I would say at least every other day, they're coming and saying "Oh, the kids have disclosed some information. I don't know what to do." Or their mum was shouting, or they did some picture drawing and things, and it doesn't look quite right. Or kids will say "I'm scared of mum", based on that drawing. (Disability services practitioner)

Capacity of systems to support quality practice

Practitioners in both disability and youth services spoke about the difficulty of maintaining consistent, engaged, high-quality practice, because systems have not been set up to support this:

> In terms of engaging with the child as well and understanding the child's wants and needs as well, I don't think there's just a baseline level of that practice that is standardised to an acceptable way. (Advocate and youth services practitioner)

This leaves children at risk because there are inadequate systems responses to ensure their safety and protection. Practitioners felt there are risks to children when systems are not in place to:

- support, sustain and resource workers to provide consistent quality practice
- have workers' questions and concerns addressed through guidance and support
- replace individual practitioners who are unavailable, on leave, or have gaps in their practice.

When there is an over-reliance on individual practitioners to go beyond their remit in order for children and young people to receive what they need for safety and to thrive, there is a high risk of systems failure. In our study, we heard about practitioners' distress, and about how dangerous it can be when people look away from DFV and abusive experiences and leave children in abusive/dangerous situations. One mother stated:

> The general message I got was that they [service providers] didn't want to know [about DFV in our family]. They just really … because Rani has so many different disabilities … that means the cast of thousands that are involved. It was, it was just so complex. People just couldn't deal with it … Everybody knew because I was very up front about what had happened. I just remember team meetings with all the people involved with Rani and there would be a big room with all these people, but the more people there are, the less that each individual person danced. Do you know what I mean? (Patricia, mother)

This may be changing as new services are implemented, at least in urban centres. For example, DFV practitioners spoke about how some DFV providers now have children's workers placed within women's/family crisis services. They become involved with children through internal referral, and are focused on short-term support for children as clients in their own right. Safe and Well Kids was established in South Australia during this research. This cross-sector wrap-around service model supports children and young people up to 14 years, aiming to provide intensive support to children and young people. It is not clear yet if this will make a difference to the lives of children with disability and their families. However, one mother's reflections on navigating systems hold some important lessons:

> Centrelink and NDIS are both just … on the surface they're supposed to help, but there are so many obstacles, and the obstacles are pretty constant with NDIS as well. Centrelink still is quite obstacle-laden, but once you have, say DSP [disability support pension], there are fewer obstacles. The obstacles with NDIS tend to be ongoing. Once you've been accepted as a participant, that doesn't change a great deal. And having a good experience is really very much determined by whether you have a good listener when it comes to things like planning meetings, and whether they're actually respectful. But also, it's very much informed by the organisational ethos, and that can vary enormously even from office to office. And that's regardless of whether you are dealing with an LAC [Local Area Coordinator] or with a planner, an NDIA planner. (Lindsay, mother)

Children and young people as individuals with agency

Investment is needed to build safe spaces in which children and young people can build their confidence and capacity to share things that are important to them. In particular, this refers to the capacity of practitioners and service systems to respectfully listen and respond to children and young people and their views and priorities. This matters for all children, but for children and young people who experience effects of both disability and trauma, it is even more important.

Young people raised practical and cultural barriers to their self-expression and capacity to share their views. Barriers included concerns about being treated differently (worse) if they ask for help; not knowing to whom or how to speak about their worries; and a lack of trained Auslan interpreters to support Deaf young people who have experienced trauma.

> Some Deaf people have taken off from their families because of domestic violence, but there haven't been enough interpreters. They can't communicate, and they try writing, and it's really hard. They really need to communicate with Auslan, and it's much better. It's worth it. They need to be strict about that kind of thing, that they can provide these skilled interpreters. Especially for domestic violence. We need to improve. (Gabriel, aged 21 to 25)

Practitioners generally felt that most service types consider family members to be primary decision-makers for children and young people with disability, and that age and disability combined to make it less likely that practitioners in either DFV or disability services would consult in depth with children and young people. DFV practitioners who supported families with children either in family violence services or applying for the NDIS noted barriers in both systems in prioritising children's views and perspectives, because they rely on adult family members to both apply and then negotiate service:

> There're two things happening here, the NDIS and the way that family violence services work, and neither of them are really prioritising the children's voice. (DFV practitioner)

Advocates and practitioners noted that families' responsibility for decision-making can extend longer into children's lives for people with disability, sometimes into adulthood. In this context, they noted a tendency for children and young people to not be asked for their views or perspectives, particularly when they have higher support needs (e.g. in school or child protection contexts), with practitioners solely relying on their parents as a result. They recognised that this is disadvantageous and pointed to the fact that parents are not always aware of young people's wishes or have different preferences to them:

> Sometimes, the parent and the young person have quite a different idea about what that support should look like. So, I've had a couple of parents who said, "Oh no, Jimmy's going to have this, this and this", and he's going "What? I don't want that!" So, there are those [questions about] what's helpful [and] what does the young person actually want? (Disability practitioner)

Some practitioners noted the effect of this on children and young people's capacity to contribute to discussions and decisions about their lives. They spoke at length about the disenfranchisement of children and young people with disability who, alongside DFV, have experienced child abuse, criminal violence, removal from their families of origin, multiple placements in foster care and residential care, and serious problems in schools. One practitioner noted how difficult it can be for children and young people to answer questions, because they have had little opportunity or practice, and because of the number and range of people coming through their lives:

> Quite often, they've lived lives [where] it actually doesn't matter what they say or do, their voices aren't heard … adults are making the decisions and even when you ask, "In an ideal world, what would you have?", I've found historically it's been almost impossible for them to really answer that question because they've never had to or never had the opportunity to. [Even when asked], they've had so many adults, so many support workers, so many case managers. It was pretty difficult for them at the time to know who did what or what was the point in even answering these questions anymore. (Youth services practitioner and advocate)

The need for children and young people to have opportunities to practise sharing their views and priorities was emphasised by all groups. This was seen as important for all children and young people, and particularly for children and young people with higher support needs for communication and cognition. Family members and practitioners relayed that these children need scaffolded, regular opportunities to practise sharing their perspectives with trusted people who can demonstrate they have heard them and can respond to their wishes and needs.

> Apart from police, they've never had an opportunity to talk, and the police were more, "What did your father do?" not, "How can we help you?" (Tracy, mother)

Unfortunately, in this study we heard several examples about what happened for young people when these opportunities were not provided or service systems did not respond to their wishes. For example, one young person's individualised communication systems fell into disuse, preventing them from expressing their wishes about their own care. Some services refused to allow young people to express their wishes about access to non-custodial parents, and failed to consider children's expressed unwillingness to see their non-custodial parent:

> Wayne witnessed his father try to strangle me. Abuse was in the house. So, when the father left, Wayne tried to do the same things to me. I kept asking for help because I was dealing with my own trauma. It was just bizarre how

> he didn't have a voice. The other two children didn't have to see [their father] because they could tell how much the abuse and everything that was happening. But Wayne was placed under supervision that he had to see his father. So that was even more stressful. And I kept asking for supports and for psychologists. I know he's hard to deal with, to manage, but you can communicate. But there's surely got to be some attempt, because the other two children were getting psychologists. (Emily, mother)

Trauma-informed and disability-informed responses

Children and young people in this study had needs related to their disability; some had emerged as a result of their experience of DFV and some had developed as a result of their unresolved trauma. These needs were entangled. For example, several children and young people had difficulties with emotional regulation and problematic behaviour. These may have emerged as a result of their exposure to DFV but were often difficult to resolve when practitioners did not appreciate or implement strategies responsive to both the child's disability and their ongoing trauma.

Family members felt strongly that the experience of DFV has had a substantial effect on their children, impacting their mental health and wellbeing, their capacity to learn, and their behaviour in response to their feelings of distress and anger.

> … the teacher at the specialist school had him draw a card for his father for Father's Day [despite a non-contact order being in place]. He's got limited ability, but he drew this card and on the front of it, it had this screaming red face and, on the back, had this little black figure sort of … it was you know, hiding under a big black cloud. (Eliza, mother)

All of the groups in the research were aligned in their focus on the importance of trauma-informed practice in supporting children and young people with disability. However, they discussed it in different ways. Children and young people spoke about it in a personal and relational way, talking about the things and people that help them to feel safe and with whom they are able to share their ideas. For example, Jason spoke about how it isn't enough just to be listened to, but that respectful feedback is also important:

> Most importantly, you have to listen to them. Listening to them is very key. At the same time … okay, generally people do not always need people to agree with them all the time when they seek help. So, sometimes we appreciate the fact that someone can be a bit more straightforward, rather than trying to beat around the bush. Sometimes it's better overall, more effective, when you seek help … to receive more critical feedback, for example. But not over the top; like, not being too harsh, but balancing it just right. (Jason, aged 17 to 21)

Some family members also had a sophisticated understanding of trauma-informed practice. They used this as a lens over service and practitioner approaches to evaluate goodness-of-fit for their child in their DFV context. For example, some spoke about the things they have seen in the relationships between practitioners and their children which has helped their children to feel seen, supported and able to grow.

