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Responding to trauma and disability in practice: Seeing the whole child – and their family

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Background and issues

Across Australia, the lives of children who experience trauma, adversity and disability are profoundly interconnected – but our service systems often treat these issues as if they occur in isolation. Child protection, disability, education, health and mental health all include the goal of improving children's wellbeing, yet their frameworks, funding models, diagnostic rules and accountability mechanisms remain separate. The result is that the children with the highest levels of need across multiple domains are too often the least well served.

The scale of overlap

Research consistently shows that disability is dramatically over-represented among children known to child protection and placed in out-of-home care (e.g. Hatzikiriakidis et al., 2023). While around 10% of Australian children have a disability, studies report prevalence rates of 30–67% among children in out-of-home care. For example, the Victorian Commission for Children and Young People (CCYP, 2020) found that 67% of young people aged 15+ years in residential care had a diagnosed disability, most commonly cognitive, psychosocial or speech and language impairments. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) similarly reported that over 40% of children in care have a disability – a number likely understated due to diagnostic barriers.

These national findings mirror what Berry Street Yooralla sees every day, with the following snapshot of children with a diagnosed disability in the child youth and family sector:

- 60% of students at our school;
- 50% of children in residential care;
- 57% of young people in Intensive Case Management Services; and
- 40% of children in foster care.

Trauma as both cause and consequence

The overlap of trauma and disability is not coincidental. Trauma and adversity, including neglect, can profoundly affect brain development, emotional regulation, language, executive functioning and learning. Decades of research – including the Adverse Childhood Experiences (ACE) studies – demonstrate that early adversity can shape lifelong developmental and health outcomes (Anda et al., 2006; Felitti et al., 1998).

Key findings about trauma and disability from research include the following.

- Trauma is widespread among Australian children, beginning in early childhood (Haslam et al., 2023).
- Developmental vulnerability is rising in Australia and children experiencing composite adversities are particularly vulnerable (Department of Education, 2025).
- Preschool children are the age group most exposed to family violence (Phillips & McGuinness, 2020) and most likely to appear in substantiated child protection reports (AIHW, 2020).
- Children with disabilities are at increased risk of being victims of trauma including abuse and/or neglect (e.g. Choudhary, 2025; Nyberg et al., 2022; Schüssler-Fiorenza Rose et al., 2025) and are more likely to experience domestic and family violence (Octoman et al., 2022).

- Trauma can mimic or mask disability, or be overshadowed by a disability, and can compound developmental challenges especially in the early years (e.g. Ford, 2023; Jackson & Waters, 2015; Stavropoulos et al., 2018; Vervoort-Schel et al., 2021).
- Children with disability often have additional barriers in disclosing trauma and being believed (e.g. Friedman-Hauser & Katz, 2025).
- Children who are neurodivergent, such as being diagnosed with autism or attention deficit hyperactivity disorder (ADHD), and exposed to trauma may be more significantly impacted than their peers (Li et al., 2024).
- Developmental delay and disability may be both a symptom of trauma and a factor that increases vulnerability to further harm (Gregory et al., 2024; Jackson & Waters, 2015).

Examples where children with disability have been found to be at heightened risk of having suffered different types of trauma and other adversities include:

- Sexual abuse (e.g. Euser et al., 2015; Friedman-Hauser & Katz, 2025; McMinn et al., 2024);
- Physical abuse (e.g. Jensen et al., 2021);
- Neglect (e.g. Barber & Delfabbro, 2009; Jackson, 2023);
- Domestic and family violence (Octoman et al., 2022; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023);
- Sexual exploitation (e.g. Franklin & Smeaton, 2017; McMinn et al., 2024),
- Criminal exploitation (e.g. Baidawi et al., 2020; Barlow et al., 2022; Lambert et al., 2024); and
- Youth justice custodial sentences (Baidawi et al., 2022; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023).

Without developmental assessments that consider family environment, relational health, history and caregiving quality, children at already heightened vulnerability risk being misdiagnosed, misunderstood, not believed and unsupported. An intersectional approach to understanding trauma and disability place them in the context of other areas of marginalisation and structural disadvantage.

Aboriginal and Torres Strait Islander children

Aboriginal and Torres Strait Islander peoples experience significantly higher rates of disability, early adversity and involvement with statutory systems (Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023). They are 11 times more likely to be in out-of-home care and more likely to experience intergenerational trauma and structural racism, while simultaneously having less access to culturally-led supports (Australian Institute of Health and Welfare, 2025). Although Aboriginal children are over-represented in child protection and reported to have higher rates of disability than the general community, there are indicators of higher amounts of undiagnosed disabilities especially for those in out-of-home care

(Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023). This reflects social and systemic inequities and barriers that require structural reform and strong self-determination frameworks.

Parents with disability

The intersection of disability and trauma also extends to parents. One in five adults with intellectual disability aged 15–44 years is a parent (Australian Institute of Health and Welfare, 2024). Nonetheless, the National Disability Insurance Scheme (NDIS) does not consider *parenting* an activity of daily living. As a result, many parents struggle to access the programs that evidence shows can improve outcomes for their children (Mazzucchelli et al., 2023b). This is part of what has been called ‘the NDIS parent problem’ – a structural oversight that contributes to family stress and, in some cases, child protection involvement (Mazzucchelli et al., 2023a).

