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

Research
Report

Wangkiny Yirra “Speaking Up” Project: First Nations women and children with disability and their experiences of family and domestic violence

Jocelyn Jones, Lynn Roarty,
John Gilroy, Juliet Brook,
Mandy Wilson, Cathy Garlett,
Hannah McGlade,
Robyn Williams and
Helen Leonard

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Research team

Dr Jocelyn Jones is a Nyoongar woman with Wadjuk, Ballardong and Palyku connections to the land in WA. She is an epidemiologist and currently program lead for the Needs of Aboriginal Australians research program at the National Drug Research Institute (NDRI), Curtin University. She has extensive experience in the fields of First Nations primary health care services, health research, policy development and justice services. She advises government through her membership on the National Prisoner Health Data Collection committee, and has recently been appointed to the Western Australian Office of Crime Statistics and Research Advisory Board.

Associate Professor John Gilroy is a Yuin man from the NSW South Coast, and is an Associate Professor of Sociology in Indigenous health, specialising primarily in disability studies at the University of Sydney. He has worked in disability and ageing research and community development with First Nations communities, government and non-government stakeholders for most of his life, and is passionate about Aboriginal owned and driven research as means to influence policy.

Associate Professor Hannah McGlade is a Nyoongar woman, and is a Senior Indigenous Fellow at the Office of the High Commission on Human Rights in Geneva, and a Senior Indigenous Research Fellow at Curtin University. She is an experienced legal academic and practitioner with special interest in Indigenous human rights with a focus on women and children, constitutional reform, and First Nations mental health and healing. Her career has focused on justice for First Nations people, race discrimination law and practice, First Nations women and children, family violence and sexual assault.

Dr Robyn Williams is a Nyoongar woman, and is a Senior Research Fellow at the Curtin Medical School, Curtin University. She has worked for over 25 years in First Nations community-based agencies, government, and in academia and has expertise in community development, advocacy and building capacity in First Nations communities. Her research interests include the impact of FASD across the lifespan, interventions for children and families, culture as intervention, and decolonising approaches to FASD. She is a co-author of a recently published book on Decolonising Justice for Aboriginal Youth with FASD.

Dr Mandy Wilson is a non-Indigenous woman, and is currently program lead for Justice Health at the National Drug Research Institute (NDRI) and a member of the Aboriginal Research Team. She has a long history of working with vulnerable groups. Her most recent work has focused on justice-involved and incarcerated populations, particularly First Nations females, with her areas of expertise expanding to include mothering from prison, females who use force, and issues around family and domestic violence. She is currently lead WA researcher on an international collaboration trialling a violence prevention intervention for First Nations and non-Indigenous women in prison.

Associate Professor Helen Leonard is a non-Indigenous woman, and has qualifications in medicine and public health. She is a Principal Research Fellow at the Telethon Kids Institute, Associate Professor at The University of Western Australia and currently holds a second NHMRC Senior Research Fellowship. She has research expertise in child disability, including autism spectrum disorders and Down syndrome, among other conditions. She has a particular interest in and has published on the social determinants of intellectual disability. Her current work includes investigations (using data linkage) of outcomes for children born to mothers with intellectual disability, both First Nations and non-Indigenous.

Dr Lynn Roarty is a non-Indigenous woman, an Adjunct Research Fellow and Senior Research Officer with the National Drug Research Institute (NDRI), Curtin University. A social scientist, she has interests in the social determinants of health and women's mental and reproductive health, and has conducted research with and for vulnerable populations for almost 20 years. In the last 8 years she has focused on contributing to research in First Nations women's and children's health and welfare with the Aboriginal Research Team at NDRI, and with the Centre for Improving Health Services for Aboriginal and Torres Strait Islander Children and Families (ISAC) at Edith Cowan University.

Juliet Brook is a non-Indigenous woman, a Master of Public Health student and biomedical science graduate who is interested in addressing inequities in population health through community-led research that is effectively translated into policy and practice. She is particularly passionate about First Nations health, women's health, child development and the social determinants of health. With a focus on maternal and child health, her previous roles in research have involved working on systematic reviews in the field of infant and child neurodevelopment and mental health, and a qualitative evaluation of a school-based intervention to reduce bullying.

Cathy Garlett is a First Nations woman and grandmother with family connections including Nyoongar, Yamajti, Nyikina, Gooniyandi, Yigi and Yarroorro clans from Western Australia. She holds a Bachelor in Social Work and has over 15 years' experience in diverse settings including working with First Nations women postnatal support in a tertiary hospital setting including case management and advocacy in areas such as child protection, justice, and with AOD issues. She has worked on several First Nations research projects and is passionate about building capacity amongst the First Nations community, particularly in the space of disability and strengths-based approaches.

For further information:
Jocelyn Jones, J.Jones@curtin.edu.au, +61 8 92661616

National Drug Research Institute
Curtin University WA 6845 Australia
T +61 8 9266 1600
E ndri@curtin.edu.au
W https://ndri.curtin.edu.au

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Acronyms and Abbreviations

Acronyms and Abbreviations	Explanation
ABI	acquired brain injury
ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
ACCO	Aboriginal Community Controlled Organisation
ACT	Australian Capital Territory
AHCWA	Aboriginal Health Council of Western Australia
AI	American Indian
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
AJA	Aboriginal Justice Agreement
ALAG	Aboriginal Leadership and Advisory Group
ALRC	Australian Law Reform Commission
AMS	Aboriginal Medical Service
AMSANT	Aboriginal Medical Services Alliance Northern Territory
AN	Alaska Native
AOD	alcohol and other drugs
ASD	autism spectrum disorders
ASWS	Alice Springs Women’s Shelter
BASSA	Broome Aboriginal Short Stay Accommodation
BRAMS	Broome Regional Aboriginal Medical Service
CALD	culturally and linguistically diverse
CAMHS	Child and Adolescent Mental Health Service
CDEP	Community Development Employment Projects program
CEDAW	Convention on the Elimination of Discrimination Against Women
COAG	Council of Australian Governments
CRC	Convention on the Rights of the Child
CRE	Community, Respect, Equality
CRPD	Convention on the Rights of People with Disability

Acronyms and Abbreviations	Explanation
DCP	Department of Child Protection
DGC	UN Department of Global Communications
DSC	Disability Services Commission
DSP	disability support pension
DSS	Department of Social Services
DV	domestic violence
DVCS	Domestic Violence Crisis Service
EMRIP	Expert Mechanism on the Rights of Indigenous Peoples
EPDS	Edinburgh Postnatal Depression Scale
ERP	estimated resident population
FAS	fetal alcohol syndrome
FASD	fetal alcohol spectrum disorders
FDV	family and domestic violence
FV	family violence
FVPLS	Family Violence Prevention and Legal Service
GP	general practitioner
GRAMS	Geraldton Regional Aboriginal Medical Service
HACC	Home and Community Care program
HREC	Human Research Ethics Committee
HREOC	Human Rights and Equal Opportunity Commission
ID	intellectual disability
IDEA	Intellectual Disability Exploring Answers database
iHEAL	intervention for Health Enhancement After Leaving
IPV	intimate partner violence
ISU	Intensive Support Unit
KAMS	Kimberley Aboriginal Medical Service
KEMH	King Edward Memorial Hospital
KPMG	Klynveld Peat Marwick Goerdeler

Acronyms and Abbreviations	Explanation
LGBTQI+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex+
NATSISS	National Aboriginal and Torres Strait Islander Social Survey
NCAS	National Community Attitudes towards Violence Against Women Survey
NDA	National Disability Agreement
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDS	National Disability Scheme
NFVPLS	National Family Violence Prevention and Legal Service
NGO	non-government organisation
NISATSIC	National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families
NPY Lands	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Lands
NPYWC	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council
NSW	New South Wales
NT	Northern Territory
NZ	New Zealand
OM	otitis media
OT	occupational therapy
OOHC	out-of-home care
PAR	participatory action research
P-CAP	Parent-Child Assistance Program
PHC	primary health care
PSS	Personal Safety Survey
PTSD	post-traumatic stress disorder
RCFV	Royal Commission into Family Violence
ROS	Reclaiming our Spirits
RTO	registered training organisation
SA	South Australia

Acronyms and Abbreviations	Explanation
SARFDV	strengthening the antenatal responses to FDV
SAT	State Administrative Tribunal
SDAC	Survey of Disability, Ageing and Carers
SEWB	social and emotional wellbeing
SIDS	sudden infant death syndrome
SMI	severe mental illness
SWAMS	South West Aboriginal Medical Service
TAIHS	Townsville Aboriginal and Islanders Health Service
TAP	Targeted Action Plan
TBI	traumatic brain injury
TTW	Transition to Work
UK	United Kingdom
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UN DESA	United Nations Department of Economic and Social Affairs
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
US	United States
VACCA	Victorian Aboriginal Child Care Agency
VRO	violence restraining order
VSU	Victim Support Unit
WA	Western Australia
WAAHEC	Western Australian Aboriginal Health Ethics Committee
WAPOL	Western Australia Police Force
WARDA	West Australian Register of Developmental Anomalies
WNHS	Women and Newborn Health Service

Defining family and domestic violence

There is currently no national definition of family and domestic violence (FDV). The House of Representatives Standing Committee on Social Policy and Legal Affairs (2021) has recommended the adoption of a uniform definition of family, domestic and sexual violence by Australian federal, state and territory governments (p. xxi). In November 2021, the Law Council of Australia hosted a national round table on family violence (FV) and released a proposed model definition (Law Council of Australia, 2021).[1]

Guidance is provided by the glossary to the AIHW report on FDV in Australia which provides these definitions:

Domestic violence: A set of violent or intimidating behaviours usually perpetrated by current or former intimate partners, where a partner aims to exert power and control over the other, through fear. Domestic violence can include physical violence, sexual violence, emotional abuse and psychological abuse.

Elder abuse: Physical, psychological and financial harm to older people.

Emotional abuse: Behaviours or actions that are perpetrated with the intent to manipulate, control, isolate or intimidate, and which cause emotional harm or fear.

Family violence: Violent or intimidating behaviours against a person, perpetrated by a family member including a current or previous spouse or domestic partner. ‘Family violence’ is the preferred term used to identify experiences of violence for Indigenous Australians, as it encompasses the broad range of extended family and kinship relationships in which violence may occur.

Intimate partner violence: Violent or intimidating behaviours perpetrated by a current or cohabiting partner, boyfriend, girlfriend or date.

Partner violence: Violent or intimidating behaviours perpetrated by a current or former cohabiting partner.

Physical abuse: Any deliberate physical injury inflicted upon another person.

Physical violence: Behaviours that can include slaps, hits, punches, being pushed down stairs or across a room, choking and burns, as well as the use of knives, firearms and other weapons, or threats of such acts.

Psychological abuse: Behaviours that include limiting access to finances, preventing the victim from contacting family and friends, demeaning and humiliating the victim, and any threats of injury or death directed at the victim or their children.

Sexual abuse: A sexual act carried out against a person’s will through the use of physical force, intimidation or coercion.

Sexual assault: A sexual act carried out against a person's will through the use of physical force, intimidation or coercion. This includes rape, attempted rape, aggravated sexual assault (assault with a weapon), indecent assault, penetration by objects, forced sexual activity that did not end in penetration, and attempts to force a person into sexual activity. These acts are an offence under state and territory criminal law.

Sexual harassment: Behaviours a person experienced that made them feel uncomfortable, and were offensive, due to their sexual nature. This includes an indecent text, email or post; indecent exposure; inappropriate comments; and unwanted sexual touching.

Sexual violence: The occurrence, attempt or threat of sexual assault experienced by a person since the age of 15. Sexual violence can be perpetrated by partners in a domestic relationship, previous partners, other people known to the victim, or strangers.

Stalking: Persistent unwanted behaviours, such as following or making unwanted contact, that cause fear or distress.

Substantiations: 'Substantiations of notifications' refer to child protection notifications made to relevant authorities, which were investigated; the investigation was finalised; and it was concluded there was reasonable cause to believe that the child had been, was being, or was likely to be, abused, neglected or otherwise harmed.

Vulnerable groups: Population groups that are more likely to experience (or to have experienced) family, domestic and sexual violence, or that face additional barriers in coping with and recovering from family, domestic and sexual violence (Australian Institute of Health and Welfare, 2019b, pp. 135-136).

Services Australia provides these further definitions:

Financial abuse: is behaviour limiting your access to money. Warning signs might be:

- taking or using your money without your permission
- not being allowed to work
- having to account for how you spend your money
- withholding financial information from you
- spending any payments you get from us without your consent.

Technology facilitated abuse: is when someone monitors what you do online. This may include:

- checking your computer and phone use
- using spyware on your phone to track you
- publishing intimate photos of you without your consent
- sharing or threatening to share photos or messages with the intention of outing your sexuality or gender identity, putting you at risk of stigma, discrimination or harm.[2]

The Western Australian Government provides a comprehensive suite of explanatory resources,[3] as do other state and territory governments, and the Federal Government (see, for example, Australian Institute of Health and Welfare, 2019b, 2022c; House of Representatives Standing Committee on Social Policy and Legal Affairs, 2021; Services Australia, 2022). Section 1 of the Queensland Aboriginal and Torres Strait Islander Women's Taskforce on Violence Report is devoted to a discussion of forms of violence (Aboriginal & Torres Strait Islander Women's Task Force on Violence, 2000).

To avoid any misrepresentation, in its discussion of the research and other literature around FDV, this report follows the terms used by authors.

Executive summary

First Nations women and children with disability are at greater risk of family and domestic violence (FDV) and its consequences than their non-Indigenous peers. A recent report found that First Nations women with disability had the highest rates of victimisation of any group, with 34.4% recorded as being victims of crime (Ringland et al., 2022). Despite this, the voices of First Nations people are largely missing from disability research in Australia (Dew et al., 2019). The purpose of this research was to engage with First Nations women and children and key stakeholders in Western Australia (WA) to: gain an understanding of their experiences of FDV, identify factors they believe open them up to the risk of harm, document their observations and experiences of barriers and/or enablers to seeking assistance and support, obtain their views on what works in currently available programs, and make recommendations for future culturally safe prevention and protection programs.

Research questions

The research addressed these research questions:

- What is currently known about First Nations women and children with disability?
- What factors and interaction/s make First Nations women and children with disability and those who are close to them at risk of being exposed to FDV?
- What are the barriers and enablers that impact on the capacity of First Nations women to seek assistance from police and support services, and to pursue court processes?
- What are the differential impacts of family violence (FV) legislation and related policy (and its shifting frame) for First Nations women with disability in different contexts and settings?
- What are some of the best practice services in early diagnosis and community led approaches to prevention and diagnosis of fetal alcohol syndrome disorders (FASD) and whole of life wraparound services for First Nations women with disability?
- What are some examples of best or promising practice, including community support services, in preventing exposure to domestic and FV and to improving outcomes?

Methodology

This research acknowledged that the concept of disability is a western one and that First Nations people often do not use or recognise the term ‘disability’. We used a participatory action research (PAR) research design within a First Nations research framework, applying a cultural lens to the design, implementation and interpretation of results. The project used a culturally safe Indigenous research method, ‘yarning’, to collect qualitative data. The research was conducted in two remote and two regional locations of WA, as well as in the Perth metropolitan area. Participants included First Nations women and children aged (12-17 years) with disability and lived experience of FDV. Data were de-identified (names and locations) and coded into NVivo, a qualitative software package, and then into themes for analysis using grounded theory.

Scope and limitations

A review of academic and grey literature was conducted, providing essential statistical data, and engaging with a broad range of issues relevant to the experiences of First Nations women and children with disability and FDV. Qualitative data were collected in five locations across WA, including interviews with 35 First Nations women and 10 children, 8 carers, and 22 stakeholders. Stakeholders included those working in Aboriginal Community Controlled Organisations (ACCOs), mainstream community services and government departments. The women we interviewed had a wide range of disabilities, many with two or more disabilities. Disability was defined by how the community and the individual perceive it, meaning that the research is inclusive of participants who identified as having a disability, regardless of formal diagnostic status.

Given the considerable body of relevant research, the literature review, while extensive, is still limited in its scope. The restricted time frame presented a barrier to accessing certain hard-to-reach groups (e.g. young people involved with child protection or the justice system). Several managers of disability and FDV services denied us access to their clients to inform them about the research and determine their interest in being involved. Some women were denied the opportunity to participate due to being under the Office of the Public Advocate. As a qualitative study, the generalisability of the findings is limited by the number of consultations conducted, and by locations being restricted to WA.

Findings

Key themes identified in the literature

- Research focus on experiences of FDV of First Nations women and children with disability appears to be growing but is still limited within the broader body of research focused on First Nations women and children and FDV.
- There are evident statistical gaps, with a paucity of disaggregated statistics.
- First Nations people, wherever located, are significantly more likely than non-Indigenous people to be confronted with a range of barriers to service access, diagnosis and service delivery.
- Serious investment in building the knowledge base, culturally competent FDV and disability education, prevention, and harm reduction strategies across society and within all involved services is crucial.
- Current strategies for prevention and support for First Nations women and children involved with the justice and child protection systems are demonstrably inadequate and harmful and must be reformed.
- Greater respect for and reliance on the voices of First Nations women of all ages in these endeavours is paramount. First Nations men must also be part of the conversation.

Key findings and implications from the consultations

Women

- Women reported growing up witnessing violence, and one third reported experiencing sexual abuse in childhood.
- Women had experienced multiple types of violence, many women reported extreme levels of violence from multiple partners.
- In many cases, violence led to disability, including traumatic brain injury (TBI), psychological trauma and physical disability.
- Women with disability are already vulnerable to mental illness, exacerbated by violence and trauma, and lack of access to culturally secure care.
- Grief, loss and child removals were reported as significant causes of trauma and psychosocial disability.

Children and young people

- Children experienced challenges with their social and emotional wellbeing (SEWB), particularly anger and emotional regulation.
- Bullying and an unresponsive education system led to long-term absences and suspensions.
- Children with disability require specialised support to stay engaged and/or reconnect with education.

Carers:

- Carers of children with disability are overburdened by a lack of formal support and respite, which impacts their SEWB.
- Carers emphasised the need for disability assessment and diagnoses to enable access to early intervention and other support.

Stakeholders:

- Stakeholders reported issues with training, retention, support, and a lack of cultural safety within mainstream services for First Nations staff.
- Stakeholders identified the lack of culturally secure health, disability and FV services as a barrier to supporting First Nations women and children.

Common areas of concern across all consultations

- Housing and homelessness were highlighted as significant challenges impacting First Nations women and children with disability.
- Barriers to accessing assessments and proper diagnoses, and limited awareness of the National Disability Insurance Scheme (NDIS), need to be addressed.
- Significant issues were reported concerning racism and culturally secure disability and FDV services across all locations.
- Limited availability of crisis and transitional accommodation was reported across all locations.
- The context of historical and continuing child removals has caused generational fear and mistrust of child protection authorities, impacting reporting of FDV.
- Some First Nations women continue to have a lack of confidence in the system due to past experiences with police.
- The current guardianship and administration system is not fit-for-purpose, and breaches the rights of First Nations women with disability.

Recommendations [including promising practice]

These recommendations were developed in consultation with our Aboriginal Leadership and Advisory Group (ALAG) involving structural reform to a number of key areas across government and non-government agencies. This list is a summary, and the full recommendations are available in the report.

- Undertake structural reform to the National Disability Insurance Agency (NDIA), child protection, education, justice, and guardianship and administration systems to better meet the needs of First Nations women and children with disability.
- Invest in sustainable long-term service funding and strengthen systematic nationwide collection of disaggregated data on First Nations people with disability to better inform policy, service delivery and funding allocation.
- Fund increases to the number and capacity of ACCOs and First Nations staff to support First Nations clients with disability in the community and prisons.
- Invest in development of culturally secure FDV services, and in training for all associated services for disability, trauma-awareness, and FDV related issues.
- Strengthen partnerships with ACCOs, tied to funding agreements and reporting obligations.
- Invest in holistic support for kinship carers of children with disability, as well as additional support for carers with disabilities.

- Ensure all children who enter juvenile justice and child protection systems receive comprehensive and timely health and disability assessments.
- Invest in best practice early intervention support to young people involved with the juvenile justice system.
- Develop processes for assessment of women and children presenting to hospitals and primary health care (PHC) services with violence-related injuries for follow-up and referral to specialist consultation.
- Provide evidence-based early intervention programs, resourced and delivered by ACCOs, catering for mothers with and without disabilities.
- Invest in culturally secure kindergarten programs to maximise opportunities for early intervention and support transition to education.

1. Introduction

> There are significant challenges involved in decolonising disability services, because of a mismatch between governance requirements and culturally appropriate care.
> (King et al., 2014, p. 738)

The need to explore lived experiences is clearly demonstrated by statistics which show the ways in which the intersectionality of being a First Nations woman living with a disability impact upon a person's risk of violence, and the compounding barriers to disclosing abuse:

- First Nations people are twice as likely as non-Indigenous people in Australia to be living with a disability (Australian Institute of Health and Welfare, 2018b), which is especially concerning given that many believe this is significantly underestimated.
- In 2016-17, First Nations women aged over 15 years were 34 times more likely to be hospitalised due to family violence (FV) than non-Indigenous women (Australian Institute of Health and Welfare, 2019b).
- First Nations children have a higher rate of disability than their non-Indigenous peers (DiGiacomo et al., 2013)2013 and are significantly over-represented in the child protection (Australian Institute of Health and Welfare, 2020a) and juvenile justice systems (Australian Institute of Health and Welfare, 2020d).
- People with a disability are more likely to experience family and domestic violence (FDV) (Australian Institute of Health and Welfare, 2019a).

The Australian Human Rights Commission 2022 *Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future* report (Australian Human Rights Commission, 2020b) identified unique barriers First Nations women, particularly those with a disability, face in reporting violence, including a fear of having children removed, a fear of what may happen to their First Nations partners in custody, and feeling a responsibility to stay strong for each other. In addition, the report identified that this group has greater barriers in accessing services and receiving support that is both culturally safe and disability inclusive.

Given the heightened risk of violence and barriers in service accessibility due to the compounding nature of disadvantage, there is an urgent need to gain an understanding of the experiences of FDV of First Nations women and children with disability that are still not sufficiently explored in the current literature.

The project overall aimed to engage with First Nations communities and key stakeholders in Western Australia (WA) to:

- gain an understanding of their experiences of FDV;
- identify factors they believe open them up to the risk of harm;
- document their observations and experiences of barriers and/or enablers to seeking assistance and support;

- obtain their views on what works in currently available programs; and
- make recommendations for future culturally safe prevention and protection programs.

Project objectives were to:

- advise the Royal Commission on the nature and extent of FDV experienced by First Nations women and children with disability in Western Australia; and
- make recommendations for ways in which to capture the experiences of FDV of First Nations women and children with disability post the completion of this study.

The project responds to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability terms of reference with regard to human rights and Australia's international obligations to provide persons with disability respect, individual autonomy, and a safe environment.

2. International Human Rights Framework

Violence against all women, including First Nations women with disability, is a serious human rights violation addressed by the Convention on the Rights of People with Disability (CRPD), the Convention on the Elimination of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC) and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).

First Nations women, especially women with disability, experience high levels of violence including intimate partner violence (IPV), family violence (FV) and sexual assault. Disability advocates point out that violence includes structural, systemic and institutional violence but this is little recognised by policy makers, and is not addressed in national planning to respond to violence against women, thus these types of violence are rendered invisible and normalised (Disability Rights Now, 2019, p. 6).

In General Comment No. 3 (2016) on women and girls with disabilities, the Committee on the Rights of People with Disabilities outlined States' obligations in relation to gender violence, including:

- the duty to exercise due diligence by preventing violence or violation of human rights, protecting victims or witnesses from violations;
- investigating, punishing and prosecuting those responsible; and
- providing redress and reparations where violations occur (Committee on the Rights of Persons with Disabilities, 2016).

In addition, the Committee on the Elimination of Discrimination Against Women[4] has issued a General Recommendation (3) on Women and girls with disabilities, providing further advice to States (Committee on the Rights of Persons with Disabilities, 2016). It is also finalising a General Comment on Indigenous women and girls, which should also be considered in future (CEDAW, 2022).

Recently the United Nations (UN) Special Rapporteur on Violence Against Women tabled at the Human Rights Council the report 'Violence against Indigenous women and girls' acknowledging: "Indigenous women and girls are subjected to a complex web of violence that is perpetrated against them by State and non-State actors in a systemic way" (Human Rights Council, 2022, p. 70). Such violence is exacerbated by their identities as First Nations, as women, and by other characteristics including disability, age and gender identity. The violence is experienced on both the individual and collective level, with the collective dimensions to the violence often overlooked even though this is fundamental to their experiences of the violence. Discrimination and gender-based violence threaten First Nations women's spiritual and cultural lives and impact "the social fabric of their communities and nations" (p. 71). The Special Rapporteur provides significant advice to States, including Australia, including that legislation against gender-based violence is fully applicable to First Nations women and addresses all violence, encompassing environmental, spiritual, political and cultural violence (p. 75).

In 2018, CEDAW reported on Australia's compliance with their findings ('Concluding Observations') noting that: "The lack of national legislation prohibiting all forms of gender-based violence against women precludes the equal protection of women" in Australia, and calling on the Australian government to "Adopt federal legislation that is in line with the Convention and prohibit all forms of gender based violence against women and girls; and shift the power to legislate on this matter to the Federal Parliament" (CEDAW, undated 28(b)). The Committee recognised that First Nations women and girls "face an extremely high risk of domestic violence and sexual assault" and also made important recommendations relating to First Nations women.

Additions to the report included a number of specific recommendations for First Nations people including:

- 12(b). Recognize First Nations in the Constitution to enable Indigenous women to claim their rights;
- 14(a). Implement the recommendations made in 1996 by the Australian Law Reform Commission on the recognition of Aboriginal customary laws and extend culturally sensitive judicial processes to all jurisdictions, using the Koori courts in Victoria and the circle sentencing programme in the Australian Capital Territory and in New South Wales as a model;
- 28(c). Expedite the establishment of the national data collection framework and guarantee that data on femicide and violence against women with disabilities is systematically collected under the framework; and
- 50(b). Increase efforts and resources to address the deteriorating mental health situation of women and girls, in particular young mothers, indigenous women, women with disabilities, women in detention, migrant women and their daughters, including those born in the State party, lesbian, bisexual and transgender women and intersex persons, and reinforce preventive measures (CEDAW, 2018).

Several of the UN Committees in commemoration of the International Day for the Elimination of Violence Against Women have further issued an advice 'Taking action to eliminate gender-based violence against women and girls with disabilities, NOW' (UN DESA, 2021). The Committees expressed alarm about the prevalence of different forms of gender-based violence against women and girls with disabilities, noting that "existing laws, policies and programmes on gender-based violence rarely address the situation of women and girls with disabilities". Also, that "there are multiple barriers to accessing justice due to harmful stereotypes and discrimination, and lack of procedural and reasonable accommodations":

> States should recognize women and girls with disabilities as human rights holders, and empower them to participate in all initiatives and measures to make gender equality a reality.

The UN Committees called on all States as parties to the Conventions to adopt their advice and recommendations, including adopting a comprehensive legal and policy framework to combat gender-based violence against women with disabilities, ensuring meaningful participation of women and girls in the designs of all relevant laws and policies, combating prejudice and stereotyping, and bringing perpetrators to justice.

Furthermore, First Nations women's rights are supported under the Declaration on the Rights of Indigenous Peoples, in particular, Article 22 provides as follows:

1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.
2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination (United Nations General Assembly, 2007a).

First Nations women's and children's human rights are dialogued, with States and UN agencies and non-government organisations (NGOs), annually at the Permanent Forum for Indigenous Issues in New York, and the Expert Mechanism on the Rights of Indigenous Peoples (EMRIP) in Geneva. First Nations women across the globe have been engaging in sustained advocacy to increase attention and responsiveness of States to gender-based violence, and violence against women and children is frequently discussed in the annual reports of these important UN bodies.

3. Review of literature

The review of literature draws upon a range of published academic and non-academic sources related to First Nations women and children with disability, and experiences of family and domestic violence (FDV). These included:

- academic literature published in peer-reviewed journals;
- 'grey' literature, such as reports and reviews, available from government and non-government organisations (NGOs); and
- information from pertinent official government websites which was not available elsewhere.

The review focuses on the ways in which discussions of FDV in the existing academic and grey literature approach issues for and identify/determine factors impacting on the experiences and needs of First Nations women and children with disability, their families and communities. The review examines literature addressing these issues with reference to:

- the historical, theoretical and social contexts;
- current statistical data for First Nations women and children with disability, and with experience of FDV;
- the social determinants such as economic, policy and social environments and vulnerabilities, and how these affect rates of FDV;
- the best practice for culturally safe programs aimed to increase awareness, enhance safe reporting practices, and reduce or prevent FDV for First Nations women and children with disability.

Academic databases and other sources were searched for relevant literature using a range of search terms.[5] Some elements of the search strategy were assisted by the subject knowledge of the research team. The review makes no claim to being exhaustive.

3.1 Introduction

The negative effects of 230 years of colonisation are recognised as contributing factors in the dispossession, marginalisation, intersectional inequality and social dislocation experienced by First Nations people in this country across multiple environments including disability, health, education and employment (Avery & First Peoples Disability Network, 2018, p. 1; Gilroy et al., 2016; McGlade, 2012). Associated with these negative effects of colonisation, violence, abuse and bullying are identified as long-term social problems experienced by Australia's First Nations population. FDV is one of the contributing factors to women's and children's poor mental health and disadvantage.

3.1.1 First Nations understandings of FDV

In their report to government on violence in First Nations communities, Memmott and colleagues (2001) used the term 'family violence'[6] (FV) to "encapsulate not only the extended nature of Indigenous families, but also the context of a range of violence forms, occurring frequently between kinspeople in Indigenous communities", such that:

- FV may involve all types of relatives. The victim and the perpetrator often have a kinship relation;
- the perpetrator of violence may be an individual or a group;
- the victim of violence may also be an individual or a group;
- the term 'family' means 'extended family' which also covers a kinship network of discrete, intermarried, descent groups;
- the community may be remote, rural or urban based;
- its residents may live in one location or be more dispersed, but nevertheless interact [and] behave as a social network;
- the acts of violence may constitute physical, psychological, emotional, social, economic and/or sexual abuse;
- some of the acts of violence are ongoing over a long period of time, one of the most prevalent examples being spousal (or domestic) violence (p. 1).

The 'Strong Culture, Strong Peoples, Strong Families: Towards a safer future for Indigenous families and communities 10 year plan' states that FV is not part of First Nations [traditional] culture, and describes FV within First Nations communities as including "a wide range of physical, emotional, sexual, social, spiritual, cultural and economic abuses that can occur within families, extended families, kinship networks, and communities" (Aboriginal Affairs Victoria, 2008, p. 8).

Women, children, and people with a disability are among those more vulnerable to these forms of violence, with First Nations women "particularly at risk and [with] much higher rates of hospitalisation because of family violence" (Australian Institute of Health and Welfare, 2021c). Data from the Australian Institute of Health and Welfare (AIHW) (2018b) show that the prevalence rates of domestic violence (DV) and (FV) across Australia are rising, costing Australia approximately $22 billion annually (Australian Institute of Health and Welfare, 2018b). Unfortunately, these cost-figures were not disaggregated by First Nations status or disability; however, the report noted comment from accounting firm Klynveld Peat Marwick Goerdeler (KPMG) that three groups of vulnerable women – First Nations women, women with disability, and homeless women – were underestimated by as much as a further $4 billion (p. xi).

3.1.2 Federal and state legislation

To ensure protection for First Nations people in FDV legislation, it must recognise these First Nations understandings of 'family violence' as involving extended family and kinship relationships. Recent FDV legislation in New South Wales (NSW), Victoria, Queensland, South Australia (SA), and the Australian Capital Territory (ACT) all now contain a form of words that can be read to mean something similar to the following description of a 'relative' in the Northern Territory's (NT) FDV legislation:

> 10(2) A relative of a person includes someone who, according to Aboriginal tradition or contemporary social practice, is a relative of the person (*Domestic and Family Violence Act (NT)*, as in force at 12 April 2017, pp. 8-9).

Additionally, the legislation in both NSW and SA includes a recognition of a carer as being in a family-type relationship with the person for whom they are caring (*Crimes (Domestic and Personal Violence) Act 2007 (NSW)*, current at 1 January 2022; *Intervention Orders (Prevention of Abuse) Act 2009 (SA)*, version 7.7.2022).

These pieces of legislation appear to provide for the recognition of First Nations kinship networks in FDV issues in the relevant states and territories.

Definitions of 'family member' and 'relative' in the Federal family law legislation *(Family Law Act 1975, as amended and in force on 28 September 2022)*, the Tasmanian (*Family Violence Act 2004* (Tas), authorised as at 8 October 2019), and Western Australian (WA) legislation (*Family Violence Legislation Reform Act 2020* (WA), as at 09 Jul 2020), are generally restricted to a western understanding of 'family relationship'. In the case of WA, this omission is potentially offset by the *Restraining Orders Act 1997* which says:

> (1) In this Act –
>
> ***family relationship*** means a relationship between 2 persons – ...
>
> (f) who have, or had, an intimate personal relationship, or other personal relationship, with each other; ...
>
> In subsection (1) –
>
> ***other personal relationship*** means a personal relationship of a domestic nature in which the lives of the persons are, or were, interrelated and the actions of one person affects, or affected, the other person;
>
> ***related***, in relation to a person, means a person who —
>
> (a) is related to that person taking into consideration the cultural, social or religious backgrounds of the 2 persons ... (*Restraining Orders Act 1997 (WA)*, as at 01 July 2022).

3.2 First Nations concepts of ‘health’ and ‘disability’

> We never use the word – we never understand the word of – the meaning of disability because we know that our children have different abilities to succeed. We nurture that ability so we just say ‘This one here we need to look after him. We need to help him a little bit more than the others’. So this is why we need to understand the interpretation of how we identify our young people or people with the needs to help them succeed. [Dianne, a Yawuru, Karajarri Senior Community Member]

First Nations’ understandings of ‘health’ and ‘disability’ differ from how western models define them. The western biomedical model of health has been described as a deficit or reductive model, whereby health is understood primarily as an absence of illness or disease (Rocca & Anjum, 2020). Within this model, the Australian Bureau of Statistics (ABS) defines disability for statistical purposes as “any limitation, restriction or impairment which restricts everyday activities and has lasted, or is likely to last, for at least six months” (Australian Bureau of Statistics, 2019b). Similarly, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) defines people with disability as “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” (United Nations General Assembly, 2007b).

These definitions of disability are at odds with Australia’s First Nations people’s cultural understanding of health and disability as holistic, encompassing not only individual but also spiritual and community wellbeing (Australian Government, 2021; Australian Institute of Health and Welfare, 2020b; Dudgeon & Walker, 2015; Ferdinand et al., 2019; King et al., 2014; Walsh & Puszka, 2021). First Nations communities interpret these western models of disability as deficit focused. For First Nations communities, what constitutes ‘disability’ is not such a settled state. The ‘No End in Sight’ report (2012) described the First Nations concept of disability in this way:

> The concept of disability is a western one. Many Indigenous organisations pointed out that Indigenous people often do not use, or recognise the term ‘disability’. People in communities frequently recognise that someone is ‘different’, but this difference tends to be accommodated where possible. When a person’s difference is manageable their various impairments are viewed as simply one part of the person, but are often not considered central or core to one’s identity (p. 8).

Gilroy and colleagues (2013) have also noted that First Nations families do not have a word equivalent to the collective noun ‘disability’ but rather that the “approach to disability in Indigenous communities is as diverse as the cultures within the Indigenous population” (p. 44; see also Gilroy et al., 2021). Stopher & D’Antoine (undated) supported this view, observing that:

> Given the diversity in Aboriginal culture and language, it is likely that disability may have been conceived and responded to in a variety of ways. The limited research since colonisation suggests that there may not have been a generic term ‘disability’ in some Aboriginal cultures, that people were referred to as having a specific impairment or ‘sickness’ that prevented them doing certain tasks, but that they were still involved in the kinship system with roles and responsibilities (p. 4).

Other research notes that for some First Nations people, their personal, cultural and historical contexts shape their concept of disability, and others may not accept the term ‘disability’ at all (Dew et al., 2019; Ravindran et al., 2017). Ethnographic observations at an Indigenous Respite Centre in Brisbane found that the First Nations clients and workers believed “the impact of colonisation ... led to disability; and the creation of a category called ‘disability’ where none had existed before” (King et al., 2014, p. 743). According to Sotiri and colleagues, however:

> Other stakeholders were keen to point out that although disability is not an Indigenous concept, it is crucial that this lack of labelling, and the non-judgement by Indigenous communities is not romanticised. The absence of support due to the lack of identification and understanding of Indigenous needs and approaches to disability continues to be a serious cause for concern, especially in criminal justice settings.
>
> Indigenous stakeholders also noted, that in some communities, the presence of disability is viewed as simply one more disadvantage in a whole raft of disadvantages, and tends not to warrant particular attention. When compared with suicide rates, imprisonment rates, levels of violence experienced in communities and institutions, drug and alcohol misuse, and other issues reflecting the challenges faced by colonised and severely traumatised communities, disabilities were often considered to be fairly low on the scale of priorities (2012, pp. 8-9).

The Australian Human Rights Commission (AHRC) (Australian Human Rights Commission, 2015) and others have noted the challenges arising from these cultural differences:

> Aboriginal families may be required to compromise their own cultural and ideological views on disability in order to accept formal disability services and supports that were provided or rationed in a manner more consistent with biomedical views of disability (Gilroy et al., 2016, p. 3).

Inadequate understandings of these differing worldviews have significant and ongoing consequences, including an underreporting of disability, and an underutilisation of services by First Nations people.

3.3 The current disability and FDV policy environment

3.3.1 National

Arising from a background of longstanding calls for a Royal Commission into disability services, the first Recommendation of the Senate Community Affairs Reference Committee (2015) was that a Royal Commission be established to inquire into issues of violence, abuse and neglect of people with disability, its terms of reference to be determined in consultation with relevant people and organisations. The Committee considered there was a need for further investigation of the access to justice needs of specific groups including First Nations women and children (Recommendation 8 p. xvii). The Committee recommended that DV protective policy frameworks[7] be updated to specifically refer to people with disability, and that increased funding be provided for the support of women and children with disability who were escaping DV (Recommendation 24 p. xxiii). It found, among other things, that the rate of disability amongst First Nations people was “almost twice as high as that among non-Indigenous people” (p. 11), and noted that the United Nations (UN) Disability Committee had commented on the issue of data collection in Australia, and regretted “the low level of disaggregated data collected on persons with disabilities and reported publicly” and the “little data on the specific situation of women and girls with disability”, in particular those who identified as First Nations peoples. It recommended that Australia:

> ... develop nationally consistent measures for data collection and public reporting of disaggregated data across the full range of obligations provided for in the [Convention on the Rights of People with Disabilities], and that all data be disaggregated by age, gender, type of disability, place of residence and cultural background (p. 41).

The 2010-2020 National Disability Strategy (NDS) recognised the role that social determinants play in the high prevalence of disability in First Nations communities, which it noted at that time was around twice that of Australia’s non-Indigenous population (Council of Australian Governments (COAG), 2011). The Strategy stated that First Nations Australians with disability faced specific barriers, and that there was a need for Closing the Gap strategies to be introduced to deal with them. The NDS has very recently been updated and is further discussed below. The Productivity Commission review of the National Disability Agreement (NDA) found that it “no longer serves its purpose, has a weak influence on policy, and its performance targets show no progress in improving the wellbeing of people with disability” (Productivity Commission, 2019, p. 2).

A joint submission from National Cross-Disability Disabled People’s Organisations to the Inquiry into DV in Australia in 2014 (Frohmader & Cadwallader, 2014) indicated that “alarmingly high rates of violence against women and girls with disability” (p. 37) were a consequence of social exclusion existing within and across multiple environments. Then current policy settings around access to income support, accessible housing, crisis support and accommodation, and legal services were evaluated and found wanting. In particular, changes to eligibility for the Disability Support Pension (DSP) requiring women with disability who experience violence to search for employment or incur a loss of income, were seen as “naïve and potentially harmful” (p. 36). Funding cuts to the National Family Violence Prevention Legal Services (FVPLS) program, were also noted in the submission as a particular risk for First Nations women with disability experiencing FDV, leaving them without access to necessary legal advice and representation. Policies such as these, the authors concluded, were likely to leave women with disability who were living in abusive situations with ‘nowhere to go’ (Frohmader & Cadwallader, 2014, p. 37).

This situation appears to not have changed in the intervening years. Access to the DSP under current policy settings is dependent upon meeting a stringent set of medical and non-medical rules as well as satisfying an ‘impairment’ rating. Failure to meet the 20-point impairment rating results in loss of eligibility, and referral to Disability Employment Services.[8] Further barriers exist around the availability and accessibility of legal assistance to support people with disability. The Indigenous Legal Assistance Program was axed in the 2019-20 Budget. At the time of writing in early 2022, remaining funded legal assistance programs on the Federal Attorney-General’s Department website are the Aboriginal and Torres Strait Islander Legal Services, and the individual FVPLS in all mainland states and the NT. Federal funding was cut for the peak body, the National FVPLS Forum, from 30 June 2020, and these funds were to be distributed equally among the 14 frontline FVPLS providers around Australia (Cross, 2019).

Walker and colleagues (Walker et al., 2020) recently reviewed seven health policy frameworks – four national, two from WA,[9] and one from NSW – for key components addressing the primary health care (PHC) needs of First Nations women experiencing FDV. The eight key components were: FV, violence against First Nations women, social determinants of First Nations health and wellbeing, cultural safety, holistic health, trauma, patient centred care, and trauma and violence informed care. This review found, among other things, that although ‘family violence’ was defined and embedded in all policies, and ‘violence against Aboriginal and Torres Strait Islander women’ in all but one, just two policies defined and embedded social determinants of health, and three ‘cultural safety’. ‘Holistic health’ was defined in three policies, but not mentioned at all in two. The three remaining key components, where present in a policy, were mentioned but not defined. The authors concluded that just one of the seven policies was drafted to “specifically address the needs of Aboriginal and Torres Strait Islander women” (p. 8), revealing significant gaps in PHC policy and practice for First Nations women who experience violence. They recommended that, to address these gaps, there be:

> A specific policy outlining a model of care based on the key concepts in this review, involving Aboriginal and Torres Strait Islander women in the process of drafting, implementation and evaluation and establishing clear links to cross-sectoral policies (p. 12).

Similar issues are discussed in research into the National Disability Insurance Scheme (NDIS) which was introduced in 2013, with trials taking place in four states, and full implementation rolling out across Australia from July 2016 (Parliament of Australia, 2018). The scheme is available for Australian citizens, permanent residents or special residents aged between 7 and 65 years who have a “permanent and significant disability” (NDIS, 2021). The NDIS Quality and Safeguards Commission is an independent agency tasked with oversight of the scheme, including the registration of services as NDIS providers, and safeguarding the rights of participants. The Commission aims for the adoption of a nationally consistent approach to NDIS services, and monitors the compliance of services with their responsibilities under the NDIS Code of Conduct and NDIS Practice Standards. Its remit includes working with the states and territories around worker screening, education, and capacity building. The NDIS largely replaces the earlier scheme, the National Disability Insurance Agency (NDIA), which continues to have responsibility for individualised plans for people with disability, the coordination of service bookings, payments and access to plans for providers, and detecting and investigating allegations of fraud.[10]

Writing in 2017, Phuong stated that the NDIS promised "changes to the lives of Australians with disability in general and for the Indigenous population particularly" (Phuong, 2017, p. 49). Phuong noted, however, that beliefs and perceptions of 'disability', the impacts of colonisation, and attitudinal, physical and communication barriers all complicated engagement with disability services for First Nations people. The study concluded that despite the broad availability of evidence of these challenges, and of recommendations for their amelioration being provided to policy makers, at time of writing the identified issues were not adequately recognised or responded to, and recommendations had not been implemented. Many of these issues were also considered in the literature reviewed by Trounson and colleagues (2020), discussed later in this review.

Gaps in coverage, low rates of eligibility, and barriers to services with the NDIS have been discussed more recently in the 'Wiyi Yani U Thangani' report, which noted that it had been described as an "opaque process that was difficult to navigate" (Australian Human Rights Commission, 2020b, p. 323). Eligibility for First Nations people with disability was found to be relatively low, with those who had engaged with the system encountering technological and literacy barriers, significant delays and, for women living in regional and remote areas, no availability of in-person support and inadequate service availability. Research by Pedruzzi and colleagues (2021) similarly found limitations in service access and in delivery for young people who lived outside urban centres, and suggested that variations in service delivery and any effects of the NDIS in regional areas be the subject of further research. This echoes research undertaken earlier, as the rollout of the NDIS had begun, stating an urgent need for further research into 'disability, mental illness and rurality' with a focus on vulnerable and disadvantaged populations including First Nations people and women with disabilities (Barton et al., 2015).

The national policy environment is currently undergoing further change with the recent release of the Draft National Plan to End Violence against Women and Children 2022-2032 (Department of Social Services, 2022a). The process for developing this plan has involved collaboration and consultation between a range of federal, state and territory government entities; the establishment of a National Plan Advisory Group and an Aboriginal and Torres Strait Islander Advisory Council; the gathering of information from other sources, including the Delegate's Statement from the National Summit on Women's Safety held in September 2021 (see EP Agency, 2021); key findings from public consultations; and the current evidence base, including the 'Wiyi Yani U Thangani' report (Australian Human Rights Commission, 2020b). The draft plan was originally open for consultation for a two week period from 14 to 31 January. This was extended to 25 February 2022 in response to community criticism.[11]

The 10-year plan rests on foundation principles of: gender equity, recognising the diverse lived experiences of victim-survivors to inform policy and solutions, Closing the Gap, and recognising the importance of taking an intersectional approach to analyses of violence against women and children. It "outlines the commitment by all levels of government and provides a nationally coordinated and long-term policy framework for ending violence against women and children in Australia" (Department of Social Services, 2022a, p. 7) and aims to target four key areas: prevention, early intervention, response, and recovery. The National Plan recognises the considerably higher levels of risk and experience of FDV, as well as of such specific forms of violence as forced sterilisation (by the State), and violence against women with disability within the home, and in institutional and service settings. The experiences of violence of children are generally framed within the woman-child dyad, and specific issues of violence against children with disability do not appear to be addressed.

With the change in federal government in May 2022, the new Minister for Social Services, Amanda Rishworth, was reported as convening an 'emergency meeting' to address issues in the current draft plan. The work of the advisory group was also reported as now to continue past the expiry date of the existing national plan on 30 June 2022 (Ziwica, 2022). A stakeholder consultation conducted by a team from the Monash Gender and Family Violence Prevention Centre, involving over 450 participants from 345 organisations, will inform the National Plan. The stakeholder consultation report has been finalised but has not yet been publicly released by the Department of Social Services (DSS). A further consultation with 80 victim-survivor advocates has also been completed and delivered to the DSS; this also is not yet available to the public.[12]

Speaking on First Nations peoples' experiences of family, domestic and sexual violence at the National Summit on Women's Safety held in Canberra on 6-7 September 2021, Professor Marcia Langton was reported as saying:

> The real problem here – and I'm going to say it out loud – the national plan and its iterations has led to unintended consequences in our communities and in our populations. ... Nobody listens to us. ... We absolutely need our own Indigenous plan for ending violence against women and children ... Lives are being lost because people who think they know better than us will not listen to us and will not act on our advice (Murphy, 2021).

More recently, in the discussion at the Wiyi Yani U Thangani First Nations Women's Safety Policy Forum on 12 September 2022, Professor Sandra Creamer, Chair of the Aboriginal and Torres Strait Islander Advisory Council for the First Nations action plan on violence against women and children, said:

> In recognition [of] a particularly high rate of violence and abuse experienced by those living with disability, the Advisory Council is focused on ensuring the action plan strongly reflects their immediate and longer term needs (Transcript of the Wiyi Yani U Thangani First Nations Women's Safety Policy Forum, 12 September 2022).