> I think a big part of the problem is that both agencies and particularly government do not understand what continuity of care actually means to people who are service users … because if you keep changing who the provider is, then that means upheaval, and having to try and establish trust with a new person again. If you actually have finally established trust with someone and they are good, you need to be able to have funding to continue working with them, with that person, not some other new person and then another new person and another new person. This is right across the systems that I've engaged with. (Lindsay, mother)

Several examples were provided by families of the effectiveness of child-centred and trauma-informed practice in helping their children to navigate stressful situations, avoid distress and build confidence. For example, Eliza described the difference that child life therapists at a children's hospital have made to both her sons' experience by taking a child-centred approach, observing that they "basically [made] the whole visit less traumatic" by providing whatever the children needed for entertainment and made the environment calm and relaxed. Conversely, when Eliza and her sons toured a high school, the principal berated her son for not making eye contact, despite being advised that he lives with a major depressive disorder. Eliza said:

> Three years ago, he couldn't even speak to grown-ups and now he's speaking and you're telling him off because he's not making eye contact. This is not a trauma-informed school. (Eliza, mother)

Some family members spoke about their limited success in encouraging practitioners and services to take on trauma-informed approaches. Emily related her efforts to get her son Wayne's accommodation provider staff to share accessible stories with him about why his circumstances had changed, in the hopes that it would help with his distress and challenging behaviour:

> We can talk more to Wayne through social stories, through understanding why the family has broken up and just simple things like that. I was the one creating social stories, nobody else. There was no support. He has got language. He has got understanding and meeting where he's at and work through that … He's really difficult. He's got a severe disability. This is what we're going to do. He's not a box. (Emily, mother)

In some cases, practitioners took on training, but with only partial success. The therapists that Tracy's children worked with received training in trauma-informed practice, but she related that little changed as a result:

> My therapy team went out and got trauma trained, but they're still having issues because it's the levels of trauma. So, they're trained at a low level of trauma where your practice is most people will turn around, but I've had people sort of say to me, "You've got more chances of recovering from leukaemia than your life." And I thought, no, I'm not going to take that for an answer. We will get there. (Tracy, mother)

Services available to children and young people were primarily through disability support (in-home support, respite, support workers, accommodation) and disability therapy services (OT, speech therapy and behaviour support, primarily), which few families found were trauma-informed. A few children and young people and family members had access to art and play therapies or psychology, mainly funded through NDIS or Medicare for a limited number of sessions per year. Some children and young people in child protection or out-of-home care were supported through youth-focused frameworks, but their capacity to express their views and agency was constrained by the way that practitioners had to apply statutory and legal restrictions, limiting the extent to which they were disability-informed or responsive in their approach. Support for the effects of DFV was family-focused, provided at points of crisis, and directed mainly through mothers.

Services and systems did not often provide support for the multiple and compounding experiences of disability and DFV on children and young people. Practitioners with specialist expertise or who were working with early intervention as a goal expressed understandable frustration at their lack of capacity to support children and families with multiple needs who are in crisis.

> And it's like, well, is it trauma, is it ADHD, is it a developmental delay, is it autism? It can be really hard for families to really get those diagnoses, and there's a lot of complexity in navigating, even getting to the stage of being eligible for an NDIS package … We meet families at a certain stage of their journey where the young person is already at serious risk of leaving the home. It's at that point that there's already so many things going on. Trying to work backwards with them sometimes when they're setting up a lot of things that probably should have been in place beforehand. And if they were, maybe they wouldn't have come to us. (Youth services practitioner)

However, this complexity is the reality of living with disability and violence for many families, and should be an expectation in services. Once a family without supports is in crisis, it is much more difficult to plan effective support that responds to children's strengths and potential rather than their immediate needs. Complicated systems of diagnosis and eligibility criteria are deficits in the support system, not families.

When families received funding for disability-related support for children and young people, their capacity to understand their packages and make use of them varied widely. There was little evidence of trauma-informed approaches when families who experienced DFV entered or negotiated systems to receive support for disability or trauma. This was difficult for people in urban areas. Practitioners working in remote communities felt there are additional cultural and whole-of-community impacts present in remote areas where rates of DFV are high in First Nations communities:

> The work around trauma at an individual level and

> community level is so significant … [There] is this incredible capacity for people to say, "Well, that's historic and we just need to heal from the history" rather than acknowledging the contemporary retraumatising and the constant colonising practices. So, it's vertical but it's also horizontal transmission. So, that's why I think collective trauma is a much more useful and inclusive term. (Remote disability practitioner)

Navigating entry into the NDIS or changes to NDIS plans while dealing with DFV crises was extremely difficult for all of the family members in this study. Participants felt the NDIS systems and processes take poor account of DFV and its impacts. For most families in this study, some aspects of NDIS were useful (such as access to a support or service) and some were not helpful (particularly the volume and complexity of work required for a limited benefit). Practitioners generally noted that those families who are in less crisis, better educated, and not facing multiple issues at the same time are more likely to make better use of their NDIS packages. When children and young people and their families were dealing with multiple issues simultaneously, they were less likely to be able to navigate the requirements of their NDIS funding. Practitioners argued that the NDIS is often unresponsive to the needs of young people and families who have experienced DFV and have ongoing trauma. They felt that the NDIS needs to ensure that funding is available to support the healing and recovery of children and young people with disability who are experiencing ongoing trauma:

> So, I think that's our biggest frustration with the NDIS, that lack of understanding of the long-term impacts. But also, just how much being in a safe environment and having that safety can actually cause a huge flow-on effect for the kid and the parent being in a much more regulated stable state, where you're seeing a lot less of these behaviours occurring and therefore requiring a lot less support. So, you're just fighting a losing battle if you're still working within those environments without safety and security being number one. (Therapy practitioner)

Funding of services to meet needs – Adequacy and functioning

All participants in this study described situations of resource inadequacy and poor system functioning. Most children and young people had access to some supports. However, this was not in a reliable or sustainable enough pattern to alleviate their ongoing needs relating to the intersection of DFV and disability.

Several participants pointed to the lack of resources and focus on prevention and early intervention to support families to resolve DFV before it escalated to the point where families needed to flee their homes or were in danger from violence. A number of family members had sought assistance several times for DFV, and both they and practitioners emphasised the focus of services on response and recovery rather than prevention or early intervention.

> We went in and they said, pretty much, there was nothing that they could do because she was able to couch surf at the time. They also said that all of the homelessness services and accommodation weren't appropriate because of the children's disabilities. So, Katie was there, and even though we flagged with [state] Housing and with [state] Homelessness that it was an unsafe environment at Katie's mum's house, they said, pretty much, too bad. And so, Katie continued having to stay there, and then tensions continued to rise. (Disability practitioner)

In some situations, lack of resources had severe effects on whole communities. One practitioner, for example, described the effect on a remote Aboriginal community of a fundamental lack of funding and support for children and young people, people with disability and families experiencing DFV – all groups at high risk in these communities. For children and young people in rural and remote communities, very little local support is available following DFV crises. In communities where rates of DFV are very high, the concept of "following" DFV is particularly flawed, assuming there are an isolated number of incidents in discrete family settings. When DFV was dispersed in extended families, children and young people showed significant signs of trauma from young ages. Practitioners spoke about the concept of collective trauma, and the need to respond carefully and respectfully to acknowledge its intergenerational and continuing nature.

In relation to the NDIS, practitioners in remote First Nations communities reported that responses to problematic behaviour of young people who have experienced trauma are increasingly

to provide "off Country" solutions which do not invest in communities:

> Now, that can be seen to work. That person's not getting into trouble. They're not behaving badly. But again, there are big questions about whether that's preferred solutions, and can we do better than that? If we're not offering on-Country solutions, then families will say, "Well, we're exhausted. We don't know what to do and if you are offering off Country, then we'll say, yes." At least it gives our young person, perhaps, a chance. The other off-Country solution, of course, is as I continue to say, is the justice system. We keep doing that to people. So limited efforts are made on Country, but there's just not enough to compensate for the sense that it's easy to remove people. (Remote practitioner)

The capacity of crisis and longer-term services to meet the needs of children and young people with disability affected the options available to families in this study. Several family members described delaying leaving unsafe homes or returning to violent partners because they could not meet the needs of their children in crisis accommodation, through friends or family or in the rental market. Practitioners also spoke about similar experiences for other families:

> I think [children's disability] impacts on a lot of women's decision to end a relationship. You think about some of the practical issues of having a child with a disability. If it's a neurodevelopmental disability like autism, the children have a real fondness for routine, for instance so it's really hard for women to decide to change everything and move to crisis accommodation, temporary accommodation and things having a period of uncertainty. With physical disabilities, there's often a lot of equipment associated with that or sometimes there's complex healthcare requirements. The child might need specialised equipment, like a feeding pump or something like that. Trying to take that stuff with you, I suppose if you leave, becomes a real practical and logistical challenge. To find some accommodation somewhere where you're going to be safe with your child if they need a specialised bed or they need access, a hotel is just not ideal for that. There's very limited accessible rooms or fully accessible rooms. It certainly becomes a huge challenge. So I think that they're the things that impact on the children the most. (Disability practitioner)

We heard that when families' circumstances changed due to DFV, the application of NDIS funding packages was not responsive to how quickly life changed, and DFV crisis support was limited when children with disability had additional support needs. This left families in severely and unnecessarily constrained circumstances unless individual practitioners stepped in to manoeuvre systems on their behalf. Several families went without needed equipment and disability-related support for weeks and months after leaving violent homes. A number of mothers described going without essential goods such as food, petrol and phone credit in order to continue to pay for therapy and other costs of support for their children. One practitioner noted:

> It's not responsive … any sudden change in people's lives can take anywhere up to 30 days after you lodge paperwork, to let them know that your circumstances have changed … And in essence, what people on the ground need to do is kind of creatively redistribute resources to respond to that situation for the participant. (Disability practitioner)

DFV, family support, youth support and advocacy practitioners all described intensive efforts in supporting families to access NDIS funds and navigate its systems when their circumstances changed.

