

Intake is more than a process

Disability, Disclosure and Accessibility

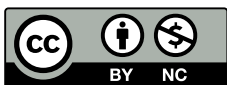
Abstract: Report of a codesign process leading to a series of tools designed to increase the accessibility of service provision in the specialist family violence sector



Published by
Central Highlands Integrated Family Violence Committee
c/- Women's Health Grampians,
728 Barkly Street, Mt Pleasant, Victoria, 3350
ABN 85 025 587 831

Suggested citation: Cadwallader, JR., Mathieson, P, Muller, S., Bilbrough, A. and Muller, M. (2024). Intake is more than a process: Disability, disclosure and accessibility. CHIFVC:Ballarat

I. Family violence -- Australia -- Prevention. II. Family violence research. III. Family violence -- Government policy.
I. Cadwallader, Jessica Robyn. II. Mathieson, Pennie., III. Muller, Susan. IV. Bilbrough, Anna. V. Muller, Maggie.



Creative Commons Licence
Attribution-Non Commercial

This licence lets others distribute, remix and build upon the work, but only if it is for non-commercial purposes and they credit the original creator/s (and any other nominated parties). They do not have to license their Derivative Works on the same terms.

Version 3.0 (CC Australia ported licence): [View CC BY-NC Australia Licence Deed](#) | [View CC BY-NC 3.0 Australia Legal Code](#)
Version 4.0 (international licence): [View CC BY-NC 4.0 Licence Deed](#) | [View CC BY-NC 4.0 Legal Code](#)

Please note that there is the potential for minor revisions of this report. Please check the online version at www.chifvc.org.au for any amendment.

Intake is more than a process

Disability, Disclosure and Accessibility

Abstract: Report of a codesign process leading to a series of tools designed to increase the accessibility of service provision in the specialist family violence sector

Acknowledgement of Country

This work was developed and delivered on unceded Country cared for by the Wadawurrung, Dja Dja Wurrung, Djab Wurrung, Eastern Marr, Jaadwa, Jardwadjali, Jupagulk, Wergaia, Wotjabaluk and the Wurundjeri peoples for many tens of thousands of years. We have sought throughout this work to pay our respect to elders past and present, and to acknowledge the insights and experiences of First Nations people.

We especially recognise the leadership and insight offered by Damian Griffis, CEO, (Worimi) and the elders who guide the First Nations Disability Network. Their approach to providing culturally safe engagement around disability first inspired this work. Closer to home, we thank Sissy Austin (Gunditjimara, Keerray Wurrung and Djab Wurrung) and Lyndel Ward (Gamilaraay), the First Nations Health Advisor Team at Women's Health Grampians, for their thoughtfulness and guidance within our organisation – you transform more than you know. Thanks also to Will Austin (Peek Woorroong, Keerray Woorroong) for his leadership and for YarnBark. The project team seek to stand in solidarity with Aboriginal people, recognising our ongoing decolonising responsibilities to Country, to ourselves, and to each other.

And Jess would like to shout out to Auntie Jane Rosengrave (Yorta Yorta), a survivor in the most profound sense of the word, and a leader whose capacity for dismantling colonial structures is, quite simply, extraordinary and remains a model – I am so glad, Jane, that you are as free as a bird and able to help the world with this work. Even though you were not directly part of this project, I like to think that this is one of the ripples from your impact on me.



A note on language

Language in relation to disability is complex, which is to be expected in a vexed political space.

In Australia, numerous different definitions of disability are used in different contexts. According to one definition, the Australian Bureau of Statistics found that 19% of Australians were considered to have disability. According to another, Services Australia deems only 4% to have disability for the purposes of the Disability Support Pension. And yet another is used in the context of the National Disability Insurance Scheme, separating out those whose disability will receive a plan and funding, and those who won't.