Action on FDV in First Nations communities has been widely demanded for some time, and this has now been met with the commitment for a dedicated ‘Aboriginal and Torres Strait Islander Action Plan’ to form part of the overall strategy. These comments from senior First Nations women reflect the need for any such plan to recognise and address the many intersecting issues involved in the disproportionate rates of violence experienced by First Nations women and children.

With regard to the aims and development of this Plan, the Pathways to Safety report makes a number of recommendations to government, the detail of which can be found in the report (Change the Record and the National Family Violence Prevention Legal Services Forum, 2021). Briefly, among the recommendations are calls to ensure “better support for people with disabilities, including support to live on Country in safety and dignity”; increased funding for FV prevention and the structures necessary for the safety of women and children; and investment in “evidence-based, culturally-tailored men’s behaviour change programs that promote and enhance safety” and in a range of culturally appropriate and community-controlled programs (p. 5).

The higher risks of FDV and specific other forms of violence against people with disability are more fully addressed in Australia’s Disability Strategy 2021-2031, released in late 2021 (Department of Social Services, 2021). The Strategy is based upon the social model of disability, which defines disability as the interaction with social, attitudinal and environmental barriers to participation in society experienced by people with some limitation, rather than the limitation itself. A ready example is that the impediment to entering premises for someone confined to a wheelchair is the failure to provide a means of entry, rather than the disability that requires the use of the wheelchair. The strategy has six safety, rights and justice policy priority areas:

- people with disability are safe and feel safe from violence, abuse, neglect and exploitation;
- policies, processes and programs provide better response to people with disability who have experienced trauma;
- policies, processes and programs for people with disability promote gender equality and prevent violence against groups at heightened risk, including women and their children;
- the rights of people with disability are promoted, upheld and protected;
- people with disability have equal access to justice; and
- the criminal justice system responds effectively to the complex needs and vulnerabilities of people with disability (see pp. 14-18).

Each of these priority areas is supported by illustrative quotations from relevant reports and institutions. One pertinent example is a quote from the Law Council of Australia stating that:

> Aboriginal and Torres Strait Islander women with disability are at an even greater risk of experiencing violence and of being involved in violence and imprisoned, as they face intersecting forms of discrimination because of their gender, disability, and ethnicity (p. 18).

Other issues are of heightened relevance for First Nations people, such as that First Nations children are significantly over-represented in out-of-home care (OOHC) (Australian Institute of Health and Welfare, 2022a), that there is inadequate culturally appropriate support available to First Nations children with disability and their families (Australian Civil Society CRPD Shadow Report Working Group, 2019)[13] and, in context of the burden of disease statistics for First Nations people across all ages discussed below, that there is an over-representation of people with mental illness and people with intellectual disability (ID) in all aspects of the criminal justice system, with assessment and support services either patchy or unavailable to those who are incarcerated (Australian Institute of Health and Welfare, 2021d; McFarlane, 2018; McGlade, 2021; Pedruzzi et al., 2021).

The Disability Strategy is supported by the Safety Targeted Action Plan (TAP), which was informed by views of people with disability through public submissions, consultations with disability representative organisations and representatives, and people with lived experience of disability. The TAP sets forth a range of actions, indicative timelines and output indicators separately to be met by the Federal Government, each of the six states, and the two territories, to build capacity and capability in services to “strengthen system design and supports to enable people with disability to receive high quality and safe services” (Department of Social Services, 2022b, p. 1).

Most recently, on 2 May 2022, the National Women’s Safety Alliance published ‘In One Generation’, a Federal Election Policy Statement (National Women’s Safety Alliance, 2022). The statement outlines government actions it considers necessary during the tenure of the next parliament to end gender-based violence. It foregrounds information on prevalence, FDV as a known driver of gender inequality, and presents gender equality as the “solution to ending gender-based violence” (p. 5). A number of priorities for an incoming federal government to undertake and complete by the end of each year of the three-year term are then listed. Of note is the call for there to be a commitment to the continuation of the National Plan Advisory Group and the Aboriginal and Torres Strait Islander Advisory Council until 2032, and that both groups should “play an ongoing role in providing advice to the new Domestic, Family and Sexual Violence Commissioner” (p. 9).

3.3.2 Western Australia

The WA policy environment for FDV is currently in the third phase of the state’s Family and Domestic Violence Prevention Strategy to 2022. The primary outcomes to be achieved by 2022 under this Strategy were threefold: prevention and early intervention, safety for victims, and accountability for perpetrators. The more recent ‘Path to Safety: Western Australia’s strategy to reduce family and domestic violence 2020-2030’ (Department of Communities, 2020b) is a whole-of-government and community plan, supported by three action plans, and with four focus areas to:

- work with Aboriginal people to strengthen Aboriginal family safety;
- act now to keep people safe and hold perpetrators to account;

- grow primary prevention to stop family and domestic violence; and
- reform systems to prioritise safety, accountability and collaboration (see p. 7).

As part of the first action plan, which ran from July 2020 to June 2022, the Department of Communities, in partnership with other government and non-government services, was charged with a range of actions, including co-designing the Aboriginal Family Safety Strategy with First Nations people and communities; and in partnership with FDV service providers, First Nations communities, and others, developing culturally appropriate programs to improve safety and wellbeing for First Nations women and children experiencing FDV to ensure they benefit from all support services available to them.

A draft Aboriginal Family Safety Strategy 2022-2032, prepared for the WA government as part of its Path to Safety strategy, was released for comment in March 2022 (Tjallara Consulting Pty Ltd, 2022). The strategy's six values – self-determination; shared responsibility; culture and identity; cultural leaders, Elders and traditional owners; respect; and safety and empowerment, support its stated purpose:

> To guide a whole of community, collaborative approach that is flexible, culturally secure, and culturally responsive to address family violence impacting Aboriginal women, children, families and communities (p. 22).

This strategy has four focus areas. Services that respond to FDV will be holistic, trauma-informed, and focused on **healing** for those who experience FDV. The First 1000 days model[14] is noted as a good practice example of a whole of service partnership model of care in this context. Services will "**recognise** the 'unique roles and responsibilities of men and fathers" (p. 29), and provide **support** specific to their needs. Service provision and systems will be **transformed** by building cultural capabilities, normalising Aboriginal cultural responses, reforming funding models, and responding to systemic racism and discrimination. The strategy aims to '**build on and build up**', embedding early intervention and prevention founded in culture and local decision-making, and addressing the social and cultural determinants of FDV. Three action plans form the strategy, the first of which will develop regional implementation plans, with expected outcomes at individual, service, system, and community levels. Governance "will be driven by Aboriginal voices" (p. 50).

It is worth observing here that these strategies do not exhibit an intersectional approach, with the Path to Safety strategy to reduce FDV referring to disability only marginally, noting that women with disability are at greater risk of FDV, face barriers in accessing support, and by citing the strategy's connection to the State Disability Plan. The draft Family Safety Strategy mentions 'disability' once, in reference to it sitting within the strategic context of the State Disability Strategy 2020-2030. The State Disability Strategy itself specifically mentions First Nations people in just five places.

The Path to Safety strategy states that, "The justice system, more than any other, must be a specific focus for reform" (Department of Communities, 2020b, p. 47). The Western Australia Police Force (WAPOL) was directed to develop a Code of Practice for response and investigation of FDV reports, with a specific focus on reports involving First Nations victims, and to undertake comprehensive FDV training for its officers. Among other actions, the Department of Justice was directed to develop a Department of Justice Aboriginal Family Safety Strategy and to implement the key provisions of the Family Violence Legislation Reform Bill 2019 (Department of Communities, 2020a).

This Bill – since enacted as the *Family Violence Legislation Reform Act 2020* – introduced new laws into parliament including the creation of a specific offence for suffocation and strangulation and for persistent FV under the Criminal Code, the creation of a serial FV offender declaration, a requirement for WA police to record every FDV incident, amendments to enhance victim safety, new penalties for some offences, and some changes to court procedures which include directions to juries to counter stereotyping and mistaken beliefs (Government of Western Australia, 2019). The key amendments are in part a response to a FV murder conviction of a First Nations woman with a disability, Jody Gore, who was wrongfully charged and convicted of murder in the context of FDV (McGlade & Tarrant, 2022). Despite this, as previously noted, the *Act* itself appears to lack specific reference to First Nations understandings of 'family' and 'relationships'.

Two other recent policy measures have relevance for First Nations women and children in WA. While there is some research conceding that pregnancy has been found to be potentially protective in some instances (Walsh, 2008; Webster et al., 1994),[15] it is acknowledged in this and other research that generally pregnancy is a time of greater risk for women to experience violence from a current or previous intimate partner (Australian Institute of Health and Welfare, 2018b; Bohn, 2005; Cooper, 2013). Prevalence of FDV during pregnancy has been estimated at as high as 20%, and perhaps higher given the extent of under-reporting (Australian Institute of Health and Welfare, 2015). Data on prevalence of FDV in pregnancy among First Nations women, however, are scarce (Australian Institute of Health and Welfare, 2015), as is quantification of poor birth outcomes for First Nations infants as a result of assault on their mothers (Gibberd et al., 2019). Screening for FDV in pregnancy has been recommended in both the academic and grey literature, in Australia and internationally (Australian Institute of Health and Welfare, 2015; O'Reilly & Peters, 2018; Spangaro, 2017; Spangaro et al., 2016; Spangaro et al., 2019; Walsh, 2008). In 2018, the WA government awarded $1.56 million over three years to the Women and Newborn Health Service (WNHS) at King Edward Memorial Hospital for Women (KEMH),[16] as part of a policy commitment for the implementation of a state-wide routine screening program for FDV in public antenatal settings. This program was to be implemented by June 2021 and has resulted in the 'Strengthening the antenatal responses to FDV' (SARFDV) project[17] developing a training program, which incorporates the screening tool FDV950,[18] for all staff working in public settings (King Edward Memorial Hospital, 2020).

The second policy measure relates to amendments to tenancy laws that have been introduced to provide a range of options for tenants who are at risk of or experiencing FDV. These include such measures as the ability to end a tenancy, to remove a perpetrator from a tenancy agreement, and to change locks or install security measures. The Safe Tenancy WA webpage provides information for those experiencing FDV within a secure incognito page which will instantly close via a one touch safety feature at need.[19]

In summary, commentary on certain policies is critical of a lack of attention to social determinants of health, and in particular, for requirements seen to restrict access to support under the DSP. There is comment around the need for more data and, specifically, disaggregated data for women and girls with disability. The lack of support for families, over-representation of First Nations children in the child protection system, and of First Nations people in the justice system, are noted in discussions of priority areas, as are cuts to funding and gaps in PHC policy and practice. Both federal and WA policy frameworks are currently being updated, with the new federal Draft National Plan to End Violence against Women and Children 2022-2032 expected to specifically address issues for women and children with disability, and to include a dedicated plan for First Nations people.

3.4 Disability, FDV, and First Nations women and children

The necessity of understanding how social determinants impact upon the health and wellbeing of First Nations people, in Australia and elsewhere, is well rehearsed in academic, government, and non-government sector literature (Australian Institute of Health and Welfare, 2020c; Dudgeon et al., 2014; International symposium on the social determinants of Indigenous health, 2007; Sydney Metropolitan Local Aboriginal Health Partnership, 2016). Transgenerational trauma resulting from past colonial policies and practices is an ever-present backdrop to present policies and practices that contribute to continued exposure to a range of harms for First Nations people, including personal and systemic racism, high rates of child removal, of incarceration and deaths in custody, and social and economic disadvantage (Atkinson et al., 2014; Dudgeon & Walker, 2015; Fisher et al., 2019; Gerlach et al., 2017; McGlade, 2012; Paradies, 2016; Shepherd et al., 2017; Zubrick et al., 2014). FDV among First Nations peoples must be understood within this context of the consequences of colonisation upon the contemporary environment for First Nations people and their traditional roles and practices. Atkinson suggests that violent behaviours “become the norm in families where there have been cumulative intergenerational impacts of trauma on trauma on trauma, expressing themselves in present generations in violence on self and on others” (Atkinson, 1996, p. 7).

Intersectionality has been defined as “different aspects of a person’s identity that can expose [that person] to overlapping forms of discrimination and marginalisation” (Victorian Family Violence Data Collection Framework, 2021). Much of the information of the experiences of First Nations women and children with disability, and First Nations women and children with experience of FDV, is not intersectional. To avoid confusion, this information is first presented separately in this review, followed by a discussion of the intersectional literature. The review includes discussion of literature not specifically focused on, but including and of relevance to, First Nations women and children.

3.4.1 First Nations women and children with disability

The ABS and others advise that the Survey of Disability, Ageing and Carers, Australia (SDAC) is the only census that should be used to report disability prevalence in Australia (Coleman et al., 2018). In 2018, the SDAC found that 24% of First Nations people living in households[20] (with similar proportions of females (24.3%) and males (23.7%)), experienced some form of disability (Australian Bureau of Statistics, 2021a), compared to 17.7% of the total Australian population (Australian Bureau of Statistics, 2019b). As shown in Table 1 below, there is a sharp increase in the reported prevalence of disability from the age of 35 years onwards.

Table 1: Aboriginal and Torres Strait Islander people (a)(b), proportion with disability by age, 2015 & 2018[21]

Aboriginal and Torres Strait Islander people(a)(b), proportion with disability by age, 2015 & 2018	2015 (%)	2018 (%)
0–14	13.9	16.3
15–34	16.2	15.3
35–54	33.3	33.3
55 years and over	57.6	53.5

[a] Living in households

[b] Excludes those living in remote areas and discrete Aboriginal and Torres Islander communities

Source: Australian Bureau of Statistics, Aboriginal and Torres Strait Islander people with disability 11/06/2021

Among First Nations people, 13.3% had a physical disability, and this form of disability was more likely for females (15.2%) than for males (10.6%), and in people aged over 55 years. As shown in Table 2 below, some form of intellectual disability was more likely to be reported by males (10.1%) than by females (5.9%). The SDAC found that while the proportion with a profound or severe limitation was similar for males (8.5%) and females (9.7%), for children aged 0-14 years this had increased from 5.9% in 2015 to 11% in 2018 (Australian Bureau of Statistics, 2021a).

Table 2: Aboriginal and Torres Strait Islander people(a)(b), disability group(c) by sex, 2018[22]

Aboriginal and Torres Strait Islander people(a)(b), disability group(c) by sex, 2018	Males (%)	Females (%)
Sensory and speech	7.8	3.9
Intellectual	10.1	5.9
Physical	10.6	15.2
Psychosocial	8.0	9.0
Head injury, stroke or acquired brain injury	2.8	1.9

a Living in households

b Excludes those living in very remote areas and discrete Aboriginal and Torres Strait Islander communities

c Excludes ‘other’ disability group

Source: Australian Bureau of Statistics, Aboriginal and Torres Strait Islander people with disability 11/06/2021

Key findings from the Australian Burden of Disease Study 2018 (Australian Institute of Health and Welfare, 2021a) showed that of the total burden of disease among First Nations Australians, 53% were a result of living with illness or injury and the remainder a result of premature death. Disease burden differed by age profile, with infant and congenital conditions predominating among infants and young children. Three such conditions of concern for First Nations children are briefly outlined below. In late childhood through to 44 years of age, mental and substance use disorders and injuries, including suicide, predominated, and from around age 45, cardiovascular diseases and cancer, with neurological and endocrine disorders increasing with age. The fatal burden had declined by 27% over the period from 2003 to 2018, resulting in a decline of 15% in total burden; however, the relative gap in disease burden (a rate ratio of 2.3 in each year) between First Nations and non-Indigenous peoples had remained the same. In 2018, the respective gaps in health-adjusted life expectancy from birth were 15.2 years for males and 13.9 years for females.

In their 2013 literature review of childhood disability, DiGiacomo and colleagues (2013) stated that, compared to age-matched non-Indigenous children, Australia’s First Nations children were 30% more likely to require assistance with learning or other activities, or to have a serious disability. Despite this high rate of disability, the review found limited data on prevalence, or access and use of services. The majority of the 27 articles meeting criteria for inclusion in this review focused on middle ear disease and hearing loss, which the authors described as ‘not surprising’ given the rates of this disease in Australia’s First Nations children. Other papers looked at ‘general disability’ (4), ‘development’ (2), and ‘vision’ (1). One paper focused on intellectual disability (ID), and none on fetal alcohol spectrum disorders (FASD).

3.4.1.1 Otitis media

Otitis media (OM) or middle ear disease is the main reported cause of preventable ear infections leading to hearing loss and deafness in First Nations children. Compared to non-Indigenous children, infection occurs at younger ages, is more severe, with recurrent infection leading to more cases of chronic disease (Kong & Coates, 2009). Reported rates of OM and hearing loss “are the highest in the world” (Thornton et al., 2017, p. 1), with the prevalence rate in remote communities in WA estimated at up to 70% (WA Department of Health, 2013). The literature on OM is predominantly quantitative, and focused in regional and remote areas; however, the epidemiological *Djaalinj Waakinj* (listening and hearing) study (Swift et al., 2020) found a similarly higher prevalence of OM in First Nations children compared to non-Indigenous children living in metropolitan Perth. Notwithstanding this, the recent unpublished *Kadadjiny Dwank* (listening, thinking and learning with your ears) study conducted with First Nations communities in outer urban areas of Perth found few qualitative studies had been undertaken on this issue with First Nations people, and none with a focus on First Nations children living in urban areas (Walley, 2020).

3.4.1.2 FASD

FASD encompasses a range of effects on the fetus resulting from maternal ingestion of alcohol which can have lifelong implications. Children with FASD become adults with FASD who may need some level of support for the rest of their lives. Globally, the prevalence of FASD has been estimated at 7.7 per 1000; in Australia, estimates from state and territory data have indicated rates between 0.01 to 0.68 per 1000 in the total population, and possibly as high as 2% of all babies born (Department of Health, 2018). For First Nations people, the prevalence of FASD nationally has been estimated to be somewhere between 1.87 to 4.7 per 1,000 births (Department of Health, 2018). In WA, a study by Mutch and colleagues (2015) with predominantly rural-based mothers (82.9%) between 1980-2010, found a prevalence of FAS (fetal alcohol syndrome)/FASD per 1,000 births of 4.08 for First Nations children and 0.03 for non-Indigenous children. A recent summary of FASD among Australia’s First Nations people reported research showing a prevalence of FASD of 194/1000 of all children born in 2002-2003 in remote communities in WA, and of 466/1000 young people sentenced to and assessed in detention in WA in 2015-16 (Australian Indigenous Health*InfoNet*, 2021). FASD has also been reported in multiple generations of the same family (Education and Health Standing Committee, 2012). Despite these official and other data, FASD prevalence is also often reported as ‘unknown’ due to no/poor access to diagnosis, and lack of resources.

Developmental difficulties for children with FASD may include problems with language and memory, motor and social skills, and with controlling their emotions and impulses. First Nations children living with FASD are also ‘much more likely’ to be involved with both the child protection and justice systems (Australian Indigenous Health*InfoNet*, 2021). There is a recognised need for the decolonisation of the justice system for First Nations young people in the FASD literature (Blagg et al., 2021; Mutch et al., 2021; Williams & Badry, 2021). Other literature supports that without diagnosis and support, many of these young people will develop secondary issues such as early onset of mental health disorders, disengagement with school, alcohol and other drugs (AOD) misuse, and involvement in the criminal justice system (Hafekost et al., 2017; Hamilton, Maslen, Best, et al., 2020; Young et al., 2016). Suicidal ideation has been reported to be higher amongst people with disabilities, particularly those with FASD (Choi et al., 2020; O'Connor et al., 2019). Despite these known issues, First Nations children have limited access to the resources and treatments they need, and the First Nations lens on disability is rarely considered in responses for their care (Williams & Badry, in press). A FASD diagnosis identifies the other comorbid conditions and the strengths and weaknesses of each child based on their disability and appropriate treatments. Early intervention determines the overall quality of life a child with FASD will have as an adult in terms of being able to live independently. First Nations people, however, continue to struggle with a high incidence of undiagnosed or misdiagnosed FASD within families (Wozniak et al., 2019).

3.4.1.3 Intellectual Disability

Bourke and colleagues (2016) investigated the prevalence of ID and autism spectrum disorders (ASD) in WA between 1983 and 2010, utilising data from the Intellectual Disability Exploring Answers (IDEA) database which gathers cases through the Disability Services Commission (DSC) and from education sources. Demographic information was gathered via linkage to the Midwives Notification System, and the Mortality Register. The authors noted that while ID may be due to FAS or FASD, it can be a result of Down syndrome or other biomedical causes, infections, or postnatal injuries, or from unidentified causes; further, that ASD and ID co-occur in around 50% of cases.

This study analysed data for 9625 children born in WA from 1983-2005 and still living in 2010, 6276 (65.2) males and 3349 (34.8) females. There were 1264 children of First Nations mothers in this cohort. Prevalence of ID for these children was 39.0 per 1000 live births, compared to 15.7 per 1000 for non-Indigenous children (8361 records). Prevalence varied by place of residence at birth, increasing in all regional and remote areas compared to residence in the metropolitan area. The study found an overall increase over the previous estimate of 14.3/1000 (Leonard et al., 2003) to 17.0/1000. For First Nations children and young adults over this period the prevalence of ID was 2.5 times that of their non-Indigenous peers. The researchers suggested reasons for why First Nations children were 'much less likely' to be accessing services, including lack of access to services, or that the children are more likely to have mild or moderate ID and thus may not raise early concerns. They noted that this can lead to children not receiving a diagnosis until school age and consequently not receiving early intervention services.

3.4.2 First Nations women and children and FDV

In her report measuring health impacts of intimate partner violence (IPV) among Australian women, Webster (2016) noted that IPV contributed an estimated 2.2% to the burden of disease for all women, and was the top risk factor for all women aged 18-44 years. The gap in IPV's estimated contribution to burden of disease between non-Indigenous and First Nations women aged 18-44 years is significant (5.1% vs 10.9%). Health conditions included in these estimations, and the disparity in occurrence for First Nations women when compared to non-Indigenous women were: anxiety and depressive disorders (5 times higher), early pregnancy loss (11 times higher), homicide and violence (13 times higher), alcohol use disorders (15 times higher), and suicide and self-inflicted injuries (7 times higher).

The most recent National Aboriginal and Torres Strait Islander Social Survey, 2014-15 (NATSISS) reported that First Nations women were twice as likely as men to experience FDV, and that 57% of these women were physically injured. Younger women were more vulnerable than older women (Australian Bureau of Statistics, 2019a). As shown in Table 3 below, almost 29% of First Nations women aged between 25-44 years, and around 10% of all women aged 15 years and over, had experienced FDV in the 12 months prior to the survey.

Table 3: Experience of family and domestic violence(a) by age group, Aboriginal and Torres Strait Islander females[23]

Experience of family and domestic violence(a) by age group, Aboriginal and Torres Strait Islander females	Experienced FDV ('000)	Experienced FDV (% of age group)	Total females ('000)
15–24 years	6.4	9.4	68.8
25–34 years	7.3	14.4	50.5
35–44 years	5.8	14.3	40.6
45 years and over	3.8	5.4	71.2
Total aged 15 years and over	23.0	10.0	231.1

(a) Based on most recent experience of physical violence in previous 12 months

Source 4714.0 National Aboriginal and Torres Strait Islander Survey 2014-15

First Nations women experience higher rates of DV, FV and partner homicides than non-Indigenous women (Australian Institute of Health and Welfare, 2019a). In a submission to the Victorian Royal Commission into Family Violence (RCFV) from the Victorian FVPLS (now known as Djirra), Braybrook (2015) stated that as a result of FV, First Nations women were almost 11 times more likely to be killed as a result of violent assault, than non-Indigenous women. She further noted that at the time she was writing, 93% of Djirra's clients were First Nations women. In 2016-17, the AIHW reported that First Nations women were 34 times more likely to be hospitalised than non-Indigenous women and accounted for 35% of all such hospitalisations. The perpetrator was identified as a spouse or partner in 62% of cases. In 2017-18, around a quarter (65,200) of clients seeking assistance from homelessness services were First Nations people, of whom 28% (18,300) requested assistance due to FV (Australian Institute of Health and Welfare, 2019b, p. 118).[24]

In its discussion of First Nations women's experiences of FDV, the NATSISS reported that compared with women who had not experienced physical violence in the previous 12 months, women who had experienced FDV were:

- more likely to report high or very high levels of psychological distress (69% vs 34%);
- more likely to have a mental health condition (53% vs 31%);
- more likely to report they had experienced homelessness at some time in their life (55% vs 26%);
- less likely to trust police in their local area (44% vs 62%);
- just as likely to trust their own doctor (77% vs 83%); and
- just as likely to report being able to get support outside the household in a time of crisis (88% vs 92%) (Australian Bureau of Statistics, 2019a).

The Closing the Gap Clearinghouse reported in 2016 that First Nations boys aged 0-14 were 6.5 times as likely, and girls 12.3 times as likely, to have been hospitalised for FDV-related incidents than non-Indigenous boys and girls in the same age range (Closing the Gap Clearinghouse, 2016).

Finally, a small mixed method study undertaken with 10 Australian First Nations women focused specifically on their experiences of sexual violence, with the lived experience of three women further explored through interviews (Guggisberg, 2019). All the women included in the study had experienced violence from former or current partners which had the potential to be lethal. Nine women reported frequent sexual violence. The three women who took part in the interviews with the researcher variously drew connections between the violence they experienced and colonisation, expectations of gender roles, AOD use, and the effects of violence on themselves, and expressed their concerns for their children and of the risks of the perpetuation of violence through the next generation.

3.4.3 First Nations women and children with disability and their experiences of FDV

First Nations women and children, and people with a disability, are among the most vulnerable groups for risk of witnessing or experiencing FDV throughout their lifetime (Australian Institute of Health and Welfare, 2019a, p. 4). The experience of FDV is, in turn, recognised as a cause or contributor to disability (see, for example, Goldin et al., 2016; Haag et al., 2022; Rees et al., 2011; Valera et al., 2022; Zieman, Bridwell, & Cardenas, 2017). The AIHW reported in 2019 that "[M]ore than half of Indigenous Australians who experience family violence have disability" (2019a, p. 118). Two recent analyses of data from the NATSISS looked at questions of disability and the incidence of violence, and the interactions of disability, interpersonal racism and avoidance behaviours. The first of these studies found that partner violence was significantly more likely to be reported by First Nations women with disability (40%) than men (4.6%), and familial violence was also higher for women (17.5%) than for men (13.3%). This study concluded that disability is associated with an increase in risk of violence, and that this risk increases with severity of disability, and with intellectual or psychological disabilities (Temple et al., 2020b).

In the second study (Temple et al., 2020a), the researchers investigated whether interpersonal racism and avoidance behaviours were more frequently reported by First Nations people living with disability, and whether this was linked to differing types and severity of disability. The study found a heightened risk of encountering interpersonal racism and of avoidance of services in government and other settings such as healthcare, education, and employment, as a result. This risk was greater for those with cognitive impairments, and those with multiple conditions. Family removal and identification with homelands were also strongly associated with racism and consequent avoidance of dealing with government services and other settings.

Women who had experienced FDV were more likely to have a mental health condition (53% vs 31%), and to have been diagnosed with at least one long-term health condition (79% vs 68%) (Australian Bureau of Statistics, 2019a). While not focused specifically on First Nations women, in their discussion of the extent of violence against women with disabilities in Australia, Dowse and colleagues (Dowse et al., 2016) noted that the risk of violence for First Nations women with disability is heightened, and that the ABS acknowledges it is likely these women are even less well-represented in the ABS Personal Safety Survey (PSS) than women with profound or severe communication disability.

New analysis of data from the 2016 PSS, released by the ABS in April 2021, found that violence by a partner was almost twice as likely to be experienced by women living with disability compared with women without disability (2.5% vs 1.3%). For women experiencing intellectual or psychological disability, the risk was almost three times that of those experiencing a physical disability (15% vs 5.2%). And, while 74% of women experiencing disability suffered with anxiety or fear for their personal safety following physical assault, just 29% made a report to police (Australian Bureau of Statistics, 2021e). Similarly, recent analysis of data from the 2014-15

NATSISS, also released by the ABS in April 2021, found that over that period, 24% of First Nations women experiencing disability or a long-term health condition experienced physical or threatened violence compared with 15% of First Nations women who were not experiencing disability or a long-term health condition (Australian Bureau of Statistics, 2021b).

Whether and how the experience of FDV differs for some groups of women with disability was discussed in a recent study by researchers from the Australian Institute of Criminology (AIC). For women with a long-term restrictive health condition, they found that FDV was significantly more likely for First Nations women (42%) than for non-Indigenous women (15.8%). The probability of experiencing the onset of physical or sexual violence (9.4% vs 4.4%), coercive control (17.1% vs 4.5%), and an escalation of physical or sexual violence (73.1% vs 53.8%) were all higher for First Nations women (Boxall et al., 2021). First Nations women with disabilities may experience disability-specific violence, such as denial or overdosing of medication, food, and water, confinement and restraint, alteration or control of assistive equipment, or threats to withdraw care (Milberger et al., 2003). The literature from Canada supports the Australian literature on First Nations women's heightened vulnerability to FV, especially for those with disability (see, for example, Heidinger, 2021; Savage, 2021).

Hayes and colleagues (2010) focused on psychosocial stressors and mental health and their effect on perinatal outcomes. Data from a revised Edinburgh Postnatal Depression Scale (EPDS) screening tool were collected from 92 women attending the Townsville Aboriginal and Islanders Health Service (TAIHS) who gave birth to a First Nations baby.[25] At their first antenatal visit, 15% of the women reported experiencing or having experienced DV, two-fifths reported a major life event in the past 12 months, and 21% reported a history of childhood abuse, 11% of whom reported that this was a combination of sexual, emotional and physical abuse. A significant association with high scores on the EPDS was only found with DV and a history of childhood abuse. Study authors noted that, while this small study is not applicable more broadly, these data are consistent with national Beyond Blue data and support other evidence from Canada and the United States (US) of a high prevalence of psychosocial stress among First Nations women.

Psychosocial stress and its impact on First Nations women's management of chronic disease was also the focus of a qualitative study conducted by Eades and colleagues (2020) with clients of four Aboriginal Medical Services (AMS) in urban, rural and remote locations in WA, Queensland, and Central Australia. Seventy-two in-depth semi-structured interviews were conducted with First Nations women diagnosed with diabetes, cardiovascular or kidney disease, and attending one of the four included AMSs. None reported suffering with depression or anxiety. While this study did not directly discuss issues of FDV, it did encompass it as one of a range of stressors the women faced in their caring roles as mothers, grandmothers, sisters and aunties. These included intergenerational trauma, AOD misuse, incarceration leading to a breakdown in family support networks, deaths in the family, and lack of cultural understanding from others around sorry business. The women spoke of a lack of formal support and of not often using health and other services because of a perceived lack of cultural safety (see Williams, 2008). The researchers concluded that this combination of multiple roles caring for others, and the lack of caring support for the women themselves from formal support services, leaves them "juggling multiple caring roles and responsibilities while potentially neglecting their own health" (Eades et al., 2020, p. 6).

Risk of past and current IPV was analysed using data from 304 pregnant women with severe mental illness (SMI) who attended the Childbirth and Mental Illness Clinic at KEMH in Perth between 2006 and 2017 (Suparare et al., 2020). Thirty-seven women identified as First Nations, comprising 22% of 125 women diagnosed with schizophrenia and 5.7% of 179 diagnosed with bipolar affective disorder. These data were not disaggregated further. Almost half of all women in the study in both diagnostic groups had experienced past IPV, and just under a quarter were experiencing IPV during their pregnancy. Findings from this study suggested that, when compared to the general pregnant population, pregnant women with serious mental illness are at greater risk of having experienced or of currently experiencing IPV. The authors noted that there are challenges in particular for screening First Nations and culturally and linguistically diverse (CALD) women due to the 'stigma' around such reporting, but that this research supported the importance of antenatal and mental health care screening for IPV (see also O'Reilly & Peters, 2018).

Two similar studies, one in the US and one in New Zealand (NZ), also focused on the impact of violence on maternal mental health. The first of these, was conducted in outpatient and urgent care clinics of the Indian Health Service hospital in Albuquerque, New Mexico, providing care for the local urban American Indian (AI) population and to AI and Alaska Native (AN) tribes (Duran et al., 2009). These authors found, among other things, that an anxiety disorder was 60% more likely, and post-traumatic stress disorder (PTSD) was more than five times more likely, in women experiencing severe IPV than in those with no experience of IPV. The second study with 828 mothers of Pacific Island infants at 6 and 24 months postpartum, found that physical violence, experienced at either time point or whether it was recurrent over the time between, significantly increased the likelihood of psychological distress (Gao et al., 2010). In common with the Australian study by Suparare and colleagues (2020) discussed above, these international studies noted the importance of early screening for IPV in primary care settings, with Duran and colleagues (2009) suggesting that the confidentiality of medical care settings could be an advantage.

The recent report by Summers (2022) noted that there were "185,700 women who experienced violence by a previous partner, who are now living as single mothers with children all under the age of 18" in Australia (p. 53). Other key findings were that over 50% of the women said that the children in their care had seen or heard the violence that had occurred with their previous partner; 49% said they had experienced violence during temporary separations; and, in common with other research, that the consequences of fleeing partner violence for many women are poverty, and for some, ongoing health problems. It was noted that the PSS from which the data relied upon for this report were drawn did not collect data from First Nations communities, and that "there is no mention of extending the data collection of the PSS to ensure greater representation" of First Nations women (p. 54). Summers does point to the finding from the 2014-15 NATSISS, however, that 27 per cent of all First Nations women "said that family violence was a problem in the local community” (p. 54). Summers further noted that the LGBTQI status of the women was not collected in the PSS, but that the ABS has said that future surveys will ask about sexuality.

There is a paucity of research around the incidence and effects of discrimination and violence for First Nations women and people identifying as LGBTQI with lived experience of disability. In their submission to the Inquiry into Family, Domestic and Sexual Violence (House of Representatives Standing Committee on Social Policy and Legal Affairs, 2021) the AHRC noted that:

> ... the limited data we have suggests that LGBTQI people experience family, domestic and sexual violence at similar rates to those who are heterosexual and cis-gendered. However, modes of violence may differ (Australian Human Rights Commission, 2020a, p. 21).

While this submission speaks of experiences of FDV of First Nations women, women with a disability, and LGBT women, it does not appear anywhere to have specifically addressed the intersectionality of these identities. Similarly, the submission from the International Lesbian, Gay, Bisexual, Trans and Intersex Association (ILGA World) to the UN Special Rapporteur on violence against women, its causes and consequences, noted that “LGBTQ+ individuals experience heightened suicidality rates, serious assaults, homelessness, and psychological distress” in Australia, but does not include any reference to disability.

Children

A body of research has explored the impacts of exposure to trauma on children in varied domains. A study conducted by Orr and colleagues (Orr et al., 2020) used de-identified individual-level linked administrative data to examine associations between exposure to FDV and increased child hospitalisation. The authors noted that research is lacking on the effects of exposure to FDV in children, where nearly “two-thirds of female victims of FDV in Australia are assaulted in their own home, with 49% of all female victims having children in their care at the time of the assault” (p. 2). The study analysed data for children born in WA between 1987-2010 and exposed to FDV between the prenatal period (12 months prior to birth) and from birth to five years of age. In WA, First Nations children made up around 7% of the general child population at that time; of the exposed cohort of 7,957 children identified for this study, 62.2% were First Nations children.

The study found that, after adjusting for sociodemographic characteristics, children exposed to FDV were more likely to be hospitalised than non-exposed children. Exposed First Nations children had higher odds of hospitalisation in most diagnostic groups, including eye, ear and endocrinology disorders and circulatory diseases, when compared to exposed non-Indigenous children. The authors emphasised the need for caution when assigning reasons for these differences, and for the disproportionate number of First Nations children in the exposed group. They point to the likely relationship between the findings around First Nations children and hospitalisations and the legacies of colonisation, including factors such as racism and intergenerational trauma, forced removal of children, and psychosocial stressors. The authors emphasised the importance of strategies aimed at prevention and early intervention for FDV which are supported by the cultural authority of the community.

Other research has examined trauma exposure and its effects on children's ability to succeed and thrive in school settings. This includes research that has addressed the impacts of trauma on First Nations children's learning and behaviour (Miller & Berger, 2020) children's ability to concentrate and learn and its links to poorer educational attainment and outcomes (Hurt, Malmud, Brodsky & Gianetta 2001) and sensory processing and emotional regulation (Costa, 2017), all of which affect a child's ability to thrive in a school setting. Other research has noted that signs of developmental disorders in children who are trauma-exposed are vulnerable to misdiagnosis with conditions such as learning disabilities, attention deficit hyperactivity disorder (ADHD), and oppositional defiant disorder (Walkley & Cox, 2013).

Researchers in WA have focused on the effects of FDV on children's readiness for and experiences with school. As part of a larger study, Orr and colleagues (Orr et al., 2021) investigated school readiness in young First Nations and non-Indigenous children exposed to FDV using statutory data collections from the WA Department of Health, WAPOL, and the Commonwealth Department of Education and Training. Of the total 7016 children in the sample, 1434 children were identified as exposed to FDV. In each of the five domains of physical, social, emotional, communicative and cognitive development, all of the exposed children were shown to have higher odds of vulnerability than non-exposed children.

A second study (Orr et al., 2022), with a total sample of 26,743 children born in 1993-2006 in WA, examined a cohort of FDV-exposed children to determine its effects on school outcomes. Of the total sample in school in years 1-10, 14,832 identified as First Nations, 433 of whom were identified as living with disability. There were 4754 First Nations and 3750 non-Indigenous children identified as FDV-exposed. Results showed that all children exposed to FDV had higher rates of school moves and school suspensions than non-exposed children. FDV-exposed First Nations children had higher rates of poor attendance, and higher odds of unauthorised absences and school moves than non-exposed First Nations children.

The evidence shows that First Nations women and children are at significantly greater risk of FDV than their non-Indigenous peers. This risk is even greater for those living with disability, and for those identifying as LGBTQI+ (who may or may not live with disability), who may experience further and more specific types of violence (Australian Human Rights Commission, 2020a; Australian Institute of Health and Welfare, 2019b). A range of physical and psychosocial disabilities may also result from the experience of violence or exposure to violence. Interpersonal racism is more likely to be encountered by First Nations women with disability, leading them to avoid contact with healthcare and other necessary services, signalling a need for greater attention to culturally appropriate services, prevention and early intervention.

3.4.4 Effects of COVID-19 policies on FDV

The potential for an escalation in cases of FDV as a result of restrictions during the COVID-19 pandemic was broadly recognised by governing and other bodies. The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) released a statement on 6 April 2020, at a time when 90 countries were in lockdown as a result of the COVID-19 pandemic, warning of a 'shadow pandemic' creating a "'perfect storm' for violent behaviour behind closed doors" (Mlambo-Ngcuka, 2020). Two months later, the UN Department of

Global Communications (DGC) noted that lockdowns had seen a rise internationally in victims of DV being ‘trapped’ in their homes with their abusers. The DGC reported increases in calls, emails, and website visits, to helplines, and for contact with frontline and emergency workers, in countries ranging from Singapore and Cyprus, to Australia, the United Kingdom (UK), France, and Argentina. Responses from governments included an increase in mobile, online and phone contact services, as well as providing hotel space as emergency accommodation. Some countries introduced safe spaces, such as supermarkets or pharmacies, where women experiencing FDV could use a code word to request urgent protection (The United Nations Department of Global Communications, 2020).

In Australia, governments made it known that lockdowns did not apply in circumstances where someone was experiencing FDV. The Victorian government, for example, said “It is important to know that you can still leave your home or accommodation to escape harm or the risk of harm relating to family violence under any coronavirus restrictions”, providing contact details for a range of crisis and other services and ways to access them.[26] The WA government, similarly, advised that emergency responses and support were still available during the pandemic and provided a list of crisis support helplines.[27] Lockdowns in WA were of much shorter duration than in the rest of Australia, to a total of six weeks over the entire period, and are therefore likely to have had reduced significance as a trigger for FDV in this state. Short videos developed by the Women’s Funding Network showing how to use, and recognise, a one-handed ‘Signal for help’ gesture for those experiencing FDV, were a presence across social media such as TikTok, Facebook and Twitter from their launch in late April 2020.[28]

An increase in FDV was also noted by researchers as a result of the environment created by the COVID-19 pandemic (Pereda & Diaz-Faes, 2020; Usher et al., 2020). In May 2020, an online survey was conducted by the AIC to examine how COVID-19 may have affected rates of DV in the three months prior to the survey (Morgan & Boxall, 2020). Of 15,000 women respondents in a current cohabiting relationship, 565 identified as First Nations. The disability status of participants was not recorded. Almost 9% of all the women had experienced or had been threatened with, physical or sexual violence by their partner in the three months prior to the study. These respondents were divided into two groups. Of those who had experienced violence from their partner prior to the pandemic, 95.4% of the 129 First Nations women and 57.6% of 387 non-Indigenous women experienced violence during the three month period of the study. Of those women who had not experienced FDV prior to the pandemic, 14.7% of the 157 First Nations women compared to 2.6% of 6734 non-Indigenous women in this group were subjected to FDV. Among the factors believed to contribute to this increase in violence towards women as an outcome of pandemic measures were: increased time spent together at home, negative impacts on psychological wellbeing due to social distancing requirements, job insecurity and financial stress, increased alcohol consumption, and limits on women’s ability to seek help.

In late June 2021, the ABS released data for FDV-related offences in 2020. Australia-wide, these figures showed an increase of 12% in victims of homicide, 59% of whom were females. FDV-related assault had increased in all states where data were reported[29] and in the NT, and most victims were female (79%), aged between 25-44, and the perpetrator an intimate partner. The highest rate of FDV-related assaults of all included states and territories was recorded in WA (65.1%), an increase of 15% on 2019 figures, with the NT recording the largest increase (up 27% on 2019) (Australian Bureau of Statistics, 2021d). These data were not disaggregated by Indigenous or disability status.[30] National data showed there had been an increase of 13% in recorded victims of FDV-related sexual assault in 2020, compared to the 2% increase that had been recorded in the previous two years. The majority of victims were female (86%) and 71% were under the age of 19 years. In South Australia (SA), the offender was most commonly an intimate partner (49%) but in other states was most often (between 50%-72%) an 'other family member'.[31]

The increased vulnerability of people with disability during the COVID-19 pandemic was recognised and discussed in reports from the UN and in and academic and grey literature. A policy brief released by UN Women focused on women with disabilities recommended, among other things, actions ranging from the collection and analysis of data on women and girls with disabilities, ensuring access to information, and implementing measures to protect those living in institutional settings (UN Women, undated). Wilson (2020) interrogated the risks of the pandemic to people in Australia subject to compulsory powers, within the frame of the Convention on the Rights of Persons with Disabilities, with particular attention to emergency legislation and guardianship decisions. This study showed that persons with disability were inadequately considered in early emergency planning and that the impact on them of lockdowns and other practices was significant.

An article titled 'Child protection in the time of COVID-19' noted that the COVID-19 pandemic had created an environment where some children may have been at greater risk of harm, and had potentially limited opportunities for the detection and report of child abuse and neglect (Australian Institute of Health and Welfare, 2021b). Data on the effect on children's safety from March to September 2020, again not disaggregated by First Nations or disability status, were compared to data prior to March 2020 (pre-COVID). Briefly, the data showed that in most jurisdictions notifications fell at the introduction of restrictions in April 2020, and increased when these restrictions eased. Substantiations during this period remained relatively stable across jurisdictions where data were available (all, other than Tasmania), as did the number of children in OOHC care, with the exception of Queensland where there was a higher increase than in other jurisdictions (5% vs 3%). This is contradicted in some research on child protection that claims the COVID period also saw "a sharp rise in Aboriginal child removals" in WA (McGlade, 2020, p. 17).

The AIHW (2021b) further noted that reports from members of the public of online child sexual exploitation material to the Australian Centre to Counter Child Exploitation increased by 122% during COVID-19, and discussed the range of environmental issues that may affect risk of child abuse and neglect. These included: availability and accessibility of support networks, financial and housing stress, stress from altered working arrangements, and the effects of these on parental mental distress and substance use. It acknowledged the findings of higher levels of DV against women as discussed above, and an increased demand for DV support services.

3.4.5 General community knowledge and attitudes toward FDV

The most recent National Community Attitudes towards Violence Against Women Survey (NCAS) report (Webster et al., 2018; see also Webster et al., 2019), showed there had been some improvement in understandings of violence against women in the general community over the timeframe of survey years 1995, 2009, 2013 and 2017. NCAS reported that key facts related to violence against women were known by the majority of Australians but that, while in general results had improved from those of surveys undertaken in previous years, some results – both for knowledge of, and attitudes to, violence against women – were less positive (Webster et al., 2018, p. 13). The age and gender of participants were among the key predictors for having low levels of understanding of violence (males over 75 years) and attitudinal support for gender equality (males over 65 years). Age over 65 years, but not gender, was one of six key indicators of high levels of attitudinal support for violence against women.[32]

Recent high profile stories of the child abuse experienced by Grace Tame and the alleged sexual abuse of Brittany Higgins in Parliament House, Canberra have brought these issues to the attention of the general public. The Jenkins review, commissioned as a response to the Higgins case as well as other reports of violence in the parliamentary workplace, noted that these and other experiences "have also prompted renewed calls in the Australian context for an end to gendered violence" (Australian Human Rights Commission, 2021, p. 12). While not focused on First Nations women and those with disability experiencing FDV, this has been an important step in foregrounding the pervasive nature of violence against women in Australia.[33]

3.5 First Nations women's and children's experiences with services

3.5.1 Women's experiences with the justice system

First Nations women are significantly over-represented in the national and WA state female prison population data. The 2016 Census of Population and Housing (Australian Bureau of Statistics, 2018) reported 798,400 First Nations people in Australia, making up 3.3% of the total Australian population and 3.9% of the population of WA at that time.[34] At 30 June 2021, the total Australian prisoner population was 42,970. Of this total, First Nations people comprised 30% (13,039), just under 80% of whom had been imprisoned more than once as an adult. There were 3292 female prisoners, 1260 of whom identified as First Nations, representing an Australia-wide age standardised imprisonment rate of 433.9 per 100,000 First Nations compared to 22.2 non-Indigenous females. For WA, these rates were 797.0 (302 prisoners) and 36.3 (336 prisoners) respectively (Australian Bureau of Statistics, 2021c).

In its final report into the incarceration rates of First Nations peoples, the Australian Law Reform Commission (ALRC) stated that First Nations female prisoners were "disproportionately more likely than their non-Indigenous counterparts to:

- be mothers and primary care givers of children;
- have experienced family violence and sexual assault;
- have mental illness or cognitive disability;
- have substance abuse issues;
- have entered into the child protection system as children;
- have earlier and more frequent criminal justice contact–including police contact and incarceration;
- be living in unstable housing or homeless;
- be unemployed; and
- have lower levels of educational attainment" (Australian Law Reform Commission, 2017a, p. 349).

With regard to the number of First Nations women in prisons who had prior experience of FV and sexual abuse, the ALRC report cited a study with First Nations women in prison in NSW in which 70% reported having experienced child sexual abuse, 44% of having experienced continuing sexual abuse, and 78% of experiencing continuing violence as adults; a Victorian study where experience of sexual, physical or emotional abuse was reported by 87% of participants; and the WA studies by Wilson and colleagues discussed below which found up to 90% of the women in their study had experienced 'family and other violence' (Australian Law Reform Commission, 2017a, p. 351).

Baldry and Cunneen (2014) have suggested that the negative effects of political, policy and legislative changes only partially explain increases in prison populations, and that such accounts largely neglect to include women. Placing this work in context, the authors noted that at the time of its publication rates of imprisonment for First Nations women had risen by 20% in one year and, further, that women with mental health disorders, and most particularly First Nations women, were also demonstrably over-represented in the prison system. This study viewed the increasing rate of imprisonment for First Nations people, people with mental and cognitive impairments, and 'especially' First Nations women, within past colonial patriarchal practices designed to support the state control of females, particularly of First Nations women and girls. As some of these policies were abandoned, the authors argued that 'mechanisms of colonial surveillance' did not disappear but were reimagined, citing as one example the changing child welfare legislation and contemporary child removal practices, and as another the NT Intervention, where imprisonment rates increased by 34% in the five years following its introduction in 2007.[35] It was argued that while there have been changes in society's understandings of First Nations culture and the history of colonial invasion and dispossession, these have not translated into change of any significance for First Nations people, particularly women, within the court and prison systems. This 'new punitiveness' and its disproportionate effects for First Nations people, and in particular women, the authors say, is not accidental but rather that the "modalities of punishment may have changed but the targets have remained remarkably consistent" (p. 292).