> Ethically you do what you do as a social worker, because that's your duty of care, and to the extent that you need to. If you need to talk to all the providers in her life around what's going on for her to make them aware of the issues, then so be it. Because now she's left this residence, I need to call the physiotherapist who can't visit her home anymore and let them know that she's at a new address and then have to work out is it safe for them to go there? And then it's the new kind of support worker and the support worker needs to be aware of what some of the risk factors are. What to do if her ex-partner comes and what are the concerns there? What to do, what's the kind of safety plan to maintain, make sure she's safe. There's a spillover effect and it just chews up the funding, which is meant to be used for disability-specific services but ends up kind of being absorbed, because you are the person who knows that client or participant the best. (Disability practitioner)

In some cases, participants described ineffective and unethical use of resources. For example, some parents said that their family members had withheld NDIS funding resources from other family members as part of DFV. Others described how their children's funding packages had been fully used on assessments by service providers over a two-year period. Some families were offered only small pockets of time-limited assistance.

> I have found bits of support at times, and often it's been very short term. And it's one of the things that I've come to realise, it's actually often further damaging. Because it's very short term … it's what I call a revolving door service. (Lindsay, mother)

NDIS support coordination is set up to be time-limited and focused on supporting people to direct their life and access disability-related supports (mainstream and specialist). Many of the families in this study had children with disability whose support needs spanned disability, education, housing, health and social domains as well as DFV. It was difficult for both DFV and disability practitioners to ignore children's and families' needs which, if unaddressed, made it difficult or impossible for children to access the supports they needed in other areas. Practitioners described taking a capacity-building approach and supporting family members to build their networks and other supports. They supported family members to use referral pathways into DFV, homelessness, and health and mental health sectors. However, family members frequently found waiting lists, eligibility requirements and disability access issues caused insurmountable problems and returned to disability providers for advice.

> For this family, I had 12 hours' support coordination for the two children. Imagine how time-intensive some of that work was? I actually spent some of my non-billable time providing this support because it was imperative [to address their crisis needs]. Otherwise, they wouldn't be able to access disability services. (Disability practitioner)

The lack of availability of quality services and practitioners to refer children and young people to was a pressing issue raised by almost all family members and practitioners. Long waiting lists for many services meant that children and young people were often not receiving the kind of support that has been deemed necessary to help them after DFV:

> Three years I've been struggling to even get a service for the kids. But then when you have a service like [therapy service], there's probably 10,000 children that need them and to make someone wait two or three years on a waitlist … they'll probably kill themselves by then. And I've noticed sometimes my boys say that "I don't want to be on this earth anymore." "Why do we live our life like this?" And I think that as a mum [this] makes you feel like crap. (Tracy, mother)

DFV practitioners also had experience of NDIS plans being derailed by perpetrators, who restricted providers' access to their homes for fear they may witness DFV taking place. They saw the need for

> a locked-in NDIS plan where there's ongoing, solid supports for the protective parent and the children. (DFV practitioner)

Several practitioners raised the need for an easier and better supported portal that is welcoming for people in crisis, including but not limited to the NDIS. They expressed the view that, while the systems were designed so that mainstream services would support families with DFV-related needs, the realities of people's lives are much more complex and more difficult to negotiate. It is unrealistic to expect that either the family member in crisis or a time-limited case manager can sustain this work.

Flexibility to use supports in ways that suit children in their family context

In the study, examples of positive practice were provided that demonstrated that flexible and responsive support for children and young people experiencing DFV helps them and their families meet both disability- and trauma-related needs. These built on elements mentioned in the previous section – relationships with trusted practitioners, trauma-informed and disability-informed practice, and timeliness of support.

Having services and supports in place before DFV happened made a big difference to Nerissa and her children. She spoke about working with therapists with whom her daughter Tammy had a trusting relationship. These therapists helped Tammy articulate her feelings, find ways to manage her anger and

grief and express herself to both her mum and her therapists. It also gave Nerissa a language and new understanding about how to support Tammy:

> When the domestic violence happened, we had outbursts of violent behaviour from her, so hitting, telling people to fuck off, so that also escalated, so working around her emotions and saying, "It's not really okay to punch someone when you are feeling like this. What can we do instead of you doing that?" And then trying to get her to realise that she is feeling angry, and she needs time … So, she's getting better now at communicating with us that she is angry or "I'm sad and I really do need a hug", so she's now been able to vocalise how she's feeling. (Nerissa, parent)

As a result, Nerissa said she has seen a big difference in Tammy in just six months: she is more settled, less frustrated and sleeping better. She said:

> I'm very lucky that I already had those services in place before the domestic violence, so I guess if we didn't have those services, trying to reach out to those services might have been quite a long process, because you know wait times, like before the domestic violence, it took me a year waiting for Tammy for OT and speech. (Nerissa, parent)

In a second family, Olivia's mother and support coordinator were able to use the NDIS as well as DFV and homelessness services. Because routine and structure are important to Olivia, her mum worked with her support coordinator to keep as much consistency as possible while the family moved across multiple crisis accommodation placements. The support coordinator was able to obtain an exemption to the usual rules so that Olivia's speech and occupational therapists could visit her at two of the three housing settings and help keep some sense of routine in place.

Some practitioners were able to negotiate more flexible supports that were responsive to the needs of children and young people and their families. For example, one therapy service had advocated to provide "joined up" support to a family in which multiple children received individual plans and positive behaviour support. With more flexibility, the service has been able to implement a family positive behaviour support model which is meeting the needs of all members better. This took several years to negotiate.

> In the early days in the NDIA, they thought of each child very uniquely and didn't think of the family unit. They're getting better at that. They're not as good as they could be, but they will think of the impact on the broader family of therapy for one child or the family as a whole. (Therapy practitioner)

It was more common that parents spoke about frustrations with funding and support. Several parents were frustrated and disappointed that NDIS funding has not been provided to support their children to resolve trauma arising from the intersection of DFV and disability. There was inconsistency in experiences, with some children and young people receiving funds for counselling and psychological support, while others did not, with NDIS planners telling parents that children and young people's trauma needs should be met by other sectors. However, a number of parents were refused supports within other sectors due to children's disability support needs:

> I went through probably two years of NDIS reviews and NDIS keep saying, "We can't fund trauma. We fund their disability issues." And my point to them was we're getting nowhere with therapy because we need to deal with trauma first … [and] we've had school psychologists say the level of trauma is too much for us to handle. It seems that if I don't have $400 an hour to pay top trauma psychologists, there's no help for us. (Tracy, mother)

This was consistent with NDIS-funded practitioners' accounts of supporting children and young people who had experienced DFV. They pointed to how children and young people's intersecting needs require a holistic understanding and response:

> If we write too much about supporting a domestic violence situation or a housing situation there's a bit of an attitude from the NDIS around, why are you dealing with this? There's a system for that and that should be dealt with by the domestic violence system and that should be dealt with by the housing system. Why are you using their disability-related funding to do this? But there's no recognition of the intersectionality and the complexity and how these are all sort of interconnected and these exact issues that we're teasing out aren't recognised, so that makes it really hard. (Therapy practitioner)

Practitioners repeatedly raised concerns about the ways that systems are typically based on the assumption that women experiencing DFV and families of children with disability can seek out the services they need. One observed:

> Families either don't know about the service, or they are unfortunately not going to reach out and access them themselves, because that would require them to know about it or to be confident in doing that and not feel intimidated or overwhelmed by those systems. (Social worker)

Practitioners raised multiple issues that make it difficult for families to find and engage with services, including lack of knowledge about services, limited literacy and ability to engage with services online, lack of transport, confusing expectations and poorly executed NDIS plans. Practitioners spoke about working with many family members trying to manage complex issues (such as their own mental health issues, financial stresses and inappropriate housing, and their children's access to education), while activating their NDIS plans. These families were often overloaded and found it difficult to juggle competing responsibilities. This often restricted their ability to access and advocate for adequate supports for their children.

> I know from the early intervention space they've said "Oh no, we generally won't put support coordination. It's not about the family unit, it's about the child." But how can you just have the child without the family unit? And if the parents aren't capable of coordinating all of those services, then really you know, that doesn't make sense to me. (Social worker)

Communication and collaboration in and between systems

Most of the children and young people in this study had used services across multiple domains: disability, health, education, housing and DFV. Practitioners and families believed that these systems need better communication with each other when DFV occurs, so that children and young people receive necessary supports safely.