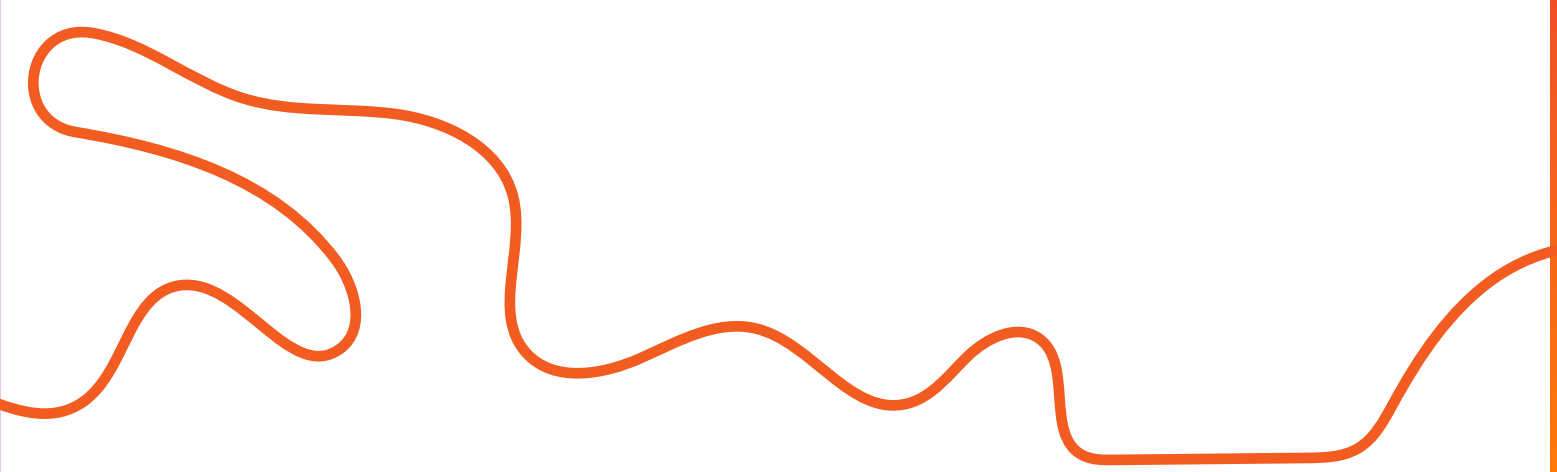
Many of these different definitions are about drawing boundaries around who can be supported and who can't, on the basis of individual impairment.

But the language we use can enable solidarity or undermine it, promote change or stifle it, and develop or undermine the mindsets that see the so-called 'problem of disability' as something we all have a role in addressing.

This is what the social model enacts, and we have chosen language to help reflect it. The social model's development in the 1980s in Britain was informed by class politics, and so the language of 'disabled' was used to demonstrate that there was something – the social world – doing the disabling. It wasn't something that appeared in someone's body, ex nihilo, but a complex interaction between that person and their surroundings.

'Person-first' language, which says 'person with a disability' or 'person with disabilities', is sometimes understood as part of the social model, and sometimes not. If disability is understood not as something that can be individually quantified into 'a' or 'many' disabilities, but rather as the complex and changing manifestation of barriers and impediments that arise between the individual and the world they live in, then it becomes clear that disability is not a 'thing'.

Acknowledging that all of those who identify in various ways with 'disability' have their own preferences, we have chosen to use both 'people with disability' and 'disabled people', in line with the above.



Acknowledgements

It is with immense gratitude that we acknowledge and thank those who have helped make this project possible:

- The Central Highlands Integrated Family Violence Committee, and particularly the System Integration and Improvement Working Group, who oversaw the development of the project.
- Our incredible Service User Input Groups, whose insights really made this project
- The Project Advisory Group, made up of Nick Rushworth (Brain Injury Australia), Elena Campbell (Centre for Innovative Justice), Associate Professor Marg Camilleri (Federation University), Jen Hargrave (Women with Disability Victoria), Mishelle Kerr (Safe+Equal), Brittany McCormack (Safe+Equal), Lisa Levis (Safe+Equal), Mandy Gambino (Berry Street), Libby Jewson (WRISC Family Violence Support), Genevieve Connelly (WRISC Family Violence Support), Margaret Cooper (WRISC Family Violence Support), Ash Egan (Ballarat and District Aboriginal Cooperative), Sherree Unwin (Grampians Disability Advocacy Association), Roy Reekie (Grampians Disability Advocacy Association), Gemma Beavis (Grampians Community Health), Kerry Robinson (SPIDAH Project at Western PHN).
- The Project Team, made up (over time) of: Dr Jess Cadwallader (CHIFVC), Pennie Mathieson (The Orange Door in Central Highlands), Maggie Muller (CHIFVC), Anna Bilbrough (CHIFVC), Susie Muller (CHIFVC)
- Many thanks also to Alison Ford, Kellie Brown, and Salvation Army Ballarat for their ongoing support of CHIFVC.