As part of a larger mixed methods study conducted in NSW and WA to investigate the social and cultural resilience and emotional wellbeing of First Nations mothers in prison (see Jones et al., 2018; Sullivan et al., 2019), Wilson and colleagues (2017) asked additional questions of the 84 women interviewed in WA, about whether they had experienced violence and whether they had themselves been violent.[36] Of the 54 women who indicated they had used violence, the authors noted that most came from disadvantaged backgrounds, many from violent homes, with most having experienced multiple traumas growing up. Just under 55% of the women had a parent who had been in prison, and 46% had themselves been incarcerated as a juvenile; 49% had experienced violence directed towards them in relationships with partners or family:

> The prominence of victimization histories among the 54 women who had used violence was stark with 49 women or 90.7% of the sample reporting they had also been victims of violence in the past. Many women linked a victimization history to their own self-defense or retaliatory violence (pp. 6-7).

In a discussion of Australia's treatment of First Nations prisoners, McGlade (2021) referred to the findings discussed above, and observed that despite the large numbers of First Nations women in prisons who have experienced violence, and women with cognitive impairments who are in contact with the justice system, WA's Bandyup Women's Prison still had no treatment or diagnostic programs for First Nations women.

The ALRC final report mentioned above noted the critical individual and community-level effects of the incarceration of First Nations women, with one submission stating that "Aboriginal women are pivotal in maintaining the health and wellbeing of families" such that the ramifications of incarceration "reverberate negatively across the breadth and depth of family and community wellbeing", including the potential removal of their children into care (Australian Law Reform Commission, 2017a, pp. 81-82; see also Jones et al., 2018). The over-incarceration of First Nations women was also pointed out in a submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry (2021), stating that it "is a family violence issue ... Up to 90 per cent of Aboriginal women in prison are themselves victims of violence" (p. 177). This submission further commented on knowledge of occasions where police had attended at incidents of FDV only to criminalise the women requesting assistance, creating a reluctance among First Nations women to contact police.[37] Two other submissions also spoke of women's fear and suspicion of police and other authorities and agencies, due to the history of removing children from families (pp. 177-178).[38]

3.5.2 Juvenile justice

In their report on youth justice in 2020-21 (Australian Institute of Health and Welfare, 2022e), the AIHW acknowledged that First Nations young people "were over-represented in youth justice supervision in every state and territory" (p. 11). Almost half (48%) of all children aged 10-17 years under justice system supervision on an average day in 2020-21, and over half (53%) in detention, were First Nations children. First Nations children were younger than their non-Indigenous peers when they entered supervision: over a third, compared to around 14% of non-Indigenous children, were aged 10-13 years.

Observing that First Nations Australians and people living with disability are over-represented in the justice system, Pedruzzi and colleagues (2021) noted specific concerns for young people with FASD. They cited an Australian study (Bower et al., 2018) that found 89% of young people held in WA's only youth detention centre "had at least one domain of severe neurodevelopmental impairment" (Pedruzzi et al., 2021, p. 2), and 36% of these were diagnosed with FASD.

In another study, interviews conducted with the caregivers for incarcerated First Nations young people with neurodevelopmental disability were focused on their experiences of diagnostic assessment (Hamilton, Maslen, Watkins, et al., 2020). This paper presented vignettes of the stories from five of the 15 yarns with participants[39] – three First Nations and two non-Indigenous – from urban (6), remote (5), and regional (4) WA. Of the three First Nations caregivers, one had a 16-year-old grandson, one a 16-year-old son, and one a 17-year-old son, all of whom had been diagnosed with FASD, had been released from prison, and were now living with them. One non-Indigenous caregiver's 15-year-old son was still incarcerated, as was the 16-year-old son of the other caregiver. Both these youths were diagnosed with neurodevelopmental impairments in the severe range.

This study found that medical terms were not used by participants, although all had an understanding of the link between the diagnosis and clinical indicators such as alcohol consumption during pregnancy, and their child's particular difficulties. First Nations participants spoke of 'that thing in his head/brain', and non Indigenous participants spoke of their child having 'problems'. Study authors found that there were differing cultural patterns in responses to the processes around diagnosis: First Nations caregivers understood the impact of diagnosis as it related to their families and communities, while non-Indigenous caregivers were more focused on what the diagnosis would mean for their children. The implications of these differences and how they relate to understandings of health and wellbeing are 'currently under-investigated'. The preference among First Nations caregivers for visual resources and strategies was noted as a strength which can be utilised to support the provision of resources, particularly via increased internet and social media access for remote communities.

As has been noted in other research, there are particular difficulties for justice-involved young people with FASD, making it essential the disorder is recognised to ensure they receive all available supports and appropriate management within the court and custodial systems (see Hamilton et al., 2019; McLachlan et al., 2020; Mutch et al., 2013).

In response to a rise in critical incidents including self-harm and attempted suicides at the Banksia Hill Detention Centre[40] in the latter half of 2021, the Inspector of Custodial Services conducted an inspection of the facility's Intensive Support Unit (ISU) in December 2021, finding that there had been breaches of detainees' human rights, and that quality of life for the young people in the ISU was poor. At the time of the inspection, 121 young people were in custody at the centre. The report arising from this inspection notes the presence of 'Aboriginal Welfare Officers' and 'Aboriginal Visitors' to the centre, but does not provide numbers and proportions of First Nations youth detained at Banksia Hill. The report resulted in the issue of a Show Cause Notice in response to which the Department of Justice supported the two recommendations made in the report, and outlined actions to be taken including addressing staff shortages and making infrastructure improvements, as well as continuing development of a trauma-informed model of care for these young people (Office of the Inspector of Custodial Services, 2022). The transfer of 17 children from Banksia Hill to Casuarina, a high security prison for adult male prisoners, in July 2022 has attracted attention from the press[41] and most recently the lockdowns at Banksia Hill have been ruled unlawful by the WA Supreme Court (Cox, 2022).

In her examination of human rights violations in WA jail cells, McGlade (2021) found, additionally, that despite the majority of youth incarcerated at Banksia Hill being First Nations, the facility had no First Nations focus such as programs for visiting Elders or provision of traditional foods. She further found that girls were disadvantaged due to a lack of facilities for their needs. Also noting the findings from Bower and colleagues (Bower et al., 2018) that over a third of First Nations young people in Banksia had FASD, and 90% "significant neurodevelopmental impairment", McGlade stated that:

> Detention centres are no place for so many Aboriginal children and youth affected by significant trauma and FASD. They are being routinely incarcerated for often minor offending in environments that do not support their cultural, psychological, social and physical needs (2021, pp. 281-282).

3.5.3 The child protection system

Recent available data show that First Nations children comprise around 6% of Australia's children, but just over 30% of those in the child protection system (Australian Institute of Health and Welfare, 2022b). Of the estimated 178,800 children receiving child protection services in Australia in 2020-21, around 58,000 were First Nations children. Across all age groups, First Nations children were 'significantly more likely' to receive child protection services than non-Indigenous children. There were 49,700 substantiated claims during 2020-21, 14,600 of which were for First Nations children, a rate of 43 per 1000. The situation is similar in Canada where Gerlach and colleagues (2017) reported that, in the province of British Columbia, Indigenous children comprised 8% of the child population, but 53% of those living in OOHC, and that across Canada child removal of Indigenous children was continuing in numbers rivalling the 'peak' of the residential school system.[42]

Cunneen and Libesman have written on the legacy of the Stolen Generations and the postcolonial trauma of the contemporary removal of First Nations children from their families (Cunneen & Libesman, 2000, 2002; see also Libesman, 2017). Situating their earlier discussion within the context of the 'Bringing them Home' report (HREOC, 1997), they noted that inquiry's finding that "basic safeguards which protected non-Indigenous families were cast aside when it came to Indigenous children", and that forced removal involved deprivation of liberty, of parental and human rights, abuses of power, and breach of guardianship duties (Cunneen & Libesman, 2000, p. 100).

The 1997 ‘Bringing Them Home’ report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (NISATSIC), examined how past policy and practice of child welfare and forced removal of First Nations children has affected First Nations communities (HREOC, 1997). Psychological and emotional trauma, mental health problems and on-going grief issues were reported by the Inquiry as intergenerational effects of forced removal, with further effects including on parental attachment, parental deprivation and loss of parenting skills (Aboriginal & Torres Strait Islander Social Justice Commissioner, 2007; HREOC, 1997). Without adequate numbers of First Nations family and foster carers, contemporary OOHC for First Nations children in both countries is likely to achieve the same results.

For the First Nations parents who participated in the 2012 study by Ivec and colleagues (2012), Stolen Generations history remained fresh in their minds, and child removal was seen as an ever-present threat. These authors suggested that the child protection system in Australia ‘straddles two worlds’, those of social work and law enforcement, and that achieving a balance between ‘a soft, supportive approach and a tough interventionist approach’ (p. 83) was caught between the provision of support and assistance and a system where ‘at risk’ children can be removed without the consent of parents. The 174 children of the 54 women in the research undertaken in WA by Wilson and colleagues (2017), for example, were potentially ‘at risk’ of removal by child protection authorities due to their mothers’ involvement with violence and the justice system (see also Australian Institute of Family Studies, 2014). In a discussion of child removal in WA, McGlade (2020) noted that then current data from the AIHW indicated First Nations children were 54 per cent of children in care in that state. She further commented on reports suggesting that First Nations infants were being removed from mothers in hospital and “within the first 30 days of their lives” (p. 3).

Recently published research into children of mothers with ID has shown that these children have a higher risk of contact with child protection authorities, and of placement in OOHC, and infants were at an even higher risk (Lima et al., 2022). This study found that the risk of removal and OOHC for children of non-Indigenous mothers with ID was 12 times that of children of non-Indigenous mothers without ID. For children of First Nations mothers with ID, the risk was significantly lower, at two times the risk of children of First Nations mothers without ID. The authors suggest this reflects the already increased presence of First Nations children in the child protection system and factors such as “poverty and entrenched disadvantage, which intrinsically make involvement with child protection services more likely for all Aboriginal children” (p. 8).

The independent review of First Nations children in OOHC in NSW provides a history of child protection in the state and a summary of previous inquiries and reports undertaken there (Davis, 2019). The report found there were still ‘significant concerns’ at the disproportionate numbers of First Nations children who were in the child protection system in NSW. This report made 125 recommendations to government, the most common of which it noted as “related to cultural planning, case planning, contact arrangements with family/kin other than siblings, record-keeping, sibling contact arrangements and restoration” (p. 48).

The most recent national report on the numbers of young people who were both in child protection and under youth justice supervision covered the five year period 1 July 2014 to 30 June 2019 (Australian Institute of Health and Welfare, 2022d). This report found that, nationally, 61% of First Nations and 48% of non-Indigenous children under youth justice supervision during 2018-19 (when aged 10-17 years, except in Victoria where young people aged 18-20 may also be held in a youth facility) had also received child protection services in the period 1 July 2014 to 30 June 2019 (when aged 0-17 years).

3.5.4 Engagement with disability services

To identify the factors influencing First Nations people's involvement with disability services, Gilroy and colleagues (2016) conducted interviews and focus groups with First Nations and non-Indigenous management and workers in one Aboriginal community controlled organisation (ACCO) and one mainstream disability service provider in metropolitan NSW. Of the total 64 participants, those from the ACCO included two management staff (one First Nation and one non-Indigenous), and two First Nations workers. Of the mainstream service staff participating, eight were non-Indigenous management staff, 48 non-Indigenous workers, and four were First Nations workers.

This study identified 12 major factors impacting on the use of disability services by First Nations people. These included differing cultural conceptualisations of 'disability' and of family and kinship roles and responsibilities, and the history of colonisation, transgenerational trauma and experiences of racism. Other barriers revolved around:

- choice of workers and services;
- trust – of mainstream services and individual workers;
- service provider connections, or lack of, to community;
- the involvement of multiple agencies in the lives of First Nations people, creating financial and personal stressors;
- mobility issues, due to remote locations or lack of affordable transport; and
- ineffective policy frameworks.

Literature detailing the continuing impacts of colonisation on individuals, and of the need to decolonise disability for First Nations peoples is supported by an ethnographic study conducted in Brisbane (2014). The study took place over a two-year period at a respite centre with First Nations people with disability, many of whom were suffering the effects of complications from type 2 diabetes or other debilitating conditions such as rheumatoid arthritis. The centre had a board of Elders and all but one of the staff were First Nations. The lead author employed participant observation and conducted more detailed research with three women in their 60s, each of whom had mobility and other issues affecting their ability to complete everyday tasks. Among other observations, the researchers noted the reluctance on the part of participants to attend non-Indigenous services, or to deal with forms and medical staff, as well as Centre Manager comments around the regulatory constraints on providing a culturally appropriate service. They concluded that “there is a mismatch between the needs of Indigenous people using Indigenous disability services and the formal structures and functions imposed on the services” (p. 748). While conceding that overcoming these differences in order to decolonise disability for First Nations people will be challenging, the study nevertheless asserted that it must be pursued.

The facilitating factors and impediments to First Nations peoples’ engagement with disability services were discussed in a review of 17 documents – 15 academic articles and 2 from grey literature – including theoretical papers, reviews and qualitative research (2020). The review found a significantly higher rate of disability for First Nations people, the greater likelihood of disability comorbidities, the inequitable access to appropriate services, and the experience of “multiple types of discrimination when racism and ableism intersect” (p. 2). They further noted that First Nations peoples’ access and engagement with disability services has not been well investigated in the literature.

Other research investigated the experiences and challenges of applying for the DSP for First Nations people living with disability, with a focus on the ‘social sorting’ that occurs within complex administration processes, resulting in people abandoning the application process (2020). Community members aged between 18-65 years who were living in one of four regional towns and had previously applied or were in process of applying for the DSP were recruited through a number of services, including employment, health and mental health services and non-government agencies. Data from semi-structured interviews showed three core areas where sorting occurred: informational sorting, polychrono sorting, and sorting through emotional distress.

‘Informational sorting’ relates to the challenges involved in accessing necessary information, contacting Centrelink staff, in sorting and understanding the information once obtained, and in lodging documents through an online system described as being ‘not user-friendly’. Some participants also found Centrelink staff unhelpful or that they had failed to lodge or misplaced documents, requiring paperwork to be gathered and completed more than once. ‘Polychrono sorting’ was defined by the authors as those processes requiring participants to time their application to ensure it fell within the stage of their illness that fitted within the DSP guidelines, and the ‘extensive delays’ in determinations of eligibility. Participants spoke of such illogical outcomes as rejection for still receiving treatment for a vision impairment which had been diagnosed as permanent, and due to being on the waiting list for an appointment with neurosurgeons while living with spinal injuries. ‘Sorting through emotional distress’, an outcome of the barriers encountered in all of these processes, led some participants to discontinue an existing application, or to resolve not to submit another application after having an application rejected, thus ‘sorting themselves out of the system’. Those people who had the assistance of an external advocate, such as a family member or a health professional, to navigate the complexities of the system were most successful in being approved for the DSP. Study authors concluded that “the accumulative impact of the combined assessment technologies means that a large number of Indigenous Australians will be unable to meet these demands” (p. 363).

3.5.5 Barriers to engaging with services and to reporting FDV

It is broadly acknowledged in the literature that First Nations women face additional barriers to reporting FDV. Some barriers, such as social norms around gender roles, affect all women to some extent. Others, such as those at the system level, are shared with women from other marginalised or vulnerable groups: lack of knowledge of and difficulties in accessing services and navigating systems, lack of services with adequate and appropriate cultural knowledge, and inadequate system responses. These barriers are intensified for First Nations women by experiences of institutional and personal racism, fear of child removal, and mistrust of mainstream services and authorities. In their discussion of the interaction with providers of First Nations women caring for First Nations children with a disability, Green and colleagues (2018) cited an observation from other research:

> Aboriginal and Torres Strait Islander women have to contend not only with the oppression of patriarchy, but also with the ongoing impact of colonization (Maddison & Partridge, 2014).

In their submission to the Australian Law Reform Commission inquiry into First Nations incarceration rates, the National Family Violence Prevention and Legal Service (NFVPLS) called these ‘complex and compounding barriers’, further noting:

- particular cultural or community pressures not to go to the police, such as perceived threats to cultural connection (especially for children) or to avoid increased criminalisation of Aboriginal and Torres Strait Islander men; and
- poverty and social isolation (Australian Law Reform Commission, 2017a, p. 352).

In her report on the experiences of IPV of Canada’s First Nations, Métis and Inuit women,[43] Heidinger (2021) noted the links between historical and intergenerational trauma and the increased risk of experiencing and/or witnessing household violence during childhood, observing that generally Indigenous peoples are more likely to have had both these experiences. While the differences in reported impacts on and actions taken by First Nations women and non-Indigenous women in response to IPV were not statistically significant in this study, Heidinger said these may nevertheless be an indication of barriers to reporting or service access for First Nations women, or, in light of the disproportionate risk to them of “growing up in and witnessing gendered violence”, that under-reporting may also reflect a potential acceptance of gendered violence where it becomes normalised, leading to a situation where the “consequences of IPV among Indigenous women may be muted or overlooked by victims of violence” (p. 8).

This observation is supported by the Australian research undertaken 25 years ago by Atkinson (1996), and more recently in the stories recounted in research with incarcerated First Nations mothers in WA. Many of the women in this latter study spoke of witnessing or experiencing violence throughout their early lives. One spoke of having been "flogged all my life by [her father]" (Wilson et al., 2017, p. 4); another said she "grew up around violence so it was just normal I thought" (p. 6).

With some caveats, a study conducted with First Nations women attending two urban and three regional Aboriginal and Maternal Infant Health Services in NSW found that confidentiality within care settings was also an important reason for disclosing or not disclosing FDV (Spangaro et al., 2016). Of 12 women participants, six had disclosed their experience of FDV when asked during antenatal visits, and six had chosen to not disclose. Cultural safety, or lack of it, was found to be central to decisions to disclose or to not disclose, comprising four elements: 'come at it slowly', 'build the relationship first', 'people like me are here', and 'borrowed trust' – which involves knowing that the AMS or other service is trusted by a trusted other within the kinship network. The researchers detailed pathways to decision-making involving a combination of direct asking and showing care on the part of service staff, feeling safe/not safe from 'him', from shame, from control, and of cultural safety.

In their further analysis of interviews with these women (Spangaro et al., 2019), the researchers used qualitative comparative analysis of women's responses to semi-structured questions around whether routine inquiries about FDV were a good or bad thing for them. Of the six women who disclosed abuse, four reported a positive impact from being asked about it, as did three of the six women who did not disclose. The elements identified within this were naming the abuse, achieving connection, unburdening, providing steps to safety and enabling informed care from the health service. Three of the five remaining women reported neither a positive nor negative impact, while two women reported the screening was a negative experience. These women experienced a lack of cultural safety and a feeling of intrusion, and had concerns due to past experiences of racism, state interference and fear of child protection involvement. When asked whether they agreed with routine enquiry generally, however, only one woman disagreed. While largely supporting screening, this study confirms the need for culturally respectful spaces, co-produced with First Nations people, and for clear protocols addressing concerns around child removal and other intrusive practices so women feel safe to disclose.

Fear of child removal by the Department of Child Protection (DCP) was also seen to be a concern for the incarcerated women in the research by Wilson and colleagues (2017), previously discussed. These authors noted that women "spoke about actively concealing family violence from police" due to fear of this resulting in the involvement of DCP and consequent loss of their children (p. 8). In their analysis of the NATSISS, Ferdinand and colleagues (2019) found, further, that First Nations people living with a disability "were more likely than people without disabilities to be removed from their families" (p. 31), and that this appeared to be unrelated to age, as it was for those affected by Stolen Generation policies. As a result, they suggested that concerns people may have about removal is 'a salient threat'.

In her submission to the Victorian RCFV, Braybrook (2015) summed up the range of barriers for women to reporting and seeking support for FDV. Among these were: mistrust of mainstream services; lack of knowledge of rights and of the availability of services; poverty and social isolation; and discriminatory practices or poor cultural competency within services, including child protection, police, and other community services. There were very real concerns about the risks of involvement with child protection services.

3.5.6 Regional, rural and remote areas

There are well known challenges for access to health care and other services in regional, rural and remote areas of Australia, such as inadequate infrastructure, staffing and retention issues, and a range of difficulties due to distance including, in particular for remote and very remote service delivery, inaccessible terrain at certain times of the year. The National Disability Research and Development Agenda identified people living in rural and remote areas as one of four cohorts experiencing 'particular disadvantage' – the others being First Nations peoples, women with disabilities, and those from CALD backgrounds (Disability Policy and Research Working Group, 2011).

Many regional towns have small hospitals as well as resident general practitioners (GPs) or health services and are often a hub for medical as well as social services such as Centrelink and Medicare both for residents and people living in surrounding rural communities. Compared with metropolitan areas, however, regional and rural areas have greater difficulties with staff retention in health and other services, and have access to a limited range of services, such as to tests requiring specialised equipment, specialist medical and related care services (Australian Institute of Health and Welfare, 2019c; Russell et al., 2017), and limited funding and availability of staff and services to address related socioeconomic issues and outcomes.

An exploratory study of community leader and service provider attitudes to primary prevention of FV within a Change the Story and community readiness framework was recently conducted in Geraldton, WA (Puccetti et al., 2019). Geraldton is a coastal regional town situated 424 kilometres north of Perth which had, at the time of this study, a 'significant problem' of FV, such that police data for the 2018/2019 financial year showed that FV in the Greater Geraldton area was "47% higher than the rate for regional WA" (p. 2). Study authors observed that FV is known to be under-reported. The city was in the early implementation stages of a Community, Respect and Equality (CRE) Strategic Plan.

Three focus groups – one with 4 women and 2 men, one with 6 women, and one with 5 men – were held with participants aged between 30-60 years, all of whom were in some way engaged with the CRE strategic plan. Two of the participants identified as First Nations. Analysis of data revealed four key themes:

- that FV is a 'silent subject', that people are uncomfortable speaking about and which has an element of shame attached to it;
- prevention is intergenerational, will require broad-based support and education, with normalisation identified as a key barrier to change;

- men, victim/survivors and perpetrators must be part of the conversation and involved in the work of prevention;
- an understanding of the causal pathways to FV is necessary for change, in particular understanding the role of gender inequality (see pp. 5-8).

This study's research team made recommendations for multi-level and targeted community education with a focus on the drivers of FV, and addressing in particular the uncomfortable issues of systemic gender and power inequalities between women and men.

The difficulties faced by regional and remote practitioners in improving outcomes for justice-involved young people with FASD and other neurodevelopmental disorders were further illustrated in two recent studies. The first of these was a qualitative study, using semi-structured interviews with 29 staff from various organisations and government departments, including case managers/workers (7) and clinical staff (6), police (2) and legal professionals (6), mediators/advocates (5), and program managers (3) in the greater Newcastle area in NSW (Pedruzzi et al., 2021). The paper does not provide information on the Indigeneity of participants. Four key themes were analysed and reported on: diagnosis and outcomes, complex needs, complex roles, and navigating the system. Outcomes from these interviews included a recognition of gaps in available services; the challenges of obtaining a diagnosis, and that its benefit was unclear to some participants; that FASD is one factor among many for justice-involved youth; and that the complexities of the roles participants needed to understand and undertake can lead to staff burnout. Among other recommendations, study authors concluded there was a need for "better information and training to facilitate diagnosis and support for young people with FASD and other neurodevelopmental disabilities" (p. 10), an improvement in information-sharing between relevant services, and available evidence-based therapeutic programs. A pilot 'model of care tool' for this workforce has been developed out of this research (see Hodgson et al., 2020).

The second study was an examination of the Audit of Disability Research in Australia for Australian studies of disability, psychosocial disability and mental illness in rural and remote locations, with the aim of identifying gaps in the literature in this area (Barton et al., 2015; see also Llewellyn, 2014a; Llewellyn, 2014b, 2017). Nine studies were found to focus on psychosocial disability, and 21 on disability and mental illness in rural and remote areas. Six studies were exclusively focused on rural and remote areas, one exclusively on First Nations people.[44] The authors noted there were no studies with a specific focus on women with disabilities who lived in rural or remote areas of Australia. They concluded that further methodologically sound research was needed, particularly around the needs of people with psychosocial disability, of women with disabilities, and First Nations peoples with disability living in rural and remote parts of Australia.

Environmental and systemic challenges for remote service delivery models, including distance and infrastructure issues, have been considered in recent research by and with people from the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Lands (NPYWC, 2018, 2019, 2020). In their recent paper, Gilroy and colleagues reported on the findings from the main study 'Walykumunu Nyinaratjaku: To Live a Good Life' relating to the barriers and challenges facing First Nations people living with disability in Central Australia (Gilroy et al., 2020).

The NPY Lands are situated in remote central Australia, stretching across the NT, WA and SA, where A<u>n</u>angu people live in isolated small communities with high levels of poverty, between 300 and 1500 kms from their nearest regional centre. Approximately 20% of First Nations people live in remote or very remote communities, and those with disability "experience worse health and greater inequality than their urban counterparts, attributable to limited access to education and culturally responsive health and community services" (p. 2919). The study used purposive sampling, and involved 62 A<u>n</u>angu people, and 47 service workers (disability workers, social workers, allied health and government workers). Of the total number of A<u>n</u>angu participants, of those living with disability (34) there was an approximately equal number of women and men, while most carers (28) were female. The definition of disability used for this study came from a South Australian NDIS trial site referring to "a person needing support with activities of daily living due to impairments that are temporary or lifelong" (p. 2921).

Barriers identified in the study were environmental, resulting from remoteness, inadequate built infrastructure, and socioeconomic disadvantage; and systemic issues such as inflexible service policies, restrictive eligibility criteria for services, and rigid government systems around funding structures and the ability to work 'flexibly' across the various jurisdictions covered by the NPY Lands. These challenges, for the A<u>n</u>angu people with disability, their carers, families, communities and service workers, require innovative approaches to policy and practice to ensure that culturally safe and appropriate services are available to people living in remote areas. The crucial necessity of getting these things right in order for the A<u>n</u>angu to live a good life on their Lands was discussed in a companion paper which found the essential elements to be "connection to their Lands, being with family and engaging in cultural activities" (Dew et al., 2019, p. 1).

3.6 Culture and practice

3.6.1 Traditional law and culture

Kwan (2015) cited research stating that in pre-colonial First Nations communities men and women had distinct roles which were complementary and non-hierarchical, and where women's role in reproduction was revered. Violence against women and children existed, but was relatively rare. Offenders were swiftly dealt with through systems of control and punishment under traditional law. With European settlement, "people lost their identities, roles, traditions, and language" (p. 3).

Other research has similarly noted that the maintenance of traditional law and culture by communities has been circumscribed by Western laws, quoting an Elder as saying:

> In Culture, uncles, brothers, cousins played a central role as protectors of women and children. They would physically punish violent men. Remove them from the community, banish them if they were really bad. Sometimes both parties would be growled by the community if both to blame and were neglecting children. Senior women look after and protect female victims ...The white system does not recognise the rights of other kin to intervene, it's just between man and wife and the state–children are their property–but in our culture child rearing is carried out by uncles, aunties, grandmothers (Blagg et al., 2020, p. 42).

Participants in this study were concerned that policies around FDV placed too much emphasis on gender inequality issues to the detriment of other relevant issues. Eight key recommendations were drawn from the research, focused on community-owned safety, justice, and other strategies led by Elder and Women's and Men's groups with support and resources from government (pp. 64-65).

Recognition from governments and the legal profession of the need for processes that can accommodate Culture in dealing with Australia's First Nations peoples who become involved with the legal system has resulted in the creation of a range of specialist courts and diversionary programs in some jurisdictions. These include the Koori Courts in Victoria, the Murri Courts in Queensland, and the Nunga Courts in SA. Circle Sentencing, where Elders and the families of the victim and the offender work with the magistrate to determine an appropriate sentence, is available in 12 local courts across NSW for First Nations people who plead guilty to a summary offence. The Drug Court of NSW also operates as a specialist court, operating a case management system that involves judges working with court teams and community agencies toward the prevention of drug-related offending. Similar diversionary programs exist in the ACT, Victoria, and Queensland (Australian Law Reform Commission, 2017b). Two specialist courts in WA – the Kalgoorlie Community Court, and the specialist FV Barndimalgu Court – were abolished in 2015. In 2018, the ALRC noted that no specialist courts or diversionary programs for First Nations people existed in WA or in the NT (Australian Law Reform Commission, 2018). The NT Government has since released a draft Aboriginal Justice Agreement (AJA), accompanied by a report into the processes by which the draft agreement has developed (Department of the Attorney-General and Justice, 2019a, 2019b).[45] Over the life of the AJA it aims to:

- reduce reoffending and imprisonment rates of Aboriginal Territorians;
- engage and support Aboriginal leadership;
- improve justice responses and services to Aboriginal Territorians (Department of the Attorney-General and Justice, 2019b, p. 14).

In WA, it seems that the Barndimalgu Court in Geraldton has been revived. The Court hears FDV matters, and "provides offenders with the opportunity to complete programs to address their violent behaviour before the final sentence is delivered" (Magistrates Court of Western Australia, 2021b).[46] Other services available through the Magistrates Court include the free Aboriginal Mediation Service, an Intellectual Disability Diversion Program Court and the Start Court, specialising in offenders with mental health issues; neither of these courts, however, is specifically First Nations focused. The Aboriginal Benchbook for Western Australian Courts is a resource for the judiciary "to alert them to cross-cultural issues which may arise in the conduct of court proceedings involving aboriginal (sic) people" (Magistrates Court of Western Australia, 2021a).

3.6.2 Culturally specific programs

The independent organisation Our Watch, established in Victoria in 2013 and supported by the Commonwealth and each state and territory government, has produced a range of reports focused on the prevention of violence against women and children, including an important background paper on understanding violence against First Nations women and their children.

This resource was developed over two years, with an Advisory Group comprising First Nations women from each state and the NT, and encompassed a number of individual and small group research interviews and over 400 people in group consultations. The voices and perspectives of First Nations men were valued and included. The resource was formally reviewed by 12 practitioners and academics (Our Watch, 2018b). The three underlying drivers of violence against First Nations women and children were identified as: for First Nations people, families and communities, the ongoing impacts of colonisation including past and contemporary racism, discrimination and structural and systemic violence; for non-Indigenous people and society, addressing and challenging inequality, discrimination, ignorance and racism; and general and specific gendered factors (Our Watch, 2018b). The first two of these factors have been considered in research presented earlier in this review.

The Change the Story framework identified gender inequality for women in Australia generally as the main driver of violence against women, founded in colonial patriarchy imposed on both men and women, and with four main elements: condoning violence against women; men's control of decision-making and limits to women's independence; stereotyped constructions of masculinity and femininity; and disrespect towards women and male peer relations that emphasise aggression (Our Watch, 2015). For First Nations women, however, these gender issues are compounded by the effects of the first two drivers noted above, resulting in "the 'double bind' of gender and racial discrimination and oppression", and by their effects on First Nations men, who as men within a patriarchal system are afforded access to power and dominance, but as First Nations men are denied it, which can lead to a 'loss of identity' in the absence of traditional or contemporary male roles or responsibilities (Our Watch, 2018b, pp. 66-67). The report asserted that the high levels of violence against First Nations women is driven by this intersection of racism and sexism (p. 65).

The resource noted, among other statistics rehearsed elsewhere, that almost 11% of the burden of disease for First Nations women aged 18-44, is due to IPV, and this is 6.3 times higher than for non-Indigenous women. The high incidence of violence against First Nations women is said to be the 'leading reason' for high rates of child removal from First Nations families. Prevention rests on addressing the drivers identified above through education, individual and collective action, and society-wide policies and practices. The resource proposed a set of principles upon which prevention should rest:

- self-determination: community ownership, control and leadership;
- cultural safety;
- trauma-informed practice and practitioner self-care;
- healing focused;
- holistic;
- prioritising and strengthening culture;
- using strengths-based and community strengthening approaches;
- adapting to different community, demographic and geographic contexts;

- addressing intersectional discrimination; and
- non-Indigenous organisations working as allies in culturally safe ways (Our Watch, 2018a).

Most recently, Our Watch, together with Women with Disabilities Victoria, have produced a national resource to prevent violence against women and girls with disabilities (Our Watch & Women with Disabilities Victoria, 2022). The ‘Changing the landscape’ project was conducted “in partnership with, and informed by, the lived experiences and perspectives of women with disabilities” (p. 6). It situates itself within the social model of disability and applies an intersectional feminist approach. Following an introduction and explanations of foundations and principles, the Our Watch report described the types, prevalence and perpetrators of violence against women and girls with disability, and the contexts in which it occurs. The final three sections of the report are focused on the causes of violence, the actions that can be taken to disrupt and prevent it, and the principles which support effective and sustainable preventative action. It is a companion document to the 2015 Change the Story framework referred to above.

As in Australia, the traditional ways of Canada’s First Nations communities have been disrupted by colonisation and its practices such as forced assimilation and child removal, leading to intergenerational trauma and a range of consequential personal, economic and social harms (Browne, 2007; Denison et al., 2013; Ferdinand et al., 2019). This also places Canada’s First Nations women at significantly greater risk of FDV than are non-Indigenous women (Daoud et al., 2013), with Kwan noting that around 65% of Canadian First Nations communities are affected by FV (Kwan, 2015).

The *i*HEAL (Intervention for Health Enhancement After Leaving) program, designed by four Canadian academics researchers who were also registered nurses, aims to improve the health and quality of life of women after they leave an abusive relationship (Ford-Gilboe et al., 2011; Wuest et al., 2013; Wuest et al., 2015). The program is trauma-informed, women-centred, and strengths-based, founded on the belief that after leaving an abusive relationship “women typically experience multiple intrusive stressors that compound the negative health effects of violence over time” (Ford-Gilboe et al., 2011, p. 201). Women suffered intrusions from continued contact by the abuser, and from the economic and social costs of leaving. The *i*HEAL program is delivered in face-to-face meetings over a period of six months, by registered nurses in concert with an advocate, such as a DV worker.

In light of research finding conventional services and interventions, or adaptations of them, tend not to work and are in some cases harmful for First Nations women (Browne, 2007; Denison et al., 2013), Varcoe and colleagues (2017) developed the health promotion intervention ‘Reclaiming our Spirits’ (ROS) based on the iHEAL program. The ROS program used revised intervention materials and approaches, included a steering committee comprised of First Nations women with expertise in FDV, and followed revised principles based on an Indigenous lens, Cree concepts, results from interviews with Elders, and the *i*HEAL prior research. The pilot study was conducted in one inner city Canadian city with 21 participants from a range of First Nations communities, all of whom had experienced abuse from a partner within the past 12 months, and most of whom had experienced sexual abuse and/or abuse as a child.

In addition to the features of the *i*HEAL program, ROS introduced Elder-led information Circles which, over time, became cultural teaching and ‘sharing Circles’. These evolved in response to feedback from the women to become a shared model delivered by Elders in concert with registered nurses, with support from the research team and others. A further study conducted in two cities with 152 First Nations women found similarly that *i*HEAL, tailored for First Nations women, was promising, but that the sharing in the Circles was a source of trauma and tension for a number of the women. The researchers concluded that “different or more intensive approaches for women who are most highly marginalized by poverty and racism” may be needed (Varcoe et al., 2021, p. 22).

3.7 Men’s programs

> As you know, we are dedicated to the delivery of a First Nations action plan on women and family violence... What is really important from a policy perspective – and I had this portfolio when we were in Opposition – is for mainstream Australia to understand First Nations women may have a different view on the best way to deal with this... I know that when I went out and spoke to women about this particular issue, our women, they had a very strong view about the role of men, the importance of programs for men, the importance of listening to men. (The Minister for Indigenous Australians, Linda Burney, speaking to the Wiyi Yani U Thangani First Nations Women’s Safety Policy Forum on 12 September 2022)

The development of a proposed violence prevention framework proposed by White Ribbon Australia was conducted in partnership with a 10 member knowledge circle of researchers and knowledge holders, both men and women, from urban, regional and remote communities across Australia (The Healing Foundation et al., 2017). In common with other research, it proceeded from a recognition of the need to first situate violence in First Nations communities and responses to it within historical and continuing effects of colonisation such as founding and structural violence, disempowerment, cultural and family breakdown, child removal, and intergenerational trauma. The knowledge circle proposed that policies to support violence prevention for First Nations people include:

- an Indigenous theoretical framework to understand and respond to violence;
- recognition that violence against Aboriginal and Torres Strait Islander women is not a cultural response;
- recognition of the cultural determinants of Aboriginal and Torres Strait Islander health and wellbeing; and
- understanding of how existing policy and funding frameworks create barriers to Aboriginal and Torres Strait Islander men and boys’ programs and program evaluations (p. 15).

Five elements were proposed by the knowledge circle as crucial to a First Nations framework. First, strong and respected cultural governance that allows for cultural processes and community ownership of issues and their solution. Second, a commitment on the part of services and agencies to co-design of programs, providing the opportunity for community members' expectations, needs and advice to inform processes, and indicators of genuine engagement and successful outcomes. Third, it must be based on "[s]trengthening ties to culture, country and kinship", empowering men to "explore their role as strong, proud leaders and protectors" (pp. 28-29). Fourth, it must be underpinned by First Nations values and principles of respect, accountability and confidence, safety, respect for identity and kinship, and support for cultural governance. Finally, it must create safe spaces for trauma-informed healing, such as a fishing trip or other outdoor cultural activities, where men will feel safe to engage. The knowledge circle identified this last element as "particularly crucial for Elders and older men to pass down cultural knowledge to younger men and boys, including education about cultural responsibilities and respect for women" (p. 33).

A number of gaps were identified by the knowledge circle, including improving the evidence base around the performance and outcomes of First Nations FV programs, increasing commitment to First Nations program evaluation, requiring First Nations led approaches and First Nations specific frameworks. The report noted, in particular, comments from other researchers (Blagg et al., 2015; Carey, 2013, in Blagg et al. 2015) that evaluations of programs should focus on the needs of users, not the requirements of funders. The knowledge group identified limited opportunities for First Nations women's voices, and an absence or exclusion of First Nations men's voices, in policies and programs around FDV prevention. The establishment of reference groups of First Nations men and women at all levels of government was recommended to support prevention programs. Finally, the knowledge circle noted that funding for programs is either inadequate or non-existent, with adequate and recurrent funding a necessity to allow for programs to build capacity and trust within communities. Case studies are interspersed throughout this report of effective men's programs that embrace these values and demonstrate elements of good practice identified by the knowledge circle: Our men, our healing (The Healing Foundation, 2021) in the NT; the Safer families, safer communities: Kimberley Family Violence Regional Plan 2015-2020 (Department for Child Protection and Family Support, 2015), and Quop Maaman – The Aboriginal fathering project, both in WA;[47] and Dardi Munwurro in Victoria.[48]

Langton and colleagues (2020) reported on the multi-sited research project, 'Improving family violence legal and support services for Aboriginal and Torres Strait Islander men who are perpetrators of family violence'. This study "focuses on the journeys of Aboriginal and Torres Strait Islander men through the family violence legal and support system" (p. 61). It involved an audit of FDV-related legislation, child protection regimes and relevant family law across all Australian jurisdictions,[49] and fieldwork conducted in Mildura, a regional town beside the Murray River in the north-west of Victoria, and in the twin border cities of Albury (NSW)/Wodonga (Victoria) separated by the Murray River further to the east. The researchers conducted 27 individual interviews and 22 focus groups with a total of 97 participants including professionals and paraprofessionals, First Nations men who had perpetrated violence, and First Nations and non-Indigenous community members, both men and women, including Elders and community leaders.

This is a comprehensive study, covering a broad range of issues involved in FDV, its causes and ramifications, and the services available or needed for First Nations people experiencing or perpetrating it. It revealed a range of inadequacies in available services and barriers to access and use by First Nations people. These included issues with funding, lack of availability, cultural competence, and privacy for clients. Men's healing programs, with a focus on Elders, holistic healing, on men supporting men through yarning (see Lin et al., 2016) and camping on Country, are all offered as useful alternatives. Within male behaviour change programs, the study identified that some had been co-facilitated by a female, which does not meet cultural gender-based needs. The study also noted that the training required for facilitators was not available in some regions.

3.8 Promising practice

3.8.1 FDV services

In a 2010 paper, Cripps and colleagues commented that "the reality often is that governments and service providers find Indigenous victims of violence with disabilities as a group 'too hard to handle'" (Cripps et al., 2010, p. 3). First Nations people and service providers from four Victorian communities participated in 1:1 interviews and focus groups, to explore and suggest new ways for how FV services and the disability sector worked together in supporting First Nations women with disability experiencing FDV. This study found that where available, mainstream services were not effectively meeting the needs of First Nations women and children with disability who were experiencing violence. Issues raised by service worker participants included that policies designed to improve services did not 'filter down' and as a result, service delivery could often be 'hit and miss'. There was an identified need for support for networking between sectors, training, and support and monitoring of workers. The lack of cross-sector collaboration, notably between gender-based and violence directed at a person living with disability, has frequently been flagged as a significant barrier in responding adequately to First Nations women with disabilities experiencing violence. One participant in this research said that:

> ... [often] people are just ignorant, and think that the disability [our] women have is being black and that their ...disability isn't even seen (p. 5).

Funding was a major frustration, as "budgets don't cater for disabilities" (pp. 5-6), such as in the example given where there would be no funding available to provide a deaf woman with an Auslan interpreter. The authors commented, further, that "services ... continue to operate as silos to the detriment of clients" (p. 6). Action was needed to build knowledge, including an increased collection of prevalence data, as well as increasing the availability of culturally appropriate help and the implementation of proactive prevention strategies.

The Kambarang Place Aboriginal Women's Refuge, run by Ruah Community Services and located in metropolitan Perth, is a First Nations specific service for women aged 18 years and over without accompanying children, who are experiencing FDV, homelessness or other life crisis. Kambarang is both women-specific and a mental health primary service. It incorporates First Nations culture and provides a wide range of culturally appropriate support and services including short term crisis accommodation, advocacy, referrals, and case management addressing AOD, housing, financial, legal and mental health issues.[50] In identifying Kambarang as exemplifying promising practice, we acknowledge that of course there will be other refuges for First Nations women, both in WA and in the other states and territories, that we were unable to speak to for this study, that also do so.

Research conducted in partnership with First Nations women service users and three DV services, Alice Springs Women's Shelter (ASWS) and the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) in NT/SA/WA, and the Domestic Violence Crisis Service (DVCS) in the ACT, used an iterative process to uncover what mattered to the women using the services (Holder & Putt, 2019). Partner services had the shared goal that "women and children are safer and women are stronger" as a result of contact with the service (p. 916). First Nations women made up the majority of clients for ASWS and the NPYWC, while DVCS, located in urban Canberra, had a small number of First Nations clients. Different methods of engaging with the women service users were designed by the services, and the activities were conducted by a worker-researcher who explicitly communicated to participants that this was outside her usual work role. This report of the research does not focus on the results of these interactions but rather on the processes through which the university researchers, the services and worker-researchers, and the women service users collaborated in co-researching questions of what was valued by women using the services. These authors do not claim their process is best practice, but do recommend 'more boldness' in fostering such relationships, allowing "space for knowledges that have been submerged and unheralded" (p. 922).

3.8.2 Child protection

MacPherson (2010) conducted a review of literature around child protection and family services, and the collaboration or relationship between these services and those serving women experiencing FDV. While this is a Canadian study without a specific focus on First Nations women and children, it has relevance to the Australian policy and service environment given the similarly high incidences of FDV among First Nations women, and of child removal from First Nations families, here and in North America. The author noted a general consensus in a substantial literature calling for a collaborative approach to FDV interventions, and that this may be 'even more significant' for First Nations women everywhere given their higher rates and experiences of, and death from, FDV.

Barriers to such an approach are variously described in the literature as being ideological, systemic, and individual. Ideological and systemic issues included differing views on 'who is the primary victim', unequal funding arrangements for services (for example, state versus non-profit agencies), a failure to agree on best practice, inadequate resources, client confidentiality concerns, inappropriate power balances in interventions between perpetrator and victim, and a lack of focus on men and the provision of appropriate violence treatment programs. The beliefs and attitudes of individual workers can also present an obstacle to engagement between agencies. To overcome all these impediments to collaboration, the literature suggests cross-training is a first step, as is greater engagement of 'violent fathers' in addressing the need to protect mothers and children. MacPherson concluded that opportunities exist for collaboration in the common ground of "shared belief in safety, the empowerment of non-violent parents, accountability for perpetrators of domestic violence, and the disruption of the transmission of family violence from one generation to another" (MacPherson, 2010, p. 276).

3.8.3 Early intervention

The Aboriginal Cradle to Kinder Program, implemented by the Victorian Aboriginal Child Care Agency (VACCA), is a culturally secure early intervention program designed to provide intensive long-term antenatal and postnatal support up to 4 years of age (Victorian Aboriginal Child Care Agency, 2022). The program is designed for women who are pregnant or within 6 weeks post-birth, and targets young mothers, mothers with intellectual disabilities, and women who have been in OOHC. It involves strengthening parenting skills, supporting infant development, enhancing the mother's connection to community and culture, and addressing the mother's health and psychosocial challenges. An evaluation of the program found improvements in family safety, self-sufficiency (caregiver employment, financial management, nutrition and transportation) and parenting capabilities. The program recognises the importance of strong kinship connections and networks in supporting families, incorporating support for fathers and extended family, and aims to strengthen ties to culture and community.[51]

The Parent-Child Assistance Program (P-CAP) supports pregnant women and women with young children experiencing problematic AOD use (Symons et al., 2022). It is a three-year program involving home visitation, counselling and case-management. The program has a substantial evidence base in the US and Canada which demonstrates the program's effectiveness. P-CAP has recently been modified and piloted in WA, where an evaluation found significant changes in addiction severity after one year, improvements in connection to services and high participant satisfaction with the program.

3.8.4 'Safe at home'

Crinall and colleagues (c.2012) provide a history of the introduction of the 'Safe at home' strategy in Australia and in Victoria in particular. After discussing three safe at home models, the authors find that the implementation of successful programs "must be informed by Aboriginal/Indigenous understandings of family violence" (p. 42), allow for women to make informed choices, and stress the importance of perpetrators cooperating and being held accountable. Risk assessment, safety planning, and and support, including financial support, are essential, as is effective collaboration and communication between appropriate services. In their discussion of housing issues for women experiencing FDV, Diemer and colleagues (2017) noted that women are increasingly seeking to have their abuser removed, while they remain in their homes. With regard to First Nations women and women with disability, they suggested that, while implementation of the 'safe at home' strategy still involves overcoming some complex issues, it may provide First Nations women the opportunity to stay connected to land and community, and women with disabilities the ability to remain in a place that has been adapted to their needs.