Practitioners across different sectors spoke about collaboration as a fundamental principle underpinning their work. When practitioners from different agencies communicated with each other and had a shared sense of purpose, positive outcomes were achieved and systems failures were minimised. As an example, parents and practitioners pointed to the ways that schools and specialist services could work together to ensure that between them children's needs were met. However, several practitioners noted that there were many examples where such collaboration did not occur, where agencies worked at cross-purposes and children's and young people's needs were left unresolved. They called for investments in holistic, cross-sectoral and responsive approaches to meeting children's needs.

Disability advocates expressed the view that the NDIS has helped to improve the flexibility for providers to support children with disability-related supports. Alongside this, however, NDIS frameworks were felt to be rigid and make it difficult for practitioners to share information that is helpful for children and young people across agencies.

> We find you don't have that framework to be able to share that information well and safely. Obviously, there is that huge need for safety and also that huge need for a quick response time to any changes in the situations and for those things to be understood by all parties. There's increased flexibility for people to be receiving their supports and at the same time, there's also that increased rigidity in the systems that don't interact with each other very well. (Advocate)

Other practitioners echoed this concern, raising issues about lack of information about what happens to children and young people at risk after referrals are made on safety matters:

> If I were to refer a high-risk case through to Family Safety Framework or try to get that brought to that, I wouldn't necessarily get the feedback, I don't think, because I'm in an organisation separate to government. [Disability practitioner]

Some young people spoke more broadly about how a lack of access to communication aids causes them great distress, compounding their sense of voicelessness in families and the system, particularly during periods of violence. Deaf children whose families do not communicate using sign language are particularly isolated in families while DFV is taking place. Similar issues are in play for children who communicate without words but are deprived of an effective alternative communication system and communication partners. Limiting

children's and young people's communication options can increase their social isolation and potentially exacerbate the effects of DFV.

Children and young people with communication support needs are navigating complex pathways with the adults who support them informally and formally. At a systems level, one practitioner reflected on the relationship between the network of services involved with "complex" children and young people and their lived worlds:

> We keep forgetting that people are living the stuff we think is too complex to integrate across white fella systems. But people are doing that every day. They've got different visitors coming from every one of those complex white fella systems, potentially helping, potentially interfering in their lives … So, there's not like there's not a lot of people busy in people's worlds. And yet we say, "Oh, that's too complex. We can't get our services to talk together and come up with collective solutions. It's far too complex." Forgetting that this is the daily experience of those families that we're all in there trying to help. (Remote practitioner)

Practice frameworks

Practitioners across different sectors spoke about the practice frameworks they use to guide their approaches to supporting children and young people and their families when they have experienced DFV. With the exception of large-scale cross-sector frameworks such as the SA Family Safety Framework, practitioners spoke about individual practice, interpersonal relationships and systems in their own organisations. Some practitioners spoke positively about internal processes and developing policies and procedures, and described how their organisations are increasingly taking leading roles in responding to complexity in the people they support. However, there was limited focus on child-centred frameworks that prioritised children with disability experiencing DFV.

Practitioners from crisis services described using a family-centred framework for responding to and supporting families. DFV practitioners characterised their work as being primarily with women, and said they have a clear philosophy driving their work about self-empowerment for women. They spoke about how their role in working with children and young people was to:

- support mothers with their trauma so they can support their children
- identify children's needs
- refer women to other services
- where necessary, intervene to ensure children's safety and wellbeing.

They readily acknowledged that this does not prioritise tailored responses to children and young people:

> It's about working with a client at her kind of pace and sometimes there are things that are not a priority for her, but we'd still support around, maybe, appropriate services and I guess we've done that before and there would be a long waitlist. So, we're dealing with all the other stuff while we're waiting for that to kind of come in place. (DFV practitioner)

Several family members pointed to limitations in family-focused service provision for children and young people with disability, noting that while women are often well supported, the needs of children (particularly older children and young people) are not sufficiently prioritised in a whole-of-family approach:

> It's not immediate enough. You have to wait then, while the woman processes the trauma and gets her life back on track. And meanwhile, the trauma wounds of the children are festering and becoming infected and deteriorating. To the point where then, you find children are acting out as a response to trauma. Their behaviour is off the charts at school. They start to get suspensions. They start to be unreachable socially. They start to close themselves off. They have self-esteem issues. They have mental health issues. The list just goes on and on as the trauma is unaddressed. And that's all because we're waiting for the parents to get their lives back on track, to be able to face the issues of their children. But by then, they're not just those issues anymore. There's layer upon layer upon layer. And a woman is just newly recovering from trauma, and you find the self-blame just comes back on, "Oh, look now, I've created monsters for children. It's all because of the choices I've made. I stayed with a man; I didn't leave their father. I have DCP involved now, because I'm a 'non-protective parent.'" The more you've got guilt and shame, it blocks the ability to do new

> learnings and grow your own capacity. And two years down the track, when you start to do some healing, but you look at your kids, and their life is a mess, guilt and shame just comes straight back on. And not only are you having to deal with traumatised kids, but you're having to deal with traumatised kids who've got established, well established, maladaptive coping mechanisms. So, you've not just got to deal with the trauma, you've got to undo the responses to the trauma. And that is too much for the average parent … I don't believe we can wait for support for mum to have secure housing, and have healthy boundaries in place, and a stable job. I don't believe children can wait. Because in the meantime, who's telling them "It's not your fault. It's going to be okay"? (Petra, mother)

Disability practitioners working with children and their families also spoke about taking a family-focused approach, and how this is complicated by intersection with a greater number of systems. In response to a staff member needing unexpected supervisory help for a family experiencing DFV, one disability organisation was developing a decision tree and process to assist all staff to respond with more confidence.

> It'll be really helpful to have a bit of a framework, a bit of a step-by-step, a flow chart – if you will – to actually support someone regardless of whether they are speech, OT, admin, social worker, whoever to actually walk through the process and identify where the [family] need to go. (Disability practitioner)

Disability practitioners worked with a continuing tension around the policy expectation that support coordination is temporary, but the lived experience of children and families that have support needs continues to evolve, particularly for families facing DFV:

> I think the nature of our role often has been we're long-term support people for these families. The intention of support coordination under NDIS is really meant to be time limited. I think their ideal is we get it all for 12 months, fix everything and then see you later, they don't need us anymore. And while we do operate from a capacity-building framework where that's the goal, we recognise that the complexities around the family's lives are going to be ongoing and changing. And especially as children grow and transition to school and then there's always new things that require that coordination. (Disability practitioner)

Social workers in the study were experienced and confident in building and maintaining cross-sector networks. They spoke about interagency and inter-professional networks as important in enabling successful referral pathways for children and young people and families when they need various kinds of support. For example, two regional social workers valued the Child Family Safety Network (a collaborative group formed under the Family Safety Framework) in their local area. It has cross-sector capacity to identify children and young people at risk, and to work across government and non-government agencies to support them holistically and reduce the need for child protection involvement.

> I think the Family Safety Framework works really well. We have to all be accountable, those that attend, and it is confidential amongst those that attend … And it's really seeing the difference of when things are put in place that we can keep some people safe [at] least for a period of time. But going just beyond that, it's not just about keeping them safe, it's about ensuring the children are accessing what they need. The parents are accessing mental health support, for example, if they need to, or referrals to drug and alcohol services or whatever it might be. So, it's really going beyond that safety and making sure there's things in place that give them the best chance I guess. (Social work practitioner)

A disability practitioner involved in a different Family Safety Network was similarly positive:

> The rollout of the [Family Safety Framework], the DV risk assessment tool, the multi-agency protection service, the specialist services, women's information service, and even some of those specialist services embedded within the police. So, family violence investigation sections and women's legal services, they were all really fantastic to deal with, and very highly skilled people who take it very seriously and want to do the best they can to support families, young people and children. (Disability practitioner)

Practitioners and families both pointed to the need for effective workers to be supported and resourced, noting that

working to support children and young people in this context is skilled and demanding work. To sustain it, practitioners need to be effectively resourced at operational and systemic levels, linked to practical systems of support (such as reflective supervision) and have their work valued. The multiple costs of under-valuing and not supporting workers were noted:

> So, the costs are enormous, not just for those doing the work, but at a whole community level of the hopelessness that comes from, "We trusted again, and we are now … That hasn't been valued by anybody." (Disability practitioner)

Discussion

This research set out to provide new knowledge on how children and young people with disability experience DFV. At a population level, children and young people with disability were found to be significantly over-represented in families experiencing DFV. The companion report (Octoman, 2022) details this heightened risk. It demonstrated, for example, how children and young people with disability were present in over one third of families experiencing DFV in Western Australia. This brought them into contact with police, hospitals and child protection services. The case study analysis revealed that children and young people are negatively impacted by DFV experiences in multiple ways, including through the experience of direct violence and the withdrawal of necessary services. The qualitative research in this report showed that existing service responses are not consistently meeting the needs of children and young people or their families for holistic, joined-up support at times of crisis, or afterwards, to provide practical support tailored to the intersecting disability- and trauma-related needs of children and young people. In this section of the report, we discuss the implications of these findings for policy, practice and future research.