Contents

Executive Summary	9
Introduction	10
What do we already know?	13
Disability definition	13
Legal obligations on family violence service providers	14
Disability and Family Violence	14
Reasons for non-disclosure	17
Key insights this project has used	23
How we went about our project	24
Codesign	24
Recruitment	25
Onboarding, consent and compensation	26
What we learned	27
Experiences of services	27
Negative experiences	27
Advocacy and the Responsibility for Accessible Services	27
Characteristics of positive experiences	28
What we designed	30
Intake can never just be a process	30
About the intake process	31
Intake process	32
Suggested script for workers	33
ABI identification	35
Where to from here?	37
Recommended change management steps	38
References	39
Appendix 1. Engagement Needs and Expectations Form	41
Appendix 2. Designing Disability-Responsive Intake Process Project Service User Input	42
Appendix 3. CHIFVC Disability-Responsive Intake Process (practice-ready layout)	45
Appendix 4. CHIFVC Acquired Brain Injury and Family Violence	49
Appendix 5. Modified MARAM Comprehensive Risk Assessment (VS) Form	51
Appendix 6. General A/TBI Screening Questionnaire	54



Executive Summary

The *Designing Disability-Responsive Intake Processes Project* was developed by the Central Highlands Integrated Family Violence Committee in 2021. It supports family violence services to meet legislative and community expectations by being fully responsive to the varied needs of people with disability.

Previous research reveals that clients routinely need to disclose their disability status in order to access accommodations. They are additionally often required to identify how a service could be modified to suit them, without knowing whether the service had explored whether it was capable of delivering this accommodation. Clients with disability have to weigh the benefit of potentially gaining a disability-responsive service (without knowing whether it will be possible) against the potential risks of disclosing their disability status.

Research in this area outlines numerous reasons why people may decline to disclose disability status, including:

- navigating the risks of stigma and discrimination
- navigating the risks of systems abuse in the context of family violence
- not identifying as having disability due to factors such as internalised ableism
- not using language of 'disability' due to cultural factors
- not having 'proof' in the form of a formal diagnosis or assessment (as required by the state in most circumstances).

The participants in this project expressed a desire for an easier and safer way to access adjustments to services. To be fully inclusive, culturally safe and fully realise human rights, an intake process must address the imbalance between services and clients. A key strategy developed through this project is offering accommodations to service provision *without* requiring disclosure of disability status.

Designed to be used during the initial stages of client engagement, the intake model outlined here will enable a safe, inclusive intake process that identifies the kinds of accommodations, adjustments and modifications that are required to deliver accessible services to all service users. Codesigned with people with disability, it addresses key barriers to service engagement for people with disability, enhancing rapport and trust and supporting practitioners to deliver truly accessible, disability-responsive family violence services.

Introduction

The Central Highlands Integrated Family Violence Committee (CHIFVC) undertook the *Designing Disability-Responsive Intake Processes Project* in 2022-23, to design an intake process that is adequately responsive to people with disability who require a family violence service, regardless of diagnosis status.

Victoria's Royal Commission into Family Violence, completed in 2017, acknowledged that people with disability experience higher rates of family violence, more severe violence and often for longer periods. It made 10 recommendations specifically for people with disability, as well as incorporating responses to this cohort throughout other recommendations. In keeping with the Commission's focus on ensuring adequate responses to diverse communities, the *Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework* includes details about people with disability and acquired brain injury.

This significant shift has been enabled by the recognition that the accessibility of services to people with disability is a human rights issue. In Victoria, access to services is required by the Human Rights Charter and Anti-Discrimination Act. However, due to a history of segregated service delivery – where disability services were provided separately to all other forms of community services – there are systemic barriers to disability-responsive services. Many services are seeking to address these barriers through strategies such as Disability Action Plans (or Disability Inclusion Action Plans) and through training of staff.

In 2020, CHIFVC joined with other sector governance bodies in Central Highlands to hold a 'Reshaping the System' event, focussed on practitioners and designed to address the question of accessible service delivery. The event was very successful, with feedback suggesting that hearing directly from people with disability about their experiences of service delivery was particularly useful. It also made clear, however, that many practitioners lacked confidence to engage with people with disability. Additionally, the systemic barriers that result from the segregated history of disability and other community services were far from dismantled.