3.8.5 FASD

The *Marulu* ('precious, worth nurturing') strategy was developed in the Fitzroy Valley in the Kimberley region in WA in 2008, with three priorities: to prevent FASD, diagnose FASD, and support affected families. The *Lililwan* ('all of the little ones') project was then developed to partner with the community to enable diagnosis and determine prevalence using data from all children born in 2002 and 2003 in the Fitzroy Valley (Fitzpatrick et al., 2017).[52] This study was undertaken between 2010-2013, concurrently with prevention activities, resulting in a documented prevalence of 120 per 1000 children. James Fitzpatrick and colleagues noted that the Marulu Strategy "was framed within a social ecological framework integrating policy, environmental, organisational, community and individual strategies to address a specific public health issue" (p. 469). Key drivers for the success of the strategy were the community-led approach, with community engagement and interagency collaborations, development of interventions at community level, and strong local leadership. This paper noted that the consultation and planning process for the *Lililwan* project had been commended in the 2010 Social Justice Report as a "template for research in collaboration with Aboriginal communities, and indeed with all communities" (p. 471) and that it could be applied in a number of settings. The 'Making FASD History' project, a multipronged prevention strategy in the Pilbara region of WA, Alice Springs in the NT, and Newcastle in NSW, builds on the Marulu Strategy.[53]

Most recently, the protocol for the Bigiswun Kid project (Rice et al., 2022) describes a longitudinal project to be undertaken in the Fitzroy Valley in Western Australia. It is a follow up of children who participated in the *Lililwan* Project and who are now 17-19 years of age, and is an outcome of community concerns that some of these young people were not doing well. The project was initiated and co-designed and will be led by the local First Nations community. Its aims are to conduct interviews with parent/carers and adolescents, and administer relevant assessment tools, across a broad range of topics in order to gain an understanding of the health and wellbeing status of the young people. Researchers will analyse data from the *Lililwan* project cohort to identify factors predicting good health and wellbeing in adolescence, and will gather information related to service gaps and barriers to service. The study will also examine changes to physical characteristics over time, to determine whether craniofacial features of FASD reduce after puberty which could require a change to diagnostic criteria for First Nations young people. All those who took part in the *Lililwan* project will be eligible to take part in the Bigiswun Kid project, and the researchers anticipate a participation rate of 95% (n=127). Among the expected outcomes, the project will "... provide novel, current data about adolescent health, mental health and well-being and the resilience, aspirations, and community contributions of adolescents" (p. 12).

3.8.6 Mental health and SEWB

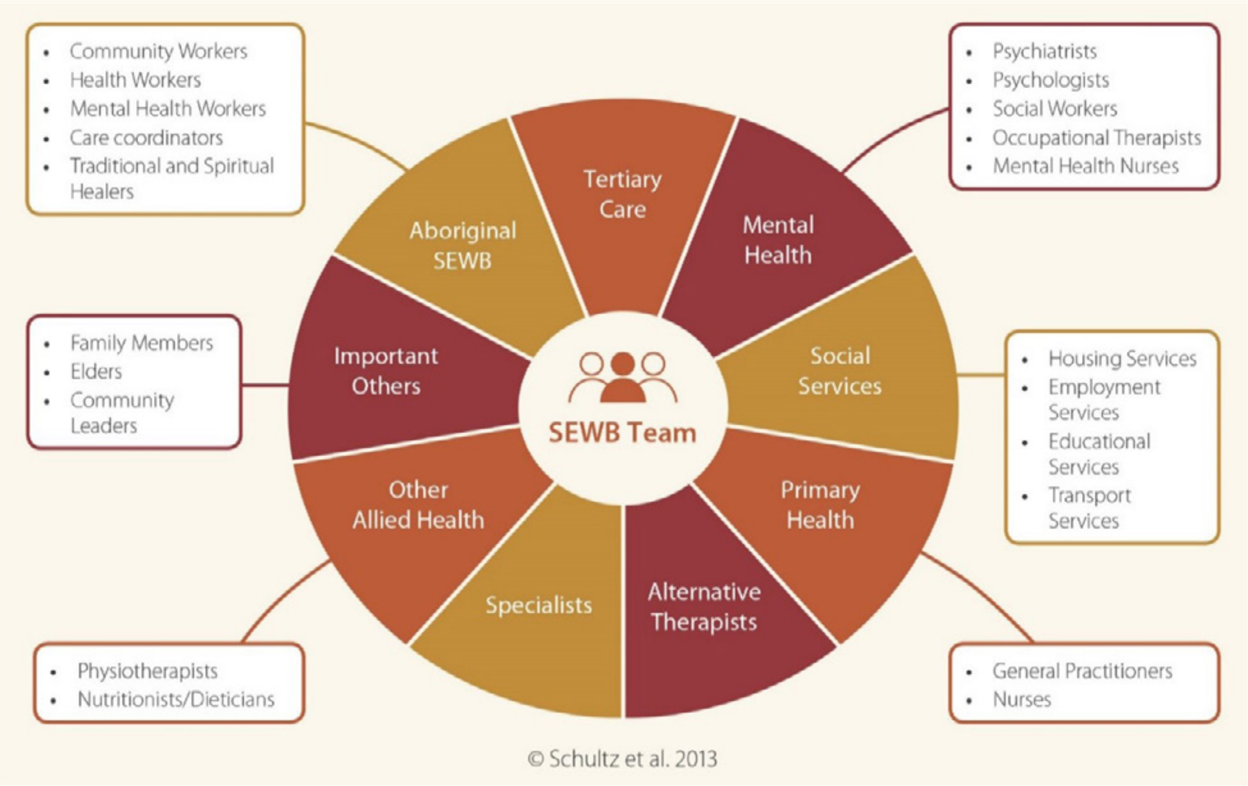
In 2013, lecturers and students in a Certificate IV in Indigenous research capacity building delivered at the Aboriginal Health Council of South Australia conducted a pilot study using a questionnaire (75 participants) and semi-structured interviews (13 participants) from NSW, SA and NT to investigate First Nations peoples' experiences of and perspectives on anxiety and depression (Axleby-Blake et al., 2013). All but two participants identified depression and anxiety as serious illnesses, with almost all having personal knowledge about them. Perceived causes identified by participants included childhood and adult trauma, including from experiencing or witnessing FDV, and loss and grief resulting from personal bereavement and from harms arising from continuing colonial policies of child removal and high rates of incarceration. Of those who participated in interviews, seven spoke of their journeys to recovery, and five struggled – four of whom were 'not yet ready to manage their conditions', and one suicided prior to completion of the study.[54] The three most highly rated health services by participants to go to for help were the GP, the AMS, and a psychologist or counsellor. The study recognised the need for a communication strategy for depression and anxiety, designed for First Nations communities. Recommendations arising from participants included following local community protocols and presenting information at a sociable event for local people, in local language, led by First Nations people, with age-appropriate educational programs including stories of resilience and examples of self-help practises. More and better mental health services, including the training of more First Nations psychologists, psychiatrists and mental health workers, and ensuring that adequate funding is available for group therapy and other programs and supports, were also canvassed.

The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing, 2017-2023 recognises the effects on social and emotional wellbeing (SEWB) of the range of issues stemming from:

> ... colonisation and its intergenerational legacies: grief and loss, trauma and abuse, violence, removal from family and cultural dislocation, substance abuse, racism and discrimination and social disadvantage (Commonwealth of Australia, 2017, p. 7).

This report describes a set of domains necessary for SEWB and related risk and protective factors, including the risk to connection to family and kinship of FV and children in OOHC, and the protective effect of the availability of “culturally appropriate family-focused programs and services” (p. 8). The framework states that management and treatment for First Nations clients should be provided by SEWB teams drawn from amongst those areas illustrated in the diagram below. It cites the proposal from the Aboriginal Medical Services Alliance Northern Territory (AMSANT) for the composition of these teams, which would include psychologists who would see clients dealing with more complex issues such as interpersonal violence (p. 39). Figure 1 below shows a model of the potential reach of a SEWB team.

Figure 1: Potential reach of a social and emotional wellbeing team



© Schultz et al. 2013

Note: (This figure has been adapted in these publications from Figure 13.2 in Schultz et al., 2014, p. 230).

This diagrammatic model is replicated and cited approvingly in the Aboriginal Community Controlled Health Services (ACCHS) SEWB service model proposed for WA, while noting that members of interdisciplinary teams must have an understanding of First Nations communities and of the many factors affecting peoples' SEWB (Aboriginal Health Council of Western Australia, c.2018, p. 8). Findings from consultations with staff from 17 Aboriginal Health Council of WA (AHCWA) member services found a range of concepts of SEWB, and qualities required for SEWB services, were shared by participants (p. 5), including a need for after-hours services for prevention and early intervention for FV, and for targeted interventions such as "culturally secure assessments, referral and support responding to" FDV, return to Country programs, and culturally appropriate support for mental health care plans (p. 7).

3.8.7 Complex care outside metropolitan areas

McCausland & Dowse (2020) examined the 'institutional pathways and interactions' of 'Casey', a young First Nations woman living in a remote NSW town who had been diagnosed with ADHD, conduct and adjustment disorders, and personality disorder. At 17 years of age she was further diagnosed with bipolar affective disorder. As well, she had been assessed as having an IQ of 64, and as having a developmental delay. From the age of 12, Casey had repeated contact with police, admissions to hospital under the *Mental Health Act*, multiple episodes in juvenile custody, OOHC, and hospital admissions for threats of and attempts at self harm. At age 18, Casey was incarcerated in a specialist acute female unit in an adult prison and on release was placed in an intensive 24-hour supported accommodation service in the care of the NSW Community Justice Program. The total institutional costs of failing to support Casey were calculated to be just over $6.8 million.

In their discussion of the ways in which Casey could have been better supported, the authors identified five elements that “may have created the foundations for a more community- and culturally-led and integrated multisystem response” (p. 331). These were: holistic and flexible models of support; a therapeutic, trauma-informed approach rather than punitive response; diversionary options at all stages of contact with the criminal justice system; disability, gender and culturally-informed policy and practice; and the provision of local, culturally safe services through a local ACCHO.

3.8.8 Men’s programs

The specialist First Nations FV service Dardi Munwurro (Strong Spirit) has been in operation since 2000. It provides a number of FV programs for First Nations men and youth, aiming to “empower and inspire individuals to heal the past, acknowledge the present and create a positive vision for the future”. There are two programs focused on men’s healing and behaviour change:

- the Ngarra Jarranounith Place residential program for men who use or are at risk of using FDV, involving completion of a 16-week program of one-on-one support and group work, followed by support for up to 18 months; and
- a community and prison program, run over around 40 hours, covering a range of topics including accountability, First Nations identity and connection, conflict resolution, understanding emotions, understanding violence, and respectful relationships.

And:

- A variety of men’s camps, separately and including as part of programs for healing & behavioural change and First Nations men’s leadership training.
- The Bramung Jaarn program, a mentoring program for young men aged 10-25 years, one-on-one with Elders and strong positive volunteer mentors. The program focuses, among other things, on respectful relationships, identifying emotions, developing life skills, and cultural connection.
- A brother-to-brother 24-hour crisis line, staffed by First Nations men, including Elders, with lived experience who can provide support for men struggling with issues around issues such as FV, parenting, and drug and alcohol or relationship issues.
- As part of their prisons program, as well as the Healing and Behaviour Change program Dardi Munwurro also runs 3-day workshops with follow-up group work sessions, on FV and healing.

- A family services unit, supporting the women and children of men in Dardi Munwurro programs who have committed FDV, as well as providing workshops and training programs for women in the general community.

Dardi Munwurro also runs regional gatherings throughout the year, and the annual Victorian Aboriginal Men's Gathering, which welcomes First Nations men from across the country to Melbourne to discuss issues of importance to the First Nations community (see Gupta et al., 2020). Dardi Munwurro's three programs have been recently examined in a cost-benefit analysis undertaken by Deloitte Access Economics (2021), using both qualitative and quantitative methods. The Deloitte report found that the programs had positive impacts in areas such as incarceration and substance abuse, and had achieved a 100% reduction in homelessness for clients who had completed the programs. The Healing programs were demonstrated to have had positive effects on the participants "across a range of behavioural and social domains" (p. 18), including accepting responsibility for violent and controlling behaviours and an increased understanding of its impacts, and managing emotions without choosing violence. The results of Deloitte's cost-benefit analysis showed that "each dollar invested into Dardi Munwurro is estimated to provide a return on investment of 50%-190%", noting that this was a conservative estimate of the benefits of its programs (p. 5).

3.9 Summary

For reasons extensively canvassed in the literature, First Nations women and children are at greater risk of experiencing all forms of FDV than their non-Indigenous peers, and First Nations women and children with disability are at even higher risk, with consequent increased susceptibility to compromised mental health and wellbeing. Despite some improvement over recent years, the relative disease burden remains higher for First Nations people, and First Nations children are still at significant risk for conditions which can have lifelong detrimental effects.

While prevalence is known to be high, FDV is under-reported and available services are under-utilised by First Nations people. Various reasons for why this might be so are discussed in the literature. These include barriers to services including availability, accessibility, racism and cultural safety, with additional issues related to distance for those living in regional, rural and remote communities. A further barrier to reporting or accessing services is the fear of becoming involved with child protection authorities. First Nations people are at greater risk of involvement with child protection, and First Nations children, particularly those with disability, are more likely than their non-Indigenous peers to be removed from their families. Involvement with the justice system – as victim or offender – and of being incarcerated, is also higher for First Nations people, with increasing numbers of First Nations women in prison, having significant detrimental effects on family and community. Substantial numbers of these women have experienced FDV and have been shown to have mental and other health conditions.

This review makes no claim to being exhaustive; however, the academic and grey literature reviewed clearly demonstrates the need for significant and targeted action and resources to be deployed to address issues of FDV for First Nations women and children with disability, and more broadly for First Nations women and children, men, and communities. National and state policies have recently been updated reflecting a recognition of the need for greater investment in FDV education, prevention, and harm reduction strategies. For First Nations people, current approaches such as culturally specific men's programs, focused health and social support programs, and the inclusion of First Nations Law and Culture in the justice system, have shown promise, but the literature makes clear that there is very significant work to be done at all levels. Current promising practice as discussed in the literature requires, among other things, collaborative approaches to FDV within and between services, a recognition of the barriers that exist and of the need for cross-training of health and other professionals, and training more First Nations professionals, in particular mental health professionals. Community-led approaches involving strong local leadership, giving voice to First Nations women and respecting their opinions and advice, are essential to establishing an environment that will provide safety for women and children and progress healing for First Nations communities. First Nations men must be part of the conversation and involved in any resulting strategy.

4. Methodology

4.1 Project Outline

4.1.1 Community-led participatory research

As a Participatory Action Research (PAR) project, a number of steps were taken to ensure our research methods were culturally safe, including a commitment to supporting the self-determination of First Nations communities through community-driven recruitment, the use of strengths-based methods for data collection, and developing a Aboriginal Leadership and Advisory Group (ALAG) of leaders and people with lived experience to act as co-researchers.

4.1.2 Working definitions of disability and violence

A First Nations cultural lens was applied throughout the design, implementation and interpretation of results of the project, including informing the definitions of disability and violence adopted within the project. This research recognises that:

> The concept of disability is a western one. Many Indigenous organisations pointed out that Indigenous people often do not use or recognise the term ‘disability’. People in communities frequently recognise that someone is ‘different’, but this difference tends to be accommodated where possible. When a person’s difference is manageable their various impairments are viewed as simply one part of the person but are often not considered central or core to one’s identity (Sotiri et al., 2012, p. 8).

A First Nations lens recognises intergenerational trauma resulting from colonisation and associated practices as the root cause of family and domestic violence (FDV), as defined in the glossary to this report. In keeping with these positions, within our project disability is defined by how the community and the individual perceive it, meaning that the research must be inclusive of all who identify as having a disability, regardless of diagnostic status. This is of particular importance given the significant barriers to obtaining diagnoses in remote and underserviced communities.

4.1.3 Culturally safe data collection framework

The research team developed a culturally safe data collection framework (Figure 2 below) to guide the research, to ensure that all aspects were conducted in a culturally safe manner. This research project considered cultural safety as:

> ... re-claiming cultural norms and creating environments where Aboriginal people transition; first from victimhood to survivors of oppression, through to seeing themselves and their communities as achievers and contributors (Victorian Aboriginal Child Care Agency, 2011).

The framework includes an appropriate debrief and referral process for participants who may relive traumatic events and become upset. All participants undertook the post-interview debrief with the facilitator/interviewer at the conclusion of data collection.

Figure 2: Working within the community's definition of disability

4.1.1 The ALAG and community partnerships

The ALAG was developed to act as co-researchers and provide the project with critical oversight informed by lived experience, ensuring that the research was culturally appropriate, responsive to participants' needs, and relevant to each region (Australian Institute of Aboriginal and Torres Strait Islander Studies, 2020). The ALAG was composed of First Nations Elders, women, children and young people with a disability from each of the key sites. Elders and community leaders provided local leadership and expertise, connected the research team to the community, and will assist with dissemination of findings back to the communities. The women, children and young people with disability worked with the research team to develop research methods and questions that were both culturally safe and disability inclusive, and to highlight any possible risks to participants. Before commencing data collection at each site, members of the research team conducted pilot interviews with women and children on our ALAG, which provided us with critical feedback and insight into participant experiences.

The research team also established partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs), including Broome Regional Aboriginal Medical Service (BRAMS), South West Aboriginal Medical Service (SWAMS), Bega Garnbirringu Health Service, Derbarl Yerrigan Health Service, the KM Noongar Consultancy Services, and disability services including Richmond Wellbeing and Life Without Barriers. These organisations played a key role in governing participant recruitment through their respective community networks, and also contributed by providing venues for data collection and support to participants on the day. This ensured that yarning sessions took place within a familiar culturally safe space where participants were comfortable.

4.2 Our research questions

First Nations women and children/young people (aged 12–17 years) with a disability were asked about:

- The nature of their disability and whether it developed as a result of violence.
- Their experiences of family violence (FV) as an Aboriginal[55] person with a disability.
- How the intersection of these identities influences their vulnerability to experiencing violence.
- Their experiences seeking support and how they believe services may improve their ability to respond to FV.

Caregivers of First Nations women and children with a disability were asked about:

- How caregivers support Aboriginal women and children with a disability who are experiencing violence.
- How may we better support caregivers of Aboriginal women and children with a disability in their role.

Key stakeholders including Elders and other community leaders, disability services, and ACCHOs:

- What are your experiences working with Aboriginal women and children with disabilities?
- What support works well for Aboriginal women and children with disability?
- What are the barriers preventing you from providing best practice services?
- Does your organisation have any specific guidelines/policies outlining how to work with Aboriginal women and children with a disability who have been exposed to violence?

4.3 Methods

In keeping with an Indigenous research framework, our research methods consisted of yarning circles and one-on-one yarning sessions, which included the use of art-based techniques. Each of these are culturally safe methods to engage with First Nations people in exploratory qualitative research (Bessarab & Ng'andu, 2010; Geia et al., 2013). Yarning:

> ... in a semi-structured interview is an informal and relaxed discussion through which both the researcher and participant journey together visiting places and topic of interest relevant to the research study. Yarning is a process that requires the researcher to develop and build a relationship that is accountable to Indigenous people participating in the research (Bessarab & Ng'andu, 2010, p. 37).

Art-based techniques included creative painting on canvas, and painting boomerangs and stones. Art activities were offered to women and children as a way of engaging participants and building a rapport. Where appropriate, women were offered the option to participate individually, or in a yarning circle.

4.3.1 Ethics approval

Ethics approval for this project was obtained from the Western Australian (WA) Aboriginal Health Ethics Committee (WAAHEC) (Ref: 1098) and Curtin University Human Research Ethics Committee (HREC) (Ref: 2021-0620).

4.3.2 Ethical considerations

4.3.2.1 Inclusion criteria

- First Nations women or young people (12 – 17 years) with a perceived or diagnosed disability and experience of FV.
- Primary caregivers of First Nations women or young people with a disability and experience of FV.
- Key stakeholders who provide a service to the primary target groups.

4.3.2.2 Exclusion criteria

- Those with severe mental illness (SMI) or profound cognitive impairment and complex communication needs were not included in the project.

4.3.2.3 Participant reimbursement

Participants (women and children) were provided with a $50 voucher as reimbursement for sharing their time and knowledge.

4.3.3 Informed consent

Prior to commencing data collection, all participants were provided with a Participant Information Form (tailored to meet age and/or cognitive needs), which included a written explanation of the aims of the research, what was expected of them, any potential risks, and how their data would be used. This was supplemented by a verbal explanation of the project and their role by an Aboriginal research officer, who assessed whether each participant had the ability to provide valid informed consent and would benefit from participation in the project. Both written and verbal consent were obtained from participants prior to the commencement of data collection, including an affirmation of their understanding that they could choose to withdraw from the interview at any time. In addition to children and young people providing individual consent, their parent/carer was asked to assess their ability to participate in the research and to provide consent on their behalf.

4.4 Trauma protocols

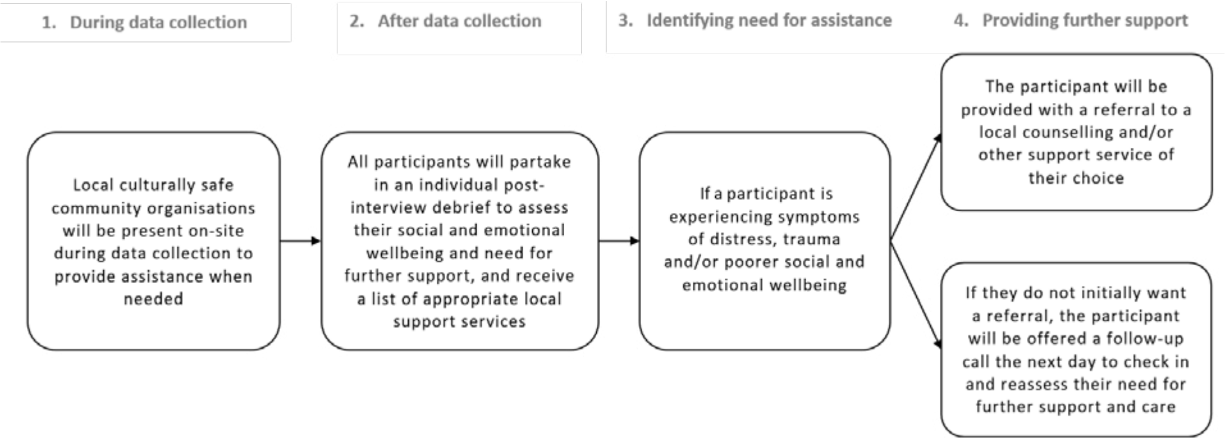
Recognising the limited utility of western definitions of trauma, the experience of trauma in First Nations peoples must be understood through an examination of sociological and historical perspectives, community wellbeing, and the intergenerational transmission of trauma (Atkinson et al., 2014). Despite the uniqueness of every First Nations community and of each individual's lived experiences, the impacts of intergenerational trauma, institutional abuse, and other harms stemming from colonisation and government practices are common themes in the experiences of many of Australia's First Nations peoples (Eades et al., 2021).

The exploratory nature of qualitative research, which enables researchers to gain an in-depth understanding of relatively unknown and understudied phenomena (Liamputtong & Ezzy, 2005), is particularly useful in gaining an understanding of marginalised perspectives and experiences. Culturally safe qualitative research with participatory approaches is therefore considered an appropriate method for exploring the lived experiences of First Nations peoples and factors affecting their health and wellbeing (Eades et al., 2021). We acknowledge the potential for vicarious trauma in exploratory qualitative research and the need to address this, and as such we have developed protocols to safeguard both participants and researchers. This is an effective and validated process which has been used previously by Dr Jones & Dr Wilson for research with vulnerable populations to assess whether a participant or researcher needs follow up support and care.

4.4.1 Safeguarding participants

Participation in qualitative research by sharing one's experiences has the ability to trigger past traumatic events causing emotional distress, particularly where the topic of research is of a sensitive nature and/or where participants are considered 'vulnerable' (Draucker et al., 2009). Research is considered sensitive if it exposes the participant to the risk of inducing or exacerbating emotional distress. To address this risk, we have developed protocols to safeguard participants from experiencing distress and re-traumatisation during and after the yarning sessions (Figure 3). In addition to the debrief and referral process, other evidence-based strategies that were used included ensuring interviewers received appropriate training to handle psychological distress and trauma, exercising continual awareness of participants' emotional reactions during yarning, and providing frequent breaks to participants.

Figure 3: Participant trauma and distress protocols

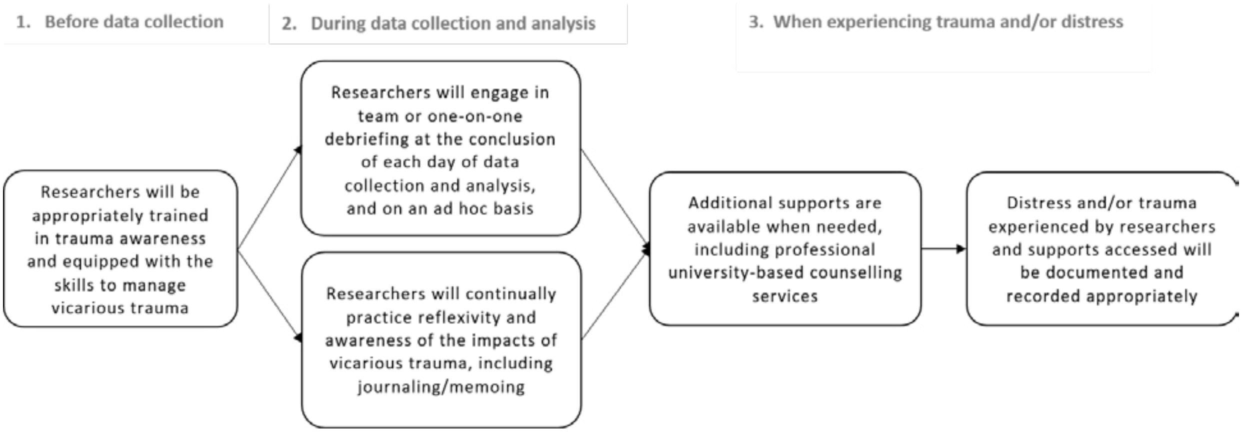


4.4.2 Safeguarding researchers

It is critical that First Nations researchers lead research undertaken in First Nations communities, particularly in qualitative research which explores peoples' subjective lived experiences and stories (Geia et al., 2013). Repeated exposure to traumatic material, however, has the potential to negatively alter the worldview of the researcher/clinician, which can impact relationships and manifest as a spectrum of affective and behavioural responses, including feelings of anxiety, depression, burnout and compassion fatigue (Molnar et al., 2017).

Vicarious trauma is the process through which "the therapist's inner experience is negatively transformed through empathic engagement with clients' traumatic material" (Pearlman & Saakvitne, 1995, p. 279). A recent pivotal study by Eades and colleagues (2021) on vicarious trauma in First Nations research highlighted the necessity of addressing this issue for researchers through involvement in appropriate training, engagement in reflexive practice, and the provision of an appropriate debrief process. As outlined in Figure 4 below, we used a number of these strategies to protect researchers from the impacts of vicarious trauma throughout data collection and analysis.

Figure 4: Researcher trauma and distress protocols



4.5 Data analysis

Audio-recorded interview transcripts were stored and coded using the software program NVivo.[56] Using grounded theory, data were coded independently using the constant comparative process whereby data are broken down, conceptualised, and pieced back together to establish analytical categories and dominant themes (Rice & Ezzy, 1999). Data were initially coded by three team members independently, before coming together to discuss identified themes and reach agreement. This process included member-checking, in order to reflect initial findings back to participants and communities to ensure identified themes accurately encompassed their intended meanings.

5. Results

As a qualitative project using a Participatory Action Research (PAR) methodology, we travelled to five key sites situated within the regions throughout WA – Meekatharra, Bunbury, Kalgoorlie, Broome, and the Perth metropolitan region – to engage with local communities and listen to their stories (Figure 5 below).

Figure 5: Map of WA showing participant breakdown at each site

We engaged with First Nations women (Table 1 below) and young people (aged 12 to 17 years) with a disability, as well as with caregivers and key stakeholders including community leaders and disability services staff, in order to gain a deeper understanding of experiences from multiple perspectives. Through yarning circles and one-on-one yarning sessions, including art-based techniques for the children and young people, we gathered their stories to explore the factors which they believed open them up to a risk of violence, and critically, the barriers and enablers impacting their capacity to seek assistance and support. Speaking with key stakeholders allowed us to also gain an understanding of the barriers they saw as preventing them from providing best practice support to their clients and communities, and of the changes they believed could be made to better support them in their roles.

Table 4: Age range of women participants

Age range of women participants (years)	% (n=35)
20-29	14% (5)
30-39	17% (6)
40-49	23% (8)
50-59	23% (8)
60-69	11% (4)
70-79	9% (3)
Not stated	3% (1)

Table 5: Living arrangements of women participants

Living arrangements of women participants	% (n=35)
Living in own home (including Department Housing)	54% (19)
Staying with relatives or couch surfing	23% (8)
In a refuge	17% (6)
Camping or sleeping rough	6% (2)

Table 6: Disability[a] type of women participants

Disability[a] type of women participants	% (n=35)
Psychosocial	57% (20)
Chronic health condition	34% (12)
Physical (including ABI)	20% (7)
Visual or hearing	6% (2)
Intellectual or neurodevelopmental	6% (2)
Undiagnosed or unsure of their disability	11% (4)

[a] Totals in this section do not add to 100% as some of the women had more than one disability.

The majority of women (32) opted to speak to us in an individual yarning session. We conducted one yarning circle, with women with disability:

- 1 x Perth (3 participants).

Yarning with children was conducted one-on-one, with carers present in two of these sessions.

Of the 35 women and 10 children we yarned with, 11 women and two children requested to be referred for follow-up support and care, as per our culturally safe data collection framework (fig. 1) and participant trauma and distress protocols (fig. 2). Five referrals were made to Aboriginal Community Controlled Organisations (ACCOs), three to government health services, four to the participant's support worker and one to the Department of Education. Members of the research team made 18 follow up phone calls to participants.

Key stakeholders, including community leaders, Aboriginal Community Controlled Health Organisations (ACCHOs), disability services, and those in the family and domestic violence (FDV) sector, predominantly participated in one-on-one interviews and focus groups. We conducted the following focus groups with stakeholders:

- 1 x Broome (4 participants);
- 1 x Broome community members (10 participants);
- 1 x Meekatharra (3 participants); and
- 1 x Perth (2 participants).

5.1 Results – Women

5.1.1 Disability, comorbidities, and NDIS utilisation

Nine women had been diagnosed with depression, four with bipolar disorder, and three with schizophrenia. At least seven had been medically diagnosed with post-traumatic stress disorder (PTSD) or stated their disability was 'trauma', relating to the violence they had experienced. Twelve women were diagnosed with a chronic health condition which resulted in disability, including systemic lupus erythematosus, renal disease and type II diabetes. Some women were diagnosed with neurodevelopmental disorders, including fetal alcohol spectrum disorders (FASD), and neurological injury due to physical violence or viral infection in childhood. A number of women had disabilities impacting their mobility, with several due to injuries from road accidents and from family violence (FV). Nine women had two or more disabilities spanning multiple categories.

Three women did not have their disability formally diagnosed. Of the 32 women with a diagnosed disability, only four women had existing National Disability Insurance Scheme (NDIS) plans. Of the 28 women who were not on NDIS plans, one had a current NDIS assessment in progress, and one had previously been on a NDIS plan but had recently been taken off. Of the remaining women not on NDIS plans, two were receiving support for their disabilities through aged-care schemes and at least two were accessing the disability support pension (DSP). This illustrates that the vast majority of women we interviewed are managing their disability and the impacts on daily living without formalised/external support, financial support, or respite for their family carers.

5.1.1.1 Impact of living with disability – psychosocial

Women with psychosocial disabilities described the pervasive impact on their life, including on their independence, ability to pursue education and employment, and on their activities of daily living more broadly:

> I've been out of work 10 years now. Because of domestic violence and with my mental health, it's impossible to do anything to get back. [5W07]

A number of women with trauma and/or psychosocial disabilities which impact emotional regulation described having issues with anger. These women often spoke about violence arising from their disability, in terms of either contributing to their own use of violence or heightening their susceptibility to the violence of others:

> I was talking to Centrelink mob yesterday. I went off at them in the office… I say, I felt ashamed now for doing it. How many times do I have to prove myself how I am? I am mental, all right? They got the security to do everything for me. It was terrible. That's why I think I've got to get back on my tablets because it keeps me in tow… If someone says something bad about me, I just cry or I just get angry. [5W07]

Other women with disability spoke of their inability to contain their own stress and anger, which led them to act aggressively towards others. A participant diagnosed with bipolar disorder described "lashing out" at her sons:

> Even to the point of when my sons were getting older, in their 20s and even 30s, and I would lash out… and they would just stand there and just let me do what – whether I was whacking them or whether I was abusing them… they had enough respect to just not even walk away because that would just make me even… They didn't want to make it [disability] worse. [3W04]

Three women with schizophrenia outlined the impact of their condition on their lives, particularly on their thought processes and awareness of their surroundings. One woman described how she used to self-harm as a result of her condition, prior to receiving a diagnosis and treatment:

> I thought I heard somebody singing out my name. Then it started getting louder and then I think I blacked out. I don't remember nothing. I woke up about three days later. They said I was talking to them and everything but I don't remember talking to anyone or doing anything... I get paranoid a lot because I'm thinking – that noise and sometimes it was telling me to harm and stuff and I did do that before. [4W06]

Disability increases vulnerability to FV and other harms, as all reported issues with awareness of their surroundings, and at least one woman directly linked this to her exposure to violence and abuse:

> I went drinking with all these people and then in the morning I woke up I had no clothes on … I think 'oh if someone comes and knocked me in the head, I won't know what to do'. [5W01]

Women with schizophrenia resulting in paranoia and disorientation can have issues with not being able to trust their own instincts and subjective experience, which heightens their vulnerability. In addition to intimate partner violence (IPV), two of the women with schizophrenia experienced sexual abuse in childhood, and one in adulthood:

> But he didn't sexually penetrate. He was just playing. But he was [twenty years] older than me… someone tried to, was touching me when I was asleep, just not long ago. So I don't know if they're taking advantage of me… I was thinking it could have been that adult man in there, or it could have been that little young fella… I don't know who. I couldn't see. [5W01]

A woman diagnosed with paranoid schizophrenia described feeling anxious that a granddaughter may be experiencing something similar:

> I get suspicious about my grandchildren and that, but it, well the counsellor said it could be because of you, because you had it done to you… I get suspicious when she goes stay with her other grandparents. [5W01]

5.1.1.2 Impact of living with disability – physical

One woman with physical disability from IPV as well as a psychosocial disability, on the JobSeeker payment rather than a disability pension, described the overwhelming challenges she faces performing daily tasks:

> Just every day's hard and it's really exhausting. When I do things, like a normal – go to the toilet, go have a shower and stuff like that. It's just battling to just do everyday tasks. Like yesterday, I had an appointment with the Joblink mob... It took me half an hour to walk there... It's my legs, my ankles, my knees, my hips, my lower back. [5WFG02]

Women with other types of disabilities also described struggling with activities of daily living, due to issues with mobility, pain, breathing issues, and/or fatigue. A number of women described being unable to perform housework due to their disability:

> Oh god, pain 24/7. Some days are better than others, I can't do long walks anymore and even doing the dishes, I'm standing there crying in pain… it's a real struggle to do anything because of this pain. I'm still forcing myself to do things but it's not as good. I've taught myself how to step over things when it's dirty, because I was really pushing myself to have a really clean house and everything and that's a good standard to have but it was killing me. [1W01]

Several women had disabilities which prevented them from being able to drive:

> I couldn't drive because I got seizures... and every time when I was going from my licence, I always used to have a seizure just before I'd go and put my name down for it. So I'm like, oh well, that stopped that. [2W01]

Several other women also required frequent in-patient treatment and relied on a partner or a family member for transportation to and from hospital. Women described how difficulties with physical mobility and transportation hindered their freedom and prevented them from participating in the community:

> Sometimes I can get help, and then sometimes I can't. If I'm on my own and I need to go anywhere, I can't because if I fall over, I'm not strong on my feet. I can't get off the ground and all that sort of stuff. If I fall over and I'm on the ground, nobody's there to help me up. So, I don't go anywhere on my own. No trains or bus rides or anything. [4W02]

Women with chronic conditions and physical disabilities described their vulnerability resulting from their inability to physically defend themselves:

> I can't really stand up for myself because I'm too – some days I'm crook. [4W02]

One woman with chronic health condition and living in a community experiencing high levels of community violence was used to protecting herself and her children. As the condition took hold and she became physically weaker, she described avoiding others because of a perceived vulnerability:

> I feel that since I've been sick and they know I can't defend myself or protect myself anymore, they're doing it more to me and my children … [disability makes one] more vulnerable, but I just try and avoid that people. [4W02]

5.1.2 Disability services and NDIS support for women with disabilities

While few women had current NDIS plans, a number of women (particularly from larger regional and metropolitan areas) were accessing home care support through alternate schemes, such as the Home and Community Care program (HACC). While a few women expressed positive or neutral feelings, a number of women were dissatisfied with the service provided:

> They never help much. I was thinking they might go out and help do this, help me do that, but nothing. [5W02]

One woman required assistance with personal care such as toileting, dressing and showering. She described how her disability service provider occasionally sends her male carers due to staffing issues. This is culturally inappropriate, makes her feel uncomfortable, and as a consequence she doesn't receive proper attention to personal hygiene:

> One day, nobody working, and I ring, ring. This man come in there. I had to dress myself while... he coming on the road. He just put me out of bed. I went to [unclear]. No shower … Just sometimes happened. I don't like it. Yeah, they really slack, them people. [5W04]

One woman was recently taken off NDIS, which she attributed to a complaint she made about her coordinator:

> I know I had about $4000 for the plan for my [operation]. That's to help with accommodation and everything. But because they cut me off, it just made it harder for me for accommodation and money wise and more stress… [2W01]

Her description echoed a common theme throughout of First Nations people being punished when they advocate for themselves in mainstream disability and health services:

> [The coordinator] wasn't very helpful and it was like she wasn't really interested. She was talking down to me and a bit rude. Then I told her, 'I don't like how you're speaking to me. You're talking down to me like I'm a kid when I'm not and you're not showing that you're really concerned'… Then I rang up and I complained to her boss and that's when her boss rang back and said, 'oh no, well, there's no one else. There's no other coordinators so we're going to have to cut you off'. [2W01]

This situation resulted in this woman being effectively forced to couch-surf during her month-long recovery after travelling for surgery:

> Then the places I was staying at… I didn't want to stay at that place. I felt uncomfortable… There was a lot of cockroaches and I'm like, no, I can't stay here... I was thinking about the eggs, about the cockroaches getting into the stitching… I said, 'can't you [the doctors] make it easier on me, because you're telling me not to stress out but at the moment I am. Where I'd rather just go home where I'm closer to my family and I've got my own house and I'll be more comfortable there'. [2W01]

5.1.2.1 Impact of lack of support

The lack of external or formal support resulted in significant stress and an exacerbation of disability for many women, particularly for those with psychosocial disabilities and/or chronic illness. One woman described the incredibly disabling impacts of the sudden onset of her chronic condition on all aspects of her life living in a remote town without access to disability services, which forced her mother and young children to act as full-time carers:

> I've lost 75 per cent usage of my muscles… It was a big impact on my life and my kids' life because everything just changed. I couldn't cope with anything. I couldn't even look after my children or send them to school. [4W02]

For a woman with schizophrenia in a remote town, the years between the onset of her condition and diagnosis and treatment were extremely challenging:

> Before, when I was a bit younger, when I first experienced, I just wanted to go and jump off a tree and stuff. Just go and hang myself on it because I didn't know what was happening to me. My family, they wasn't very supportive. It was like... they kept me away from the hospitals and doctors and that because they were thinking that I might get sent to Graylands and stuff. Then in the end, I ended up putting myself in there. [4W06]

Another described how a diagnosis of mental illness came only after she had been in jail:

> I'm beating up myself about it. But that's a real serious problem because, like I said, I'm 46 now and I only got diagnosed two years ago for bipolar. That's only just the start of my problems. I'm still learning about myself. It took me to go to jail and a judge to jail me to – and my children to look at me and say, 'Mum, there's something wrong with you. You got bipolar'. Someone else telling me. Because I grew up thinking, 'no'. But now there's a medication, there's a name for whatever. [5WFG02]

Lack of support resulting in feelings of hopelessness and despair and leading to suicidal ideation and suicide attempts was a consistent theme among women with disabilities in remote towns:

> When I got to the stage of, 'I don't want to be here', which I did, I just lock myself in my room and took tablets. I had enough. [4W01]

There was a common theme of women who were unable to maintain employment due to their disability being on the regular JobSeeker payment rather than the disability support pension. One woman who is unable to work due to her disabilities and accesses support through a disability service provider revealed that no one has ever tried to assist her to access the disability support pension:

> I'm at [name of disability service provider], I'm with a disability mob, but I'm not on disability… No, I'm on JobSeeker. No, not in my life [did anyone try to help me to access the DSP]. [1W07]

One woman outlined the impact of stigma on asking for external help for mental health issues, and the burden this can place on families:

> The one biggest thing that I just found that [talking about] mental health was very taboo for Aboriginal families. It still is… There's no support for the kids that are dealing with their parents or whatever having mental health… you cry out for help [from services] but it just seems to be falling on deaf ears and we often don't want to – being black fellas, we don't want everybody to know [because of shame]. [3W04]

The extreme burden on women with disability and their families in under-resourced towns can lead to the development of more disability over multiple generations. When asked about the cause of her grandchild's disability and behavioural difficulties, the woman's mother replied, "It's all to do with [my daughter] being sick, from what I can see." [4W01]

5.1.3 Violence contributing to disability

5.1.3.1 Psychological trauma and mental health

While the development of psychosocial or physical disability is usually multifactorial, many women had acquired their disability during their lifetime and drew direct links between violence and their disability:

> Everyone thinks I've been traumatised from childhood and up, but it's only been from the relationship. All my trauma has happened in that time and changed me as a person. [1W04]

> I think the mental abuse got him [her partner], that's why I'm depressed too still. [4W05]

> I know I probably had mental illnesses from a whole life of trauma, but I do think that's [FDV] the biggest part that just fucked up my life. [1W03]

A number of women believed IPV they had experienced to be the main cause of their disability. Several who drew connections between FV and their disability were diagnosed with PTSD. Some women described their disability as 'trauma', but were diagnosed with depression and/or anxiety. All of these women who described their disability as trauma experienced clear signs of complex trauma resulting from prolonged or repeated traumatic events, including family and sexual violence, resulting in significant distress and impairment in their lives:

> Then that teenage years, like 18 years and over, and I'm married and started getting bashed around something wicked. That's why most of the time I don't sleep at night… I just sit up … I've got anxiety attacks. Even when somebody shouts, I jump… I just sit down and just block everybody out and don't even think about anything. I just go numb. [4W04]

One woman linked the onset of her heart problems with the stress from FDV she experienced previously:

> I still take tablets for – I asked the doctor because every time when I sleep – it's been six or seven years and it still flashes in my head because that's what led me to my heart problem because he was bashing me too much… They [the doctors] worry… if I was stressed the old ticker will go off and they said, stop stressing. But I'm on a lot of nice tablets to help me sleep. [3W01]

A woman who experienced grief and loss in childhood also attributed her mental health problems to trauma from IPV:

> For me, I think I've got it from a little kid time because my mum lost two kids to SIDS [sudden infant death syndrome] and then I had to care for my siblings from a young age. Then when I got older, I got into a domestic violence relationship for 10 years. It took me forever to get out of that. [1W03]

A poor understanding of trauma and lack of trauma-informed care in services can exacerbate a woman's trauma:

> When I did have my baby, and my second baby, it brought back the trauma from the rape. I tried to explain, all the pain that I'm feeling down there, is exactly the same. I said, it hurts. I got really upset because as I was giving birth to my son, I was like, 'oh fuck it, I want to die'. This pain is – and the next – I went back in the room, and before I could see my son, they had mental health doing assessments on me and asking me why I want to die... I was looking at them like, confused, like, you are the professionals, don't you know that when you go into labour you say any type of thing? Like, what the heck? [1W04]

This experience ultimately compounded her trauma and mental health issues, which were then further heightened by the removal of her children by child protection authorities:

> I used to have really bad outbursts on the street… I assaulted an ambulance officer… I stopped going to hospital. That kind of turned me off. I hate hospitals altogether. [1W04]
>
> Then DCP [Department of Child Protection] came, and I was screaming... I could not go through that again...reliving that [child removal] could make me hurt myself really badly. It's – I told them, I said, it's like they're dead, but they're there. It's like they've been taken away from me, and I just can't get them. They're right there, but I can't get to them. I have this big plastic wall in front of me stopping us. [1W04]

Child removals were a source of trauma and disability for women, both as mothers, and as children who were themselves removed. One woman described the trauma she experienced as a result of removal from her family:

> The trauma. It just blocked everything. Being ripped away from your family. That's the hardest thing. They said that I was a child that stopped speaking… they had to teach me how to socialise with other children, because I was so bent on keeping myself away from everybody, because of my trauma...That's what they put me down as, as an unnormal child that didn't respond to anything. They thought it was something that was in my mind [a developmental delay or intellectual disability], that I had developed. So, I think that being mistreated, if – it wasn't sexual, it was physical, that caused me to have that trauma... at the age of two [when I was taken], there was a blockage there. [5W03]

There was a similar pattern among other women's stories of the manifestations of trauma being misidentified as a neurocognitive or developmental disability.