Disability, complexity and causation

A fundamental finding from this research is that the over-representation of children and young people with disability is not because of children and young people themselves. *Disability does not inherently equate to risk*. This is very important, as historically, both policy and practice have assumed disability in children and adults increases risk of multiple negative outcomes in families (Llewellyn, 2020; McCarthy, 2019). In our study, children and young people and families had unmet needs in terms of support, experiencing unresponsive service systems and intersectional disadvantage related to violence, poverty, housing crisis, and discrimination. These complex and compounding circumstances often included disability, but disability was not a driver of DFV. However, DFV did cause some children to experience or develop disability, and increased the impact of disability for some children and young people. As Lindsay (2021) persuasively argues, reframing attention on abusers and systems that do not act to protect victims and survivors is a more productive approach than focusing on the mental capacity or personal qualities of children and young people with disability that may increase or mitigate individual risk.

What will improve support for children and young people with disability experiencing DFV?

Understanding and responding to children and young people's value, needs and wishes

Being viewed as capable and respected, and acknowledged for the things you contribute, was very important to children and young people involved in this study. When difficult things happened in their families, being seen as a whole person with strengths and capacity, relationships, and a full life mattered.

In this study, there were not a lot of ways that children and young people who experience DFV were asked about what they want for their lives. This is in no way to diminish the role and efforts of their parents to identify their needs and advocate for what they believe is in their children's best interests. Protective parents loved their children, knew them intimately, and advocated hard and well for them. Services in DFV, disability and other related sectors are not set up to prioritise children's voices. There are not systems in place to capture the perspectives and priorities of children and young people about their everyday lives, about when difficult things happen, and about what children and young people would like to change. Individual practitioners sometimes worked hard to listen well and to take forward the views and priorities of children and young people into planning and decision-making around their services and support. But this was fragile and dependent on the quality of each person who comes into children's lives.

The more services that were involved in young people's lives, the harder it was to ensure that the child's views were captured and remained central to the ways that workers, organisations and services responded to issues of violence. As the number of people and organisations (who each had their own views and priorities) increased, so the ability for children and young people's views to be prioritised reduced. Family members and practitioners needed to focus on children and young people's difficulties in order to meet eligibility criteria for funding and access to services to meet their needs. When family members asked for support for their children and it was refused, they had to focus even more intensively on their

children's problems and difficulties in order to advocate for their needs to be met.

> It will improve children and young people's lives if there are planned, thoughtful ways for their ideas and priorities to be heard and responded to in the services they use.

In the context of DFV, finding safe people and spaces for listening to children and young people's ideas and priorities matters. Many of the children and young people in this study did not share their ideas in a direct way, or through conventional speech. Some people communicated through behaviour, others through augmentative and alternative communication systems and Auslan interpreters. Some needed people they knew well to help explain what is important to them and why. But they all showed people close to them how they felt about what was happening in their family life. With support, they could share their perspectives about their daily life and changes to their circumstances, and what they like and don't like. Using this information to respond to children and young people's preferences not only increases their agency but also their sense of safety. This is consistent with the findings of other research with young people with disability about the things that promote their sense of safety and self-efficacy (Franklin & Smeaton, 2017; Moore et al., 2020; Robinson & Graham, 2021; Robinson et al., 2021). Supported decision-making is an important rights-based advance for children and young people with disability. Receiving support to make decisions that convey the will and preference of children and young people with disability is an important way for trusted adults to respect their rights and demonstrate their worth, dignity and value (Laurens et al., 2021).

> Finding safe places and people to listen to what is important to children and young people can help to build child-informed knowledge about how to respond to their needs and preferences. Where children's networks are limited, focused support to identify and sustain relationships with trusted adults is essential to build children and young people's capacity to exercise their voice and agency.

Children and young people were asked by the researchers for their ideas and advice about what would help other kids feel safe and happy. Their most common response was being with people who helped them to feel supported. For most, this was family members who had provided them with support in the past and were currently supporting them – people they trusted. Children suggested that trusted adults had a role to play in distracting them from fears and worries, reassuring them and helping them to feel safe. For several, friends were important sources of support, and others pointed to the importance of having access to adults in a range of professional and private contexts.

When the children and young people had found trusted adults, they shared ideas and priorities with them in a range of ways, including verbally, through drawings and through their behaviour. These people identified the meaning in children's words and actions and translated it into ways that services could help. Trusted adults advocated for systems to release resources in ways that would work to meet children's intersecting needs. They found ways to show children that they were heard by scaffolding support in ways that were clear and accessible.

Safety is bound up in relationships. However, trusted adults are not the same kind of people for all children and young people. Finding people who are safe and trusted by children and young people with disability who have experienced DFV, building those relationships, and sustaining them matters. Having more than one safe adult matters. For children and young people who are very poorly heard and very socially isolated, this is especially important.

Responses are needed that understand and acknowledge how disability is interwoven with trauma for children and young people with significant support needs. Skilled support and therapeutic responses are needed as a priority to help children and young people begin to recover from DFV.

The effects of trauma on children and young people in this study were pronounced. Where children and young people were severely affected following DFV crises, they struggled to progress in their lives. Their family members were distressed and concerned about their children's pain and trauma, while managing their own. Some practitioners were familiar with trauma-informed practice, but it was not a routinely understood and applied approach in the context of DFV and childhood disability. There was an evident need for practitioners in both disability and DFV to build knowledge of the intersection of disability, DFV and trauma.

Frameworks for understanding and applying trauma-informed practice in this context are needed. Practitioners and families need access to training and resources to build understanding and capacity to support children and young people who have experienced trauma. Children and young people need to be provided adequate, appropriate information and support so they can understand and recover from their experiences and avoid future harm. Frameworks and practice guides need to be culturally responsive to the needs and circumstances of First Nations and CALD children and young people with disability and gender-diverse young people with disability. This is not a new call in research, and our findings are consistent with those of others who have demonstrated the need to build understanding and skill in this area (Jones et al., 2017; Maher et al., 2018; Morris et al., 2020).

Improving support to families so they can support their children

The level of complexity in systems, particularly the NDIS, is too high to be accessible and appropriate for people who are experiencing DFV crises. Support coordination and case management are necessary to ensure that the DFV and disability systems are available and accessible to children and young people with disability and their families.

Periods in which families experienced DFV and escaped it were very difficult for family members involved in this study. They were required to navigate multiple service systems, as well as support their children while managing both personal and legal processes around their own DFV experience. Many of the family members in this study were resilient, capable and persistent women. They worked hard to promote the rights and interests of their children. However, there appeared to be little practical recognition of the circumstances of the families in terms of making their access to service systems or processes any easier. Access to case management assistance in DFV or support coordination in disability was helpful in reducing parents' confusion and feelings of being overwhelmed, as well as their feelings regarding rejection of their children from services they were referred to.

Practitioners often worked outside of their roles and service parameters to link families to what they needed in times of crisis – for example, by working more than the number of billed or funded hours. Where family members received helpful support, it often came from individual practitioners with whom they had a trusted relationship, and these relationships were often established independently of, and prior to, any DFV experience.

We need to recognise the importance of family to the lives of children with disability, but also take a child-centred approach to recognise the needs of children and young people as individuals with needs that are distinct from the needs of their family. This is especially the case for those who are involved with multiple service systems, have multiple and compounding disadvantages related to intersecting inequalities, and experience their own trauma.

Trauma-informed practice approaches for children and young people with disability must take account of this complex and unique context for both children and their families.

The needs and experiences of children and young people with disability and their families are often closely interconnected. All children are enmeshed in their family life, but for children with significant support needs, the connections are often even closer. Approaches that prioritise women so that they can recover and be best placed to care for their children were helpful for parents in this study. However, children and young people are distinct from their family members. Parents felt that children and young people with disability are viewed passively in this approach, as the responsibility of parents and not a primary concern of DFV services.

Children with disability also have high levels of child protection involvement in their lives compared to children without disability, particularly when their parents also have disability. This can isolate them from their families, both parents and siblings alike, and leave them vulnerable when living away from these important carers and advocates. Both our quantitative and qualitative studies were consistent with earlier research that showed the over-representation of children with disability in child protection and out-of-home care, as well as the significant negative impacts on children and young people with disability (Jones et al., 2012; Llewellyn, 2020; Maclean et al., 2017). In cases where parents and children both have disability and there is violence in their home, it is highly likely that child protection systems will be involved. Support for parents who are in crisis could reduce this, improving life for children and parents.

Our findings suggest that mother- and family-focused (family-first) supports need to be inclusive of and responsive to the unique needs of children and young people with disability. Practitioners also need to be skilled in recognising and responding to children and young people within their family context. Families need to be supported to provide care for their children – in the main, they are their best advocates and staunchest allies. Parents pointed to the need to support the whole family unit affected by DFV, including siblings. This not only maximises the chances for children and young people with disability to recover and thrive, but also for them to do so in the context of the family life which they know and value. But this on its own is not sufficient.