CHIFVC designed the *Designing Disability-Responsive Intake Processes Project* to respond to issues identified through the 'Reshaping the System' event. Many service engagements rely on intake processes to first ask whether someone has disability, and only then make disability adjustments available. In some cases, disability adjustments are not offered, but must be advocated for by the client.

While offering disability adjustments, accommodations and amendments solely on the basis of disclosure of diagnosis works for some people – notably those with a long history of engaging with services – it doesn't work for all. Some people don't identify as 'having disability'. Some Aboriginal and/or Torres Strait Islander people are unlikely to identify this way due to 'disability' being a colonial frame. Some choose not to disclose their disability status or specific diagnoses for fear of being stigmatised or discriminated against, a fear that is often well-founded in experience and borne out by research.

People who have recently or historically acquired a brain injury through family violence, but have not been diagnosed, may be unable to disclose. There are also people who cannot disclose as they have not yet been diagnosed and are unaware of their disability; many autistic people or people with ADHD, especially women, remain undiagnosed due to historical sexism in the function of diagnostic criteria. For all of these various cohorts, the current approach to disability in intake processes is unlikely to result in disability-responsive service engagement.

The aim of this project, in light of these observations, was to develop a culturally safe, disability-responsive intake process to be used in a family violence response. The process includes a tool designed to support delivery, along with supporting documents and tools to assist in the implementation of the model into practice.

The project involved two phases. The first phase comprised of desk research and the setup of a Project Advisory Group (PAG) that brought together industry experts, leaders across community service agencies and researchers in the field to assist with oversight and support of project activities. Consultations with two separate groups of people with disability and lived experience through the service system took place over a series of meetings in 2023. The groups were consulted on what the process should look like and offered their expertise, experiences and feedback on the intake process as it was drafted.

The first phase took place over the course of 2022-2023, with delays experienced due to COVID safety measures and internal staff changes at CHIFVC. The second phase will include testing and piloting the model across the Central Highlands region and is set to take place during 2024.

The Disability-Responsive Intake Process is designed to be utilised by practitioners engaging directly with clients. It will identify modifications, adjustments and accommodations that can be made to practice to support increased service engagement. It does *not* necessarily identify disability, but can ensure that those with undiagnosed disability, as well as those who disclose disability, receive a service that meets their needs. Disclosure should not be the condition for an accessible service, especially given the significant risks of discrimination, stigma and systems abuse that can be associated with disclosure.



What do we already know?

Before exploring how to improve intake processes through a codesign process with people with disability, the project team sought to understand disability in a service context, and to consider whether there were already successful approaches to intake for us to learn from.

Our desk research thus sought to explore:

- Defining and understanding disability
- Intake processes in the context of disability
- Anti-discrimination legal obligations on services
- Reasons for non-disclosure of disability status or diagnosis, including:
 - *Stigma/discrimination*
 - *Heightened risk of child removal*
 - *Not identifying as disabled*
 - *Undiagnosed or unidentified disability*
 - *Unidentified acquired brain injury*
 - *Self-determination and colonisation*
 - *Perceived benefit of disclosure*
 - *Stereotyping*
 - *Trust*
- Practice change.

We share what we have found here both to ground the rest of our discussion, and to support agencies, sector leaders and others in considering how to approach the provision of services to people with disability.

Disability definition

People with disability experience the world and themselves in diverse ways, and as such use different language to describe disability. The language used in this report is intended to reflect the full diversity of people with disability and their right to enjoy equal opportunities in an inclusive society, in line with the Convention on the Rights of Persons with Disabilities.

For some First Nations language and beliefs, for example, disability as a distinct label is rejected, the term being understood as a result of colonialism and the impact of Western systems that cause harm (*Libesman et al., 2023*).

Additionally, as highlighted in our 'note on language,' definitions of disability are often about separating out one cohort from another on the basis of a specific set of characteristics. These definitions are often 'disabling,' created by professionals who hold power or whose expertise arises from the theoretical values described by a particular model of disability, such as the medical model of disability.

In contrast, the social model of disability situates the environment and society people live in as disabling and inaccessible. This places onus on the society, not the individual, to provide necessary adjustments to ensure fair and equal access to opportunities (Libesman et al., 2023).