5.1.3.2 Impacts of violence on mental health and wellbeing

In some cases, the ongoing and incessant violence culminates in women fighting back against their perpetrator, which can result in incarceration. This in turn can compound trauma and poor mental health, and have implications for child protection and housing. The following woman, who was subject to extreme violence and pushed to a breaking point, lost her housing and has been homeless since her release from prison:

> My kids' father, he used to knock me down, boot me. Broken ribs all the time. Used to actually jump on my head, jump on it. used to have black eyes. Plaster all the time on my arms. He used to break my arm all the time. Even while I was asleep, he used to whack me with things. He broke my leg once. I was sound asleep and whacked me with the iron and it frightened me, but at the same time, I felt that pain go through my leg. Then, years ago, I ended up fighting him back. Yeah, he had a knife to my throat. [4W03]

Many women reported having poor mental health and trauma as a result of the violence and abuse they had experienced, which significantly impacts on all parts of their lives. Depression, anxiety and low self-esteem were extremely common:

> He was in control, I didn't know who I was, what I was. Didn't know if I was coming or going. I hated myself. [5W07]

The impact of violence on mental health was compounded by the impacts on the other parts of women's lives, including other relationships, employment or education, and in some cases, child removals. Several women lamented how different their life could have been without the violence and trauma:

> I know I always think no regrets, no regrets, but that's what stopped me from taking my dancing and singing career to another level. Even my kids, my sons say, 'oh mum, you wouldn't be here right, you could have been in America' and 'you could have been here and you could have been' – only if – and I just couldn't. I couldn't because it just wasn't – I just couldn't. Too hard. [3W04]

Anger was commonly reported by women with trauma, which sometimes led to fighting or aggressive behaviour. One woman described how the impact of the violence and resulting trauma fractured her other relationships, including with her family:

> [During the relationship] I used to have really big episodes where the police had to come and I'd go to hospital to calm down. Just – those episodes would turn me against my mum and dad, and I would fight against them while I'm having those episodes, like trying to scream at them, like it's not me. They didn't used to understand, but they think I'm disrespecting and that I'm just acting out. So – but yeah. So, that – it was hard with that. [1W04]

One woman described how her anger, combined with a lack of awareness of the impacts of trauma in health services, resulted in her not getting the mental health support she needed:

> They tried to involve me with mental health. The thing with mental health, as soon as I told them to fuck off, they fucked off. They didn't come back. I told them 'fuck off' a couple of times, which anybody does when they're angry and don't want to talk to you. I was just over having people tell me who I am and what I am. It's not – you don't – they don't know me or what I am. So, it was really hard. I didn't really have much mental support that way. [1W04]

Around one-third of women reported having suicidal ideation, and a few reported self-harm or having attempted suicide:

> Every time I'd get angry, I'd just grab a knife and just slice the shit out of my arm or – yeah just because of anger, hurt, and all of that. But I'm so happy I'm over that. [1W04]

> I've been ready for a long time. I want to go be with my mummy. [5WFG02]

Some women had experienced suicidal ideation as a response to the pain:

> ... I used to be a heavy drinker... I don't want to be on this earth. I want to commit suicide. I can say it but I won't feel like doing it… because [of] him doing all that there making me feel like I'm going to be like my brother. But at the same time, I can fight that. [3W01]

Sleep was an issue for many women, further compounding the impact of the violence and trauma on their mental health and exacerbating disability:

> I don't go to sleep [until] about two o'clock. I feel like it's safer sleeping during the day ... I have about three hours sleep. I think depression, oh no, that man is coming. [3W01]

A number of women reported lacking any sense of safety due to their violent relationships, which continues to affect their wellbeing long after they have left their partner:

> I try to move on with my life, but you can't because you're always looking over your shoulder because [of] the way they threaten you and stuff. [4W04]

When asked if she believed her disability had made her more vulnerable to violence from her ex-partner, a young woman responded:

> Yeah, definitely. I think if I would've been in the state that I am now, he wouldn't stand a chance... Then the abuse just made me more weak [for him]. He realised doing once, he could get away with that. [1W03]

5.1.3.3 Head trauma and brain injury

A number of women either had diagnosed or suspected traumatic brain injury (TBI), and this number could be even higher due to known issues with underdiagnosis. Head injury from FV was fairly common, was usually a frequent and ongoing occurrence among women who experienced it, and occasionally resulted in loss of consciousness and/or hospitalisations. Multiple women had been kicked in the head or had their head 'stomped' or 'jumped' on by their partner:

> He stomped on my head, he kicked me and it was terrible. [5W05]

> I couldn't tell you [how many times I've been hospitalised due to violence] because I lost count… You couldn't even lift your head up those days. You couldn't even lift your head up or you'll get smashed in the face… I got scars all over my head [4W04]

Several women had had multiple hospitalisations due to head injury, but were unsure whether the longer-term effects of head trauma had been investigated during their hospital presentations, and had not received education or follow-up support:

> He pushed me over, and when I fell I hit the corner of the table so I split my head and then I had to go in the ambulance… I remember I had 13 stitches in my head… No [nobody asked me how I came to fall]. [2W01]

One woman reported having seizures following a head injury and loss of consciousness:

> I got hit and I fell down and hit my head to the curb. I got knocked out for 40 minutes, I think they said. Had seizures. [4W03]

Several women stated they struggled with memory loss, irritability/anger and impulsivity despite having no diagnosis to account for this, and involvement in the justice system was common in women who have experienced head injury:

> I get wild very quick… that's why I don't like going to town, because I see someone I don't like, I don't know. I just can't hold myself… I even threw a chair once in the courtroom, at the judge… [my ex-partner] used to actually jump on my head, jump on it. I used to have black eyes… trying to hit me with a machete… when I was pregnant, he used to grab me by the hair and sling me off of chairs. [4W03]

When women with experience of FDV and concurrent issues with alcohol and other drugs (AOD) use reported symptoms like memory loss, they reported it was often immediately attributed to their AOD use without consideration of possible acquired brain injury (ABI) from physical violence:

> She went back to that bloke and he [belted her up]. When she went to get it over here, he belted into her… and drugs and alcohol. [woman's name] lost her memory now. She doesn't remember anything. [She's only 30] Yeah, she stuffed her brain up. [2W04]

5.1.3.4 Injuries and physical mobility

A number of women had physical impairments impacting their mobility that they attributed to repeated injuries from FDV:

> Just my knee, arthritis. I've been getting hit on the leg and my husband was – my first husband was very rough with me and keep on hitting me. I said, 'you keep on hitting me, you go to jail'. That's how you go. He – the second one, I think he hit me here... on this side there. I can't walk… not long distance I can't walk anymore. I've got stabbed in the back. [5W02]

One woman with ABI noted how violence and abuse resulted in her disability through both physical head trauma and psychological trauma:

> I've got a hearing disability because of all the floggings and hidings and that. Beating around the head and all that there. So, I'm deaf on the left side ear. I think it's a lot of stress, depression. Trauma. Yeah, from that. [5WFG03]

Another woman said her disability to institutional violence experienced while growing up in missions after being taken from her family:

> Now with the leg, if I'm walking, if I pound too hard or pull it back too hard … maybe from the time I got flogged when I was a little kid – with a walking stick… unknown to us younger girls, they was running away and we all got trouble with his walking stick… Yeah [I believe its connected to the hidings]. Yeah, I didn't have any [other] accident in my life. [1W08]

5.1.4 Access to services

Women reported that distance, transportation and cost were significant barriers to accessing services, including disability services and specialist medical treatment related to their chronic health issues or other disability. Many needed to travel or to move long distances in order to access support:

> She can't afford more bills. She has to travel to Perth on a monthly basis for infusion treatment. She needs a car. She has to have a car... that's another bill for her she can't afford. [4W01]

This comes at significant personal and financial cost, as women move off Country and away from their support networks. Many women did not have adequate financial support, appropriate accommodation or other supports in place when travelling to metropolitan or major regional centres, which in most cases impacted their access to treatment. One woman who relied on her family as carers, left Perth where she was accessing treatment early because she did not have appropriate supports in place there:

> I come back home because I just couldn't cope down there on my own. I needed 24/7 care… Normally I have treatment once a month. I go to Perth once a month, but it got to me financially. I started struggling real bad. I stopped going, and I know it's very important. [4W02]

She also described the significant cost to her social and emotional wellbeing (SEWB) when moving or travelling off Country, and of how in her case this had exacerbated symptoms of disability:

> Yeah, this is all my family [here in town]. Yep, because I was really depressed, really down because my life just changed. [4W02]

A lack of reliable public or private transport was a significant barrier for people with disabilities, particularly those living in remote towns:

> [It would make my life easier] if we had more access to stuff that we really need. Cars or buses to help us, take us around… I really need more support because we've got to walk everywhere to get our needles. Then by the time we get home it's hot. Then you've got to sit down and wait for a good enough while before it cools down, before you can give it to yourself. Because you can't have it hot. [4W04]

While the barriers of cost, transportation and accessibility determined their ability to physically access a service, cultural safety and trust were the most important factors impacting women's willingness to access a service related to their health and disability. Trust and building relationships were particularly important for women who said they had been 'burned' by services and agencies in the past:

> I've got to have that trust... Of people I've been trying [to] trust by welfare… They still put us back because he was rehabilitated. So, they broke that trust there. Some who help, but some just don't – they just there for the money. Just another [unclear] another pay check or just another number in the case. [5WFG02]

Some women reported an intense mistrust and fear of mainstream services which resulted in complete avoidance in times of high need:

> I don't know, I just was a bit scared like, you know, they might probably – like I was scared that if I went into hospital and I probably had a concussion to my head and they probably put a needle in me and I'd probably die or something, you know? [5W05]

The importance of culturally safe environments where clients may be comfortable was clear from women's descriptions of environments they found unwelcoming. Women described the importance of yarning and of building a genuine connection. One woman described how traditional counselling could feel too clinical, and said she considered yarning style interviews to be more therapeutic:

> Well [the counsellor] come and say, 'hello, [woman's name]' and 'hello, have a bottle of water'. Yeah, but this is a counselling, I think. Like this. Yeah, yarning like this. Because it'll come out. [1W08]

Women expressed the view that sharing their stories is valuable and highly therapeutic, but that sterile and clinical environments can be a barrier to facilitating open yarning:

> We sit in an office, I don't think it'll come out. [1W08]

There was a common theme reported by women that, when they were a child or adolescent, they had been expected to report sexual abuse or assault to a male police officer or counsellor, which was a barrier to creating a safe environment where they could share their story openly:

> So, they had us in separate rooms, and I just looked at them, like – because, first, it was a male sitting across from me, and I thought, 'I'm not saying anything'… So, I wouldn't say anything, until the officer said, 'well, okay, we'll let the ladies talk to you'. [5W03]

Some women reported concerns about confidentiality, and feelings of shame, particularly when accessing support for mental health or family and sexual violence. A few of these women preferred to access culturally safe mainstream services when discussing more ‘sensitive’ issues, particularly when they had family working within ACCHOs:

> Because most of them – I like to talk to people that are not related. All these people here are all, you know… Sometimes when I get down, I just talk to – I just go to the women’s refuge because they all like me, and let all my problems out with them. I trust them, yeah. [3W01]

One woman reported feeling overwhelming fear of speaking out about the institutional abuse she had experienced as a child, and recalled her thought processes and the words said to her by a female teacher which made her feel secure enough to finally break her silence:

> Because I had this awful feeling that if I went back there… I could feel myself sinking into my chest, like, I’ll get half killed here. That’ll be the end of me. She said, ‘no, you won’t go back there. I’m going to make certain it won’t happen’. It took me around about six or seven minutes to really [feel confident I could talk to them]. Then I started talking, but then I said to them, ‘you won’t tell him?’ They said, ‘no. This is confidential. Confidential means it stays in this room, and no one knows about it’. I said, ‘oh, okay’. So, it made me feel a bit more comfortable. Then I spoke to them and I told them what happened. [5W03]

Shame may have been a driver of some women’s hesitancy to access external support:

> I don’t really ask for help, unless I really need and necessarily have to. [5WFG02]

> Yes, it is. I mean I’d rather go and talk to a complete stranger, or like my sister girls or something, you know? [2W03]

Some women reported a fear of judgement by mainstream health providers, or of ‘looking stupid’:

> I don’t want to go to the doctors because I don’t want to explain all of that. They’ll probably think I’m just as stupid for not getting help or getting medical… [1W03]

A lack of health literacy or knowledge of available support was a barrier to accessing services for some women:

> Yeah, I didn’t think about anything like that. I didn’t know there were things – something can be done. [1W08]

To remedy this, women highlighted the importance of education to increase awareness of supports available:

> I don’t think they’re aware of the support out there that is available to them maybe, so like make it sort of – make an awareness to it, the support, just so people know where to go for it, you know what I mean? That could be a big challenge to some people… Yeah and so they’re just maybe stuck in the same rut, or the same cycle because of their – they don’t know. [5W06]

Some women experienced re-traumatisation due to a lack of trauma awareness within services across multiple sectors. As well, many women reported fatigue and disillusionment at being forced to constantly re-tell their story and re-experience their trauma. Staff turnover in regional areas is a strong contributor to this, impacting cultural security and continuity of care:

> These nurses and that that come and go, that’s like I’ve got to repeat myself to every person that comes along. [4W06]

Many women reported poor experiences with some mainstream healthcare and support services, making them less likely to seek their support in future:

> I’m just saying all the Aboriginal people, they don’t like going to the hospital because it’s only Panadol. If you’re sick they only give you Panadol and they say – and they just send you home. [3W02]

Some women felt judgement from hospital clinicians, particularly in regional towns, which also impacted their willingness to seek help in the future:

> Every time I go to the hospital they always tell me, ‘my records tell me... you’ve been drinking’. I say, ‘how many years have I told you people I’m not drinking?’ I say, ‘you wonder why I come to the stinking hospital’… and they say, ‘every time you come in here... you come in stressed’. [3W01]

As discussed elsewhere, women’s inability to advocate for themselves within mainstream services, without being labelled as ‘trouble-makers’, was also a common theme:

> Some of the other ones, they didn’t treat you right. They would talk down to you and that’s what I said… I’m not deaf or I’m not a little kid so don’t speak to me like that, please. Then once I get loud – if I used to be loud, they’ll be ringing security on me. [2W01]

There were, however, some examples of culturally safe practice where women had positive experiences within mainstream services. These were associated with clinicians, most often general practitioners (GPs), building strong relationships, incorporating informal yarning into healthcare consultations, and treating women with respect:

> My doctor is a real good doctor. He’s really good. I can talk to him about anything. Doc has known me for a long time. Him and Dr [name], that’s the main two I speak to, that I can talk and say anything. I can swear and laugh and cry. They’ll have a laugh with me. [4W02]

> They know everything about my history, my daughter's history, my grandkids' history and yes, two of those doctors tried to be as helpful as they can. [4W01]
>
> [My GP] always often asks about me, so he'll be seeing me today. Yeah, he is [pretty supportive]. He's like a gentle giant. He's a big man and he works with the [organisation]. [5W06]

One woman reported a positive experience at a public hospital when travelling to the city for healthcare, which she attributed to the fact that she had existing relationships with two of the workers and the hospital had an excellent Aboriginal liaison officer:

> I knew two of the workers that were always there with me. The Aboriginal liaison officer was really good. [2W03]

5.1.5 Experiences accessing FV services

Having children was one of the most significant barriers to women accessing FV services. Even for refuges and crisis accommodation that allowed women to bring their children with them, most weren't equipped to meet the needs of larger families:

> I went to a refuge, they could take in one mother with three or four kids, or two kids, but not a mother with six kids, they weren't… I did but then I had to wait for two rooms so that I could have three kids in one room and me and the younger ones in the next room. That caused a bit of anxiety separation in a sense because I wanted them all to be where I could see them. You know when you're going through things you just want them all together, not being separated. [1W07]

The locations of refuges and crisis accommodation in smaller regional and remote towns were well known within communities. Due to the lack of anonymity of these refuges, some women felt unsafe and reluctant to access them when escaping FDV:

> I said, can you give me more, a proper [restraining order] to keep away, put me in the women's refuge? But they [unclear] been there for years and years and he knows when he sits outside… Sometimes I get – there's a hostel I can go stay there, but he knows that hostel. So I've got to give up and just go back to him. [3W01]

The lack of capacity was a significant barrier to accessing refuges, particularly in regional towns. Women in one town described the restrictive policy of their local refuge, which had a limited length of stay of two-three days. After this, women were provided with transport to leave town and find support elsewhere:

> There's a women's refuge down here but when you go there they only give you one or two options. You either stay here for two nights or hit the road out of town with no help. You expect to go to somewhere else safe and they just get you out of here. Not knowing

> – they could just chuck me on the bus and send me to Perth or something. That's all they give me, just a bus ticket. Where do I go from there? [4W06]

Women who were forced to leave town were often not provided with basic necessities like appropriate clothing and food, which ultimately resulted in them returning to town and their abusive partner:

> They just dropped me off and left me with nothing. Out bush there's no shop. There's families out there but you've got to fend yourself if you've got - they can only give you so much feed and you've got no clothes. You had to cadge people for clothes and that. [4W06]

In a regional town, accessing the refuge after-hours was challenging, presenting a significant barrier for women accessing crisis support when they need it most:

> But that's hard to – they need somebody there or they need a [phone] or something. When you go there, they don't even leave their phone number outside. There's got a big fence there. How do you tell somebody that you want to get in there? You've got to go walk all the way to the police station. The police station, if going there at night time, the police station has locked their doors and you've got to stand there banging on the door. There's no way to tell the refuge mob that you're there waiting to get in or something. [4W06]

Another woman described the extremely traumatic experience of having her baby removed by child protection authorities and police while she was at the refuge. Experiences like this can prevent women from seeing refuges as a safe space and accessing their services in times of crisis:

> I was at a refuge and they couldn't – they took [my son] to another room and they took me to another – oh, you need to go in there. So they took him to the front and they took me to the other room and I was just like screaming and yelling, oh, where's my baby, where's my baby, what are you doing, no, don't do this to me, please. I want him, that's my baby, please, I want him to be with me, I don't want him to leave, please. They had like lots of police officers like probably eight of them there were stopping me and there was a DCP lady that took him, just put him in a baby seat and just took off… my heart just shattered in so many pieces. It felt like I lost him, you know? I felt like he was gone forever. [5W05]

5.1.6 Violence (including sexual assault)

Women are experiencing multiple types of violence in each relationship, including physical, emotional, financial and sexual abuse. Many of the women we interviewed have experienced extreme, prolonged violence from a number of different perpetrators. In some cases, they had experienced violence in every intimate relationship in their adult life:

> Yeah, [the scars are] from being hit with bottles to the face. When you're not expecting anything, they just whack you for nothing... All the men that you live with throughout your years. [4W04]

5.1.6.1 Physical and sexual violence

The women we interviewed have experienced unimaginable levels of physical and sexual violence. While physical violence is not part of every abusive relationship, almost all women we interviewed had experienced physical violence. Head injuries were relatively common, and a number of perpetrators used weapons including guns, knives and axes, or household objects such as glass bottles or irons, to inflict violence:

> With an axe in my back here, one chop here. That's my husband done this to me. [3W02]
>
> Even while I was asleep, he used to whack me with things. He broke my leg once. I was sound asleep and whacked me with the iron. [4W03]
>
> Yeah, bit me, sliced me. My nose was literally open like split open, you can see there. No, I had to – they stitched it, they just have the stitches because I had like – it was like teeth marks were on my nose... He stomped on my head, he kicked me and it was terrible, you know, it was just terrible. I would have actually lost my son that day because I was holding him. [5W05]

Several women had experienced stalking, drug-facilitated sexual assault, kidnapping, and even attempted murder, including by intimate partners – some of whom were non-Indigenous men – and strangers:

> Getting locked up [in] a room and getting punched. I had two big black eyes. Couldn't go out of the house with broken ribs. My family couldn't even come because he had had wild dogs and couldn't even ring... [he put a] chain on my ankle and you stay in a room, the bedroom and I had to wee in a bucket. [3W01]
>
> Well, I've got a lot of this [motioning to sexual violence card] from all over the place. Got it from my family, but not my mum or my dad. But from my uncle. Then also from strangers. I got mild and I got serious. Like kidnapped, tried to be murdered. Real heavy shit. Rape, and rape at gunpoint. The sexual abuse from the partner, now that was a weird one. [5W01]

As the above quote illustrates, sexual violence within women's intimate relationships could be confusing for women. One woman had begun sleeping in her car after travelling to avoid going home, but was unsure whether what she had experienced within her marriage would be called sexual violence:

> The sexual abuse from the partner, now that was a weird one. Because he – every night he wanted to have some sex. He couldn't go to sleep otherwise... I mean I couldn't go to bed by myself. I couldn't read a book because that was betraying him. We always had to go to bed at the same time... I don't know if that one counts in my marriage or not. [5W01]

Many women experienced sexual violence within their intimate relationships:

> Yeah, used to force, flog me then have sex. [5W07]
>
> One time he had a knife and he tried to put that between my legs. [3W01]

5.1.6.2 Verbal abuse

Emotional and verbal abuse were very common in women's relationships:

> Verbal abuse, and – I mean that's as bad as the physical in itself... you know, degrading and everything... [2W03]
>
> When I look at [partner's name], he's, like he wants to control my way of thinking, like, oh, you shouldn't have said this, you should have said this. He does harass. Yeah, he does harass, through talking. [5W03]

Some perpetrators threatened to hurt themselves to coerce women into staying within a violent relationship:

> Yeah, and saying, no money for you, lose weight... I've got no self-esteem and I say, [unclear] come back to you [unclear] the way he says he's going to hang himself. [3W01]

5.1.6.3 Financial abuse

Many women reported being controlled or 'told what to do', which sometimes included financial abuse. One woman described financial abuse as one of the first signs of abuse within their relationship:

> It was all rosy until then. Slowly all the other things started to add on. Taking away the money, and then swearing at me in front of his friends and family and calling me all sorts of names. Telling me I'm not allowed to talk to any of my family. The sexual abuse came a bit later when I started to feel like not interested in him and not wanting to participate. [1W03]

Financial abuse took a variety of forms, including inhibiting women from working and tightly controlling their access to money:

> Controlled the money because he was the only one with an income. So, he controlled where I went and how I could get anywhere. That made it hard to leave him, and all of this. [1W03]
>
> It's kind of belittling. He makes you feel like a kid when you have to ask for money and he only gives you a certain amount, you know what I mean and it's your money. It's yeah, very controlling. [5WO6]

Another woman experienced a different side of financial abuse, whereby she was forced to work and provide for her abusive partner, who was unemployed and relied on her for money:

> I always made sure that I would try and get a job that was worthwhile, the pay, so that I could cater... He was drinking and taking drugs and he would take whatever he wanted to take. I would have to accept that otherwise he would just punish me. [3W04]

5.1.6.4 Stalking and surveillance

Several women reported issues with stalking and surveillance in their abusive relationship. Some of this was facilitated by technology, which enabled perpetrators to have full access to their partner or ex-partner regardless of physical location. One woman reported that she had changed her phone number 'more times than she can count' but that her ex-partner always seems to find her new number. She spoke about how he taunts her via phone, pretending to be in town when he really isn't, giving an illusion of omnipresence and inescapability that prevents her from ever feeling safe:

> Every time he texts me – this is my nearly 100-time phone, SIM card, because I haven't had... His ex-in laws in [town], my family [give him my new number]... He says that he's here but he's 1,000 miles away. [3W01]

Another woman experienced tech-facilitated abuse, in the form of revenge porn:

> He posted all these pictures of me when I was young, like nude, on the internet and tagged all his friends and family... I didn't even – I remember them things being taken and that was – and I'm usually very private about my body... I wanted to kill myself at that time. It was the most embarrassing thing, and humiliating, and fucked up. Out of all the abuse, I think, that was far the worse. I felt like it was the end of the world when that happened. [1W03]

5.1.6.5 Jealousy and control

Many women reported that their perpetrator's controlling behaviours and physical violence were rooted in jealousy:

> Yeah. That's what started everything up, jealousy. [1W05]
>
> Getting kicked around the head. You know how mans are when they start. They're very jealous people. You can't even talk to your own family without them thinking, 'oh, who we setting you up with now?' [5WFG03]
>
> Yeah, or [he] when got suspicious or paranoid about me wanting to be with someone else, or leave, or anything. [1W03]

They reported that perpetrators used violence and the threat of violence to systematically isolate women from their families and communities:

> Or if I wanted to do anything or attend anything or even see my friends or even certain family members, he would just make something up that I – or just beat the shit out of me and I wasn't allowed to do it, basically. Just 'you're locked in a house, you stay there, I'm gone for such-and-such' and I've got to wait until he comes home. [3W04]

Perpetrators also prevented women from pursuing education and employment opportunities:

> Moved away and lived with this man that controlled every aspect of my life. I wasn't allowed to have friends. I wasn't allowed to work. I had to stay home. He made me pull out of the courses. [1W03]

One woman described how isolation and alienation of her family resulted in her having to put all her trust in her partner, as he became her entire support network:

> So I wasn't allowed to talk to many – only my mum and dad, and that was even controlled. He had to be around me when [I'd] talk to them on loud speaker and only small, timed conversations... now I think I was so gullible to go, especially when I knew I had no support there, but I put trust in him, and I kept thinking we love each other. [1W03]

5.1.6.6 Power imbalances

Several women who had an abusive partner with a prominent role in their community reported a power imbalance between them which played a role in women being disbelieved by police and other community members:

> My first husband, because he was a [occupation] he thought he can do anything and that's why I used to cop it all with him. [5W07]
>
> Well when I was in [town] he was [volunteer role], so the police wouldn't even believe me. Then the violence got so bad, like he'd flog us if the football team would lose, me and the kids... I should have left then when he assaulted my daughter when she was two, and [his work role] and nobody believed me because the way I carry myself, you know everything looks really good. [1W07]

Power imbalances were especially apparent in the cases of women who had experienced child sexual abuse, usually either by staff in government institutions or by an older male relative. One woman described how when she was eight years old, a male relative had sexually abused her:

> I was sexual active early, when I was eight, yeah, and my brother-in-law, my sister's man, I touched him in the private and I was only a little girl and he took advantage of that and he kept doing it... He was just playing. But he was older than me. He was in his 20s or 30s. [5W01]

5.1.7 AOD

AOD were used by women to make life more bearable within their violent relationships and to cope with trauma from past relationships. Alcohol use to cope with violence can contribute to disability, as several women developed chronic conditions related to their alcohol use. For some women, recognising the impacts of their AOD use on their health, and the role it had played in their experience of violent behaviours had marked a turning point, prompting them to seek help:

> I think us women too, we've got the alcohol and the drug problems, and we use that to numb everything we're going through. But we don't realise how much trouble it's causing us because when we don't have that, that's when – it affects us big time and we're all back to reality. I found that drugs and alcohol played a big part in my domestic violence. So, I went to rehab. [4W05]
>
> After I finished up with him, yes, I was doing it because I was drowning my sorrows. Then getting over how he treated me. I more or less stopped once I knew I was getting [the health care I needed]. Stopped everything. [2W01]

Alcohol was responsible for grief and loss due to its escalating role in violence and from being used by women to cope with violence:

> He was a alcoholic drunk. My mum ... died of a blood clot to the brain and alcohol poisoning. She used to drink because she knew what was coming. So, drinking numbed it and it ended up killing her. That did hurt me. It broke me. [5W02]

One woman described how she smoked cannabis with her partner as it stopped him from being violent. Others said that they drink or use drugs to 'keep up' with their partner and to 'block them out' when they're violent. However, this can place women at a greater risk of harm, and can prevent them from seeking help. In one woman's case, she hadn't realised she had been stabbed by her partner and did not seek treatment for her injuries until the next day, due to the effects of alcohol:

> Yeah, and because we was drunk when it happened, so I never went straight to hospital. We slept all night and next day, I just realised it was him. [4W03]
>
> When he's drinking, I'll have a smoke, smoke marijuana and everything. When he's drinking as well as smoking marijuana, he's in a calm state because he just sits there stoned. I used to drink to try and keep up with him and that smoking the dope was just to block him out or to relax me so I didn't get too stressed out. [2W05]

With high rates of unresolved grief and trauma, and a lack of support for their disabilities, many women described using AOD at some point to 'self-medicate':

> All this – I do think about all this stuff that happened over the years. I don't like getting into that because it's upsetting. That's why I have to train myself to block everything out. I just block everything out of my head. I use alcohol to calm myself down more or less, and gunja to relax. I've got to calm down. Cigarettes – I smoke a lot currently. I smoke and smoke. [4W04]

Several women with severe trauma, including from childhood sexual abuse and early exposure to violence, described using alcohol to cope with their feelings of despair and hopelessness:

> I watched my mother get flogged. Watched my grandmother get flogged with broken arms and legs all the time she used to have. Grew up watching it all… I feel down. I just go home and sit in my room and just listen to everybody. I get that far down, I say, anyone got any cans? Then I listen to music. But then when I listen to music, I start crying. [4W03]

Some women said that their partners rely on AOD to cope with their own trauma (see section on men's trauma), which results in the violence and trauma being perpetuated across generations. Several women said that their partner is fine when sober, but that violence only occurs when there has been drinking or drug use. When prompted, some women admitted, however, that this occurs on a daily or regular basis:

> I think my health is good but it's just the relationship and the person I'm living with is not. He's not there. When a man is drunk, they don't know what they are doing. They are a different person. That's how I see him... [1W05]

> [I was abused] every time he was drunk, and he'd be drunk for days. [4W05]

> ... It's not the alcohol really, when you think about it, it's the thought that they had already, that they were harbouring inside, they just needed alcohol to tip themselves over the edge. [1W07]

Methamphetamine use was a significant problem across several sites, with women reporting that men are often using it during the most extreme incidents of physical violence:

> Well, he was stoned, whacked off his face, coming off 24 hours drinking, and driving when you're on the gear for 24 hours, and he started punching me in the head on camera. [3W01]

One woman said AOD were used against her by her partner as a form of systems abuse. In this case there was a power imbalance that may have contributed to her being disbelieved:

> When me and my defacto split up, he put down as I was an alcoholic because everyone believed on his side. I had to go through custody for the last 12 years with him and domestic violence was through him... it was 12 years until I actually got [my kids] weekends and all that, but they're all adults now… he was into the drugs, and he put me in that it was all mine. [5W07]

Some women noted that AOD are used as a manipulation tool, to keep women reliant on their partners. They described being 'tricked into it' or given drugs against their will, which over time can contribute to dependence, and in turn, make a woman more dependent on their abusive partner:

> What I'm saying is, they use the drug – they'll buy that drug, and they'll say, here. I ended up getting into the ice because I was tricked into it by that one, that [spiritually abusive] one. I got into the abuse with him. He tried to use it to control me and manipulate me to live his way. I was living his life with him. I was who he wanted me to be. I was living in his shadow. He got me on it because he couldn't control me as a drunk. Because I was a drunk. He couldn't control me as a drunk, so he got me on that there. [5W02]

5.1.8 Grief and loss

The impact of grief and loss from a range of harms was a theme through many of the stories told by the women. Some spoke of the removal of their children due to police processes, and of child protection authorities intervening to remove children due to FV or other reasons:

> Then unfortunately three years later, I lost a little boy. He was only three months. But the work that the detectives done, they wanted to take the pants and bra that I had on. ... this was the second one, so...I said, 'I understand. You guys got to get evidence because – look, I said, only God can be my witness. Only God can answer me as to why something like this happens and hit me again'. That year... I was a nervous wreck. I took tablets. I cut my wrist ... There was a lot of things that I did. Yeah, went on a wild rampage. [1W02]

> They both live with my mum, and they've got the same dad. So, when... that happened between me and him, the domestics, there was just too many police calls... so then they just came and took [my babies] off me – they took them off me... But I left him, and in that time that I left him... All in that year, all in the last year, the kids were taken off me, and then I lost my big sister, and then I lost my brother. [1W02]

> I walked down into a meeting and the nurse said 'oh, we have to take baby now, we have to take her away, you know? So she's not going to be with you' and I felt a bit upset... Yeah, like I was just thinking 'oh what is happening to me? like I'm actually the good person here, like I can take care of them, my son and my daughter. I can take them away to my family to support me, to look after them, to help me grow them up'. [5W05]

And women spoke of losing multiple children due to miscarriage, some directly as a result of FDV:

> Two girls at that time. I've had 13 kids, but I've lost seven and I've got six with me. So, I've had 13 kids to him… I lost seven due to domestic violence… all miscarriages, just too much stress. Now I've been on mental health tablets for over 15 years because I suffer badly from anxiety and depression. [1W07]

Other women spoke of ongoing grief and loss due to themselves being removed from family as children:

> I got lost because my mum passed away when I was only 10. That's when we moved from ... my hometown. We moved from the bush and had to come to the city because my mum passed away in the city hospital. Then from there, when I lost my mum, that's when the abuse started with that white father. Then they put us in the foster homes. Then for 30 years, I've been grown up in the city. Took me 40 – 32, 35 years to get back to my hometown and my people [up there]. [5FG02]

> Well, my mum and dad was an alcoholic at the time and... I was about in high school, about 13, and my youngest brother, we were walking across coming from school and they had a big flood there in [the town]… I had the youngest one up top and the water was right over

> his – right up here and I'm trying to put this – I was lifting the other one while the other one was sitting up. By the time we got over the other side of the road we had 10 policemen and welfare and all pick us up. We didn't see our parents. We all got put into that [Name] mission… [3W01]

One woman spoke of having been removed from family at the age of six, and of leaving the institution 10 years later only to be reunited with her grandfather for half an hour before he passed away:

> So we got a message our grandfather was dying... When I was sixteen. And I had to travel all the way down there in an old bomb. We was going up to [the farm] and we made it. He had half an hour left. He was gone... I got hard… I lost my family I only cared for, and my grandmother came back to [place]. [1W08]

Other women spoke of the pain of losing loved ones to violence, preventable illness, and suicide:

> He killed my mum. He end up bash my mum to death... He was a alcoholic drunk. My Mum... died of a blood clot to the brain and alcohol poisoning. She used to drink because she knew what was coming. So, drinking numbed it and it ended up killing her [unclear]. That did hurt me. It broke me… That's where the 13 foster homes in 12-months and me fighting authority comes into it, in all of that there. But that gave me my strength. Not to let no man do that to me again. Let alone a white man. A black man might get away with a little bit more because I'm more lenient towards my – us mobs. Because of everything we've been through. [5FG02]
>
> In and out of prison, plus they've had the loss of their father… and their grandmother … all last year… That's a big load, yeah. Plus my grandson, he's – his mum was tragically murdered a year and a half ago, so he's going through that. [2W03]
>
> Well, my brother, he's gone now. He committed suicide. One done the damage and the youngest one now only got born in 1972, he's a druggie. So I'm the only one trying to protect our [family]... [my mum] she passed away at the age of 53, and I'm around about that age … because of [her] heart. Same as my dad. My dad died about – he was about 57. [3W01]
>
> … it's through my menopause, the depression, and plus losing mum, so. Like people say time will heal, but I've got news for them – that it doesn't heal, you just get used to the pain… That's the way I look at it – it doesn't heal, you just get used to having that pain. [2W02]

And others of the grief resulting from being prevented from attending a loved one's funeral:

> I reckon that's what gets me down a lot, mainly because – I don't know. What gets me down the most is me being in jail when mum passed away, because yeah, they wouldn't let me go and see her [because I was] in the jail. They wouldn't let us stay at the cemetery to take care of the graving… They would not let me go and see my mother. They wouldn't – they let us go to the funeral in prison clothes. I don't talk about it. [4W03]

The impact of grief and loss on whole families was evident in many of the stories the women shared:

> Yep, and the murder happened in my mum's house, and now he's back at – me and my sister drove all the way to Geraldton to pick him up on his release. He won't go back into mum's house. [4W03]

> Must be seven of us left now. Three gone. Yeah, seven of us. I used to have a lot of worries about them. You know, my youngest one passed away, brother. I sort of worried and I said – this one behind me. She said, 'don't worry too much. You'll get sick. You've got to move along'. [5W02]

> The sad thing about it is I always recollect of losing someone, like my partners, and I – it dawns on me every time that death is not far. It comes knocking on your door. [5W03]

> ... but he didn't do redress because I've – at the time I was working for [workplace] and I asked him if he wanted to do redress, and he says 'no', and I didn't try to push him, but too many wounds that would have been… [Name] was sexually abused as a child, so ... counselling comes in every two weeks. So his daughter only passed away three months ago… so she left behind a three-month-old baby. So that's what we're trying not to deal – we've got to – [with] grief. [4W07]

> …in one side, and he's totally deaf on the other. Busted eardrum when his mother threw him out of a car when he was two years old, and he hasn't done nothing about it, and I'm just pushing, pushing, pushing. [4W07]

> I lost my old husband, not last year, year before… He was a kind old man… No, I just worry about my old fella, who I lost. Yeah. Like I'm sort of – every time when I go home and I think, when did he come and pick me up and we go [out] bush, you know? That's how my head works. [5W02]

> The youngest boy [when] we grew up, he always say, 'oh, I'm going to go home and see my dad's [unclear]' and I said, 'don't worry about it. He's gone and we've got move along with our life'. But he thinks and worry and cry on his own. [5W02]

> [I started getting sick] after… that little boy, when he born now? Five. [1985]… he passed on. He was three. That's why I went off and drinking, drinking till I got sick… Mm-hm and that's all – that sent me right off. I drank and drank till I got sick. [5W04]

> I've been living with my mother-in-law and she passed away. We went up for her funeral and my little boy, my first child, he came up and she was going to help me. She was going to make the plan to help me to get my boy back. [5W05]

5.1.9 Police responses to FDV

A prominent theme in the women's interviews both within and across the sites was the variability of police responses, from poor, harmful and/or negligent practice to responses showing empathy and resourcefulness, which can ultimately be lifesaving. Overall, there was a feeling of positive change or progress, demonstrated by one woman's differing experiences with police over the course of her life:

> One cop there – I was only, what, 17. Anyways, then I wasn't doing my fingerprint for him … Boof. Straight on the stainless-steel bench… He boofed – smashed my head on the stainless-steel bench before I got to say to him, 'or what?' Give back the attitude – bang. [5W02]
>
> They [the police] helped me. They got me away from and made me feel safe by locking me up in the police station and lock me up in the paddy wagon. Then they went and grabbed the kids from school. They arranged accommodation. They got together with the doctor because the doctor was the one that pushed them and told them, no, you're taking this one serious ... He seen the big picture. I owe my life to that judge. [5W02]

In remote towns with few health and social welfare services, police were reported as playing an important role in youth engagement, particularly supporting young people with disabilities and intervening to prevent contact with the juvenile justice system. The police also play a key role in trying to mediate community fighting/feuding, which requires them to be very well-connected to families in the community:

> Oh, no, [policeman's name] is good. He wants to help him, but [son's name] – he can never catch him to sit him down and talk to him. That's the police officer. The children's one here. He helps [son's name] a lot. He worries for [son's name]. He just pulls up for a yarn. He just comes in to have a yarn just to check him out. [4W02]

While some women reported positive experiences, others reported unhelpful or harmful experiences with police. Several reported being not believed by police during incidents of violence, or police not attending promptly, which put them at greater risk of violence and had a negative effect on their willingness to seek help in future:

> When you do ring the police, they come too late, or they think that you're talking shit, to tell you the truth. So, I don't bother. [4W02]
>
> Police done nothing, and then when we ring them sometimes, they say, don't ring, don't ring. Yeah, I said I'm going to be fucking dead before you fellas come... Yet they're up and down my daughter's house six, seven times a night on a curfew check for my grandson, waking us up, all hours of the night. [4W03]

There was concern about reactive policing, specifically when women know something is about to happen but police have told them there is nothing they can do:

> What's really annoying is you know something's going to happen but you can't do anything about it. It's just no, we've got to catch him in the act… we've got to have proof, we've got to have evidence. [5W03]

Several women reported issues with the effectiveness of restraining orders, that they are not always properly enforced and may 'add fuel to the fire':

> He's not allowed to come near me for 100 yards for 10 years... That's just across the street. He'll probably sit out there [laughs] looking at him just like, 'oh, I've got to go back'. [3W01]

> The VROs [violence restraining order], those are all right. But like women say, the little piece of paper can't stop them because at the end of the day they're still stalking, and then when the police got to catch them too, because they breached their thing, they don't catch them until a couple of years later. [5W03]

When reporting FV, several women described feeling that they were not being taken seriously and were being punished by being the one removed from the family home. They felt that they were being treated like the perpetrator:

> I think they failed me. Several times they made me leave my own house so he could stay there with my children. In that time, he told my children stuff about my body, my sex life, like really things – I have sons – they shouldn't hear; even if they were girls, they shouldn't hear that. So, I think, no, nothing really much good to say about the cops because I don't feel like I should ring them anymore because they don't help me. They make me feel like the perpetrator. They treat him like the victim. [1W03]

> Three times I rang up the police. They just got me removed… I get taken away and I'll just say, can I come, can I come? They just leave me out there. Then he starts up again and just [unclear] this place. This is my homeland. [3W01]

Incarceration was seen as not proven to be effective in rehabilitating their partners, and that it was only a temporary fix:

> With the police? Yeah. I've been involved with the police. Done a lot of violence restraining orders [VRO]. But they don't stop them. They just go straight through them and they end up back in jail. Do their time and starts all over again. [5W03]

Under-policing of FV and the criminalisation of trauma responses also caused anguish:

> The police done nothing, and they wonder why I go off my head… We put restraining orders on him, he breached it over and over. Police done nothing. Then when we go to town, I see him, I start on him, they arrest me. Yes, they even had my – he held my little 14-year-old daughter down with his foot on her head, into the dirt. He never got charged. [4W03]

This woman had trauma from childhood sexual abuse and experienced ongoing violence throughout her life which manifests as high levels of anger and distress. Without the proper intervention and a lack of support, this has resulted in early and frequent contact with the justice system throughout her adolescence and adult life.

Other women reported noticing a clear difference in their treatment by police when alcohol is involved and/or when they fight back:

> They're pretty helpful when you're sober but if you're drunk and you're fighting and whatever, they don't really help. They just give you a move-on notice. The person who's being attacked and assaulted or being hassled. They give that person the move-on notice. [4W06]

And one woman described how traumatic it was to report sexual assault and be disrespected and disbelieved by police:

> I tried to charge them because it happened three or four times in one night...but the detectives were so biased against me – they were laughing at me, and were like, you know that if you go to court, the judge is not going to believe you, like one person against two is not going to help you in court … They took the statement, and they took my evidence. I had my clothes I was wearing that night. They took the towel. I told them it has evidence on there, like proper evidence in the bush, and they went and found it the next day, it was there, exactly where I told them to go and get it, and they threw it in the bin before they put it through the evidence machine… [1W04]

While some women reported neutral or positive experiences with police – that 'they done their job' – there was an overall feeling that their experience can be up to the 'luck of the draw'. Women said there was a strong need for improved cultural awareness training, specifically training that is area-specific and takes place prior to relocating police to a town:

> I think they do need more training. Yeah, I do believe that. You got them, some of them they come from Perth, you know what I mean? They stay for two, three years and they're gone and then another lot comes, so they don't get used to community and – you know what I mean? [4W07]

5.1.10 Experiences with the Public Trustee

Some women reported being under guardianship and administration orders as disempowering and causing them significant distress. One woman, who lost her housing and custody of her children due to prolonged and extreme violence, had recently been placed on an order without her knowledge. Her greatest immediate concern, however, was the impact of the trustee arrangement on her life. She reported feeling dehumanised by the lack of control she has over her own finances:

> She's like my – she's like a king for me, ruling my life… All those people in Perth are controlling my little life. I'm trapped in a cage… they're controlling my life with the control, do this, that, go this way [making hand motions to imitate a string puppet]. [3W02]

She directly compared the extreme physical violence perpetrated by her ex-husband to the level of control she experiences from the State Administrative Tribunal (SAT):

> Even the Trust don't understand. But what I'm going through, I went through here, through here and ears. With an axe in my back here, one chop here. That's my husband done this to me… then the Trust here is doing the same thing like my husband, controlling… [3W02]

She spoke of feeling humiliated by the treatment she receives in the community as a result of having no control over her own finances:

> All the people laugh at me, make fun of me. I feel sad, even my friends say … they said to me, oh $100. $100 paid… 'oh look at who is coming, $100 money coming'. They laugh. [3W02]

She reported that her Public Trustee is highly unresponsive, and she receives disrespectful treatment which leaves her feeling distressed and helpless:

> They laugh at me too on the phone... I try to ask how much balance I have, she wouldn't even tell me… she won't answer my phone… all the messages and emails I sent to her, never came back… It's stressing me out, I might hang myself. That's what I think to myself. I look at people eating, I get hungry, I wish I can eat, I think. But ringing her, it's too hard, she's hard on me. [3W02]

Despite the Public Trustee managing her disability support pension, she is homeless, which forces her to resort to couch-surfing and sleeping rough. As a young woman with a disability and a survivor of violence, this leaves her with grave fears for her safety:

> I do worry about myself, getting, you know, raped. Whenever I sleep, you know, boys, men, you know, might rape me. I need a house for myself, and I need to pay my debt for Homeswest. [3W02]

In addition to being homeless, she is unable to afford basic necessities as a result of having very limited access to her finances, and reportedly unable to access her own victim's compensation funds related to physical IPV:

> Trust took it, $20,000… $20,000 for me. I want to get a – try to get a house. [3W02]

5.1.11 Elder abuse

Several women had experienced abuse directed towards them by younger relatives. Predominantly, the abuse reported was verbal and financial with a small proportion describing threats of, attempts at, or actual physical violence. Some women experienced multiple forms of abuse, as captured in the narratives below. Numerous women attributed the violence they were experiencing to their relatives' drug use.

The following participant described the verbal abuse she experienced from her daughter:

> No bashing but the tongue. You know, what they call it? How you explain that? The words … Running me down to the [lowest]. Pick on you and laugh about you, maybe because I'm old now and useless, I suppose. [1WO8]

Echoing her experience, another woman spoke of how she was:

> ... sick of being abused by her [daughter]. She says the nastiest things ever... she'll try and rush me, you know, try and hit me and everything.

It was a worry for this participant that her grandson resided with her and was also being abused:

> It's not good for my grandson either and he gets abused by them too. [2W02]

One mother experiencing abuse believed that AOD played a large role in the violence inflicted upon them, as described below:

> You know, before this gear stuff, meth, got into them, they were the best kids out, you know happy-go-lucky, laughing all the time, cracking jokes … [i]t's a different thing, when they're on the drugs, and I just don't want them here full stop. [2WO2]

Describing interactions with her son, another woman relayed the following:

> My son always get all my money out before. I said, 'you've got to stop. I'll show you. I'll fix you up'. So, I just gave it to the taxi man. Taxi man look after it for me. He's growling for it now these days. 'Where's the money? I want money.' 'You want money for your gunja.' I can get rough sometimes with him. [5W02]
>
> Experiencing the same financial abuse from her daughter who also used drugs, this participant had placed her trust in a taxi driver and given him her bank card to look after. This strategy meant her children could not take the card from her. As a result, the taxi driver had become an important and independent source of support and regularly helped her with shopping and other tasks. Other women spoke about feeling helpless to do much about their situations while some, such as the woman above who relied on the taxi driver, managed to create strategies to thwart further abuse.

Speaking of her grandson and granddaughter who would steal her money from her purse to finance their drug habits, one participant explained:

> I always have it in my hand now … [or] I got a little purse, I put it in my bra. Sit down. [5W04]

The following woman whose daughter had threatened to ‘burn down the house with me in it’, was scared for her safety. However, she had for some time let her daughter stay:

> She just stays here and then thinks she can live here for free you know, this all goes there, and then I’ve got to supply them with food, electricity, gas, bed – no help – was no help. It was more … it was getting me down. [2W02]

Eventually, in response to her daughter’s increasingly erratic and aggressive behaviour, she was able to secure a violence restraining order (VRO) against her, which meant she was no longer allowed to come to the house. Calling on the police and obtaining VROs, was a strategy used by some women, particularly when the violence and/or threats escalated. For others, they felt unable to stay in the house because of their relatives’ violence and saw moving out to be the only answer:

> My daughter’s been hitting me … I can’t stay there anymore. I want to move. She [is] a drug addict. She old junkie. She’s aggressive. Aggressive every time you talk to her. [5W04]

The women’s children and sometimes other family members often came and went, helping themselves to food, staying in the house, and creating trouble:

> ... [the daughter] and her drunken and drugaholic mob come and made humbug, you know? I had to call the police all the time. [5W04]

Similarly, a grandmother who had several grandchildren, their partners and children living with her, told of an evening when she believes her granddaughter left the house to obtain methamphetamine and, on her return:

> ... was going off … I had to call the police straightaway because she was fighting him [granddaughter’s partner] in there … Then I had to explain myself in the morning to my neighbours. [5W07]

The abuse the women experienced from younger relatives, exacerbated social and emotional problems for participants, most of whom were already struggling, financially and with disabilities. While women wanted to help their children and grandchildren, they were frequently left without food or money as relatives were not able to pay them back:

> I told him like this – he told me, like this, oh mum, can you give me a bottle price? I said, ‘look, I’m battling, I can give you money, but I haven’t got it. Anyhow, that’s the last I give you money. What you want to pay your board because money don’t grow on tree. You can’t have a free feed with me’, and he don’t like me to get this and that. ‘Get the proper food what I eat.’ What he eats. What about me? [5W04]

Another women's daughter was involved with a controlling partner, and she would come to her mother asking her for money to feed her grandchildren:

> He has plenty of money but doesn't give her any money … I said, 'I'll lend you money', but I just think of the children because they have to have food. She came around the other night and I couldn't give her a lot. I could only give her money for bread so she could make some sandwiches. [She's not able to pay back] or so she says. [2W04)]

A few women spoke about the emotional impact of abuse, as described by the following woman:

> I've had it very hard. I've sat and – I used to sit after the daughter would abuse me and swear at me and say I do nothing for her, and just sit and cry. Then step back up and say 'okay, the moment's over'. She'll come back in tomorrow like nothing happened. [4W01]

5.1.12 Interventions for First Nations men's trauma

Many women emphasised the need for culturally safe therapeutic interventions and programs to help men heal from their trauma. Several noted that that their partners have unresolved trauma from abuse, as well as struggles with grief and loss, which lead to poor mental health and the use of alcohol and illicit drugs to cope:

> There's no men's outreach for him, there's nothing for him. Nobody goes to him. [Partner's name] is totally deaf on the other [from physical abuse in early childhood], and he hasn't done nothing about it … he was sexually abused as a child... counselling comes in every two weeks… [drugs] helps him cope, I see it. [4W07]

Men's ongoing trauma due to exposure to FDV and abuse experienced in childhood was linked by several women to their partner's abusive behaviour:

> It was hard because the partner – the father of my kids, I loved him. I still do... My first love... We did so many things together. It's not just something I can forget about… So, I do understand that he's healing as well… I think he was assaulted – sexually assaulted when he was younger. His mother is an alcoholic. His father passed away when he was young. So, strangers coming in, you know like them real drunken mob house. That kind of house. So, he had the childhood trauma and brought the trauma onto me. Then I had that trauma ... [1W04]

Women spoke of partners or sons who, having grown up exposed to or experiencing FDV, were now perpetrators of violence themselves:

> To see my kids go through it is even worser. Even my boy – one of my boys – he started hitting his girl around... I said, 'you've got to stop and think about that. You've seen your mother go through that all the time. You didn't like it, so don't put your woman through it'. [5W03]

> I know... it even happened to my partner you know, like he's actually been so scared that he never actually told anyone else but me. It's like he trusted me. He was saying his dad hurt him, because he was so scared that he couldn't even protect his mum. His dad was hurting his mum, you know? He hurt her so much and then she had to move away from him and then he was violence to him, so he had like literally hurt him, so he was scared. That's why he probably – probably when he was little, he thought that it was okay to do that to his woman. [1W05]

5.1.13 Turning points and sources of strength

Despite the many harms and negative experiences that women recounted throughout these consultations, there were stories of help and goodwill from others, and of the sources of strength that had led to a turning point in women's lives.