Improving systems and structures

Across service types and sectors, it was evident that service systems are struggling to provide practical and joined-up responses for children and young people with disability and their families who are experiencing or who have experienced DFV. The issues troubling children and young people and their families were most often not the issues focused on by systems. Young people and their families asked for help to remove the barriers that prevented them from safely leaving violent homes and to recover from the trauma caused by DFV. Service systems largely focused on disability-related supports for children and young people that were tangentially related to DFV and its impacts. This is a longstanding problem, identified consistently in the literature for nearly 20 years as a major barrier for women and children with disability experiencing DFV (Baldry et al., 2006; Fraser-Barbour et al., 2018; Robinson et al., 2015; Robinson, valentine et al., 2020).

By not directly addressing the intersection of disability and DFV, disability services did not appear to offer holistic and flexible approaches to support children and young people and their families in their particular contexts – either from a child-focused or family-focused vantage point.

Similarly, family violence responses were often unhelpful for families with children with disability. This was seen in families who were:

- refused crisis accommodation due the support needs of children with disability
- expected to repeatedly organise multiple assessments of their children, build evidence cases and apply for funding for disability-related support with minimal assistance (e.g. from DFV or homelessness services).

Some families had the capacity to work around these barriers, but those who did not continued to live in danger and children and young people missed out on needed supports.

Children and young people's access to funding to meet their support needs should not be reliant on the capacity of their family members to apply and negotiate with systems on their behalf. Children and young people with disability have the right to support to meet their needs. Where they and their family members require support to navigate systems due to the impact of DFV, it must be provided proactively to support children and young people to use it well and thoroughly.

This includes the NDIS and other sectors important to children and young people's lives – education, health and mental health, housing, child protection and guardianship and so on. Such support also needs to be actively informed by children and young people. It should focus on their developing capacity, voice and agency and help them to have input into their plans and how they are implemented. While parents are nominees or guardians for young people under 18 (as is the case in NDIS plan management), this is inconsistent with wider social norms and practices that do not exclude young people from involvement in their own lives.

Children and young people with disability need access to funding models that support flexibility and holistic approaches and do not lose children and young people in cross-systems referral.

In this study, many children and young people had fallen between cracks in systems. The provision of trauma-responsive supports was limited across all sectors. Disability services felt under-equipped to support families with DFV; DFV services felt under-equipped to support families with children and young people's disability-related needs; and schools, youth services, child protection and guardianship bodies were all challenged by the complex intersections between DFV and disability for children and young people. As a result, there was a significant amount of referral of children and young people and their families between different service systems but minimal direct support provided. This did not always meet the needs of children and their families, and sometimes people ended up with no helpful support despite being involved with multiple services. When conflict was high and continuing in families, this had particularly poor outcomes for young people and protective parents. Practitioners pointed out that previously there was a system where a case manager or social worker was responsible for supporting families across multiple systems. Now this is much less common, and this work falls to families who are far less able to coordinate holistic service delivery, particularly in times of crisis.

Building the skill level and readiness of practitioners across all sectors working with children exposed to DFV is a priority task.

Practitioners in non-specialised service systems – particularly schools, childcare, healthcare, and family support – should be resourced and equipped to be "disability ready" and trauma-informed in their practice. This will help practitioners respond confidently to the complexity of children and young people's circumstances as part of their everyday practice, improve the quality of support to children and young people and increase the potential for early intervention. Training and capacity-building can offer opportunities to respond to children and young people's expressed priority for trusted people.

Stronger referral pathways and inter-sectoral collaboration between specialist support systems in child protection, youth, mental health, DFV and disability are needed.

Accountability for positive progress in children and young people's lives needs to be jointly held across service systems and considered in terms of children's trajectories, not the timelines of bureaucracies. Six months is a long time in a six-year-old's life. Two years (as experienced by several families in this study) is an inexcusable delay in providing services to a traumatised child with significant support needs.

Frameworks and processes that support practitioners to take a systematic approach to their work were viewed positively by practitioners as helpful for building good practice.

Practitioners expressed a shared desire for a unifying structure and guidance to support and facilitate good practice across sectors. However, they recognised that it needs to be fit for purpose and centred on the rights and interests of children and young people with disability. The final section of the report proposes a set of principles and operational standards to underpin a framework for practice.

Local communities have expert knowledge that should be sought when developing solutions to improve practice with families, especially in First Nations, remote, and CALD communities. Their knowledge needs to be valued and resources must be allocated to enable this knowledge to be used to inform policy and practice.

The situation-specific knowledge that young people, family members and practitioners shared in this study has broad applicability to national practice, but is also important at a local and community level. There were many kinds of communities involved in this research. Broad-brush solution-making is unlikely to meet the particular needs of different remote First Nations communities, regional towns or CALD communities, for example. People who are experts in their communities – people with disability, Elders, practitioners with long-term knowledge and respect in the community – must have opportunities and resources to shape evidence to fit communities and share their knowledge.

Implications for policy

The implications of the findings for national policy are significant. The findings of this study are relevant to the accountabilities of three national strategies: the *Australian Disability Strategy (2021–2031)*; *Safe and Supported: National Framework for Protecting Australia's Children (2021–2031)*; and the *Draft National Plan to End Violence against Women and Children (2022–2032)*. These findings are released as all three strategies and supporting action plans are being finalised.

This study provides important evidence to strengthen the focus of the National Framework on children with disability and/or parents with disability as one of four priority groups, and the focus areas of early intervention and targeted support for children and families experiencing vulnerability or disadvantage. Our research is consistent with the aim of the National Framework to support families in a "holistic, coordinated and timely way", including priorities for action around multidisciplinary practice models, addressing access barriers, and strengthening the interface between service types. Although the National Framework articulates the need for children to be protected from harm generally, it may be enhanced by further clarifying how children (including those with disability) might be protected from DFV and supported to heal and recover.

Given that they are over-represented in the population of families affected by violence, children and young people with disability need to also be recognised as a priority group in the first Action Plan of the Draft National Plan and in the Safety Targeted Action Plan of the ADS, where children are largely absent. The Draft National Plan acknowledges children as victims and survivors in their own right, and includes foundation principles to "draw upon the diverse lived experience of victim-survivors to design appropriate and effective policies and solutions" and to take an "intersectional and evidence-informed approach that considers the complexity and diversity of people's lived experiences" (Commonwealth of Australia, Department of Social Services, 2022, p. 7). The four proposed pillars of the Draft National Plan are prevention, early intervention, response, and recovery. The unique needs of children and young people are given little attention in the Draft National Plan. We suggest that children and young people with disability need to be recognised as

a priority group, independently and within their families, with attention given to their lived experience, childhoods and safety.

Our study shows children and young people with disability require urgent policy attention and greater investment in early intervention, trauma-informed response and recovery efforts.

This is particularly so given the emphasis of the Draft National Plan on changing the trajectory for children and young people and families with higher-than-average risk of DFV, and on "high quality and culturally appropriate response services [and] a more integrated and enhanced service system [which] can also support recovery, healing, wellbeing and positive life outcomes for victim-survivors" (Commonwealth of Australia, Department of Social Services, 2022, p. 7).

For such attention to have effect, children and young people with disability and family members need to be included in the action plans of all three strategies as they enter their second decades. This will help to recognise the intersecting nature of their needs and counter the longstanding problem of being recognised in statements of principles, but falling between policy jurisdictions in terms of practice responses.

High-level strategy needs to include the allocation of specific initiatives, programs and resources directed to addressing the needs of these groups as we have started to articulate them in this report. Further clarity is required on how the three strategies join up and what processes are in place to ensure that children and young people at the intersection of these three policy documents (i.e. children with disability) are not lost in the gap.

This is particularly important when recognising and resourcing trauma-informed responses. For example, if services can refuse to provide supports to children with disability because they are acting out, then they are not trauma-informed. Systemic changes are needed in order to improve the capacity of both service systems and individual services and workers to provide trauma-informed responses to children and young people with disability and their families. This includes the allocation of resources, workforce training, leadership development, and discretion in eligibility criteria (Jackson & Waters, 2015).

The increasing complexity of service systems must be addressed for children and young people and families who are not able to navigate it in times of crisis.

Access to intensive support coordination and/or case management is needed so that children and young people do not miss out on services to which they are entitled because they are reliant on traumatised family members to negotiate their access. Policymakers need to attend to children as the focus of services by the NDIA and DFV services, rather than parents as decision-makers for children.

The research findings are also highly relevant for the Disability Royal Commission in identifying the rights of children and young people to safety and protection. This research offers the Commission an opportunity to take a child-focused lens on the experience of violence, abuse, neglect and exploitation. To date, this has not been an intensive public focus of its work.

Implications for practice

Children and young people in this research were clear about things that mattered to them.

These children and young people wanted to be known and valued as people. They wanted support to have their material needs met through help for their family members. They wanted their behaviour to be recognised as protest against decisions they did not agree with, such as being forced to spend time with fathers who are violent towards them and their mothers. They wanted trusting relationships, advice,

and reassurance from people they knew and felt safe with, and access to a range of trustworthy people to turn to with worries and concerns. They wanted disruption in their lives to be minimised, and stress to be reduced so they did not feel so anxious.

Children and young people's priorities were often not well met by services and systems

A primary finding in this research was that children and young people with disability fall between gaps in service systems.