Fragmented systems create fragmented care

Berry Street Yooralla is currently undertaking a literature review of public inquiries conducted in the past decade relevant to disability, trauma and both and have found 67 such inquiries. Across the board, the message is consistent: service systems are not designed for children with complex, overlapping needs such as trauma and disability. Key gaps include:

- Inconsistent NDIS access for children in care due to diagnostic delays, unclear guardianship and frequent placement changes;
- Insufficient system and services responses to Aboriginal children with disability and their families, thereby increasing marginalisation;
- Siloed therapeutic responses, where speech therapy, behavioural work, education supports and trauma therapy occur separately, without a shared plan;
- Systems designed for ‘simpler’ circumstances – such as the NDIS model of individual choice and control – which do not align with the lived realities of children in care; and
- Workforces that lack shared expertise across disability, attachment, trauma and child development.

These system failures result in children moving between placements, providers and diagnoses with little continuity and, too often, gaps in history. Many children with clear developmental vulnerabilities receive no formal diagnosis, no sustained intervention for them or their families and carers and no tailored educational support. The consequences are lifelong.

Action/Response – What we are doing

Berry Street Yooralla is working to build and advocate for an integrated approach that genuinely sees the whole child – and the context in which they grow. This means bringing trauma-informed and disability-informed practice and services together, rather than expecting families to navigate multiple disconnected systems.

Building stronger universal services

Universal settings – early learning, primary schools, community health – are critical because they are where developmental and relational needs first become visible. We advocate for an investment in strengthened universal services that can:

- Identify concerns early;
- Respond in a developmentally informed way; and
- Link families to additional supports quickly and smoothly.

Drawing on evidence (e.g. Goldfeld & Harman-Smith, 2025; Oberklaid et al., 2013; O'Connell, 2025), we endorse a 'stacked support' model, where universal settings are linked to multidisciplinary teams offering allied health, parenting programs and family or family violence services. This creates an ecosystem of support calibrated to each child's needs rather than a single intervention applied in isolation.

Supporting the child by optimising their relationships

Our therapeutic programs emphasise the core principle that children heal in the context of relationships. Evidence-based interventions such as Child-Parent Psychotherapy (Lieberman et al., 2015) and Multisystemic Therapy (Henggeler & Schaeffer, 2016) support the children and caregivers simultaneously. Socio-ecological models such as these that map the child's context, promote safety and target the disruptive legacy of trauma on children's development and caregiving relationships can facilitate powerful change (Ishikawa et al., 2022; Lieberman et al., 2015; van Ee & Meuleman, 2024; Vogel 2024). These holistic models recognise that a child's healing from trauma and child and parenting development draw upon the foundational stability and capability of their caregiving and community environment.

Connecting sectors: The Bridges Program

One of our most significant achievements is the Bridges Program, the culmination of a 4-year partnership between Berry Street Yooralla and Anglicare Victoria. This program brings together specialist disability support coordination, psychology and positive behaviour support for children in out-of-home care. More than 150 referrals have been received from residential care teams.

The outcomes speak for themselves:

- 33% increase in NDIS access;
- 95% increase in total NDIS funding for referred children;
- Measurable improvements in staff confidence; and
- Reduced occupational violence across placements.

These outcomes are not accidental – they are the result of a deliberate, integrated model that treats disability and trauma as interconnected, responds flexibly to placement instability, and fills system gaps with multidisciplinary expertise.

Lessons learned and future directions

The evidence from both our practice and national research points clearly to what needs to change.

1. Complexity is normal; systems must adapt

Children in out-of-home care rarely present with a single issue. Disability and trauma are intertwined, and assessments should assume this intersection until proven otherwise. Diagnostic

caution, especially in the preschool years, is essential. Practitioners must consider adversity, caregiving quality and trauma alongside developmental profiles.

2. Families and relationships need to be at the centre

Children flourish when their caregivers are supported. Parenting programs designed for parents with disability must become accessible through the NDIS and other systems. Early help for parents reduces stress, prevents escalation and promotes family preservation and child wellbeing. Where caregiving relationships have been impacted by trauma, therapies targeting the relational context are essential for optimising child and parent healing and development.

3. We need integrated, not parallel, systems

Fragmented responsibilities lead to fragmented care. Better outcomes depend on:

- Shared assessment tools;
- Joint planning;
- Collaborative funding arrangements;
- Teams that include child protection, disability, education, health and mental health.

The Bridges model offers a blueprint for what integrated practice can achieve.

4. Workforce capability must change

Practitioners across all sectors need training in both disability and trauma. Disability workers must understand attachment and behaviour as communication; child protection workers and associated fields must understand the functional impacts of cognitive and developmental disability. A shared professional language is needed.

5. Children need continuity, regardless of placement

Therapeutic, disability and allied health supports should continue even if a child moves placements or schools. Systems must be robust enough to follow the child – not restart the process with each move.

6. Culturally led responses are essential

For Aboriginal and Torres Strait Islander children, healing is inseparable from culture, community and self-determination. Integrated systems must be grounded in cultural safety and community control, not simply adapted versions of mainstream practice.

7. Foundational supports must be fully implemented

Emerging reforms – such as foundational supports and simpler NDIS pathways for high-risk children – must be designed with this cohort front of mind. Faster access, fewer diagnostic hurdles and multidisciplinary support teams will make a profound difference.

Conclusion

Disability and trauma do not exist in separate parts of children's lives – and our systems must stop responding as if they do. Children involved with child protection are among the most

vulnerable in our community. Without integrated, developmentally informed and culturally grounded systems, we risk compounding the harms they have already experienced.

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