One woman who had suicidal ideation due to abuse from her partner stated she wouldn't act on it out of respect for her sibling who had committed suicide and wanting to be strong for her family:

> I used to be a heavy drinker… I don't want to be on this earth. I want to commit suicide. But from the respect of my brother. I can say it but I won't feel like doing it… I'm the only one trying to protect our [family] [3W01]

One woman described how various people had drastically altered her life's trajectory after over 30 years of violent relationships with the men in her life, beginning in childhood:

> I left here with my children. Police and welfare all put together money because I was with the kids 15 years. The police and the doctor, who was a doctor after the last miscarriage. That doctor that was looking after me, he was my God sent guardian angel… every now and again, I'd get a God sent guardian angel that'll help me out. Like a doctor or judge or a cop. [5W02]
>
> Building trust is particularly important for First Nations women with experience of trauma and FV, many of whom have been continually failed by the institutions in place to protect them over the course of their lives. This woman spoke of her differing relationships with two important services:
>
> I've got to have a connection with that person. Like a special connection with that person before I actually listen to that person and share with that person. I've got to have that trust. That's the one. That trust of that person because a lot of letdowns… [5W02]
>
> My doctor is a real good doctor. He's really good. I can talk to him about anything. Him and Dr [name], that's the main two I speak to, that I can talk and say anything. I can swear and laugh and cry. They'll have a laugh with me. [4W02]

For another woman, being connected with services and culturally secure support while incarcerated marked a turning point and enabled her to finally receive a diagnosis for her disability after many decades of being undiagnosed and unsupported:

> It took me 30-something years to [get diagnosed] – I end up getting jailed. That wasn't even in the state, in my home state. It was in another state... Because they deal with it a lot over there. They more – in touch and more advanced – more mobs' health and family's health. [1W02]

While a number of external events may have triggered a turning point in the lives of women, including coordinated responses between skilled healthcare providers, police and FDV support services, seeing the impacts of violence on their loved ones, or finally receiving the support they need, their stories are fundamentally a testament to their own inner strength and resourcefulness, and the sources of strength in the community around them.

5.1.13.1 In themselves:

> So, after that, that was the last straw that happened and then he would just threaten that he was going to kill himself and things and that was the last straw. I just walked out with him trying to put a rope around his neck in the shed and I just vowed that I wasn't going to fall for his crap again, which I knew he wasn't going to do. Then that's when I ended up coming back home. [3W04]

> What makes me strong is... Been through it too long and I've had enough. You can only take too much. If you've got to give up everything what you love and to get that, you have to do it... It's a better life too. It doesn't really have to be involve another person, it can be all sorts of things. Getting into community groups, meeting other people, going out and mixing. Finding new friends. It's changing the whole circle. That's how I got over all my drugs and alcohol. It's pushing that circle away and not going back in it. Everyone who comes around me, I just put my hand up. Don't even go there. You fellows seen me struggle for so long and now that I've got help and I'm going – doing the right thing, help me. Support me. Give me good words. Encourage me to keep going. Don't try and bring me back. Because being in that place is a very dark place. It's hard to get out. Only you can do that by putting your mind to it and doing that right thing." [5WFG03]

5.1.13.2 In family:

> So, I had to – my oldest sister [name], she been 30 plus years in the government system, working at the prisons. So, she's the only one that could tell me – because in my family, there's only a handful of people that can tell me what to do and I'll listen. What's best for me and I'll listen... She was the one that told me... 'Sis. Stop fighting. You been fighting for all them years now. The babies been over there that long. They've found their roots. Their roots is here now. So, you've got to go over there and you've got to…' [5WFG02]

5.1.13.3 In their children:

> You know with your first boyfriend, you're like… [besotted]. Yeah. But yeah, I've never looked back now... Yeah, then it became, yes, then it became all about my children, yeah. I got them out of that environment. [2W02]
>
> I've woken up to myself by seeing – really woken myself in the last four years by seeing my own daughters go through what I'm going through. So, it affected me more to see my own kids going through. So, that's why I've snapped right out of it. I'm thinking, 'well, I went through all that and I don't want my girls to go through it' because I know how bad it was and how it affects you mentally and emotionally… My mother went through that. But I don't know. Four generations. Yeah. Four generations of it… I'm thinking, I'm not going to let my girls go through it. [1W02]

5.1.13.4 In community:

> All them Nyoongar's in that town there, they was all like family, oh yeah. No, they looked after me and everything there. They're [unclear]. But they could see. That's a good little town, that mob. [5WFG02]

5.1.13.5 And in culture:

> Going through all this drama, that what I've been through and my kids and now my grandchildren, they make me strong. Because I don't want them to go through what I went through. I mean they've got their partners. I could see that they're actually living a better life than what I had with their dad, yeah. So and that's what makes me stronger, and I try and help others if I can, you know family, if I can give them a yarn or something and let them know what I've been through, I'm happy to do that… That's the main thing that makes me strong – my culture. My grandfather's background and my Māori grandparents' background – the Nyoongar side and Māori side, yeah. [2W02]

One woman summed up the satisfaction she felt in joining with others and being asked for her story, and the value and respect she felt from being listened to:

> I feel good. Sitting down and listening to all the girls, it makes you feel more – get up and be more open. I found it quite comfortable talking amongst us all. Hearing other stories is good because you understand what the other ones is going through. It helps in a big way. Then now, when this is over, we can all help each other. Encourage each other and give each other strengths. [Perth yarning circle]

5.2 Results – Children and young people

The children in our study reported a range of life experiences and confronting situations that had resulted in detrimental effects on their SEWB, their sense of safety, and their willingness to attend school. Children evidenced good insight into the issues they discussed with us and were able to develop coping strategies for dealing with them. They also spoke of the and sources of strength they had found for facing these many challenges to their health and welfare and the possibilities open to them into the future.

5.2.1 Anger and aggression

Children experienced anger out of grief and loss, particularly from witnessing violence and bullying:

> I was trying to find whether I was angry at the world, or I was angry at my life, about my life. But then I was just angry with myself of how I came out and all this… I didn't get to protect my younger siblings and I promised them I would. [5CH04]
>
> Annoying me – someone annoys me and keeps bullying me, I get angry. [5CH01]

In some cases, children's disabilities impacted their ability to regulate and control their emotions, which children reported manifested through anger and aggression:

> Yeah, and I do have anger issues and I've been breaking my phone enough time. Yeah, then sometimes like a couple of days after, I get a new one and break that one. [2CH01]
>
> I used to be really extremely angry, like I used to smash shit and just trash my room, like if mum said something that triggered me, I'd go to my room and bash everything and smash everything everywhere. So, I was more physically outbursts. [5CH03]

One child reported that her issues with anger and ability to self-regulate had improved over time:

> So, I've more gotten past my own anger and it's just working out how I can, when I get angry, how I can more… like what's the word? Keep myself together in a way and just explain why I'm angry. [5CH03]

Anger was often targeted towards their family and impacted their close relationships:

> I mean it affected mum a lot. She got the brunt of everything, because I would be really angry and I would take it out on her. So, it was more people that were closer to me. [5CH03]

Anger and aggression also led to getting into trouble with the police, suspensions from school and exclusion from community facilities:

> [I got banned from the pool because] They were being nasty to me at the pool, so I chucked their bikes in… I hit stuff. I smash stuff up, and I can't stop. They sit there and laugh at me … So, I smashed the car up. [4CH01]

> I got into a fight in I think Maccas, in McDonalds. Yeah and that's when the police rocked up. The second time I smashed a bus window. Yeah. Angry because the bus driver wasn't letting me on. [5CH02]

When asked how he feels when he wakes up in the morning, one boy simply responded, "I feel angry".

5.2.2 SEWB

For a number of children, irritability was exacerbated by poor quality, interrupted sleep:

> Because everybody gets up and they'll be loud in the house, and I can't sleep in bed anymore. I can't sleep when they be loud, yeah. [4CH01]

Sleep was an issue for a number of children for a variety of reasons. Several children reported being nocturnal, awake all night and sleeping during the day:

> Yeah [I call myself] the owl because I stay, because I stay up all night and I go to sleep in the morning, like during the day. Then I wake up during the night yeah. [2CH01]

> So hard, yeah… Waking up early in the morning sometimes. so sometimes I go on like TikTok and watch videos, and that makes me stay up like half of my night. [5CH01]

The lack of sleep impacted all parts of their lives, including their schooling:

> One school I used to fall asleep in class and that. [2CH01]

> There was no food and yeah, I would just be tired or just don't want to go to school. [5CH02]

Children in regional towns were often living in overcrowded conditions, which meant they had no personal safe space. In one town where children were often up walking around the community at night, a participant recalled a safe community place and suggested that something like this service be resumed:

> They closed it down and that was like a fun thing for the kids. They could go there, lay around, watching movies, cook a feed, lay down. There was always food there… Yeah, and if you don't want to be with your siblings or your mother, you can just go there. [4CH03]

> Every night they [could] just put on a little movie and play music. Do something like that every night for the kids. Then the siren goes off and then they can just go home, you know? Something like that [4CH03]

The absence of a secure space for children at night resulted in children roaming around and fighting in the community:

> He can go all night. Yeah, he sleeps in the morning time, but when it's night-time, he gets up and plays all night. He flogs a lot of kids. They're only little, like this little, and a lot of kids they're only like this but they let him… hit him back. [4CH01]

A few children reported fatigue and a lack of sleep due to stress and worry, and others depression and sadness:

> Sometimes, I always used to stay up all night and then I'll go to sleep early in the morning. I don't know. [Because] I just think of a lot of stuff. [5CH02]

> Yeah because I'm up all the time at night time because I'm watch – I even look at anyone who goes through that front door. [2CH01]

> I get depressed sometimes. I just – I don't know. I just feel sad… Tired… Probably because I haven't seen my sister and my siblings for a while. [5CH02]

A child described how her father made her feel guilty which impacted her emotional wellbeing:

> But it's really sad, that makes me the worst, because I feel guilty, and he also used to make me feel extremely guilty. That was one of his other things, he'd guilt trip the fuck out of me and now I've got guilt issues. [5CH03]

Another child described feeling a sense of hopelessness and despair due to being separated from her siblings by child protection:

> Sometimes, sometimes I would sit there, and I'd think about I'm not good enough for this world. But then I sit there, and I think to myself I can't do anything because of my siblings. My siblings need me… I was just laying in bed. I didn't get – I didn't really have enough energy. I wasn't myself all the time. I would get angry if people annoyed me with asking me just one question. [5CH04]

This child described the trauma from the removal and the events that followed, and explained the impact of this trauma on her engagement and attendance at school:

> It was because first off when we first got removed from mum's care we went to my nanna's, her mum, and we got placed into her care… it was fine until my sister left me and then I was like really – felt like sad all the time so I just stayed at home and didn't worry about school… the school noticed that my grades and everything were dropping and so they spoke to me. [5CH04]

The child protection removal, based on a hospital presentation due to skin infection and allegations that the child felt were untrue, heightened her feelings of anger and despair:

> The reason was because we had school sores so it was all over school sores when the doctors told us that we could go home. But then they put more things on mum saying that it was because she was on drugs, and we were getting flogged and all that when we were going to school with bruises and that on us when we wasn't. [5CH04]

She felt a strong sense of responsibility for her sibling who was abused in care, resulting in self-blame and feelings of failure at being unable to protect them:

> But then I was just angry with myself of how I came out and all this… I didn't get to protect my younger siblings and I promised them I would. Yeah, it was a promise that I would keep them safe everywhere we go and now bad things have already happened I don't really see myself as a big sister anymore… Because I take the blame for it. [5CH04]

5.2.3 Bullying

Bullying was a significant problem impacting children with disabilities, which lead to further trauma and in a number of cases prevented children from being able to attend school:

> They would say, look at that ugly girl. Saying mean stuff, you know? [4CH03]

At least one child reported experiencing bullying due to racism, which prevented her from going to school and had a significant impact on her education:

> That I didn't have no friends or no one at school would like me and just didn't really get along with most of the kids… some of the girls who thought they were popular in primary school, and they just didn't really like black kids so they always made fun of my race and all that, so I stopped going to school for a year and came back… Yes, there was a lot [of white children], and I hardly had no friends because of how people treated me and that and so I just stopped going to school and didn't really worry about it… I didn't like school because I just felt like I was different. [5CH04]

This child, and others, also spoke of being prevented from attending school due to prolonged bullying, which for one child had become normalised:

> [Bullying makes me feel like] not going – not going to school. [5CH01]

> Every time I'd go back to school, they would bully me and tell me that I deserved it and all this and that… Yeah, really nasty. I didn't really have any friends there and I felt like I was alone and so every time recess and break would come, I would always go and sit in the toilet because I didn't want to be seen from other kids. [5CH04]

> Not really, I just don't worry about it [bullying]. Yeah, because when I was little I used to be scared of it but now, not really. I'm not really scared… [I've had lots of people bully me before] so I'm used to it. [2CH01]

One girl described not being supported by the school during her pregnancy and being unable to continue attending due to bullying and feeling unsafe:

> I couldn't go actually. Nan stopped me because I had, yeah, I got in a fight there when I was pregnant. Yeah, against two girls, they just wouldn't stop, so I had no choice but to fight back. No, it wasn't safe at all, school. Yeah, so I just left and didn't go back. [5CH05]

Children developed strategies to deal with bullying, including involving teachers, ignoring the bullies, or standing up to the bullies. This had led to some children retaliating and getting in trouble:

> No, they were doing it to my little brothers. And kept cheeking them, like other boys, it was boys. So like they started swearing at me then, so I just, yeah, kept flogging them … I flogged another kid and got expelled… No. It's just like, kids like little, like bully kids, like want to cheek people for nothing. [4CH02]

> I couldn't go actually. Nan stopped me because I had, yeah, I got in a fight there... Yeah, against two girls, they just wouldn't stop, so I had no choice but to fight back. No, it wasn't safe at all, school. Yeah, so I just left and didn't go back. [5CH05]

> You know kids laugh at you when you have school, but I just kept ignoring them. They just gave up because I kept ignoring them… They would say, look at that ugly girl. Saying mean stuff, you know? [4CH03]

> Well sometimes like – so every time I tell on the kids, they start getting like sooky, you know… Yeah like start getting sooky, like at me, because I told on them. [2CH01]

5.2.4 FDV

Most children reported witnessing violence, often directed at mothers and nans. In some cases, this had led to children standing up against the perpetrator from a young age. Some children reported witnessing a number of different forms of violence:

> I'd try to be as confrontational, and he also used to abuse my nan too. I used to see him [laughs] hit my nan and like she'd be making spaghetti and she would put something, too much salt in it and he'd hit her across the face for that, like that stuff. [5CH03]

> I saw mostly all of them ... I just felt like worried. I felt like my mum was going to get hurt. Yeah… Scared… [I tried to protect my mother] once. This one boy he tried to – he hit my mum so I got a stick and hit him. Yeah. It wasn't that – I was just still little then. Yeah. [5CH02]

> Yeah. It was quite like basically every day [violence] until it got up to 2019 until she passed and then he got locked up and then… [Mum passed away] Yeah, it just happened from there. Nan was just like – I think she just gave up after that. [5CH05]

> He punches her and everything. He's been hurting mum, and mum has been calling me at five o'clock in the morning asking – no, telling me what he's been doing. He kicked her out and made her sleep on the beach and he flogged her and everything and he's a bit of a moody boy. [5CH04]

One girl explained the impact that trauma from witnessing violence had had on her life, explaining:

> [It's affected me] a lot. That's what affected me now probably with school. I'm trying to get a job. [5CH05]

Children also reported witnessing community violence, often involving people under the influence of AOD. In some cases, children themselves experienced violence:

> The violent thing I've seen was… we were all going back to home to our own houses and then that's when my brother – I don't know, he was drunk – this one other boy, he walked up and hit him with a stick in the back. So, my brother got wild, and he went and grabbed a shovel and knocked him out with a shovel. I was screaming and crying, and I went running down the road to tell all my other siblings and they rang up the help. [4CH03]
>
> Yeah, like most of physical abuse mostly happened at [street name]. Like all the drugs, they would get drunk, yeah, a smash would end up happening at the end of the day no matter what. It's like knowing me I would run in and go try and stop it… Yeah, and then again with my little sister. She was like – no-one would be there to help if something would happen. Especially to our nan as well and our aunty. It's just me and my little sister there and we'd have to run to our next-door neighbour… yeah, at one point he slung me and my little sister from stopping him from – trying to stop him from grabbing nan and shit. Yeah, it was pretty hard trying to stop that at a young age. Yeah, it was pretty crazy. [5CH05]

All children experienced some form of verbal abuse, either through bullying behaviour or often from male perpetrators who were under the influence of alcohol:

> He calls me every name under the sun… he'd make it everyone else's fault to be honest with you and then he'd get really drunk and he'd get angry… that's another thing dad used to call me, that – like a biggest trigger. [Partner's name] once said that I was thick in the head… and I got so fucking mad… I was an idiot, or I was fucking stupid or that I was dumb. That was also another thing that I worked hard to prove. [5CH03]

One child described having experienced sexual abuse in early childhood, and of how her now partner limits her contact with her family:

> No. He tried to actually sexually harass me actually. Yeah, and I was that young I thought – like I didn't know that was even – didn't know nothing of it. Yeah. [5CH05]

> Yeah, like with my partner. He just – he doesn't like me and my family because he thinks my family are robbing me and I'm trying to tell him no, I'm not in that. They're not like that. I hardly get to see them. Yeah, it's like they just – even for Mother's Day I couldn't even see her. [5CH05]

5.2.5 School and education

Most children reported having difficulty concentrating in class, due to both disability and trauma:

> [My disabilities] are both diagnosed. I have severe ADHD and mild dyslexia, so I'm not super dyslexic, but it does affect me very, very, very strongly and with my ADHD it's been hardest for my concentrating and if I don't like what I'm doing I just don't really feel the need to do it. Or I can't concentrate, which doesn't help me the best… just concentrating to be honest and not… not doing things on time, I was very bad at that. [5CH03]

Some children reported issues with sensory processing and auditory sensitivity which impacts their concentration and learning:

> I struggle with school a lot, yeah. Reading and there's too much talking and that. I can't concentrate. [5CH02]

As was noted earlier, some children reported sleep problems, which further impact concentration and learning, and can aggravate symptoms of disability:

> One school I used to fall asleep in class and that… yeah because I'm up all the time at night time because I'm watch – I even look at anyone who goes through that front door. [2CH01]

Children reported maths as being a particularly challenging subject to focus on:

> Maths is hard, and yeah, I don't really know. Hard to concentrate. [4C01]

> Oh I don't know. Oh the people – sometimes you do math and I find it a little bit difficult … I get the answers wrong. The answers wrong at school when it's hard. [5C01]

Many children found that their school did not provide a learning environment that was suited to their needs or strengths. One boy described how hard it was to concentrate in school, however, when painting a boomerang as part of the yarning session his aunty commented:

> This is the longest I've seen him sitting and doing one thing. [4CH02]

A few children highlighted that the inflexible teaching methods did not take their individual needs into account. Children reported some teachers having a lack of understanding and awareness of disability, and their student's needs and how they learn. For example, one child preferred reading on paper to online learning:

> I'm just like 'look, I'm extremely bad at writing. I can try my hardest, but I'm just going to need more time. I'm going to need a little bit of assistance if that's possible' and that kind of stuff. I mean I love reading, but I still struggle to do online stuff, so I just yeah, I just ask for paper or if I need to sign documents, I might [say] is it okay if I can get someone else to sign it for me. [5CH03]
>
> People still don't really understand it. With most disabilities or stuff, people don't really take the time to see it. They kind of just be like oh yeah, ADHD [attention-deficit hyperactivity disorder], 'here you go, here's some things that will help you' and it's like 'no', not all those type of things help. [5CH03]

A lack of understanding of disability and the impacts on learning and behaviour, resulted in children being reprimanded:

> I had this one [teacher] when I was only young basically tell me I was stupid because I couldn't write [due to disability]. That was really offensive. She made me feel like I was dumb, like she used to scream at kids. She – yeah, just no one really knew and no one really understood why I was like the way I was and I'd get in trouble shit times. [5CH03]
>
> So I was practicing my cards and she screamed at me in the front of the class and I was like 'oh hell no'. I was like 'all right, here you go', gave it to her and [unclear] I went out, some of the kids were like 'oh, you've got to go back in, she wants you [there]' and she started screaming at me. So I was like [unclear], 'you want to have a go?' [5CH03]

This child identified that, despite her strengths, she found school overwhelming and got left behind due to the lack of support and teacher ratios:

> So I'm very smart, very, very smart and I did all my ATAR classes, but it got so overwhelming. Especially with other things going on and because I was also diagnosed with depression and anxiety as well. So that didn't help and I got really overwhelmed and I dropped out of ATAR… but there's not really enough support in classes like that, especially ATAR, because they have to look after so many kids and then you kind of get left behind if you don't kind of sort it out. [5CH03]

And this same child, among others, reported issues concentrating at school due to both depression and a lack of sleep:

> It hit me again and I started struggling with getting there on time and waking up and just being depressed all the time and then trying to be there. [5CH03]

A number of children reported being told they were, or made to feel, 'dumb', including by teachers, which eroded their self-confidence and affected their school attendance:

> That's what affected me now probably with school… A bit hard if you kind of think 'oh fuck, I'm too dumb, I can't do it'. [5CH05]

Children did, however, describe the positive aspects of school, which included learning, sport, hanging out with friends and cousins, and engaging teachers:

> A couple of the times. School is good – I learn new stuff. [5CH01]

> I like maths, yeah, and sports. Basketball, football, yeah and a lot of sports that we play. There's soccer. [5CH02]

> Like I just hang out with my cousins… So that's why I want to hang out with him at the – he's usually goes to the basketball courts. [2CH01]

> But I got better slightly when I went to my other high school because I was friends with everyone there. No one was mean to each other, so I was very good there socially. [5CH03]

> But then I got a really nice English teacher that year, he was amazing actually. I didn't do too well in his class. I got really bad, but it still was really nice there, like he made it a bit more enjoyable. [5CH03]

Some described being supported in their future employment goals and the importance of being a role model for their younger siblings:

> I want to focus on school and get a good education for my little siblings. [5CH04]

> Yeah, they're helping me with a job now. You feel you're going to be all right with that. [5CH04]

5.2.6 Coping strategies, family and sources of strength

Children had developed a number of strategies to cope with their stress and anger. A number of children listen to music and use their phones to calm down:

> Upset that's why – because I'm getting phones to listen to music to calm me down. I listen – walk around listening to music. [2CH01]

> I just put my Air Pods on and just listened to music… Yep. Yeah, but I just sometimes go for a walk. [5CH02]

At least one struggled with taking his anger and distress out on objects, which frequently resulted in his phone being damaged and needing to be replaced:

> I use phones all the time just to walk away, yeah… [But I have] a lot of anger too. Just – I don't know really. It's like every time I have electronics in my hand, like a phone, I smash them all the time. [2CH01]

Another child spoke of walking away from a stressful situation to calm down, a strategy used by other children in the study:

> I get wild… I just swear at them back and just – but yeah, I don't get too carried away, you know? Yeah, I just swear at them back. Then I just go, walk off, go for a walk somewhere. [4CH03]

Children also recalled calling on the support of their Elders in times of need, including to help them deal with anger:

> Oh I go walk. I talk to my Elders – Elders – my Elders. [5CH01]

Children described the positive influence from the involvement of families in educational settings:

> Sir [name] is cousin brother who works in the dorm, he's a dorm parent. [5CH02]

Their mother played a significant role in one child's life, described as a "saviour":

> My mum's just been my biggest saviour to be honest, I'm just very lucky for her… mum's just had me for a solid 16 years, 15 years of just caring for me. [5CH03]

Another child described support and guidance from her nanna to help her engage with educational resources:

> Felt like sad all the time and all that so I just stayed at home and didn't worry about school. But nanna told me to download these Apps on my phone that would do my timetables and all that. [5CH04]

And an aunty in the interview described the important role of the nan in the boy's life:

> Nan try – Nan understands and tries to settle him down and don't make things a lot worse for him. (4CH01)

Children felt stronger when they were connected to their family, culture and country. When asked about sources of strength, children described going out On Country with their family:

> I did – I do like fishing. I've been doing that since I was little. Well my cousins did – took me out there. [2CH01]
>
> Once I went fishing, well crabbing. Yeah, in I think Pinjarra wasn't it? Yeah, with my aunties and that. [5CH02]

Another child described learning about her cultural history from her nanna through art and storytelling:

> I know lots because of her art, like she obviously doesn't really speak fluently in the language because of that, but I've learnt a lot through her art and her storytelling. Even though she's got Alzheimer's, she used to tell me a lot of stuff when I was younger and I used to ask her stuff as well, so I do know quite a lot from it. [5CH03]

Several children expressed that being a role model for siblings was a strong driving force for them:

> My little nieces and nephews, they look up to me. My older brother, he looks up to me. My little sister, she looks up to me. [4CH03]
>
> Seeing my little sister [makes me strong]. Yeah, knowing she's okay and she's doing good and that makes me want to do good. [5CH04]

Another child described looking up to their older sibling and getting guidance and support from them:

> My brother [name] bought me a $200 perfume. It made me happy and that, yeah. [My older siblings help me] all the time. [5CH02]
>
> I go to my oldest brother and my little sister. [4CH03]

When asked where he gets his strength, one boy responded 'Just myself. I just thought about it, like because I lived this life'. [5CH02]

Results – Carers

The carers we interviewed included four mothers, four grandmothers, and one foster carer. A few of the carers also had a disability. Some carers provided intermittent care for multiple children, while others were long-term carers. The majority of carers did not receive the carer payment. One grandmother had relocated towns to gain access to NDIS services.

5.2.7 Child disability and the impact on mothers

Mother carers described common challenges around sleep, medication, violent behaviours, and their concerns for the future:

> The anxiety side of things I find when he doesn't take them. Like because it's hard when he's – when he's awake I'm sleeping and when I'm awake he's sleeping. So then it's kind of hard to catch him to take his antidepressant, anxiety tablets. So then I notice the change in his mood when he doesn't take the anxiety tablets. Then he starts to get upset easily and angry easily. [2C01]

> Just take off. Like when he wasn't at school, he'll take off with his friends and go and meet up with them and do stupid things; stealing and whatever… He's still going to court now but yeah, just stealing… Yeah. I worry about that… I was in another house but still had trouble with him for schooling, because of his behaviour with other kids. He's got a temper – short temper. [5C03]
>
> From my exes, from living with them… Through domestic violence.... He would have seen him hitting me. We'd all screamed at… Sometimes he won't sleep till early hours in the mornings. Then he's late to go to school, doesn't want to go to school because he's sleeping, can't sleep. [5C03]
>
> Yeah, like I'm planning her future. I've got a lot of support from school... At the moment we're planning her life... what's going to happen when she leaves school... there will be a job for her. But I'm saying as a parent I wouldn't want her to live on her own. There will always be someone with her. I tell everybody I'm saying 'well, yeah, I'm planning her future' I'm saying 'but she won't be having no boyfriends. She won't be having no babies' – them sort of things you know? [1C02]

This woman, and others, spoke of their unmet needs for support while supporting others:

> Struggle, struggle all the way… No one there for me, not even – my mum passed away when she was 51 when [child] was seven years old, she passed away then… Yeah, she would have been my support but because she wasn't there, I had no one. The old people that grew me up, they passed away too. [5C01]
>
> I'm supporting them as well as my son… I'm supporting people, not me getting support. But I've been getting support from [mental health provider], you know, I ring them up and I talk to them, and I tell them when I need my glasses or need my sleep apnoea... I don't leave things until late or leave it, I just do what I have to do every day. [5C01]

5.2.8 Impact on Grandmothers and other family carers

One grandmother had been advocating for some time to gain a diagnoses and support for her grandson. She gave an insight into the kind of behaviour and support she manages in regards to his uncontrolled and violent outbursts:

> Very active, he can go all day, he can go half of the night. It's draining when he was ... smaller because you constantly had to watch him. [4C01]
>
> I'm constantly having phone calls. I constantly go to her house, and he won't calm down and I'm the one who's got to put up with it and take him for a ride and talk to him and when he's calmed down, he goes back…Won't go to school…Haven't been to school all this year. [4C01]

In common with the other grandmothers, her caring is informal as children float between parents and grandmother:

> ... in the last six years these kids have been in and out of my house on maybe a weekly basis, a two-day basis, a month stint, back to their parent – mother or their father. [4W01]

> I've raised these kids yeah, you may as well say I raised them as well. The father help when he want to. He's got his own house. She's got her own house. I don't know what else you can do with – they're drug affected and the three that are, are 16, 15 and 13. The 13-year-old is the ADHD. Very abusive. [4C01]

Another grandmother has been caring for multiple children long-term. She had been the first point of contact and provided crisis support to ensure her grandson is stable. She has another grandson who self-harms. She stated she has attended to this type of situation more than once:

> He's probably nearly 30... we took him when he was only a baby because he was only 2lb 12ozs... born three months early… We didn't know that he had a disability until he was about a few months old... they picked up that he had cerebral palsy… All the specialists and up and down to Princess [Margaret Hospital]. We take him down there. He had two major operations down there… Yeah, he still stays here but I reckon he wants to get out on his own as well. Yeah, you're all right. But you've got to work out what the visitors that come here – they take everything that you've got… I've got another worry too, my other grandson…he gets really depressed and cut himself, so I took him up there, the second time not so long ago… he said, 'Nan, take me to the hospital'. [2C01]

Two other grandmothers had been providing support to their non-verbal grandchildren. One grandmother is 54-year-old with chronic health conditions and had been providing support for her 23-year-old grandson since he was a baby:

> Yeah, I get up early, do the things for him, cooking everything and then I feel tired, I want to have a rest and a lay down… No one to watch him, I just get up and look around, where are you?... that's why I get up and look around, or he might walk off… I'm there with him all the time, yeah, 24/7... No, that's what I want now, respite care. [4C01]

One grandmother spoke of her deteriorating health and her frustration with poor responses from services:

> Well, he was staying with this dad... I would have to walk from my place to my son's house ... and just to check him up every time if he's all right... on my pension day, I'd buy some stuff what he likes so I'd just drop it in for him and ask him if he's all right... he's 21 and I chased Centrelink early last year but, you know, what can they do for him. They said maybe you need to get him a laptop so he can learn from a laptop. [1C01]

> I support myself all these years on my own… I would probably be dead and gone by next year… I'm getting pains everywhere and I can't do much... I think the pressure – because of you're under pressure... So this is where you need that respite – getting someone to advocate to take care of him for a couple of days and make sure he's fine. [1C01]

An interview with another grandmother provided insight into the extent of intergenerational disability, and the impact on child carers as young as eight years who undertake responsibilities similar to the work of paid carers. This particular household represented three generations of disability with multiple caring: the grandmother with a diagnosed mental health condition, the daughter with a chronic health condition, and a grandchild with a disability, with the other children carers all helping with the family responsibilities:

> Big burden. The boy was 12 or 13, he was dressing his mother when no one else was around. Little girl was 8 and she had the biggest responsibility – because the boy backed off – of making her a cup of tea, changing her clothes, putting socks on her when she was cold, turning her over in bed at night because this child was constantly with her. [4C01]

5.2.9 Impact on foster carers

A First Nations foster carer who is raising and caring for two First Nations male adolescent siblings, one with a cognitive disability and one with other health conditions. This carer spoke of the challenges of navigating children's disability and the toll it had taken on her emotional and social wellbeing:

> I think as time wore on, people started explaining to me about [his] mum's drug use, and alcohol use when she was pregnant… I wanted him tested for FASD... DCP uses PATCHES [Paediatrics]… Them just saying he had 70 per cent cognition – that's what they diagnosed him with, which is quite severe. I still believe he's got FASD. [5C02]

> I've got a lot of issues with [child] who has multiple physiological issues because of what happened to him in utero. So I'm constantly at Perth Children's Hospital with him and treating him…. they're thinking of putting him with a different school that is more flexible with attendance. His psychologist is like, she's impressed even if he does one or two days a week [at school]. He definitely has PTSD, he's been diagnosed with that. So it's a pretty full on mixed bag in this house and carer's fatigue is real, I do not doubt that now. [5C02]

> But he's a lovely kid, he really is, but he's in the throes of that disease. The main thing for him now is that – he punched me before it happened you see. So now it's all with the Public Trustee and this kid gets $160 – no $120 a week plus a $20 food voucher… So he's not even – and he's on the disabilities and the NDIS and they don't do anything... he's got a mentor... He's managed to get three days temporary accommodation for him... But this is a boy that has been, for the last five to six years, let down at every turn because they've labelled him as a drug addict. [5C02]

5.3.4 Intervention support

Many carers raising children with suspected disabilities emphasised the need for accessing early intervention support and comprehensive clinical assessments in order to obtain correct diagnoses for their children and grandchildren.

Children in care are most at risk of receiving incorrect diagnosis, which can lead to detrimental outcomes and complications throughout life. One carer commented:

> … so, he's only [got] 70 per cent cognition but I really do believe the people that assessed him for FASD were mickey mouse. That particular company was run out of Fitzroy Crossing because of their ineffectual assessments, and because DCP use them as the provider of choice… I had enough of that rhetoric from them, that I went to Princess Margaret's Indigenous team and I said, 'help me, help me get him assessed'. [5C02]

Carers were frustrated with having to advocate for the children in their care and with navigating the DCP's complex disability assessment procedures in order to gain support and diagnoses, which added to the burdens of daily caring:

> He would have been assessed already. He would have been approved to be on the NDIS. The problem is that they probably didn't advocate into carers' areas or [for] different organisations to come and assist them with help with his own personal needs, as well as assisting this one here [the carer] that comes up and makes sure he's all right. [1C01]

The challenges for many families in gaining assessments via the public system are often lengthy wait times and many families are unable to afford private assessments:

> Yeah, and if you – you can be paying to get him actually assessed with autism, be from $2,000 by a psychiatrist or psychologist … but I'm going – I'm working towards getting it done, yeah, if the paeds doctor can't do it then I'll have to look elsewhere. I'm just trying to find answers. Yeah trying to find the right diagnosis I guess. [2CH01]

One carer said the family had been dealing with her adolescent grandson's behaviour for some time. He was being treated and prescribed medication by his doctor for his mental health instead of for his disability, but was reacting badly to the medication:

> So, he did diagnose him with ADHD. He did have him on some tablets. The first time he took those tablets they made him terrible … Yeah where he just was really upset and wouldn't stop crying. I was like, 'what's going on here?' He didn't even know what was wrong with him and I just put it down to being those tablets. Yeah because it's – I know that there's something not right. [2CH01]

This grandmother, living in a regional town with no access to disability services, found herself mentally exhausted from dealing with ongoing behavioural issues stemming from his disability:

> Yes, adolescent… who's had ADHD from very small… He's only been diagnosed in the last six years I'd say. He was only diagnosed because of the school. Every time I did want him checked it was like 'no, nothing's wrong with him, nothing's wrong him'. Eventually yes, he got diagnosed. [4W01]

Carers commented that lack of appropriate early intervention contributed to the escalation of negative behaviours in the children they were raising. The lack of support to intervene in this behaviour has left carers vulnerable and exposed to violence. Many carers pointed out that with early intervention support difficult behaviours and wellbeing could have been better managed:

> He's violent to his parents. He has smashed car windows. He has smashed house windows. He has tossed everything around in the house. He has smashed a TV or two… He's supposed to be on a juvenile justice plan… good luck if you can get him to attend it. [4W01]

5.3 Results – Stakeholders

We interviewed twenty-one stakeholders across the five sites. Six were working in ACCOs (four in health services, two in community organisations), five in Family and Domestic Violence Services, six in disability services, one in a public hospital (in a town with no Aboriginal Medical Service (AMS)), and three were employed by local government. Their roles and responsibilities varied, providing a broad range of perspectives on the challenges impacting First Nations women and children with disability both in relation to FDV and more broadly. This includes both those directly providing support to First Nations women and children, and those more involved with policy and management, with stakeholders often having experience from both perspectives. While each site reported a variety of different issues facing First Nations women, children, and families, as well as specific priority areas and solutions for their community, a number of common themes were identified. Some themes were found across all sites, while some were clustered by the site's level of remoteness and resources.

5.3.1 Broome

We interviewed three First Nations and one non-Indigenous stakeholders in Broome, two each from the Broome Regional Aboriginal Medical Service (BRAMS) and a Yawuru Chairperson/ Elder. In the interviews from Broome, the word disability was not commonly used, and it was evident in discussions with stakeholders that disability needs to be embedded in a cultural framework.

Stakeholders noted the extent of FDV among people with experience of disability, and the circumstances in which this occurred refuge:

> ... there's a lot of DV that's still occurring. We know that houses in our community has got a lot of disability people. People with special needs. Children as well, not only adults but children who are witnessing all of this behaviour. [1H04]

> So, we've seen domestic violence in amongst disability and suicidal ideations that has occurred and this – the ongoing you can't sleep, rest, your loss of rest, your loss of security for yourself, the lack of other programs. [1SH04]

> So, families with disability or special needs are already going through the trauma and witnessing the trauma. So, all of the things that I've mentioned here – the fear, the anxiety, the supressing of all your emotions – it's already taking place, it's unfolding. So, it's causing more towards the person with the special needs. [1SH04]

> ... my heart goes out to single parents with children or themselves with a disability and they've been through so much violence in their life. Sometimes it comes down to, they don't know who to talk to, they don't know where to go. They don't know what to do; they think – sometimes it gets normalised within their life and they think it's okay. It's – but it's not, but it's how do you get them to understand, this is not normal. [1SH01]

> They're scared. It always comes down to their wellbeing, what – they're scared. They feel that it could come back and turn around – basically like karma; they think that, but it's not. We know that but it's a process, so they know once they've – once you interact with police that you've started the process. Once you hit – start that process, you then trigger the violent – the person that's the perpetrator to then basically become more outraged. There's that – there's a bit of a barrier to report… [1SH01]

5.3.1.1 Child protection

The use of multiple carers raised serious concerns regarding the care of one young boy, and highlights regular staff turnover, and lack of training for inexperienced staff. The inconsistent care impacted on this child's welfare and mental health:

> That, for me, is what has broken my heart at the moment because yesterday I spoke about one kid who has already had four or five different carers just this year alone. Most of them have been young. Girls. You know, young ladies. Some of them have been old. But some of them have also been really, really young. So just this whole element of guidance is not consistent enough. You know, there's obviously this message of care and support but he's learning it from so many different people in so many different ways. I'm pretty sure these kids just give up. That's why they lock themselves in their room and they just wonder who is going to be the next person to walk through that door and care for me, you know?" [1SH02]

Stakeholders also highlighted the prevalence of generational disability on households and the burden on elderly women. It was common for elderly women with a disability to be caring for their partner as well as for grandchildren with little financial support. Stakeholders shared best practice principles in supporting elderly carers by assisting them to maintain cultural and social emotional wellbeing support. Among these were the provision of cultural healing spaces such as activities and cultural outings with peers, connection with regular health checks, providing a space where they can yarn and be heard, and most importantly the provision of practical support and advocacy to address relevant and current needs.

5.3.1.2 Perception of disability

Explanations of disability reflected the different view of disability in contrast to the western definition, focusing on strengths rather than deficits:

> Well, at the moment I'm going through the process of how disability – though how I see it is that it is done in a white society, so we've got to bring it back to the home ground of our culture and how we deal with these kind of disability mob. [1SH03]
>
> It's not different being disability, it's just understanding there's people that need something more than what they really need and that is spiritual by listening, feeling, and also being accepted. [1SH03]

All four stakeholders commented on the high rates of disabilities in the family, and that there are many First Nations women who have been identified as having a disability and are registered with NDIS. They noted that disability in some families is multi-generational:

> We know that houses in our community has got a lot of disability people. People with special needs. [1SH04]
>
> Well I mean for me, as an Indigenous person, you know growing up in an Indigenous community and sort of speaking from my own lived experience, there is this fundamental element of abuse that really stops our mob. It's generational. [1SH02]
>
> I got a lot of carers that look after their other half, or they look after their grannies and things like that. [1SH03]
>
> I don't know off the top of my head at the moment. Kids – we've got a fair few kids between the ages of 2 to 17; obviously from 18 they're adults. But 2 to 17, we've got a fair few of them on our – participating with us. Then we've got the mothers; we've got a – actually, we've got one, two – I think definitely two – I know definitely right now we've got two mothers that have their children – they're on NDIS and so are their children. [1SH01]

5.3.1.3 Cultural safety

Stakeholders comments outlined aspects of cultural safety in the ACCO sector and its importance when working with First Nations clients with a disability. In some cases, tension exists between ACCOs and mainstream organisations due to the different perspectives on disability and ways of working. Early access to services was identified as important to prevent existing health conditions escalating for their clients:

> The thing is, is that's what we want; we want Aboriginal people working with Aboriginal people. We want to build that trust and the only way you can build trust with Aboriginal people is by getting them to work with Aboriginal people. [1SH01]
>
> That support is that by trying to be there for them, to listen, to try and steer them in a way [is what works for First Nations people] – in a proper way that they can try and reduce that risk of being sick themselves. [1SH03]
>
> This is why I talk about liyan.[57] Liyan is the most critical part of all this setting. You've got to think about liyan. Liyan will portray so many different aspects of people's emotions… Emotional, social, spiritual, health and wellbeing. [1SH04]
>
> There's always a good healing on country; there's a good healing of talking to Elders and listening to Elders of their stories of how they grew up. It's more of a cultural significance where they can learn the process of dealing with their problems and having a knowledge of coming back to that spiritual connection with Elders... So with my clients that come in

> – like, I've got one client that comes in regularly, have a cup of coffee and – he comes there to have a cup of coffee, sit down and be acknowledged. That's how I deal with him and he feels happy and everything like that... I think it's a sense of knowing that he is welcome... that he can get support, that someone that can listen to him and understand his ways. That's the cultural significance that we have to bring back to them; hearing the Elders, hearing their spiritual voice, as well as feeling the country under them, grab them and hold them tight. That's the wellbeing that we need to bring back to our... Aboriginal disability... [1SH03]

5.3.1.4 Staff workload

Stakeholders' highlighted major gaps in service provision for ACCHOs, with the strain from lack of adequate funding versus the workload generated, and stretched capacity to meet the NDIS threshold:

> She [a worker] goes and picks them up. 'How are you going?' She's only one person. Her workload is enormous. [1SH04]

> [Do I feel well supported when working in the disability sector?] Not really. I've just noticed that I had to write – or my co-worker wrote up – because we had some facilities happening in here for disability as well as health issues and everything from different organisation that ... held meetings in these [name] centre. [1SH03]

5.3.1.5 NDIS issues and disability access

The NDIS scheme is still new in Australia, and these comments by stakeholders provide an insight into the level of exploitation by some external providers of services. ACCHOs are having to advocate and monitor NDIS plans when it comes to external services to avoid exploitation of their clients:

> They charge above and beyond what a normal gardening service would charge but they minimise – they have a minimum standard of what they can deliver ... when I saw one of their quotes, I nearly fell backwards and go, 'are you serious, you're going to pull this out of their plan?' It's like half of their – or quarter of their funding gone. [1SH01]

> … they've taken – this is like a system that's abusing the system. So, I've asked – our workers are always like, 'no, we've got to get second quotes'. [1SH01]

> Kimberley Support, which is under KAMS [Kimberley Aboriginal Medical Service] ... the last meeting I had with them, they then advised me that they are trying to support and help anybody that wants to become service providers for NDIS participants. Basically, how to get their business up and running, what are their requirements and whether they want to become registered or not registered... and just their feasibility on how much they would be able to charge and just things like that. So, KAMS are offering that to anybody that wants to become service providers so they're opening the doors up to say we're here to help you get your business up and running if this is the pathway you want to go down. [1SH01]

The steps and work required to enable a client to meet the threshold for NDIS funding was also discussed by stakeholders:

> We do a referral to that position, to that person and what the evidence and access coordinator then goes and does is collate evidence... for the potential participant to have access met by NDIA [National Disability Insurance Agency]. All medical records, OT [occupational therapy], specialist reports... basically as evidence to say, this person has a disability… 80 per cent of the time is BRAMS; the 20 per cent would be other specialists that may need to be referred or they could have come from... another town that we'd need to get some medical information from another AMS. But that's all done here, through our doctors with the medical assessment side of things... A lot of them, when they come through that assessment are under those criteria, fit those criteria; NDIS – they have to meet it. The NDIA – we can't do anything until NDIA have approved their plan or have advised us that they've access met. Once they've done that then that goes to the next stage of their planning, plan approval and then come over to us to then deliver service. Obviously, if they've chosen us as a service then they come over to us, then that's when we deliver the service. [1SH01]

5.3.1.6 Service issues

A range of issues were raised by stakeholders as urgent in the town, among them lack of after hours service a lack of crisis accommodation, and being under resourced. The lack of availability of support after hours for victims of FDV is contributing to suicidal ideation for some victims:

> Yep, so until the victim... can actually go down to the courthouse to complete the interim VRO and then be heard in front of a magistrate; basically, to have it approved. Then served is another component, as well... if the incident happens on – say on a Friday night, your 72-hour order, that's going to lift on Monday night. You go to court on Monday, fill out your interim VRO; the court... may say – the majority of the time in Broome is, I'm sorry but we don't have any opening until tomorrow'. Basically, if that incident happened Friday night at eight o'clock ... the perpetrator's been served at eight o'clock, 8:00 pm, that the interim police order comes off at 8:00 pm on Monday night. So, what happens between 8:00 pm to the next day until that victim has been heard in front of the magistrate? That's where the gap is. It's really – it's scary. It's scary for the victims, because there's always a gap. [1SH01]

> But they're hitting brick walls too because there's clients that'll ring up one of the Transition to Work (TTW) saying, 'I'm going to kill myself' and this and that, 'I need to talk to someone'. But there's no one after those hours, after midnight, to talk to and then you're twisting and turning because you don't know if this person's going to kill themselves at the spur of the moment. You're trying to ring around and find out if there's someone that can help this person. But there's no help – there's no organisation that helps after hours and this is where the downfall is, and this is where suicide prevention is trying to – hopefully they are stepping up; I'm not too sure what they're up to, but they need to step up on their hours because it's a 24-hour thing with people with mental illness. [1SH03]

One stakeholder also spoke about unsatisfactory practices when working with people with mental health issues:

> ... So, when they changed those routines like that, he was very distraught. Then it took me having to bring him around and having to sort of... not friend him up but just bring him down because he was quite upset about it... because of his mental health, he relies on structure and routine... he's very sensitive to that. So he had it against me. He's like 'why didn't you pick me up?' I was like 'I'm sorry, it wasn't well communicated'... So I had to sort of go, you know, and then all of a sudden, yeah... after all of that, three weeks later, got a new carer. So a whole new person. [1SH02]

As at other sites, crisis accommodation and under-resourcing was a significant issue:

> No, and women are being turned back, some are. It's hard. Then you've got BASSA [Broome Aboriginal Short Stay Accommodation], which is the short-term accommodation, but again, that's not a refuge. But there is ... there's accommodation available there. But if you're fleeing domestic violence and stuff there… [1SH01]

> They do have [good access to the refuge] but, when they get overcrowded, they don't... fair enough, there's one in [Derby], one here but they only can have so much people in each room.... there's four rooms. There's one room for single mothers, there's three rooms that has family members like the mother and the kids can stay in a room. So there's a limitation of access of that because of – there's not enough rooms to be allocated to them. [1SH03]

5.3.1.7 Services for men and other gaps in service provision:

> But what I do find is that there are far more programs available for women that are exposed to domestic violence than males. Males only have sort of that one sort of domestic violence program that they do. They do get – there's counselling and stuff that's available around those issues, through us, through the clinic, or through mental health, or through men's outreach, or other sort of counselling agencies, Boab Health Services. But you know, like they're running this Shark Cage program which is once a week, this intensive program. I'd like to see more things like that with men. [1SH02]

> There are certainly a high level of gaps here. The service providers, they give a small percentage and what they do is, 'I'm sorry that's not under me. That's [not] my role. You have to go and speak to this one'. Then they'll... refer you to another agency. The other agency says, 'sorry I can't help you, you have to go to this one'. In the meantime the exhaustion is that these people, who are walking and trying to get transport to and from these agencies, psychologically they are exhausted... Repeating themselves trying to make sense of what has just happened during the mental health disability period of domestic violence. The complexity surrounding that is so enormous to try and comprehend what has just happened. They might say, 'my child has just had a mental health breakdown. He's suicidal. We're trying to focus on trying to keep him safe. I've gone to this service and they

> say one thing. The other service is telling me that I should get access to this service. The process is too complex for me to understand. I'm exhausted'. [1SH04]

5.3.1.8 Practical support

Elder abuse was raised as a serious concern, and as was common in other interviews during the site visit. Stakeholders spoke of advocating for the elderly and of organising and providing necessary services:

> I deal with the advocating over to elderly abuse or I deal with people that [are] needing help with disability, like going onto NDIS, asking NDIS, as well as giving that support of transport. Also they can access white goods, now the new policy is 1500 to help them maintain their house, like fridge freezers, washing machine, air cons and whatever. So they come to me for help or anything like that. [D1SH03]

> They might have things in there like daily living... household stuff that needs done. Funding is allocated to activities then community access. Then we then ask them how many – it's up to them; when they want it...who they want... delivering the services to them… They'll have a set of goals in their plan that we will help them to achieve basically within the timespan of their plans. A lot of them are things like getting their driver's licence or getting a part-time job or getting – doing study, or even it's as simple as wanting to engage into the community and do group activities. [1SH01]

5.3.1.9 Experiences of racism

Stakeholders noted that some women felt they were being discriminated against because they were First Nations women:

> So you could have a whole string of 10 violent related events in one night. The super – the super sergeant or the sergeant in charge decides which is a priority and which is not. So I imagine, without being too racist, I'd imagine most white ladies that call for violence and assistance regarding a violent incident would have more resources allocated to her as opposed to an Indigenous woman who would have rung for the same sort of assistance, who would have probably been in similar sort of risk. But you do tend to get that you know, 'They just typical black fellas'. You'll always have those coppers that are just like, 'That's just typical'. [1SH02]

> No, they don't really because in a way they feel – when they go out in the community, they feel like – oh, they feel so infuriated that people are looking at them, they feel that they're judgemental about them, you know. This is where they feel saddened by themselves because of how they look, how they've – how people see them, but realising they are the same as them and all they're doing is just reaching out for extra help. So this is sad – a really sad situation." [1SH03]

5.3.1.10 Experiences with police

There were positive and negative responses to questions about experiences with police by three stakeholders:

> … when a female has rung the police and called for support, it's a roll of the dice... If you get a good copper, that copper is good. You know? He will – he will go above and beyond to try and help this lady, respond to her call, capture the details of the incident, make sure that she is left protected or feeling safe or that she's not vulnerable. That's someone who will do that. But then there's that next progression of events, right? So from that, once the record has been – it then goes to the senior sergeant because it's a senior sergeant on duty at the time that basically prioritises what gets done and what charges are more higher or more relevant than others. [1SH02]

> Because sometimes the police system doesn't go in your favour unless you push and push and push. I've seen that happen on a number of occasions. You ring the police, and you say, 'My partner's here, he's abusing me, he hit me or whatever, I'm locked up in the room. Can you come – can you please hurry up and come?' These – Broome police are really good. I've noticed that they are really good. When it comes to domestic violence, they are straight on to it. It's amazing how quick they actually respond to domestic violence behaviours. [1SH01]

As well, Broome is a popular tourist town (and more so during COVID) and the influx of tourists has an impact on local vulnerable women and children in terms of resources such as policing:

> Women say the police are really stretched, they're short-staffed up here. For the amount of people that are still coming into town – and we have an influx of people – there's a lot of DV that's still occurring. [1SH04]

5.3.1.11 Recommendations for the ACCO sector

The ACCO sector is best placed to offer disability services, given that mainstream services have low engagement levels of First Nations clients. Stakeholders commented on two areas of recommended improvement from the ACCOs:

> Yeah, definitely [there are gaps in provision of services for children with disabilities]... ultimately, we're all working in the same environment, but we do it in such isolation and we only wait for something to go wrong before we all come together and address the issue. You know what I mean? Whereas I think every year we should have like an annual sort of conference where we get together and have these sort of regional forums with all of these mental health services and medical clinics and all of these sort of services. Boab Health, BRAMS, CAMHS [Child and Adolescent Mental Health Service]. All of these agencies come down and sort of collaborate together and basically share. I mean they're supposed to do that. That's supposed to happen, right? [1SH02]

> One would be a mother's information where they can access different organisations and what organisations do, would be a good outcome of having a big forum for mothers with disability people. That'd be one good thing. Also understanding... what process... these different organisations give as well because they don't explain what they give or what they hand out for that support. This is where the organisation[s] have to put it out there what they'd really do, and if there's any other access that they can access in that organisation. [1SH03]

5.3.2 Bunbury

In Bunbury, we interviewed a staff member at an ACCHO, and a staff member from a residential disability service. Among other services, the ACCHO provides health promotion, counselling and social work to clients with mental health and/or substance use concerns, as well as referrals to specialist services. They are able to provide psychosocial disability assessment so clients can access NDIS. The residential facility provides supported accommodation focused on mental health recovery.