They are at more risk than many other children and young people of being lost in referral between systems, as they are involved with a high number of systems (Hollomotz, 2011; Llewellyn, 2020; Sloper & Beresford, 2014). This increased risk is recognised in related research (Jones et al., 2012; Sutherland et al., 2021; Wayland et al., 2016), but our research has provided new evidence of the impacts from the perspective of children and young people themselves in parallel with their supporters. It has documented the impacts of DFV from disability and child- and family-related perspectives. Implications noted in the first report (Octoman et al., 2022) emphasise the risks to children and young people with disability when services have strict exclusion or eligibility criteria and children and their families do not receive needed services because of safety concerns by service providers. First-response services such as hospitals and police took a significant role, and ensuring personnel are effectively skilled to work with children and young people with disability in this climate is a priority.

Other implications identified from analysis of the large-scale data in Phase 1 of this project included the intersecting and compounding effects of poverty, complex child abuse and neglect, and homelessness. The needs identified for structural reform, workforce development and access to psychological support for children and their families align with the findings of the qualitative research.

Many practitioners in the services used by children and young people and their families were not skilled in trauma-informed practice, disability-informed practice, and child-centred practice.

Many brought one or two of these skill sets into their practice with children and young people, but few were skilled across all three. Consequently, few children and young people experienced responses from practitioners in services which:

- established and built trust and capacity
- centred their perspectives
- found ways to prioritise what mattered to them
- created a circle of communication so children knew what to expect in their relationships at a time of DFV crisis or afterwards
- adequately met their needs.

It was encouraging that practitioners in this study were overwhelmingly reflective and open about the need for practice improvement, and eager for guidance about how they could contribute to improving service systems.

They readily acknowledged the need for children and young people with disability to have improved access to a baseline level of quality in service provision, across sectors, when they experience DFV.

A collective approach to meeting the needs of children and young people with disability as a priority group may offer opportunities to build on the enthusiasm of practitioners for practice frameworks and the individual good will and desire to do better for children and families in this position. This may include interagency collaboration or new approaches to working cooperatively with children and young people and their families. A collective approach responds to:

- the urgency of need for support to respond to the intersecting effects of DFV and disability
- the evidence that children and young people with disability are present at increased rates across multiple sectors
- the priorities identified by children and young people

themselves to be heard, known and responded to
- families' preferences for working alongside key supporters.

This research did not set out to collect the evidence needed to build a practice framework, but our findings point clearly to the need for improving systemic and structural responses to children and young people with disability experiencing DFV. There is strong commitment to the principles that underpin positive practice, but an evident gap between principles and practice. Systems are needed to help services bridge the gap, concretising what they say and what they need to do.

The framework below responds to children and young people's priorities and the emphases of families and practitioners. It draws from intersectionality and systems theory (Braithwaite et al., 2018; Cho et al., 2013; Stubbs, 2015); principles of trauma-informed practice for working with people with intellectual disability (Jackson et al., 2015; Noble-Carr et al., 2020); and advice from practitioners and policymakers in Phase 3 of this project.

A full trauma-informed practice framework is needed that sets out specific standards, targets, and measures of excellence in practice. Further research and development are also required to build meaningful quality assurance mechanisms across sectors. However, we offer some initial thinking about what is needed to develop a practice framework that is fit for purpose and meets the needs of children and young people with disability who experience DFV.

Strengths and limitations

The mixed-method approach of this research has brought to light new evidence, and new kinds of evidence, about the DFV experiences of children and young people with disability and their families. Bringing together population-level data, case-study analysis and qualitative research has been important in demonstrating the breadth and depth of this problem. The results of the research are timely for national and state policy and practice in both DFV and disability arenas, with action plans under new national plans and strategies in development.

Several challenges were experienced around recruitment and fieldwork, closely connected to the COVID-19 pandemic. Recruitment of family members and children and young people to the study initially relied on practitioners to identify and share information about the project with families and young people. It was often difficult for practitioners to identify families or young people who were not currently in crisis, or practitioners did not feel comfortable or have the time or opportunity to discuss the project with families. Adapting the recruitment method helped, but recruitment of family members and young people took several months. Fewer family members were recruited to the study than we had hoped, even with adapted recruitment methods which yielded greater participation. As the fieldwork progressed, it became clear that there were several reasons for this, including the sensitivity of the topic, concerns around privacy and safety, and people's capacity to participate in something additional to what was necessary to daily life. This was particularly pronounced during and after tightening of restrictions and lockdowns due to COVID-19.

The perspectives and experiences of a wide range of children and young people with disability have been canvassed in the study. While a comparatively small number of children and young people provided their perspectives directly to the research team, the experiences of children and young people with high and complex support needs have been carefully integrated into the research through parents' testimonies about the effects of DFV on their lives. A high degree of consistency in themes across participant data and early coding saturation gave the research team confidence in the qualitative results.

The study aimed to include two regional and one remote location. Due to COVID-19 lockdowns and travel restrictions, travel was not possible to any of the locations. Many regional services were reluctant to take part, citing additional resource pressures, and those who were interested in participating struggled to recruit practitioners to participate. Additionally, many DFV services struggled to participate due to a significant funding restructure in the state in June/July 2021 which saw changes in priorities and staff availability. DFV services also indicated that their availability for research was significantly impacted by lockdowns, which saw a significant increase in families leaving violent situations.

Table 5: Principles needed to develop a practice framework that meets the needs of children and young people with disability who experience DFV

Principle	Operational standards
Child-centred	Practice prioritises children's needs (particularly for safety and protection from harm). · Practices are in place to act early in the life of the child and early in the life of the problems they encounter to minimise harm and trauma · Practices are responsive to the individual child's unique developmental, support and growth needs · Practices are collaborative and build on and galvanise the child's and their family's formal and informal support networks Practice responds to the individual priorities and needs of children and young people · Practitioners have multiple ways to listen carefully and well to children with disability in all the ways they communicate. They demonstrate they trust and believe child and young people's accounts of their lives and priorities · Practitioners have systematic ways to record children and young people's priorities. They communicate clearly with children and their families about actions taken to respond to priorities and needs Practice prioritises children, and also situates them in their family context. · Regardless of support needs, practitioners speak with children and include them in visits and discussions · Children and young people are known, respected, and valued for their unique contributions · Practitioners understand children and young people as independent from, as well as part of, their families
Rights-focused	Practitioners build agency, authority and capacity in children and young people. · Practitioners build rapport with children and young people · Practitioners demonstrate trustworthiness over time Children and young people's right to participate in decisions affecting their lives is balanced with their right to be safe and protected. Children and young people's expertise about their own lives is prioritised. This is particularly important in contexts where practitioner and expert evidence can discount children's and families' perspectives and priorities (such as assessments and intake processes for services).

Principle	Operational standards
Trauma-informed	Practice approaches to children and young people with disability are trauma-informed. For example: · Common behaviours of trauma response are recognised, understood as adaptive behaviours and supported · Physical and social environments promote a sense of safety, calming and de-escalation for clients and staff · Children and young people have meaningful opportunities to share their perspectives, show what matters to them, be heard and be respected · Staff have access to training, supervision and other resources to support trauma-informed practices · There are multiple ways for children and young people to develop safe support and therapeutic relationships · Services are provided in a culture grounded in safety, relationships, collaboration, choice, and voice- and person-centred practice · Organisational structures and practices are in place to support staff through skills and knowledge, policies and procedures, environment and resources, and leadership and culture (Jackson & Waters, 2015)
Disability-informed	Disability is a contextual factor in children and young people's lives. It brings strengths and contributions along with needs for support. On its own, disability is not a reason for referral away from generalist services into specialist systems. Children and young people's needs for support determine where support is provided, and by whom · Practitioners understand that a significant percentage of children and young people in their service cohort will have disability · Services build skill and capacity in their workforce to respond effectively to this client group
Holistic	Support is routinely provided to the child or young person and their family to navigate systems. Services have capacity to work with children and young people and their families to identify their most important and immediate needs, and work together to meet those needs.
Investment-oriented	Service providers and policymakers: · prioritise prevention and early intervention · invest in skill and knowledge development in practitioners · ensure leadership which prioritises a culture that respects and values children's participation and rights · hold practitioners and systems collectively accountable for action to improve children's lives · develop strategies which operate at multiple levels

First Nations children and young people and their families are not strongly present in this study, despite our initial aim. Consultation in the design of the research proposal was undertaken with key representatives of First Nations disabled people's organisations and providers in the APY Lands. Both identified the research aims and approach as important to First Nations young people and their supporters. However, on further consultation with community members and organisations, the ethical risks of interviewing children and families in the APY Lands due to several risk factors were clear, and the research team withdrew from this part of the study. Practitioners were interviewed in this site, providing systemic views of the issues facing children, young people and families.

Directions for future research

Several priorities for future research have been identified in the analysis of this study.

Changing the trajectory of children at increased risk of harm is identified as a fundamental priority in both research and policy. There is almost no research on factors that prevent violence from occurring in the lives of children and young people with disability and that support children and young people to enjoy safe childhoods. This is critically needed to arrest the high rates of various forms of violence and abuse experienced by both children and adults with disability.