Legal obligations on family violence service providers

Accessibility of services to people with disability is a human right, but it is also legislated in Australian and Victorian jurisdictions.

The Convention on the Rights of the Person with Disabilities (CRPD) was ratified by Australia in 2008, enshrining full human rights and freedoms for people with disabilities. These rights need to be considered when developing and delivering services to ensure they are accessible (United Nations, 2006, art. 18). The CRPD includes an obligation to provide accommodations for people with disability so they can participate in life activities on an equal basis with their peers. The CRPD also includes an obligation to actively include people with disability voice in developing policies and services (United Nations, 2006, art. 4).

Family violence agencies also have a positive duty through legislation to ensure their services are accessible and non-discriminatory to people with a disability. The CRPD (2007), The Disability Discrimination Act 1992 (Cth) and Disability Act 2006 (VIC) are legislative instruments that make direct or indirect discrimination unlawful against people with disability – this includes in service provision. The legislation requires services to make reasonable adjustments to give people equal access to their services. Complaints against agencies under these two pieces of legislation are possible via the Australian Human Rights Commission (AHRC) and Victorian Equal Opportunity & Human Rights Commission (VEOHRC).

Disability and Family Violence

Prevalence

Women with disability are at much higher risk of violence than women without disability, which the statistics clearly illustrate. The Australian Bureau of Statistics (ABS) Personal Safety Survey found women with disability were more likely to have experienced physical and/or sexual violence from an intimate partner after the age of 15 than women without disability (ABS, 2022). Men with intellectual or psychosocial disability were also more likely to experience physical and/or sexual violence from an intimate partner than men without disability (ABS, 2022).

Women with Disabilities Australia's report (2007) found that 'compared to their peers, women with disabilities experience significantly higher levels of all forms of violence more intensely and frequently and are subjected to such violence by a greater number of perpetrators'. Although the violence is more severe, causing greater injury, they are less likely to be believed when reporting violence and less likely to have access to support services and an adequate justice response (WWDA, 2007).

Crime and other statistics do not paint a full picture of the problem. There are acknowledged barriers to reporting for people with disability, and research such as the explorations of the Australian Bureau of Statistics frequently exclude so called 'hard to reach' populations such as women in group homes (ABS, 2022; Dyson, Frawley & Robinson, 2017).

There is also diversity in how women with disability experience violence, and therefore different requirements for service response (Powers et al., 2009). The literature agrees on one point: a one-size-fits-all method to accessibility or service provision does not suit women with disability accessing family violence or sexual assault services (Dyson, Frawley & Robinson 2017; Libesman et al., 2023; Powers et al., 2009).

Perceived benefits of disclosure

There is little research on disclosure of disability status to community services, let alone family violence services, however there is significant research on reasons for non-disclosure of disability status in the education system (Clark, Kusevskis-Hayes & Wilkinson, 2018; Kreider, Bendixen & Lutz, 2015). Unsurprisingly, this research shows reasons for non-disclosure include anticipated stigma and the effort of disclosing and negotiating accommodations. Despite the accommodations being legally required, students have to seek accommodations and negotiate for their needs, a process that is emotionally and physically exhausting. A process where accommodations are offered routinely without requiring disclosure of disability status would therefore reduce the stress of advocating and negotiating.

In relation to Acquired Brain Injury, a study by Riley and Hagger (2015) showed the process of weighing up risk versus benefit that a person would do when deciding when and if they would disclose their disability status. A person would be more inclined to disclose disability status (though they may still weigh risk against benefits) if they already knew there would be sufficient practical benefits in doing so.

In relation to the family violence sector, research showed women with disability felt safer to engage with services if they knew what to expect of the service and what was available to them in advance. Dyson, Frawley and Robinson, (2017) found women with disability were often unsure of their rights or the services available to them and it was beneficial to be informed of this before the appointment. McConnell and Phelan (2022) noted safe family violence service provision included offering of many unconditional options to the person and allowing the person to feel safe to express their disability status without fear of judgement or being seen as dependent.

The development of a process where the benefit of accessible service delivery is offered without requiring disclosure of disability status would increase the likelihood of providing accessible services, increasing rapport, and potentially also support increased disclosure.

Trust

Trust is an important factor for people with disability when considering whether to disclose disability status or family violence. A relationship needs to be

built before a person can trust a worker with intensely personal information, especially in a context where violence is occurring. A paper by Powers (2009) showed women with disability sought out already built relationships of trust when disclosing family violence, usually a friend or support worker. Trauma and its influence on the way a person engages with a service must also be considered when building a relationship with a client.