5.3.2.1 NDIS access and disability services

As with other sites, according to stakeholders there is likely significant levels of undiagnosed disability and underutilisation of NDIS by First Nations clients in the South West. The staff member from the residential disability service noted a lack of recent referrals for First Nations clients:

> We support the NDIS. So, they might ask – they might come here, counselling support, and then we provide psychosocial disability assessment for NDIS so they can get access to NDIS package. Yeah, so that's how we link or how NDIS links in with our team. But to answer that question, there hasn't been many [Aboriginal clients]. [2SH01]

The SWAMS [South West Aboriginal Medical Service] staff member noted that despite a significant number of their clients likely having a diagnosable psychosocial disability, they have challenges assisting them with accessing NDIS without accessing a more specialised mainstream service:

> Massive amount [should be under disability care]...a lot of them, in order to meet the criteria for disability, they really need some specialised services if they come through with disabilities or very highly complex type of needs that really, our counsellors – we're [a] mild to moderate service. A lot of the ones that are coming through, they're highly complex – massive amount of stuff going on. [2SH01]

5.3.2.2 FV services and current responses

Stakeholders observed that current responses to FV are not working for First Nations families and discussed an alternative, the 'Safer Together' model, which involves providing holistic support to families:

> Well, some of the barriers is even the framework of – they're in a domestic violence situation. We find that... putting in trespass orders and no contact orders and VROs and that stuff doesn't really work. They really want to be reunited with their loved one and so there's a crisis, get these VRO orders in place. But the Safer Together model would work a lot better of where... when you're trying to work with the whole family instead of separating the family, because they just come back anyway... the barriers are just not enough stuff going on to try and help men, we're finding. Anyway, there's only one men's behavioural change program but there's no cultural – [not] a lot of cultural safety. It's only just started. [2SH01]

In terms of programs and support for male perpetrators, stakeholders mentioned the men's behavioural change program run by Relationships Australia. They noted that the program was not culturally adapted for First Nations men and the program had not been evaluated on impact or acceptability. Stakeholders spoke positively about the South West Refuge, but noted funding and capacity could still be improved by upgrading bed capacity to cater for the demand:

> They're excellent. Wonderful. Yeah, but – if they're full, they're full. [2SH01]

5.3.2.3 Funding and resource issues

Funding and resource issues were highlighted at SWAMS. Specific issues included the lack of support for men and after-hours support, and noted that FV support may soon also be a gap. The escalation of FV during the pandemic had led to the funding of two FDV workers at SWAMS, but the contracts were unlikely to be extended due to lack of funding:

> Lack of resources is a big barrier. We know it's a huge issue. At the moment there's – we receive funding for two FDV workers on one-year contracts, and it's not likely to be renewed, yeah, because it was under... COVID funding. So when that funding's gone, possibly the – unless SWAMS cover the costs, then that service will be gone as well. So yeah, so funding's a big issue. [2SH01]

5.3.2.4 Support for men

While the lack of support for men was observed universally, stakeholders in Bunbury specifically noted the lack of services in the South West running culturally tailored programs for men focused on FDV, and providing support for men in prison:

> There just needs to be more investment into the space of family domestic violence; it's a really under-resourced space. Just bugger all happening for men. That's the sad part. Yeah, that's right [they're all sitting in prison]... It just goes around in a cycle, or the cycle is repeated... yeah, it's just a massive cycle. [2SH01]

Conflicts between state and government contracts cause frustration for stakeholders, because this restricts their ability to support their existing clients who have been involved in FV and other issues through prison outreach and transitional support:

> But... that's what creates barriers. The client doesn't understand that. You say, 'I can't, yeah, come and see you, bro, because of commonwealth funding', because I'm not a – 'What's this commonwealth funding crap?' It's – you know, a person's a person, really... we can provide some support to them. [2SH01]

5.3.2.5 Accommodation and challenges with service constraints

As with all other sites, stakeholders in Bunbury highlighted the difficulties in assisting women leaving FV with finding housing. Specifically, stakeholders in Bunbury spoke of the lack of transitional and short-term accommodation reserved for women leaving FV:

> You've got Step Up, Step Down, which is a local place here for early intervention mental health and AOD, but again, they're only – they won't touch you if you've got any substance-related issues going on. A lot of people in family domestic violence situations, there's some – a lot of them have some drug use. There's cannabis use, some alcohol use and a lot of the time it's to numb what's happening in their life, or even [when] they know that there's going to be some violence occurring, so they take some sort of drugs to get them through. [2SH01]

A stakeholder described the paradox that arises from the interconnection between violence, trauma, and disability – that even though the main criteria for eligibility is mental distress, the service is not resourced to support people in crisis:

> We're not a DV refuge here, right? So that, if somebody came to us with DV being their main reason for wanting to come and stay here, they wouldn't be accepted because [they] would be more kind of suited to a refuge, because there's that worry about imminent risk. We don't have heaps of security here. Anyone could come and knock on the door, because that's ... the way our service's created, that people can live independently. People can come and go as they please. People can have whoever they want to come in… We don't have those safety protocols in place here because we're not that sort of service, but everybody who experiences violence obviously has trauma and then mental distress because of that. But our intake parameters are mental distress is the priority. [2SH02]

5.3.3 Kalgoorlie

We interviewed three stakeholders from services in Kalgoorlie: the Bega Garnbirringu (Kalgoorlie's ACCHO) Healthy Lifestyles Centre, the Department of Communities, and the Mara Pirni Healing Place, one of Western Australia's two new 'one-stop' FDV hubs.

5.3.3.1 Underdiagnosis and service gaps

In common with many regional or remote areas, a lack of specialists in Kalgoorlie presents a barrier to diagnosis, resulting in people with disabilities being undiagnosed and unsupported:

> We've got a lot of people with psychosocial disabilities, a lot of people with autism, ADHD, also a few people that have had amputations. So it's a lot of every – everything… We don't have many specialists that do come here. The only one – the specialists that are here do

> diagnose them, but there's a huge waitlist because most people have to go to Perth to get diagnosed, especially with autism and ADHD as well, because there's only one paediatrician at the hospital that can. [3SH01]

Compared to more remote towns, Kalgoorlie is relatively well-served with disability services. Nevertheless, stakeholders expressed that there could still be more given the town services the entire region, and there are issues with the accessibility of existing services for First Nations people with disabilities. This is supported by our own observations, as we consulted with a number of disability service providers in town in order to facilitate participant recruitment, many of whom stated they currently had few to no First Nations clients despite there being a number of First Nations people with disabilities in town. Stakeholders observed that the transience of the town's population, with many people coming to Kalgoorlie to access healthcare and other services, could contribute to this and that it is a barrier to accessing and following-up clients:

> So, we just refer and then help them follow through with transport to go to the appointments, but also a lot of the women that we see at the hub are also not from Kalgoorlie. So once they go back to wherever they're from, we lose that communication. [3SH03]

Within the disability sector, stakeholders stated that respite care is a significant gap due to a lack of 24-hour carers and respite accommodation, drastically increasing the burden on families. They also highlighted a shortage of First Nations carers, impacting the cultural security of care received by First Nations people with disabilities:

> Twenty-four hour carers. More Aboriginal carers as well. A lot of them do feel more comfortable with Aboriginal carers. [3SH01]

5.3.3.2 Barriers for remote communities

The lack of services and transport are some of the biggest barriers impacting women in remote communities, who travel extremely long distances from towns including Warburton (~900km), Tjuntjuntjara (~650km) and Blackstone (~1110km) to access care in Kalgoorlie. A stakeholder recommended that the bus running between Kalgoorlie and Warburton be extended to run year-round:

> So [there is a] plane, but that's only if it's medical, so they come down here. Or in the car with family. But then family take off and leave them or their car is shit and – or the car's been impounded. But we do have the Summer Response, so a bus goes to Warburton and back to drop people off, but it should run all year, not just… It's only in the summer. It's just started back up now. Yeah. It can't come back to Kalgoorlie, so that the bus goes from here, goes to Warburton, drops people off. No one can jump on the bus to come back. [3SH03]

One stakeholder appeared to feel quite hopeless about the barriers preventing First Nations women with disability in remote areas from accessing proper care, and with how without proper care injuries from violence compound over time, leading to more and more disability. They referenced the lack of follow-up as a key issue preventing women living in remote towns from getting the support they need:

> Definitely being taken advantage from family and the ongoing trauma. So they may not have had the follow-on from their disabilities in medical-wise, and they can still sustain new injuries, and their old injuries are getting worse, and their bodies are just like an 80-year-old person's body at 30. That's the hardest to see. The gap will never be – it will just get bigger and it does... These women are going to, sadly, die not really ever having the proper help, because there's just a lack of it here and there's a lack of follow-ups. So, 'oh, they've moved. They've gone back to such-and-such'. [3SH03]

5.3.3.3 Healthcare and cultural security

Several stakeholders had concerns about cultural safety in the mainstream health services in Kalgoorlie and other neighbouring towns. A stakeholder noted that their First Nations clients feel more comfortable accessing the local ACCHO, Bega Garnbirringu, for their healthcare needs. One stakeholder noted that First Nations people living in towns like Laverton and Leonora often prefer to travel to Kalgoorlie to access care from Bega, rather than access the mainstream hospitals in their towns:

> With Aboriginal people, they feel more comfortable going to Bega. [3SH03]

> If they need [to] come for physio, if they need to get wheelchair repairs, if they need to come for occupational health, speech therapy, all of that, they need to come here. Even if they're just seeing the doctors as well. So there is a mobile clinic that goes out there and they do have all the nurses stations but some of them feel uncomfortable going in there, they'd rather come to the AMS in town. [3SH01]

This stakeholder also expressed concerns about a lack of cultural security and responsiveness within the hospital in Kalgoorlie, describing a situation in which they had to go out of their way to advocate for a client:

> Cultural perspective, the hospital doesn't really help that much, like, as much as they could. We had a client with a disability who we needed to admit to A Ward and it was 14 visits in the last month before they actually admitted him to the ward... we actually had to fight for that and we had to do a... sectioning form to actually have him admitted because he was ... suicidal, he was trying to hurt himself. Despite all of those visits, they actually said he doesn't meet the criteria to be admitted to the ward. So we was like, okay, we need to do something else, and there was like a huge meeting and then finally he was there. He was only there for a week and then when it was time to be discharged, they found his family at the park and dropped him off to them. So he wasn't actually discharged properly or anything like that. No after care as well… they weren't really culturally appropriate, but we've got a lot of those problems with them. [3SH01]

5.3.3.4 Lack of support for men

Stakeholders noted that support for men is a significant gap in town. Bega Garnbirringu run the Sobering Up Shelter in town, which provides a safe space for First Nations men and women to sober up and access assistance for their AOD concerns:

> Well, there aren't any [services for men]. We've got one guy in town that I can send blackfellas to, and he's overwhelmed and busy and I want some funding, I've put it forward to several agencies, to several members of parliament that I really would like the funding to have a man work for the refuge and go out with our mobile worker and be effective in talking to the whole family. Because I'm sending two girls out to remote communities. You know culturally that's not ideal to be able to even approach or talk to men, especially at certain times or what's going on. [3SH02]

5.3.3.5 Service access issues

The stakeholder from the Goldfields Women's Refuge spoke of significant trouble with services handballing clients due to strict and inflexible service parameters, particularly surrounding disability and mental health. She also highlighted that substance use and a lack of stable accommodation can be barriers to accessing a variety of support services:

> Especially around mental health and disability, where do we put someone – we have people come here and they've obviously got mental health issues and they have some forms of disabilities because of their mental health issues, and there's nowhere for them to go. Mental health say 'Oh no, they're not – it's behavioural, it's a disability'. Disability say 'No, no it's mental health', so we end up with people that actually this is not the right space and there's a big gap. 'Oh, they don't meet our criteria because they don't have a return address'. Well not everyone has a return address. Like, some people aren't even registered as being born. [3SH02]

This stakeholder also noted that the Goldfields Women's Refuge may not be accessible for all women with disabilities, including those who use wheelchairs, which is a significant barrier to this group escaping FV:

> So, we're restricted by what we – so we can't have anyone that's for instance in a wheelchair, because I don't have the capacity and I don't have the ability to staff the house 24/7. We're already on call 24/7, seven days a week. [3SH02]

5.3.3.6 Accommodation, housing and homelessness

Each of the stakeholders we interviewed highlighted the significant housing crisis in Kalgoorlie, and the critical role housing and accommodation play in improving outcomes for people experiencing FDV. They emphasised that lack of housing in town is at crisis point. There is a strong need for more short-term and transitional accommodation in Kalgoorlie. The Goldfields Women's Refuge are able to take in women experiencing homelessness, however the service is often at full capacity. There are only two other short-stay services for people in need, servicing the entire region. As noted earlier, many people travel to Kalgoorlie from surrounding towns, including Laverton and Leonora and remote communities as far away as Warburton near the state border, in order to access healthcare, which reduces the number of short-term accommodation beds available in town:

> Then we've only got Trilby Cooper Hostel and Boulder Short Stay and that's it. This one here takes people from the [Lands][58] for medical, so that could get filled up really quickly. That's it. That is it for this town for the Goldfields. [3SH03]

This lack of housing and short-term accommodation results in many families living in severely overcrowded homes or sleeping rough in camps on the outskirts of town. Several stakeholders spoke of empty boarded-up homes owned by the Department of Communities and other unused accommodation in town, referencing high labour and construction costs as the main factors behind this:

> That's a huge problem with our clients for NDIS that most of them are homeless, and then the ones that do have a house, there's like 14, 15 people live in like a three-bedroom house as well. So that's hard. There's not a lot of respite homes here, and then the ones that are here, there's a huge wait list… Yeah, and there's so many homes that are just boarded-up. So I don't know if that's something to do with their funding or something but there's heaps of houses around town that are just empty and boarded, and a lot of our people actually go into those houses that are boarded-up and make it a home; even though there's no electricity, no water, they still just stay there. [3W01]

> This is straight across the board, no one gets a house, nobody gets anything. Because in Kalgoorlie, if you have a look around and you go to all those houses, Homes West houses [unclear] what have they got on it? They [smashed it, the locals]. They've got boards all on them, they're all boarded-up, there's no housing in Kalgoorlie. To get a house in Kalgoorlie it takes up to five years. [3W05]

It was noted by stakeholders that people with disabilities experiencing homelessness was a significant problem in the community. Two out of three stakeholders reported feeling disgusted and ashamed by the extent of the issue, particularly given the large amount of wealth generated by the town:

> Well, definitely for mental health, definitely a problem and definitely for homelessness with disabilities, nothing, nothing. I know, we should be ashamed. [3SH02]

> We don't have the accommodation here in town. For the town that we are, and we service the Goldfields, their accommodation is just disgusting. Yep. It's nothing. [3SH03]

5.3.3.7 Police responsiveness

Stakeholders had positive things to say about the police in Kalgoorlie, particularly the Domestic Violence (DV) unit. There was a feeling of change and progress in the manner in which the police handle cases of FDV. We observed that the police appeared to be well integrated with community and fairly responsive to women's needs:

> I don't think there's much of a difficulty… they're good in that way. [3SH01]
>
> The domestic violence unit are amazing here. They do ask that you ring the police number, but are also advised to ring the domestic violence unit, only because they're more compassionate and they have the – more of an understanding of what's going on. [3SH03]

One stakeholder, however, reported that women are often 'let down' by the courts. As with other sites, there was a sense that current responses to FDV are not working for First Nations women and families:

> Police don't want to see domestic violence, but it's the courts. It's the courts that's – has the last say and it hasn't been the best. It's like a slap on the hand, especially for reoffenders. Just slap on slap, even when it's stated that they've reoffended over and over and over. Yet, the woman has also a VRO in place. What's the point of getting a VRO if the court's not going to uphold it? So don't – so with the police, I think they do a great job, but it's the court that is the let-down. [3SH03]

5.3.3.8 Guardianship and administration – the Public Trustee

The Public Trustee is responsible for the financial affairs of people who are deemed to have a disability impacting their decision-making, while the Public Advocate is responsible for making decisions on behalf of their clients. Stakeholders shared their experiences of dealing with the Public Trustee to advocate for their clients:

> I feel sad for my people… I'd never ever recommend it to anybody. Because once they get that money they... her trust fund person lives in Perth, they don't have to answer her calls, they can say they're out. They never take her calls, they're always telling her she has no money, but she's in a trust fund. They get her pension put into there. What's happening with that pension? These people need that money, these people are suffering. She's suffering badly. She's got other people's clothes on. She can't even buy underwear for herself. When I say personal items, tampons, pads, lady wants, deodorant. They live in Perth. What's wrong with them coming out and actually seeing her and seeing the problem themselves? [3W05]

Women and stakeholders reported that some trustees only answer the phone to Bega Garnbirringu, rather than to their homeless client for whom they are responsible, which places an enormous additional burden on the workers:

> She's homeless, but we keep tabs on her because she's on NDIS with us, so we keep tabs, go out and – like welfare check, see how she is, if she needs to come and see the doctors. But her biggest thing, when she comes to see us, is her money. We've got to ring up that trust fund lady and we've got to talk to that lady to see what's going on. [3W05]

This stakeholder noted they are aware of several more First Nations people in Kalgoorlie who are under guardianship and administration orders, indicating that this woman's experience is indicative of a broader systemic issue:

> I see there's a lot of young fellas here as well that are on it, they just walk around and they – I know a couple of people, young people that [unclear] only get $50. Some only get $50 a week. One is a young girl and she's actually pleading and crying. [3W05]

5.3.4 Meekatharra

We held two interviews and one focus group in Meekatharra, in total speaking to four stakeholders who work directly with First Nations women, children and young people in the community. We spoke to one stakeholder at a First Nations community-based organisation, a local community-controlled organisation that runs the community hub and a number of outreach programs, and provides a link between the community and mainstream services in town. We also interviewed one member of staff at Meekatharra hospital, which provides critical mental health support to the community, health promotion, coordination of referrals and remote community outreach. We also ran a focus group with two staff from the Shire of Meekatharra, which runs a variety of afterschool and evening programs for youth in town.

5.3.4.1 Gaps in service provision

Between the monthly community Aboriginal Reference Group and a local community hub, services appear to be well coordinated and integrated with the community. While Meekatharra do not have their own ACCHO, the Geraldton Regional Aboriginal Medical Service (GRAMS) used to do outreach to Meekatharra, including a psychiatrist who specialised in grief and loss, as well as a sexual assault service. Funding and resource cuts have resulted in both of these services terminating, which, in the absence of another service providing counselling to men and women in town, has left significant gap in the counselling and disability services provided to the community of Meekatharra.

The Aboriginal mental health worker who helps chair the community reference group meetings described the community's main priorities as addressing the community violence and feuding between families, AOD issues, unresolved trauma, and the lack of appropriate counselling services which address the high rates of grief and loss in the community. This supports the urgent need for cultural secure counselling services identified in the women's interviews. Stakeholders also noted several known incidents of girls suffering sexual assault, highlighting the strong need for healing services which specialise in sexual abuse:

> … a lot of issues we’re having in the community, mainly about feuding, drug and alcohol, maybe counselling services. Because there’s a lot of grief and loss issues within the community and there’s no one to talk to… Not only for grief and loss, there’s also – we used to have a service coming up from Geraldton for sexual assault and that, they don’t come anymore because their funding got cut. When I first moved here back in 2013, there was about four or five young girls that had been used and abused and there was no support here for them. [4SH02]

> Well on the trauma side of things I think having more social workers or counsellors that can – it’s easy for the GPs to go, here have some medication. But I’m a strong believer of, if you’re going down the medication course you have to do the counselling otherwise it’s just going to become a big fog in your head. There’s no real platform for our ladies or young people to just sit down and just let everything out. [4SH01]

Mission Australia runs the Family and Domestic Violence refuge in town, and employs an AOD worker. They are reportedly funded to employ a mental health worker, however stakeholders said that the role is currently vacant. Youth (12-25 years of age) can access counselling support via Youth Focus. Although we did not speak to any employees at Youth Focus or young people who had accessed the service, stakeholders said the service is well connected to the community through employed community liaisons. According to stakeholders, however, Youth Focus do not have a clinician who specialises in supporting youth with disabilities, and there are no other disability services in town. This prevents NDIS from being implemented in Meekatharra, leaving families without support, and ultimately forces families with disabilities to relocate to other areas. Specifically, there is a strong need for respite care and home care services which assist families with activities of daily living. The absence of these services places a significant burden on grandparents and children, and ultimately results in generational disability.

5.3.4.2 Barriers to accessing services

High turnover of services due to funding issues has reduced the community’s trust and willingness to access new and existing services. There was a sense that people were fatigued by the frequent changes to services, as well as by a culmination of poor prior experiences. This is a priority issue for the community, which led to the establishment of the ‘hub’ to provide a link between services and the community, and to reduce some of the stigma surrounding different services:

> When you’ve got NGOs that may only last 12 months or may only have funding for a short amount of time it’s very difficult to convince a family to give them another shot if they’ve been burnt by one in the past. Yeah, and that is a big reality of out here. Like, there’s always rollover, this one will end, another one will start, and I think some of the families are just tired of it. [4SHFG]

Other barriers spoken about included distance and transport, disability-related barriers, racism, lack of cultural safety, shame and trauma from re-telling their story, a lack of trust and concerns about confidentiality.

5.3.4.3 Perspectives on disability

Stakeholders noted the significant burden of psychosocial disabilities including depression and anxiety, and complex trauma/PTSD. Trauma was highlighted as the greatest cause of disability in Meekatharra. They noted a relative lack of people with physical disabilities in town, which one stakeholder attributed to the fact that many families with disabilities and/or complex health conditions are forced to relocate to larger regional or metropolitan areas in order to access services:

> I'm really passionate about mental health. I see that as one of our biggest contributors to unhealthy lifestyles in remote areas. [4SH01]
>
> I think the biggest disability would be trauma. Trauma is huge. [4SH01]
>
> Yeah, we're talking about depression, we're talking about suicidal instincts, we're talking about self-harm, we're talking about advancing levels of self-medicating, dangerous levels of self-medication. [4SHFG]
>
> No, not a lot, not a lot [of people with physical disabilities]. There is some though. I won't say rare but normally because there's no real service for it the family will move. [4SH01]

5.3.4.4 Barriers to diagnosis and accessing services

Stakeholders consistently noted high rates of undiagnosed disability, including suspected FASD. They noted barriers to diagnosis, including the inaccessibility of healthcare due to infrequent rotations of specialists, a lack of understanding about disability, and a normalisation of disability in town. Families have a number of other issues going on at the same time, which take precedence and contribute to the 'referral cycles' as described by a stakeholder below:

> With the kids that are going through our systems undiagnosed who may have complex needs and they don't – it's not recognised through what the family a) financially, are given in relation to a carer's situation, and b) because so many families are struggling with it. There's not the, you know – sort of everyone goes, 'well, we're all in the same boat, we've all just got to deal'. It's that survival mentality which, again, ties in with the lack of being able to tell their story over and over again. [4SHFG]
>
> As in CAMHS and the mental health providers do that, but if you've got a child who is differently-abled then they need to be seen by someone who's in that field, as well as doing the other things. That's why it gets brushed over, because what'll happen is they... get caught in, like, what I call a referral cycle where the hospital goes well, they will refer them to a psych so they can get diagnosed… but we're talking about a 15-year old boy whose family aren't going to want to get involved in it. He doesn't want to have to be labelled with anything like anything like that. So he just comes straight back out and instead of doing VSU [Victim Support Unit] he'll smoke a thousand cones and back into the same environment, same cycle. [4SHFG]

Stakeholders observed cycles of disability spanning multiple generations, which one partially attributed to the responsibilities placed on some children to act as caregivers, either for siblings and/or a parent with disability:

> Due to the parentified nature of our kids anyway, due to systems of and generations of, if there's someone who has got additional needs and then they have children and then those children have children and so on and so on. It's like any type of cycle, but these kids don't have necessarily the education around the dangers of parentification. You can talk to families about it, but when it's been going on for a long time that becomes survival… the girl who's doing this is heavily traumatised, she's a victim of sexual abuse, she potentially has additional needs. [4SHFG]

5.3.4.5 Community challenges

Many of the key issues raised in Meekatharra, including community violence, substance use, and mental health issues, appear to stem from a combination of intergenerational trauma and entrenched socioeconomic disadvantage. Stakeholders described normalisation of many of these issues creating a cycle that perpetuates across generations. Notably, two of the stakeholders grew up in Meekatharra and expressed that community wellbeing has been declining in recent years.

5.3.4.6 Youth at-risk

Every stakeholder we interviewed spoke of the problems impacting youth in town including disengagement from education, poor mental health, and an early uptake of substance use (particularly cannabis) to cope with stress. Youth in the 13-17 age-bracket, and girls in particular, were highlighted as being at an increased risk, primarily due to increased caregiving responsibilities in the home and a lack of external support:

> It's that bad here at the moment that the young ones are – it's like a normal behaviour. So they're growing up thinking life is about drinking and drugging and all this stuff that comes with it. So trying to break that cycle for young people is I think one of those things we really need to concentrate on. [4SH01]

> We generally find that 15 is the cut off time for a lot of our girls who, because of the parentified roles that they've lived up until this point, they – that's when they really start to disengage. They start self-medicating heavily in order to cope with their issues. They are in a more formal role at home looking after the little kids, which they've done anyway, but now they're at home, self-medicating. The motivation to go back to school is very difficult and then they're also brought into the family feuds about it. [4SHFG]

> Yeah, they're getting younger. As you know, kids do what their parents do, that's how they learn behaviour, so they see their families drinking or doing drugs, well they're going to do it as well because they think it's normal. [4SH02]

5.3.4.7 Community solutions

5.3.4.7.1 Youth engagement

Stakeholders identified the need to address entrenched disadvantage through early intervention, with a particular focus on educating and empowering youth.

A local community organisation and the Shire run programs and provide critical support to young people. The Shire employs a number of full time and casual workers, enabling them to run after school and evening programs for children during the week. Given the absence of respite for caregivers, the community would greatly benefit from increased funding to extend programs over the weekend and the school holidays:

> There's no access to respite care here which is a huge, huge barrier for many of the matriarchs and patriarchs who have taken care of their youngest ones… So we are almost like an unofficial respite because, like on the holidays we found a lot of these families, and certainly with [girl's name] Nanna [name] will drop her to us so she gets that little bit of time, even if it's just five hours a day, where she doesn't have to be constantly in care mode... We don't only offer that respite for parents or grandparents, but for our young girls as well. We give them a space to come and have a break away from being that parent when mum or dad can't be. [4SHFG]

Stakeholders identified the need for youth mentorship and empowerment programs in order to break the cycle of entrenched disadvantage impacting many families. Their suggestions included showing a variety of examples of what success looks like, and providing support and encouragement to pursue education or employment opportunities even if it means leaving town:

> It's about that empowerment that – just because I grew up in Meekatharra, I don't have to get to 18 and then have kids. You know I can go and chase my dreams. Yeah, that's the mindset that we need to put into a lot of our younger people and it's okay if I want to go chase a job with Rio Tinto, it's okay that I move to Perth. I love where I'm from, I love my country and I'll miss it but I want to chase my dreams too. [4SH01]
>
> When I was working for Youth Focus I actually did a presentation over in Melbourne about the correlation of music and art and working with young Aboriginal kids and how they engage. Yeah, I know that everyone thinks it's football and sports are the biggest thing with Aboriginal kids but there's a lot of Aboriginals that don't do that either. [4SH01]

5.3.4.7.2 Greater opportunities and support for men

Stakeholders identified unemployment and a lack of opportunities for men as one of the drivers of high rates of AOD use and violence. They identified the need for training and support for men to build skills, and the need for a variety of opportunities for work (not just limited to mining):

> There’s still – there’s a lot of transient anyway within our people, but we do need something that empowers the men, like maybe a men’s shed or training for them that they can go on to jobs because they have the skills. Not just mining, they need to be with their families as well and just work day-to-day and not 12-hour shifts and that on the mines, because that’s not good for them, away from their families and that. [4SH02]
>
> There’s not much really in town to empower men. They don’t have a men’s group where they go and have a yarn and talk to other men and maybe some role models go in and, you know, give them some skills or knowledge. It’s just they need it for the men here in town because they have nothing. [4SH02]

5.3.4.7.3 Supporting healing

The community would greatly benefit from a counsellor who specialises in healing from trauma, grief, and loss. Stakeholders also identified the need for rebuilding community spirit in Meekatharra in order to address some of the problems surrounding feuding and violence within the community:

> I think building that thing around community helping community. At the moment we don’t have much of a community spirit in Meekatharra, it’s been quite damaged over the last couple of years. So just trying to rebuild that community spirit that we can all move forward together. [4SH01]

5.3.5 Perth

We held five interviews and one focus group in the Perth metropolitan area, speaking to a total of seven stakeholders from Richmond Wellbeing, Life Without Barriers, KM Noongar Consultancy Services and Kambarang First Nations Women’s Refuge, operated by Ruah Community Services. Five stakeholders worked in the disability sector and two in the FDV sector.

5.3.5.1 NDIS and disability service access

Compared to the regional and remote sites we visited for the project, the Perth metropolitan region is relatively well resourced in the disability space. Notwithstanding this, there were still issues surrounding the availability of disability services that are culturally secure for First Nations clients. Stakeholders noted that the lack of culturally secure approaches in the sector inhibits the optimal use of existing NDIS plans, and contributes to a lack of progress they observed in their First Nations NDIS clients:

> As [name] alluded to a bit earlier, a lot of our people that are on NDIS with a disability don’t really make a lot of progress it seems. [5SHFG]

> The therapy that often is quite well-funded in Nyoongar or Aboriginal people's plans is more often than not, is not used effectively. That's because the only therapy models out there are wadjella [white person] therapies… I think that's why quite often you'll see that they don't implement Aboriginal plans effectively enough, because they're missing the cultural component. [5SHFG]

Stakeholders recommended more First Nations-led disability services and First Nations workers in mainstream services, highlighting the importance of offering clients choice – so that 'they can choose Aboriginal if they want'. They also emphasised First Nations disability advocates, coordinators or navigators as best practice in optimising support for First Nations people with disabilities, to build their capacity and understanding, and assist First Nations clients in navigating the complex world of the NDIS and disability services.

Similar to findings from other sites, stakeholders noted the awareness of disability and the lengthy and challenging process of applying for NDIS are hurdles for the First Nations community in Perth.

5.3.5.2 Best practice in the FV sector[59]

5.3.5.2.1 Connection to the community

Kambarang provides crisis accommodation and casework support that is culturally secure and highly responsive to the needs of First Nations women. Having been at the same site for several decades, the refuge is very well-integrated with the Nyoongar community, which not only means women feel comfortable accessing the service but they are safer due to the level of respect the refuge holds in the community as a trauma informed service:

> Kambarang's been on this site since the '70s and it's always been Aboriginal-specific. I think it's well known within the Aboriginal community and I also think it's well protected within the Aboriginal community. For example, we never get perpetrators trying to locate women here. I think the Aboriginal community keeps us very safe and men know that this is a women's space and it's a safe space and they don't try and come here to locate women. The only time we've ever had perpetrators turn up on site is when they're wadjella. We've never had an Aboriginal man try and locate women here, which is lovely. [5SH03]
>
> And we get women calling us – we had a woman call us this week who exited our service probably eight months ago and she was just calling to tell us how well she's doing and that she's done a course and that she's got a job, just to touch base and say thanks [laughs] and just let us know how they're doing. A lot of clients will do that. They will always call in, let us know, turn up on the door, when something good happens, they'll let us know that something nice has happened. They know we're here when they need us and if we can't help them, we'll find somewhere to help them, always. [5SH03]

5.3.5.2.2 Disability awareness

We observed that staff at Kambarang had excellent disability awareness, including how women with disability may be more vulnerable in the context of FV and how to best support First Nations women with disabilities accessing the service:

> I think she was referred to the Salvation Army that help get accommodation for her. I suppose it's really difficult, because it's – you have to be able to try and get the right accommodation for her. With her diagnosis and everything, some people would find that very difficult to understand and manage. A lot of people would actually find that she could be probably an aggressive type of person, but we understand that she has that inability to regulate her emotion due to her diagnosis. We can handle her in a different way. [5SH05]

In this case, they identified the link between FV and disability, particularly how complex trauma can result in women being unaware of the extent of the disabling impacts of experiences of violence, and how the feeling of safety that comes with accessing the refuge gives women the space to assess what is going on for them. Kambarang sees this as a window of opportunity to educate women, identify any underlying disabilities impacting them, and assist them in getting the support they need. This involves having specialist disability organisations coming to the refuge to provide education on topics such as acquired brain injury from DV and the impacts of non-fatal strangulation:

> Some of them actually don't even realise that what they're experiencing is from DV, from head trauma. Sometimes they'll just say, my memory's really bad. We have got one that has loss of hearing. Sometimes they don't make that connection, as well. I've noticed that because we've had a really good service come out called Synapse and they talk about acquired brain injuries and – associated with domestic violence. It's amazing how many women look around and they want more information because they think, I've got this. We had a talk on non-fatal strangulation and the impacts of that and brain injury and what that looks like. Most of them have experienced that and I don't think they understand the after-effects of what that can look like, too. When they get into the refuge, they start to – this is a time where they're safe and they can start to really see what's going on for themselves and having education coming in and doing all that kind of stuff, it helps them to see. [5SH05]

Ruah Community Services has recently hired a disability navigator, who we met when undertaking consultation at Kambarang, who expressed to us that she felt there was a strong need for her role at the refuge due to the high rates of undiagnosed disability (particularly ABI including FASD) in that service. This emphasises the importance of addressing disability within FDV services, which may involve training and capacity-building among staff, hiring specialist staff where possible, and partnering with specialist organisations.

5.3.5.2.3 Supporting women's choices

Stakeholders at Kambarang discussed the importance of supporting women's choices and empowering them, and highlighted a number of flaws in traditional refuge models, including not recognising the complexities of why First Nations women may not leave their abusive partners:

> That's what's wrong with the FDV model, we're focused on women who want to leave, but a lot of women love their partners, have been with them for a long time, have a lot of children with them, there's family considerations, cultural considerations and to force a woman to leave when she's not ready is horrific. Sometimes she needs respite, which is what they come here for. [5SHFG]
>
> So, how can we best support you and linking you in the right – I've heard that refuges will kick women out if they know that they've seen their perp. We know what the cycle of violence is. Cycle of violence – we possibly know that the clients are ringing a perp or going out and meeting, so it's about being transparent and how to safety plan for them to keep themselves safe but also make the right choices. You can't dictate who you can and can't see and kick them out because they have, or pressured that maybe they should be getting a VRO. That's not for everyone and in a lot of cases, can escalate the perpetrator. It's about listening to what it is that they want and supporting them and educating them to make the right choices for themselves. [5SH05]

This is supported by our findings that women at other sites spoke of feeling alienated by staff at a refuge who were 'telling them what to do' and 'bossing them around', which decreased their willingness to access the service in the future. Stakeholders at Kambarang highlighted that no victim of coercive control will respond well to having their own sense of agency removed by a service provider, no matter their intentions.

5.3.5.3 Funding and resources

As with many other FDV services, there is a strong need for increased funding to enable Kambarang to expand their service to support more women:

> So, we keep track of what we call our unassisteds, people that we're not able to assist. I think in the – I've just done my stats, my reports for this past six months. I think during the last reporting period there was over 230 women that we weren't able to support. [5SH03]
>
> We recently put in application with the Department of Communities to renovate the whole back end of the refuge, the accommodation end, to make it from – so rather than eight shared rooms, to 10 single rooms. We got the architect in, we designed it all, got it all ready, but we were declined. [5SH03]

Single rooms are especially important given the women accessing the service will have complex trauma and may have unique triggers and needs. Stakeholders noted that any conflict that happens between women results from issues associated with communal living, and that giving women their own rooms would better support them in the process of healing.

5.3.5.4 Housing and homelessness

Among other factors, the impact of the pandemic and funding cuts for social housing has led to a severe lack of housing in both regional and metropolitan areas, which has drastically increased the waitlist for public housing and the competitiveness of the private rental market. In addition, a stakeholder highlighted how systemic racism impacts the ability of First Nations people to find housing through the private rental market:

> Very rarely are you going to be offered a Department of Housing house by the time you leave the refuge. So, we actually need to look at other options of housing. Private rentals, forget about it. They're not going to look at someone on a Centrelink benefit and then on top of that, they're not going to – it's even a barrier because they're Aboriginal. That's the reality of it. I took one client in for a viewing and the actual – the real estate actually said, 'If we offer you this, you're not going to go walkabout?' [5SH05]

5.3.5.5 Homelessness and continuity of care

Stakeholders continually emphasised that stable housing is the greatest identified need of women leaving FV, particularly First Nations women with disability:

> I think one of the biggest challenges that I find supporting our women, and this is not while they're in the refuge, but trying to get support for them when they leave the refuges, is a lot of our ladies don't have stable accommodation. Stable, safe, long-term accommodation. And this really impacts on the services that we can link them in with, because everybody works from this sort of geographical area, and you've got to fit in with that and our ladies don't live like that. They might stay with this family member for a week, then that family member for two weeks or then go to country for a little bit and come back. It's really difficult to fit those service parameters of, you live in the Armadale area, you've got to be linked in with Armadale Mental Health. We find it really difficult to refer on to other services because our ladies don't have that stable accommodation, I think. That's a big challenge for us. [5SH03]
>
> Originally, she was living near the [name] area so she was obviously being linked in with [name] Mental Health. Now that she's come into refuge and she's in [name], she needs to go to the [name] mental health. She was comfortable… she knew the care there that she was going to get and unfortunately, the care in different places, it varies. You're not going to get the same care everywhere. [5SH05]

5.3.5.6 Disconnection from culture and the role of kinship systems in addressing violence

Stakeholders in Perth spoke in depth about the impacts of colonisation and the breakdown of culture in First Nations families. Particularly, highlighting the critical role of kinship systems both in supporting people with disabilities and in preventing and addressing FV. Specifically, they discussed the importance of Elders and youth coming together to identify community solutions, and the key role men must play in dealing with FV in their families and communities:

> I personally, as an Elder, am really strong on the kinship model, even with my own family. It's not perfect, but I believe that if we're to be looking at who best to care for us, it has to be our kinship, our family members. Unfortunately, because of history, a lot of our kinship model has been ripped away... and/or drug and alcohol, and other issues. But I just think if we can – if I anyway, in my role, can demonstrate that the kinship model is the best practice model for survival, then we may be able to start … [5SHFG]

We interviewed a Nyoongar Elder working in the disability sector, who advocated for the vital role First Nations men must play in preventing and addressing FV in their communities:

> Do we need or can we expect more support from the men who don't engage in family violence? Where do they play a role? Because I think if I look at kinship groups and I look at tradition and I look at generational trauma and I look at a whole number of things where I'm sitting at 73 – been through a lot myself, including that issue – one of the missing factors in all those years of my life is men stepping up and playing a role in this. It's often we blame services. Isn't going to work. But there must be some strong, creative, brave men who can take on this issue of the men who are doing this to our women. [5SHFG]

As with other sites, Perth stakeholders observed that current responses to FV are not working for both victims and perpetrators, particularly the manner in which male perpetrators are dealt with by the justice system. They also discussed alternative solutions for dealing with FV, or how existing responses can be improved by incorporating cultural practices and strengthening men's cultural and spiritual wellbeing, which Perth stakeholders perceived as a significant gap. This also includes creating safe spaces for men to yarn-up and reflect on the issues they're experiencing:

> So, you know, if it is abuse, men – and they do get charged, they're going into prison. Prison sometimes isn't the best place for them to be because you've got mob that's going to fight for the sister or their aunty but if they can work on themselves outside – and that could be going with men out to Country as well. Building them – how to – with relationships, … how to communicate. [Nyoongar men in Perth miss out on going out to Country] Learning culture. Even just that, you know? A lot of that gap is the men don't know their culture. I mean, we've got some men doing a bit of the dancing. They never, even had ochre on them so when they put ochre on them, they felt like they were really connecting to their culture. They felt really good about themselves. [5SH02]
>
> [They feel really proud too] Having good men around I guess to create that safe space to have a yarn as well. Then work out how their behaviour impacts, you know? [5SH02]

5.3.5.7 At-risk youth

A stakeholder who managed a short-stay accommodation for at-risk youth noted a lack of progress in the outcomes of youth in care, particularly for older children and boys. Barriers to improvement included untreated trauma and disability, as well as a lack of engagement with their DCP caseworkers:

> Lack of engagement with their caseworkers. Not all of them, but a good majority of them don't actually have a lot of faith in their caseworkers or the department. So, they don't – the majority of them don't engage with their caseworkers because they feel often that the caseworker is not working for them. [5SH04]

> They've become really wise street kids, and anything other than – that's stability for them. They're not comfortable with – for example, a 15-year-old that's been on the street for three years, how are you going to get them into a family? How are you going to put them into a foster placement? The struggle there is these kids are street kids and they're very wise. Going back into a normal family environment could be quite tough for them. They've got rules and expectations when they go into a foster placement, as they do in ARYA [House]. We have rules and expectations at the House, and they struggle with those. [5SH04]

They noted that many of the young people who enter their service are homeless as a result of having been in prison. Stakeholders also emphasised that involvement in the child protection and juvenile justice systems substantially increased risks of homelessness and poor outcomes:

> So, that can be quite a challenge because some of those kids come out of Banksia. They'll either be referred to us or they'll just couch surf – if they're not keen to go where their caseworker wants them to go, they'll just couch surf or they'll sleep on the streets or in the parks. [5SH04]

Stakeholders described a number of workforce and resource issues within the youth homelessness service, highlighting a continuing cycle of skill shortages and staff turnover. They noted that despite working with children and young people with high rates of complex trauma, mental health challenges and disability, many staff are employed without training in dealing with mental health or disability. This lack of skills in effectively managing challenging behaviours contributes to a high turnover of staff.