Further to the implications for practice detailed above, research is needed into child-focused, cross-sector capacity-building approaches that sustain supportive practice for children and young people with disability. Resources should be developed for organisations and sectors to allow engagement with, and implementation of, disability-informed and trauma-informed practice. These could include:

- an evidence-based framework for practice that is applicable across sectors
- measurable standards to which organisations are held accountable
- a quality assurance framework to support organisations in achieving and exceeding standards.

There are some groups of children and young people with disability whose circumstances are particularly poorly represented in wider research, but whose experiences of violence and needs for better responses are known to be extremely high. These include:

- First Nations children and young people with disability, especially in remote communities
- children and young people with disability in CALD communities
- incarcerated young people with disability
- children and young people with disability in rural and remote communities.

Research exploring the experiences of children and young people in these particular circumstances is needed to develop responses that are tailored to their needs and the systems and communities in which they live.

Conclusion

Through its mixed-method approach, this study has revealed new knowledge about how children and young people with disability and their families experience DFV. Separately and together, the components of the study reveal important new insights to improve support for children with disability and their families.

The results from Phase 1 indicated that at a population level, there are high numbers of children and young people with disability in families experiencing DFV and that these experiences have a significant impact on them. We know that they come into contact with all sectors when they and their families experience DFV. Practitioners in all sectors working with children need to be ready and skilled to work with children and young people with disability experiencing DFV.

The results from Phase 2 offered firsthand experiences of children and young people, families, and practitioners that showed there are some serious shortfalls in how systems respond to children and young people with disability and their families. Children and young people have few opportunities to have input about what they want to happen in their lives and how they want things to improve. There are multiple examples about how it is possible to do this ethically, positively and constructively. Practitioners want to know more about how they can be part of this. Many have good personal practices and want frameworks that standardise them.

It is encouraging that, despite the terrible experiences of many of the participants in our research, many people shared hopes and ideas about how things could improve. In Phase 2 and through focused workshops in Phase 3, people identified many opportunities to improve policy and practice in ways that would positively shape children and young people's lives. Some of these strategies are simple things that practitioners can incorporate into their daily routines immediately. Others will take resources and policy commitment. All need to be underpinned by a commitment to seeing children and young people with disability at the centre of their own experience of DFV and as experts in their own lives.

Author contributions

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APPENDIX A:

Invitations

Children and young people and family members

Parents

APPENDIX B:

Easy read consent form – Children and young people

Connecting the dots: Understanding the family violence experiences of children and young people with disability

Hi there. We are Sally and Amy. We work at Flinders University. We are doing a research project. It is about how services can help young people with disability when their families have had a hard time.

We are trying to find out how good the help is and if it can be made better.

Would you like to speak to us about how services work with you and your family?

You can have someone with you when we talk if it helps you to feel comfortable.

When we talk, we will ask about:

- what types of help you are getting
- how has it made a difference
- if there is anything you want help with but are going without at the moment.

Talking to us will go for 30 minutes to 1 hour. We will ask to record what you say. We can write it down instead if you don't want us to use the recorder.

You will get a $40 voucher as a thank you.

It is your choice to speak to us or not. You can say no. It will not change the help you get from any services.

You can choose what questions you want to answer. You can say no if you don't want to answer a question.

It is your choice to tell us only the things as you want.

There are lots of ways you can have your say. When we meet, I can show you some ways we can work together so you can tell us what you want.

You might like to draw, just chat, or show us what matters to you.

If you choose to join in, you can change your mind at any time. You don't have to stay for the whole time.

The answers you give will not be shared with anyone else.

Your name and personal information will be kept private.

If talking to us makes you feel sad, you can tell us and we will help you find someone you can talk with.

You can use the phone numbers and email addresses on the next page to find out more about the research or if you have a question or concern you would like help with.

If you want to talk to us, please sign your name on the form that says "I want to take part".

If you change your mind, you can stop our conversation at any time and sign your name on the form that says "I changed my mind – I don't want to take part anymore" and we will stop and take your information out of our research.

Thank you

Sally and Amy

People to talk to about the research

If you have questions about the research, you can talk to Sally Robinson at Flinders University at sally.robinson@flinders.edu.au or 08 7421 9845.

If you want to raise an issue or have a concern about this work, please talk with the Flinders Ethics Office on 08 8201 3116 or their email is human.researchethics@flinders.edu.au. Tell them this number: HEG-4131.

If you feel sad after answering our questions, you can call *beyond blue* on 1300 22 4636 or Lifeline on 131 114 and they will be happy to talk with you.

I want to take part in the research

- [ ] I am signing this form because I want to talk with a researcher about services and help for young people living with disability who go through violence in their family

- [ ] I am happy to have my our conversations recorded

- [ ] I understand talking in our conversations will not change what help I get

- [ ] I understand I can stop our conversation at any time and ask researchers to delete my answers

.....

My signature

.....

Write your name here

.....

Date

I changed my mind – I don't want to take part anymore

I am signing this form because I changed my mind. I don't want to take part in the research about services and help for young people living with disability who go through violence in their family. In changing my mind, I understand the answers I gave in our conversations will be deleted by researchers.

.....

My signature

.....

Write your name here

.....

Date

Please return the signed form to: Sally Robinson, College of Nursing and Health Sciences, Flinders University.

APPENDIX C:

Social story for recruitment – Children and young people

How to have your say with us

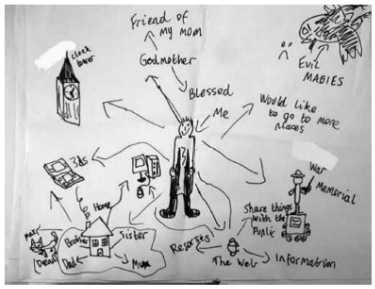
There are lots of ways for you to tell us what you think

This book tells you about some of the ways you can have your say

We want to find out who and what helped you feel happy and safe when things were hard

There are lots of ways we can find this out together

You can make a map



We can draw the places and people that help you feel happy and safe

You can make a story board

We can put pictures together to tell a story about what helps you feel happy and safe

You can talk to us

We can have a talk about the people and places that help you feel happy and safe

We can have a walk

We can go for a walk and you can show me things that help you

We can play games

We can play some games that show how you feel happy and safe

We know you have good ways of having a say already

We can learn your way if you don't want to do any of these things

We hope you like some of these ways of having a say

Sally Amy

We will talk to you and your supporters about what is the best way for us to work with you

APPENDIX D:

Interview guide – Parents

Intro to selves and about project.

Before interview:

Are there any things you would prefer us not to ask or discuss with you?

1. **Can you tell me a bit about yourself and your family?**
   - Who lives in your household?
   - Who is important to you in your everyday life?
   - Who is important to your child in their everyday life?
   - Who do you go to when you have questions about
     a) something your child needs
     b) what you need for your child e.g. Centrelink disability support
     c) what you can do if things aren't going well or you are in trouble?

2. **What would you say is most important for you about supporting your child right now?**
   - Do you feel like your child is getting the things they need/want to feel safe and well?
   - What are those things?
   - What do you think they would say they need to feel safe and well?

3. **What family support services do you access for your family? (for example neighbour aid, domestic violence services, etc)**
   - What support do members of your family receive from this service?
   - What support does your child receive from this service?

   [identify and name each service and purpose, briefly]

   [map or conversation – to tease out formal and informal supports]

4. **What services do you use for your child? (for example OT, support worker, youth club etc)**
   - What support does your child receive from this service?
   - What support do other members of your family receive from this service?

   Is anything about those services relevant to the experiences your family has been through? Do the service providers know about your family's experiences of family violence?

   [identify and name each service and purpose, briefly]

   [map or conversation – to tease out formal and informal supports]

5. **What have services done that have helped to support your family when things have been difficult?**
   - Have there been services which have helped when it comes to your child's safety when your family has been going through a difficult time?
   - Could you tell me more about the help you were looking for before you starting using [this service]?
   - How do you feel about the help you're getting through this service?

6. **What advice would you give someone in a similar position to yourself?**

7. **Is there anything else that we haven't covered that you want to share?**

APPENDIX E:

Interview guide – Practitioners

Intro about project and recruitment for families and YP.

1. **What supports/services can/do you provide to clients who are CYPWD or who have CYPWD?**
   - intake
   - caseload and casework
   - exit

2. **How do you recognise disability?**
   - For young people
   - For other family members

3. **How do you respond to disability?**
   - For young people
   - For other family members

4. **How do you recognise and respond to the risk and experience of DFV?**
   - For young people
   - For other family members

5. **What is your view of the capacity of your service and other services in the community to support families with children with disability (diagnosis or lived experience) who experience DFV?**
   - What's working well?
   - What isn't?
   - What are the gaps and what can you tell me about them?
   - What can you tell me about progress in the child protection space and what concerns remain for you?
   - What does Police engagement look like?

6. **Regarding your work creating linkages in the community, what is working locally to support collaborative practices?**
   - What are the challenges/gaps?

7. **What improvements do you see are needed?**
   - Between services and clients
   - Between services
   - Between services and government/political bodies

8. **Is there anything else that we haven't covered that you want to share or think we should know about?**

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to Reduce Violence against Women & their Children