They also explored some of the challenges of working with the DCP to improve outcomes for the young people who come through their service. There was a sense of a lack of capacity or willingness to share information and collaborate, impacting the continuity of care received and hindering progress:

> So, you've got to get all that's going on and write that up and send that to the caseworkers, but then you don't get feedback when they come – so if they've come back the following week, you don't know what's happened. The child protection might not share all that information, what they have done. [5SH04]

Stakeholders also emphasised the importance of having more First Nations case managers in the DCP and felt that one Aboriginal practice leader per district is not sufficient:

> I just think – and I guess it's in terms of the kids that we work with, particularly Aboriginal children – is, I think there needs to be a higher focus on when an Aboriginal family come into care where possible it needs to be an Aboriginal caseworker. I think the kids would benefit from that, but I know that comes with its own issues because we can't always get – that's a bit of a wish list thing for me. I feel the department have Aboriginal practice leads in all districts, but I think one isn't enough… How can you make a decision or – this is what I think, if you've not actually met these kids. How can you know what's best for them by hearing it three and four hand down? [5SH04]

These stakeholders also noted that the Aboriginal practice leaders do not work with youth directly, echoing a theme we heard from several stakeholders throughout the project in a number of different contexts – 'How can you know what's best and make a decision on behalf of someone you've never met?'.

6. Discussion

There is an extensive body of literature demonstrating the deep personal, community and wider society costs of the range of harms arising from colonial policies and practices First Nations people experience (Fisher et al., 2019; Paradies, 2016). These harms, often resulting in intergenerational trauma, contribute to higher rates of family and domestic violence (FDV) among First Nations women and children (Atkinson et al., 2014; Australian Bureau of Statistics, 2019a). The research tells us that notwithstanding these known high levels of FDV, with higher levels of risk for those with lived experience of disability, FDV is under-reported (Puccetti et al., 2019), and a range of barriers to services leaves them underutilised by First Nations people (Australian Human Rights Commission, 2015).

6.1 Disability

As was noted in the desktop review, the First Nations worldview focuses on strengths, not deficits (Ferdinand et al., 2019). Participants in this research felt that the western definition of disability and the diagnostic framework are at odds with their concept of disability. In the interviews from Broome, for example, the word disability was not commonly used and participants referred to disability as having a ‘special need’, ‘a struggle’, or ‘trauma’, which was simply understood as some people needing extra support in order to succeed. Further, many participants did not identify chronic health or mental health issues as a disability. This lack of congruence with ‘disability’ as it is understood in the wider community, and more particularly within the health profession, results in underdiagnosis, and leads to the true extent of disability in First Nations communities being unknown.

In addition, community and family attitudes and awareness of disability, in particular the high level of stigma surrounding disability and diagnostic labels, are a barrier to diagnosis and early intervention for children. First Nations families may feel that the western diagnostic framework is at odds with their understanding of disability, or that the lengthy process of pursuing a diagnosis is futile, due to the unavailability of culturally secure support services.

Stakeholders reported many further barriers to diagnosis and early intervention. Disability in children may be unidentified where families may be dealing with unsupported parental disability, mental health issues, housing insecurity and homelessness, FDV, and substance use concerns. The substantial burden these issues place on children, especially when combined with an undiagnosed or unsupported disability, can result in long-term disengagement from education and high levels of stress, and may lead to declining mental health, and alcohol and other drug (AOD) use. Children and young people with disability and/or with family caring responsibilities, in particular, need additional support to stay engaged and re-engage with school and make positive post-school transitions. Our results show that intervention needs to specifically target these young people, as most at-risk of negative outcomes.

The issue of more than one generation in a family living with disability was shared by the First Nations community with the Western Australian (WA) parliamentary inquiry into fetal alcohol spectrum disorders (FASD) a decade ago (Education & Health Standing Committee, 2012).

This was observed in some of the families of our participants, where carers had themselves developed physical and/or psychosocial disability due to the lack of appropriate support and respite while caring for a family member with a disability. Many women in our study reported psychosocial disability caused by intergenerational trauma from stolen generations, child removals and grief and loss (Australian Institute of Health and Welfare, 2018a).

The psychological and physical toll on elderly women who are grandmothers is enormous. As holders of knowledge, they play a significant part in the family, providing spiritual and emotional support and keeping families together. Grandmothers with chronic health conditions are having to grow up young children with disabilities into adult life while being themselves unsupported. They cook and clean, and some are working part time to support families financially. They are advocating and following up with services to provide appropriate support for themselves and their families. Grandmothers are providing transport, monitoring behaviour, and acting as mediators for conflict within their families. These findings suggest that there is an urgent need for evidence-based approaches to early intervention and the provision of appropriate resources and support.

The lack of external or formal support resulted in significant stress and an exacerbation of disability for many women, particularly for those with psychosocial disabilities and/or chronic illness. Additionally, trauma from family violence (FV) was a significant contributor to poor mental health outcomes. Feelings of hopelessness and despair due to a lack of support for both disability and violence can lead to suicidal tendencies (Australian Institute of Health and Welfare, 2021e). Suicidal ideation is reported to be higher amongst people with disabilities, particularly those with FASD, traumatic brain injury (TBI) and psychosocial disabilities (O’Connor, et al, 2019; Choi et al, 2020). This identifies another urgent gap and the need for mental health services to adapt suicide interventions/therapeutic practices for clients with disability who experience suicide ideation.

Best practice in general reflects the importance of practical support across a broad range of basic needs of First Nations people with disabilities. In this regard, the importance of culture being the foundation of any program, activity or service to support disability, health, and wellbeing was emphasised by the women in this study. This is consistent with research which has identified that engagement within the community and group activities that are culturally therapeutic are essential for enhancing social and emotional wellbeing (SEWB) (Gupta et al., 2020)

6.2 Violence

Women we interviewed reported experiencing extreme, prolonged violence from multiple intimate partners throughout their lives. First Nations women with disability experience substantially heightened barriers to leaving a situation of FDV. For many people with disability, violence and trauma have been ongoing to the point that the cycle of violence is normalised, creating more barriers to breaking their silence and leaving a violent relationship (Puccetti et al., 2019). The fear of escalating the violence may also prevent reporting, particularly given that many First Nations women, as was reported by some of our participants, have had poor prior experiences with police.

The well-founded fear of repercussions from child protection and related issues around loss of home and community were huge barriers to reporting FDV for First Nations women (Ivec et al., 2012). There was a strong desire among women to keep their families together. Women were starkly aware of the risk of removal of their children by child protection authorities if they reported violence in the home, and of the ongoing consequences of this for their families. For First Nations women, particularly those living in regional and remote communities, leaving an abusive relationship can entail leaving their family, community and Country. Removing a woman from her home and community, however, is not a sustainable solution to FV, as she can be forced to return to her perpetrator for a variety of reasons, including the desire to stay in her home, connected to family and community, and to live on Country (Diemer et al., 2017). Unless each of these barriers is addressed, current responses to FV will continue to let women and families down (Cripps & Habbibis, 2019).

Women identified alcohol and illicit drugs as contributing factors to the escalation of violence in their relationships. The interconnectedness of FV, trauma, disability (including mental health), and AOD issues highlights the importance of ensuring that relevant services are well-equipped to respond to FDV. In particular, participants with psychosocial and other types of disability were at risk of not having their needs met due to siloed service parameters and funding. The revelations from First Nations women of being drugged without their knowledge by their partners to keep them dependent and facilitate sexual abuse was a new finding in this research. Many stakeholders reflected on services ‘hand-balling’ clients to other services due to one or more of these interconnected issues, which can result in at-risk clients being lost in cycles of referrals. These stories from the women and stakeholders in the study supported a need for greater intersectoral collaboration between systems and a stronger understanding of how trauma and FV feed into the many interrelated issues women may have (Australian Institute of Health and Welfare, 2019a; Guggisberg, 2019).

Conversely, the bi-directional relationship between disability and violence illustrates the importance of ensuring that FDV services are well-equipped and resourced to handle disability. This should include screening for disability upon entry to the service in order to make any required adjustments to care and management. Staff members need to be trained to work with women with disabilities and have some understanding of the NDIS process. Ideally, FDV services would take this a step further and use the time as a window to intervene, providing education on disability (particularly TBI and psychological trauma) and beginning to address any underlying issues the women have (Puccetti et al., 2019; Zieman, Bridwell, & Cárdenas, 2017). This may include providing referrals to specialist services for assessments and support, and where feasible, support to attend appointments including transportation and childcare. It is important to ensure, wherever possible, that these referrals are made to Aboriginal Community Controlled Organisations (ACCOs) or to mainstream services that are known to operate in a culturally secure way.

Trauma from sexual abuse was a significant contributor to lifelong psychosocial disability for many women. The majority of women had experienced some form of sexual abuse in their lifetime. Some participants were disclosing this abuse for the first time, while others had sought help but were unable to access support due to unavailability of specialist services and counsellors in their region. Some who had never had the chance to speak to someone about their abuse said that they had found the experience therapeutic.

Stakeholders reported violence frequently occurred after-hours. This was identified as the most precarious time for women and families seeking crisis support, but also as a time where there was a lack of availability and resources, particularly in regional and remote areas. Refuges are critically under-resourced, restricted by policies, and do not cater for large families and older children. As well, both women and stakeholders in this study stated that mainstream refuges are not culturally secure for First Nations women. Fundamental elements of cultural security include two-way dialogue and respectful communication, the development of trust, and an environment that is free of racism and discrimination (Department of Health and Human Services, undated; Williams, 2008).

Kambarang Place Aboriginal Women's Refuge, a mainstream service for First Nations women experiencing FDV, has been on its current site in Perth since the 1970s. Kambarang exhibited elements of best practice in cultural security, including strong connections to the First Nations community and employing and supporting First Nations staff. Stakeholders commented that this service is 'well protected' and that First Nations men know not to attempt to locate women there. The program manager reported that women who exit the service will frequently call in to let staff know how they are doing, and that women in the community know the service is there if they need it. Generally, however, there is a lack of culturally secure FV services, which impacts the accessibility of support for First Nations women and children.

6.3 At-risk groups and child protection

First Nations children comprise just over 30% of all children in the child protection system (Australian Institute of Health and Welfare, 2020a). FDV is a significant contributor to these higher levels of removal of First Nations children by child protection authorities, and to the greater involvement of First Nations people with the justice system (Australian Institute of Family Studies, 2014). Young people with disabilities are overrepresented in both the out-of-home care (OOHC) and juvenile justice systems (Australian Institute of Health and Welfare, 2019d). In our consultations, lack of routine and structure for children in residential care were described as culturally unsafe practice that contributed to poor mental health and trauma.

Best practice, supported by literature, is that stable placements with consistent routine and structure are imperative to provide for their basic needs and disability (Burns et al., 2021). Government-operated residential care that cater for this at-risk group must have skilled staff trained in supporting young people with complex needs. It is imperative that all services geared towards at-risk youth are disability-aware and accessible, and that youth workers are confident in supporting young people with disabilities. This is particularly important given that some neurodevelopmental disabilities present with similar behaviours, and some, such as FASD, are known to be misdiagnosed or underdiagnosed (Bourke et al., 2016; Wozniak et al., 2019). In addition, it was suggested that the value of having First Nations staff with lived experience in residential care had been overlooked. Building a culturally secure service entails a commitment that managers support staff with any conflict which may arise from vicarious trauma and/or their own lived experience, and value their lived experience as a strength.

6.4 Men

Without in any way excusing the violence perpetrated by their partners, many of the women reported their understanding of the struggles the men had with unresolved grief, loss and trauma, which contributed to poorer mental health and AOD use. Several women reported that their partners had experienced sexual and other forms of abuse in childhood, as well as exposure to violence more broadly. Some women indicated that their partner having a history of trauma created further barriers to leaving a violent relationship: in addition to love and connection to their partner as the father of their children, where they were the sole confidant of his childhood trauma the sense of loyalty can be reinforced, particularly if she herself had similar experiences in childhood.

The review of literature discussed a number of programs for First Nations men, in particular the Men's healing and behaviour change programs delivered by Dardi Munwurro. These programs demonstrate best practice, are evidence-based and culturally secure (The Healing Foundation et al., 2017). In general, however, there is a significant absence of such programs for First Nations men. Women's experiences and stakeholder's perspectives emphasised the urgent need for therapeutic interventions, and behaviour change and healing programs which are culturally appropriate and accessible for men struggling with mental health and AOD use.

6.5 Police and the justice system

The historical relationships between First Nations people and police were said to be partly responsible for women reporting mixed experiences in their contact with police and the justice system. While some women reported positive experiences, others reported feeling there was a power imbalance where they felt intimidated and disrespected. Some women felt that their experience of reporting violence to police mirrored the dynamics of the violence itself, resulting in re-traumatisation. This had destroyed any remaining sense of safety and trust they had in the system to protect them, affecting their willingness to call for help in the future and thus putting them at greater risk of violence. Women expressed a strong desire to have access to female police officers to assist them where there had been an incident of family or sexual violence. Stakeholders stated police are overstretched, short-staffed and under-resourced and therefore competing priorities can leave women and children at increased risk, particularly after-hours when services are not available.

The limitations of restraining orders have been widely acknowledged, and cases such as Andrea Pickett's illustrate the tragic consequences of when orders are not enforced (Hope, 2012). Among women and stakeholders there was a perception that the process of obtaining restraining orders could be futile, as they appear to do little to prevent perpetrators from harassing women, and sometimes even cause more harm to women and families.

A stakeholder from an Aboriginal Community Controlled Health Organisation (ACCHO) expressed concern about adequate funding to provide support to existing clients in prison and on transition to the community. The inability to support clients who are involved in FDV matters through prison outreach and transitional support greatly impacts the cultural safety and overall quality of care received by First Nations men and women in prison (Department of Social Services, 2021). This also forms a barrier to engaging perpetrators of FV in a way that meaningfully addresses underlying issues.

6.6 Public guardians and trustees

There is an urgent need to further investigate the nature and impact of guardianship and trustee arrangements for First Nations people with disability, particularly for those in regional towns. It was clear from consultations both with the women and stakeholders that, while there is an undeniable need for public guardians and trustees, the current system is not fit-for-purpose. Issues with public trustees controlling women, denying access to essential funds, and not supporting decision-making in the woman's best interests, were raised by stakeholders and women participating in this study.

Both reported that the guardians and trustees, who are responsible for making decisions and managing finances on behalf of women, have a lack of understanding of disability, trauma and FV. While there are known issues with the public trustee and guardian systems in various states, an important finding of this research was the extraordinary level of control experienced by the women at the hands of an opaque and unresponsive system. As was the insight from the women that the control exercised by the Public Trustee felt similar to the controlling behaviours they had experienced from their abusive partners, leaving them feeling trapped. Of significant concern was the statement from stakeholders in the FDV sector that women being under the Public Trustee and also homeless was not the exception but the rule for the women they see.

Also concerning were allegations made of non-response to clients, placing an additional burden on people in already stretched services to advocate on their behalf to ensure that their concerns were heard. One stakeholder recalled an occasion of having to advocate to the Public Trustee on behalf of a woman whose cultural needs and protocols were not being respected. This stakeholder emphasised that the barriers put up by the Public Trustee are challenging to navigate as a service provider or clinician who has a sound understanding of the various systems, let alone for a woman who has a disability and experience of trauma. Women and stakeholders both said that guardians and trustees needed to build better relationships with their clients and to be accessible to them in their local community. Stakeholders said that their clients further commented on the lack of transparency about the roles of the guardians and trustees, as well as about the appeals process, access to legal representation and the provision of support to mount a successful appeal.

Stakeholders identified clear elements of best practice for guardians and trustees working with clients who are First Nations women experiencing FDV, many of whom also have disabilities. These elements of best or promising practice were primarily around culturally safe practice and cultural awareness, including an understanding of the impacts of intergenerational trauma, as well as of women's obligations and other cultural considerations. Without this sound understanding, a guardian or trustee is unable to make decisions that are in the best interests of a First Nations woman.

6.7 Underdiagnosis and underutilisation of the NDIS

In all areas, there were issues with underdiagnosis and underutilisation of the National Disability Insurance Scheme (NDIS), and with disability support by First Nations clients, stemming from a variety of issues concerning the availability and accessibility of services (Phuong, 2017). In one location, this was thought to be predominantly due to the high burden of proof required which is best met by assessment by a paediatrician, psychiatrist or another specialist. Another location similarly noted an over-stretched capacity to meet the NDIS threshold and provide services for their clients. A lack of disability services inhibits the rollout and uptake of the NDIS in regional and remote areas, and in larger regional centres and metropolitan areas the cultural safety of disability services presents a further barrier to accessing disability support and optimising the effectiveness of NDIS plans. A lack of disability awareness, as well as the high burden of evidence required and difficulties in accessing specialist services, are barriers to timely diagnosis and early intervention, increasing the burden of disability in regional and remote locations.

Stakeholders reported a misuse of funds by some service providers, including services inflating costs and double-dipping. They stated that the NDIS is unregulated, and there is no capping on what external services may charge. They believed this placed a further burden on Aboriginal Community Controlled Health Services (ACCHOs) to ensure their clients had enough funding to cover their required needs for the year. Some ACCHOs have taken the initiative to train First Nations people to become providers of some services such as gardening and home maintenance – services that were previously provided by local Commonwealth Development Employment Project (CDEP) programs.

Consultation with a number of stakeholders across the FV and disability sectors has identified the importance of roles such as the newly created role of disability navigator at Kambarang Place, which is currently filled by a First Nations person, to provide education and advocacy for people with disabilities and assist them in navigating the complex world of the NDIS and disability services.

6.8 Housing and accommodation

Housing and accommodation for First Nations women and children with disability is paramount. At time of writing, WA is said to be experiencing a housing crisis (Ferguson, 2022; Macdonald, 2022; Perpitch, 2021). ShelterWA reported that in the 2020-21 financial year, total social housing stock in WA was 42,661 (ShelterWA, 2022). In August 2021 there were 30,394 people (17,480 households) on the waitlist for social housing; 7065 of these people (3548 households) were on the priority waitlist. The majority of women we interviewed were homeless (including staying with family, couch-surfing or in a refuge) and many were waiting for public housing. Other women were unable to be added to the waitlist due to debt to the public housing authority, which one woman reported had accrued when she fled the home due to FV.

The COVID-19 pandemic, cuts to public housing, and an increasingly competitive private market has increased the vulnerability of First Nations women with disabilities, which is particularly concerning given FV has been found to have spiked over this same period (Morgan & Boxall, 2020). Given First Nations people with disability are less likely to be diagnosed and accessing the appropriate support, many are on the significantly lower JobSeeker payment rather than the Disability Support Pension (DSP), which impacts their ability to secure a private rental. First Nations people experience additional barriers in the private rental market due to systemic racism, as was noted by a stakeholder in the FV sector who observed a real estate agent asking her First Nations client whether she would ‘go walkabout’ if offered the rental property.

First Nations people with disability are at a greater risk of homelessness, and First Nations women with disability who are leaving FV suffer a double disadvantage in being unable to access appropriate housing. Refuges operate with variable policies, with some providing limited stays as short as three days. Women reported instances of receiving paternalistic and disrespectful treatment within mainstream refuges, and of feeling as though their needs were ignored.

Given that the limited length of stay in most refuges is usually not enough time in which women can be approved for public housing, case workers and other stakeholders have to support women to find other options. They spoke of having some success in getting women and their children into residential rehabilitation facilities, but that it can take anywhere from a few weeks to a few months to do so. In addition, ongoing substance use and a lack of stable accommodation can be barriers to getting people into residential facilities, both of which may impact women leaving FV. For women with mental health issues and other disabilities, experiencing FV and other crises can be a barrier to acceptance into residential disability and mental health recovery services, reducing the quality of care and accessibility of these services for First Nations women with disability.

6.9 Barriers to accessing services

A barrier to consistent service access that is unique to metropolitan and larger regional areas is the impact of unstable accommodation on continuity of care. When a woman is accessing a refuge, relying on personal networks through couch-surfing or otherwise experiencing homelessness, she may be unable to access her previously existing services, due to service parameters. This may impact the quality of care received, lower women’s trust in services, and cause further trauma from needing to re-tell their story. It also increases the risk of women falling through the cracks and being unsupported, and may contribute to the risk of returning to a perpetrator.

Lack of reliable transport was also identified as a significant barrier to accessing services for women in regional and remote areas. Many do not have access to reliable vehicles due to poverty, and those with disabilities may be unable to drive. Many women were forced to travel long distances (of up to 13 hours) between communities and regional centres. Stakeholders reported that some women were accepting lifts from people they did not know. This presents a safety risk, especially for women with disabilities who may be more vulnerable.

As was noted earlier, substance use and lack of stable accommodation are barriers to accessing support services. Given the already high risk of homelessness for First Nations women with disability who experience FDV, this is especially problematic in light of reports from women in this study of their use of AOD to cope both with symptoms of disability and with FV.

More broadly, barriers to accessing services included concerns surrounding trust and confidentiality (particularly in smaller communities), a lack of trust due to systemic racism and poor previous experiences, and high turnover of services due to funding issues resulting in services which are poorly integrated with the community. The main service gaps across the five sites were for culturally safe counselling and healing services (including for current and historical sexual abuse), support for men and men's behaviour change programs, and after-hours and crisis support.

6.10 Cultural safety and workforce issues

Women and stakeholders highlighted the importance of creating a culturally safe environment for First Nations people with disabilities. A culturally safe environment is one where:

> ... there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening (Williams, 2008, p. 213).

Stakeholders reported that First Nations clients respond to being welcomed, to not feeling judged, and to informal yarning over a cup of tea, and that this needs to be valued as an important part of a service. This is cultural safety and informal counselling in practice, as many First Nations people are often reluctant to engage with formal counselling. Lin and colleagues (2016) outlined the validity and importance of the role of yarning in working with First Nations clients in the management of their health plan.

Women described having positive experiences when accessing services in relation to their health and disability, where clinicians created a more comfortable and culturally safe environment through building genuine relationships with their clients based on reciprocity. This involved more informal yarning and listening, and ideally meeting in an environment where the women were already comfortable. This resulted in greater trust, increased willingness to seek help in the future, and improved the quality and continuity of care received.

High turnover of the workforce in regional areas was seen as a significant barrier to women having positive and consistent experiences when reporting FDV. It was noted by study participants that proactive police officers who had developed strong relationships with the community were often promoted or otherwise relocated elsewhere, which reduced the cultural understanding within the workforce.

Challenges may arise for First Nations people working in mainstream services or government agencies when there is conflict between their duties within their role, and their values, obligations, and reputation within their community. This is an added layer of stress and complexity for these workers, further complicated in instances where the obligations of their role may require them to participate in systems which have resulted in historical and continuing oppression, disempowerment and harm to their people. In addition to conflict arising from cultural obligations, they must also navigate the impacts of witnessing overt and covert racism towards themselves and their clients, which is known to impact stress and SEWB. ‘Fighting against the system’ to provide a culturally safe service to deliver the best outcomes for their clients can contribute to burnout and staff turnover. This is a significant barrier to retaining a skilled workforce and building culturally secure services for First Nations communities.

Stakeholders in regional areas expressed frustration with the high turnover of new services and programs due to time-limited funding. As a result, communities were hesitant to engage and build relationships despite their high need. They reported that when the community have built relationships and trust with service providers and the funding is discontinued, they become disillusioned and less likely to engage with future services. Rather than allocating funding to new services that may provide similar support, stakeholders said that it was critical to increase funding to existing services that are already well-integrated within the community.

It is clear there is a real need for greater First Nations employment in the disability sector in a variety of roles, in particular as support workers, coordinators/plan managers, and advocates/navigators. Where this is not possible, greater emphasis should be placed on the importance of ensuring non-Indigenous staff are able to provide culturally secure support to First Nations clients. Placing the responsibility of supporting First Nations clients solely on a limited number of First Nations staff has been reported as a contributor to burnout. Stakeholders agreed that ultimately the key element is supporting the choice of clients, and ensuring that they have the opportunity to choose First Nations staff and services.

Many women carry a significant burden of disability resulting from unresolved trauma due to long histories of abuse, grief and loss. Counselling services in particular are urgently needed, particularly in regional towns. Services must consider gender and cultural obligations in staff recruitment, ensuring that First Nations clients have the opportunity to be supported by gender-appropriate staff (Langton et al., 2020).

6.11 Children

The children who took part in this study spoke of a range of harms impacting on their daily lives as a result of disability, often intensified by the occurrence of FDV.

6.11.1 Education

A recent review outlined the impacts of trauma on children, specifically on their learning and behaviour in a school setting (Miller & Berger, 2020). Trauma can affect children’s ability to concentrate and learn in class, and is linked to poorer educational attainment and outcomes (Hurt et al., 2001). Additionally, trauma can impact sensory processing and emotional regulation, which decreases their ability to cope with the school environment (Costa, 2017). Children with trauma often exhibit signs of developmental disorders and can be misdiagnosed as having disabilities including learning disabilities, ADHD, oppositional defiant disorder (Walkley & Cox, 2013). More recently, studies conducted in WA have found that FDV affects school readiness in young children (Orr et al., 2021) and outcomes for children up to and including year 10 (Orr et al., 2022).

Many children reported difficulty concentrating, and challenges with emotional regulation and sensory processing, which impacted their educational attendance, performance and outcomes. Children reported that maths was a particular area of difficulty, which has been identified as crucial for empowering children to make better social and economic decisions later in life (Council for the Australian Federation, 2007). Children emphasised the importance of flexible and tailored approaches to teaching and learning to cater to individual children's needs, especially for children with trauma and/or disability. This is supported by the findings of a recent review, which identified the need for culturally informed educational pedagogies (Miller & Armour, 2021).

6.11.2 Bullying

United Nations Convention on the Rights of the Child (CRC) articles 28 and 29 pertain to the child's right to an education that is accessible and develops each child to their full potential. In many cases, bullying fully inhibited children who participated in this study from attending school and accessing a quality education. Short frequent absences from school due to bullying led to longer periods of absences. This resulted in children falling behind in their studies, and contributed to longer term disengagement from education. The Education Department must play a key role in early intervention for disengaged children and in addressing bullying behaviours.

Children described being teased both due to their disability and due to racism. Children reported that the bullying also impacted their SEWB and self-esteem. There was a theme of teachers not intervening, or not intervening effectively. A number of children reported experiencing negative repercussions due to speaking up or fighting back against bullies. This included more bullying or getting in trouble at school, including suspensions.

In a regional area which had problems with community feuding, violence often flowed into the school environment, which is reflected in the literature. A study that investigated bullying in a First Nations context found that bullying is perpetuated by FDV (Coffin et al., 2010). Cultural identity is protective for First Nations children's development and wellbeing (Kickett-Tucker & Shahid, 2019), and strengthening cultural identity has been identified as a key action to address bullying (Coffin et al., 2010).

6.11.3 SEWB

Anger is recognised as a key emotional sign of trauma, along with anxiety, guilt, self-blame, trouble concentrating, and feelings of hopelessness. Aggressive, self-destructive or harming behaviours can also manifest due to trauma (Atkinson et al., 2014). Anger was a prominent theme in both the women's and children's interviews. This was often due to trauma (from child removals, grief and loss, sexual abuse, and FV) and exacerbated by certain disabilities. Women and children with trauma and/or disabilities impacting upon emotional regulation had anger issues which sometimes led to acts of aggression. For some women and children, this led to consequences including suspensions from school, exclusion from community life and facilities, and contact with police and the justice system.

Sleep difficulties were a prominent theme, reported by most children. Children reported that their sleep impairment exacerbated irritability and issues with sensory processing, concentration and emotional regulation. Research has found exposure to trauma and FDV is associated with higher levels of sleep difficulties in children (Wamser-Nanney & Chester, 2018). Studies have also found that trauma due to family and sexual violence is more associated with sleep impairments than is other types of trauma, such as from road accidents and natural disasters (Lind et al., 2017).

Children reported feeling a strong sense of guilt and self-blame, particularly due to grief and loss, and from being separated from siblings due to child removals. They described feelings of hopelessness and despair, and one had developed depression as a result of her removal and separation from her siblings.

6.11.4 Witnessing and experiencing violence

In 2016-17, the Australian Institute for Health and Welfare (AIHW) reported that approximately one-quarter of hospitalisations of children under 14 years of age due to assault were of First Nations children (Australian Institute of Health and Welfare, 2022a). This was mostly perpetrated by a parent or family member. The report also outlined that FV encompasses the witnessing of violence by children, which was common among the children interviewed. This violence was usually directed towards mothers, aunties and nans. They had a strong urge to protect their mothers or siblings. Many children reported that they had attempted to intervene from a young age, which placed them at risk of harm.

Children reported that AOD played a significant role in the FDV that they were exposed to. One child reported that the trauma from witnessing FV ,affected her engagement and participation in school.

6.11.5 Family support and sources of strength

Children had a number of sources of strength and guidance. This especially included seeking support from Elders and family. Siblings were an important source of strength for children. Younger children described looking up to their older siblings and going to them for guidance and support. Older children reported that being a positive role model for younger siblings was a strong motivator for striving within education and employment. On the other hand, children who were separated from their siblings felt a sense of powerlessness and failure, which strongly affected their SEWB.

7. Conclusion

First Nations women and children with disability are among the most vulnerable group in Australia, placing them at an exceptionally high risk of experiencing family and domestic violence (FDV). First Nations women and children suffer a disproportionate burden of disability, which further heightens their risk of victimisation from FDV, including sexual violence.

The women and children's stories recounted in this study highlighted the continuing impacts of colonialism and associated government practices, and the prevalence of institutional and structural racism in their lives, resulting in overrepresentation in the child protection and criminal justice systems. Furthermore, women with disability themselves have higher rates of child removals and a history of child protection involvement, compounding their vulnerability. As a result, First Nations women and children with disability experience heightened barriers to seeking assistance from police and support services in instances of family violence (FV), including fear of repercussions from child protection authorities, lack of trust in police, and the risk of losing their homes. In some areas there was a sense of positive change in police relations, including a stronger connection with families, the community, and more proactive policing. While this is encouraging, many First Nations women continue to experience racism, intimidation and victimisation by police when reporting violence, resulting in a lack of trust that the system will protect them.

On a structural level the National Disability Insurance Scheme (NDIS) and disability services are not built to be accessible or to meet the needs of the clients who need them most. Additionally, there was often little knowledge among First Nations participants about the scope of the NDIS and availability of disability services. Current systems supporting First Nations people with disability must be reconfigured to overcome cultural, linguistic, cognitive and structural barriers to accessing support. These issues require urgent attention and ongoing financial investment.

Access to community controlled services, or mainstream services which are culturally secure to avoid retraumatising women and children, is paramount. These services must be well-resourced, with secure ongoing funding to allow for familiarisation and acceptance by First Nations people, and to ensure that staff turnover is minimised, particularly in non-metropolitan areas. Centralisation of services can be an effective model for service delivery; however, there must be a cultural shift within institutions, a decolonisation of services and a breaking down of cultural barriers to allow for productive and genuine partnerships.

We have heard, in this study, from First Nations women and children of experiences shared with us many times before in a variety of forums, including previous government inquiries, and it is inexcusable that these issues remain unaddressed. It is to be deplored that there is still widespread ignorance and misunderstanding of the historical and ongoing causes of many of these issues for First Nations people. Until this is addressed, the extent of the difficulties women and children face will remain invisible to those with no understanding of their lived experiences as a First Nations woman or child with a disability.

8. Recommendations

8.1 Commonwealth, state and territory governments

- Explore data sharing opportunities between Aboriginal Community Controlled Health Organisations (ACCHOs) and government agencies to inform resource allocation, policy, and program development within principles of data sovereignty.
- Reform and decolonise the guardianship and administration system to ensure greater accountability and provide safeguards to protect the rights of First Nations people with disability:
    - Provide anti-racism and trauma- and disability-awareness training for public guardians and trustees.
    - State and territory agencies which operate guardianship and administration services to the public commit to and invest in recruitment, training and employment of First Nations staff.
    - Decentralise the State Administrative Tribunal (SAT) with the creation of offices in major regional centres.
    - Notify the relevant First Nations spokesperson or advocate when a referral to SAT is made for a First Nations person.
    - Create a more transparent, reasonable and accessible appeals process:
        - Provide clearer information online that is accessible to people with different types of disabilities.
        - Provide contact details for community legal centres/disability advocates in different areas.

8.1 Commonwealth, state and territory governments (continued)

- Undertake structural change to the National Disability Insurance Agency (NDIA) to make the National Disability Insurance Scheme (NDIS) more accessible to First Nations people with disability. This will entail strategies to overcome linguistic, cultural and cognitive barriers to access. This must be implemented in conjunction with other recommendations related to the resourcing of ACCHOs below.
- Provide programs with sustainable long-term funding to ensure that disability does not continue to be perpetuated through the next generations in First Nations families.
- Provide funding for holistic, family-focused alcohol and other drug (AOD) residential healing and recovery services.
- Ensure police and the criminal justice system follow all legislated procedures in responding to and prosecuting the sexual assault of First Nations women and children.
- Fund qualitative approaches to research into female experiences of violence, with a policy and practice focus on prevention and identification and culturally acceptable interventions.
- Fund research to investigate issues of First Nations peoples' access to and engagement with disability services.
- Fund the improvement of systematic nationwide collection of disaggregated data on First Nations people with disability within the child protection and justice systems to better inform policy and funding allocation.

8.2 Aboriginal Community Controlled Organisations (ACCOs)

- Commonwealth, state and territory governments provide funding to increase the number and capacity of ACCOs, with a focus on the development of a strong First Nations disability services sector:
  - Re-direct funding from mainstream organisations to community controlled organisations.
  - Allocate funding for ACCOs to improve their data collection systems.
- Commonwealth, state and territory governments fund and strengthen ACCHOs to support clients with disabilities:
  - Improve the accessibility of assessments through funding ACCHOs to undertake diagnostic assessments (especially for neurodevelopmental, psychosocial and acquired brain injuries (ABI)-related disabilities).
  - Provide education to the community to increase awareness of disability and support available.
  - Link First Nations clients to culturally secure disability services and other supports.
- Fund ACCHOs to perform outreach and transitional support to First Nations clients in prison.

8.3 Family and domestic violence (FDV) sector

- There is an urgent need for investment in the development of women's refuges which are inclusive and responsive to the needs of the community and First Nations families escaping family violence (FV). This requires that the FDV sector operate under a culturally secure, holistic and family-focused healing model, working with the family unit to address FDV and incorporating community-based interventions.
- Culturally secure, accessible and trauma-informed services for First Nations women and children who have experienced sexual abuse.
- FDV services mandate training to ensure staff have appropriate disability and trauma-awareness, including an understanding and awareness of:
  - The heightened vulnerability of women with disabilities to victimisation.
  - Undiagnosed disability, with a particular focus on the impact of repeated physical injuries, neurodevelopmental and psychosocial disability.
  - The impact of complex trauma from family and sexual violence, grief and loss, child removals and intergenerational trauma.
  - Disabilities which can be caused by violence. This includes education, by specialist services where appropriate, on traumatic brain injury (TBI) from physical violence and non-fatal strangulation.
  - Reducing barriers to the accessibility of services for women with disabilities.
- FDV services commit to developing genuine and sustainable partnerships with services (ACCHOs, AOD services etc.), which should be tied to funding agreements and reporting obligations.
- Future refuges in regional areas be developed using a model of best practice for a First Nations women's refuge such as that identified in Perth (Kambarang Place Aboriginal Women's Refuge), incorporating disability and trauma-awareness, employing First Nations staff, supporting those with lived experience, and developing stronger connections to the community.
- Invest in increasing the accessibility of after-hours crisis support in regional towns.

8.4 Child protection

- Residential care must be culturally secure, therapeutic and trauma-informed:
  - Train youth/support workers to identify disability and trauma and manage complex behaviours. This should involve working with First Nations registered training organisations (RTOs) to develop a course focused on disability similar to those available for mental health and aged care qualifications, as well as incorporating modules on disability into youth and health worker qualifications.
  - Residential care should be operated by the ACCO sector, particularly in regional areas.
- Improve processes for health and disability assessments for children who are wards of the state.
- Greater investment in recruiting and supporting First Nations people to become kinship carers, which will involve more financial incentives, other resources (including transport, home support, disability-awareness training) and respite (more than one weekend per fortnight).
- Case managers must be trained and competent in supporting children with neurodevelopmental disabilities and FASD.
- Kinship carers with disabilities should be allocated their own caseworker to support their needs, additional to the caseworker for the child’s needs.
- Provision of evidence-based intervention programs, resourced and delivered by ACCOs (e.g., Parent Child Assistance Program), catering for mothers with and without disabilities.

8.5 Juvenile justice

- Reduce the number of First Nations youth with disabilities in the justice system through:
    - Police trained to work proactively with young people with disabilities to prevent offending and deter incarceration.
    - Greater investment in providing early intervention support through models of best practice (e.g. Koori and Murri courts).
    - Comprehensive assessments (to assess neurodevelopmental, psychosocial and TBI-related disability) in community-based corrections and the children's court system, and the timely provision of referrals and disability support.
- Raising the age of criminal culpability to 14 years.

8.6 Healthcare and early intervention

- Training of healthcare practitioners (particularly emergency department workers) to improve awareness of health issues and disability related to violence (TBI, physical injuries, trauma).
- Developing processes for assessment of women and children presenting with violence-related injuries for follow-up and referral to specialist consultation.
- Strengthening the capacity of child health nurses to recognise and respond to disability.
- Funding and resourcing ACCOs to implement evidence-based early intervention programs.

8.7 Education

- Investment in culturally secure kindergarten programs for First Nations children to maximise opportunities for early intervention and support their transition to education.
- Teacher training, education and funding:
  - Implement cultural and trauma-informed practice, including recognising signs of trauma in disruptive behaviour and managing children with complex needs.
  - Ensure teachers are adequately trained and resourced to meet the needs of children with disability.
  - Implement strategies to support the training, recruitment and retention of First Nations teachers and teaching assistants.
  - Provide additional training to school nurses, counsellors, or other specialised roles, to identify and support children with disability.
- Include a focus on First Nations history and culture in the curriculum to improve confidence, cultural identity and feelings of inclusion.

8.8 Workforce and training

- Provide incentives (remuneration, relocation support, ongoing contracts, mentoring and support) to increase the recruitment and retention of mainstream and First Nations carers and support coordinators in the disability sector, particularly in regional areas:
    - Invest to increase the recruitment and retention of disability respite carers in regional areas for First Nations clients.
- Processes for formal and informal debriefing to support First Nations workers with lived experience and vicarious trauma be implemented in all services and communities.
- Provide training to strengthen workforce capability to deal with clients with complex interrelated issues (for example, mental health and other types of disabilities, AOD issues, and FDV).
- Employ skilled disability navigators and advocates (including those with lived experience) to work in community services to support and educate clients and staff, and overcome barriers to clients accessing services.
- Implement anti-racism training based on best practice models in police forces, women's refuges, disability, health care agencies and other government agencies and community services with a role in supporting First Nations people with disabilities.

8.9 Support for men

- Commonwealth, state and territory governments invest in the delivery, evaluation and replication of programs for men that are:
    - Evidence-based and identified as best practice (e.g. Dardi Munwurro's suite of preventative and perpetrator programs).
    - Implemented by ACCOs or by culturally secure mainstream services.
    - Designed to promote healing and behaviour change to overcome or prevent violence.
    - Accessible to men with disability (particularly neurodevelopmental and neurocognitive disability and mental health).
- Commonwealth, states and territories invest in the development of short to medium-term supported accommodation (similar to women's refuges) for male perpetrators following a FV incident.
- Commonwealth, states and territories commission and fund qualitative research with First Nations men to hear their voices, ideas and solutions surrounding FV, trauma and disability.

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10. Endnotes

1 See https://www.lawcouncil.asn.au/policy-agenda/advancing-the-profession/model-definition-of-family-violence
2 See https://www.servicesaustralia.gov.au/what-family-and-domestic-violence?context=60033
3 See https://www.wa.gov.au/government/document-collections/what-family-and-domestic-violence
4 Committee on the Elimination of Discrimination against Women, Concluding Observations on the eighth periodic report of Australia, CEDAW/C/AUS/CO/8
5 Proquest/PubMed/PsycINFO. A range of search methods were used (keywords and phrases, boolean & proximity operators and truncation methods), for relevant terms and variations thereof including Aboriginal and Torres Strait Islander, First Nations, women, children, disability, family, domestic, intimate partner, violence, abuse, coercion, disease burden, COVID-19, child protection, services, rural and regional, law and culture, best practice.
6 Authors of this report state “the term ‘domestic violence’ was felt to be unsuitable for any analysis of violence in Indigenous households and was replaced with the term ‘family violence’ for this report” (p. 1).
7 The National Disability Strategy, the National Plan to Reduce Violence against Women and their Children, and the National Framework for Protecting Australia’s Children.
8 Services Australia. Disability Support Pension, https://www.servicesaustralia.gov.au/individuals/services/centrelink/disability-support-pension, accessed on 25 September 2021.
9 Western Australia Department of Health. Reference manual for health professionals responding to family and domestic violence. Western Australia: Western Australia Government; 2014; and Western Australia Department of Health. Guideline for responding to family and domestic violence 2014. Western Australia: Western Australia Government; 2014.
10 See https://www.ndiscommission.gov.au (accessed on 12 April 2022).
11 See https://www.abc.net.au/news/2022-01-14/draft-national-plan-end-violence-against-women-children/100756294
12 See https://www.monash.edu/arts/gender-and-family-violence/research-and-projects/national-plan-consultation-project
13 Convention on the Rights of Persons with Disabilities.
14 See https://www.dss.gov.au/families-and-children-programs-services-children-protecting-australias-children/the-first-1000-days
15 Described as where perpetrators have ceased or decreased violence for the duration of the pregnancy or, in some cases, paused physical violence but continued psychological violence.
16 KEMH is WA’s largest maternity hospital and only hospital for high-risk pregnancies.
17 https://www.kemh.health.wa.gov.au/For-Health-Professionals/Family-and-domestic-violence/Training and https://www.kemh.health.wa.gov.au/~/media/HSPs/NMHS/Hospitals/WNHS/Documents/Professionals/Evaluation-snapshot-jan-sept-2020.pdf, accessed on 18 September 2022
18 https://www.kemh.health.wa.gov.au/~/media/Files/Hospitals/WNHS/Our%20Services/State-wide%20Services/WHSP/Screening%20for%20Family%20and%20Domestic%20Violence.pdf
19 https://www.commerce.wa.gov.au/consumer-protection/safe-tenancy-wa, accessed on 25 September 2021
20 Data from the SDAC were limited to First Nations people living in households; it did not include people living in care accommodation or people living in very remote areas or discrete First Nations communities.
21 Table format has been adjusted.
22 Table format has been adjusted.
23 Table format has been adjusted.
24 The report states: “Family violence is the preferred term for violence between Aboriginal and Torres Strait Islander people, as it covers the extended family and kinship relationships in which violence may occur (COAG 2011). For this report, domestic violence is considered a subset of family violence and typically refers to violent behaviour between current or previous intimate partners” (p. 2).
25 Babies were identified as First Nations where either parent identified as such.
26 See https://www.coronavirus.vic.gov.au/family-violence-crisis-response-and-support-during-coronavirus

27 See https://www.wa.gov.au/service/community-services/counselling-services/family-and-domestic-violence-support-and-advice, and https://www.wa.gov.au/organisation/department-of-communities/covid-19-coronavirus-family-and-domestic-violenc1

28 See https://www.womensfundingnetwork.org/2020/04/28/wfn-announces-signal-help-program-new-lifeline-trapped-home-abusers/

29 Data for Victoria and Queensland were not published; the ACT recorded a decrease of 4% on 2019 figures.

30 While the publication does report some statistics on First Nations victims of crime, these data were only reported for New South Wales, Queensland, South Australia and the NT.

31 Data for relationship between offender and victim were not published for WA.

32 See https://20ian81kynqg38bl3l3eh8bf-wpengine.netdna-ssl.com/wp-content/uploads/2019/12/300419_NCAS_Summary_Report.pdf

33 The most recent 'National Community Attitudes towards Violence Against Women Survey (NCAS)' report stated that key facts related to violence against women were known by the majority of Australians; for example, understanding the range of behaviours that constitute FDV against women. Other results were less positive.

34 Data from the 2021 Census had not been released at the time of writing. ABS released an updated Australian population of 25,739,256 at 30 June 2021; see https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release. Estimated resident population (ERP) projection for First Nations people in 2021 is 881,600; see https://www.aihw.gov.au/reports/australias-welfare/profile-of-indigenous-australians

35 See, for example, https://www.monash.edu/law/research/centres/castancentre/our-areas-of-work/indigenous/the-northern-territory-intervention/the-northern-territory-intervention-an-evaluation/what-is-the-northern-territory-intervention

36 The Social and Cultural Resilience and Emotional Wellbeing of Aboriginal Mothers in Prison.

37 Ms Cheryl Axleby, Co-chair, National Aboriginal and Torres Strait Islander Legal Services.

38 Ms Phynea Clarke, Deputy Chairperson, NFVPLS Forum; Mrs Debbie Medhurst, Team Leader, Change Em Ways / Strong Women, Strong Families Program, Mens Outreach Service Aboriginal Corporation.

39 The article notes that 'For cultural reasons, our article only reports on the experiences of female caregivers. A focus on the distinct experiences of male caregivers warrants further investigation' (p. 1592).

40 Banksia Hill Detention Centre, located in Canning Vale, a southern suburb of Perth, WA, is a corrections centre for young offenders aged between 10-17 years.

41 See, for example, https://www.abc.net.au/news/2022-08-05/figures-detail-mental-health-of-banksia-hill-detainees/101288324 and https://www.abc.net.au/news/2022-08-19/former-guard-at-the-crisis-plagued-banksia-hill-youth-detention/101348944.

42 The purpose of these schools was described by a report of the Truth and Reconciliation Commission of Canada as "not to educate [the children], but primarily to break their link to their culture and identity". See Truth and Reconciliation Commission of Canada. (2015). What we have learned: Principles of truth and reconciliation. https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Principles_English_Web.pdf.

43 Hereafter 'Indigenous women' in Heidinger's report.

44 See Biddle, N., Yap, M., & Gray, M. (2013). Disability. CAEPR Indigenous Population Project. 2011 Census Papers.

45 This report notes that of the five AJAs introduced between 2000 and 2010 (in Queensland, WA, NSW, Victoria and the ACT), only that in Victoria was still active at the time of writing.

46 Desert Blue Connect provides a family violence intervention service by direct referral from the Barndimalgu Court, as well as a range of other services (not First Nations specific) across Midwest WA including a men's community intervention service for men who commit FDV, and a crisis accommodation service for women and children.

47 https://portal.thefatheringproject.org/wp-content/uploads/2016/10/AFP-Final-Report-Final.pdf

48 https://www.dardimunwurro.com.au

49 The legal framework discussed is complex and cannot be revisited here, but see Langton et al. 2020 pp. 32-38.

50 See https://www.ruah.org.au/services-support/family-services/kambarang-place-aboriginal-womens-refuge/

51 See https://providers.dffh.vic.gov.au/cradle-kinder-evaluation-summary-word

52 With a total population at the time of the study of 4500, approximately 80% of whom identified as First Nations people.

53 See https://www.youtube.com/watch?v=MiX6QVbztVw and https://alcoholpregnancy.telethonkids.org.au/our-research/research-projects/making-fasd-history-multi-sites/

54 Although not stated, the missing 13th interviewee appears to be the partner of one of the other interviewees.

55 Consultation questions were formulated in this way in recognition of participants using the word 'Aboriginal' to describe themselves and others.

56 NVivo is a qualitative data analysis computer software package. See https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

57 "Liyan (wellbeing) is a vibrant Yawuru philosophy that weaves people, culture and country together. The concept of mabu (good) liyan is the foundation of Yawuru's development approach. It is at the heart of the modern Yawuru economic and social agenda which is inclusive, supportive and committed to the principles of sustainability and community cohesion." See: http://www.yawuru.org.au/community/mabu-liyan-framework/?doing_wp_cron=1655794208.5049510002136230468750

58 The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Lands encompass parts of the central desert in Western Australia, South Australia and the Northern Territory.

59 In identifying Kambarang as a mainstream provider exemplifying best practice, we acknowledge that of course there may be other mainstream refuges for First Nations women, both in WA and in the other states and territories, that we were unable to speak to for this study, that also do so.

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