The opportunity for relationship building starts before the initial intake appointment, through careful questions and listening into what the service users' needs are. Dyson, Frawley and Robinson (2017) found that taking time before the first appointment to provide accessible information and to plan the service provision to meet the client's needs helped build trust in the service and empowered women to safely discuss their needs. Time spent understanding needs and helping a person to digest information allows the person with a disability to feel confident the worker and service have knowledge of disability and can be trusted to cater for their needs.

It is however, important not to ask more questions than required and consider the cost to a client of requiring certain information.

Disability-responsive practice

The literature focussed on the delivery of family violence services to people with disability (Dyson, Frawley & Robinson, 2017; Libesman et al., 2023; Maddox et al., 2019; Powers et al., 2009) and whilst sparse, provides some key recommendations for practice change through a disability informed lens.

A disability informed approach includes not singling anyone out, or othering, instead practicing as though every service user may have a disability. This ensures responsiveness to those with so-called 'invisible' disability, and can also indicate a destigmatising approach is taken by the service.

Recording disability status should not be only used as a box to tick on a form. Rather, best practice is to use disability information to inform planning and design of appropriate services.

On an individual service user scale, the research reveals people with disability would like service providers to focus less on their disability or diagnosis and focus more on the issue that they had sought assistance with. When considering needs of those with neurodiversity, Maddox et al. (2019) found practitioners often got distracted by the disability and felt they were ill-equipped to provide services to the cohort. This frequently meant that support was limited for the presenting concern and people were sent elsewhere. Libesman et al. (2023) had similar findings with parents with disability, as disability and associated negative stereotypes were used as the main component for risk assessments rather than the issue of family violence that they were seeking support for.

Each service user should be asked sensitively about what they require for service provision to be effective for them and practice adapted to suit, without a focus on disclosure of disability or diagnosis. Libesman et al. (2023) found improved trust and engagement occurred when asking every service user about their needs for the best service to be provided and then adapting practice to those needs, rather than assuming needs based on disability diagnosis.

A recommendation that occurred repeatedly throughout the literature was about the investment of time required for service delivery periods with people with disability. Significant time needs to be invested in planning the service period, providing accessible information and setting expectations about the service. The literature (Dyson, Frawley & Robinson, 2017; Powers, 2009) found differences in the length of service provision, with women with disability needing more contact hours and more frequent contacts than women without disability. Maddox et al. (2019) had similar findings stating those with autism found success when requesting slower paced appointments and adequate time to take in information and consider options. When considering the environment appointments were held in, a holistic approach is recommended with sensory components of the environment considered alongside the physical components.

Maddox et al. (2019) highlights the specific strengths and needs each service user holds, with time needing to be invested to find out what they are for optimal client engagement. This process is likely to reduce the emotional load people with disability often experience when approaching services and advocating for their needs by providing safe opportunities to discuss needs and find out what accommodations can be made before sharing personal information.

Above all, the literature emphasises that flexibility in service delivery must be supported and encouraged. In order for disability-responsive modifications to be made on an individual accommodations level, they must be supported through a strategic, organisation-wide best practice model. Co-design is the gold standard way to develop these, as it supports the honouring and inclusion of disabled people's experiences in service design, and also training of staff (Maddox et al., 2019).

Reasons for non-disclosure

There are many reasons why a person with disability may choose not to disclose their disability status. The choice to speak about disability in relation to a person can be either empowering or discriminatory depending on who is talking about the disability and the context in which this is happening; but frequently clients entering a service do not know in advance how safe the service environment will be to disclose disability status in. It is important to remember that whilst clients are entering a specialist family violence service seeking support with the violence they are experiencing, they are also navigating an array of other risks, including those potentially posed by the service.

The language used to describe disability can also be empowering or have a negative impact. Libesman et al. (2023) also found that it is empowering for a person choosing to disclose their experience of disability in a safe non-judgemental space where they know the benefits of disclosure in advance.

Stereotyping

Stereotyping people with disability as being homogenous contributes to barriers in accessing family violence services. Libesman et al. (2023) found child protection practice models were deliberately broad to encompass the needs of as many parents as possible without the need for specific adjustments and this type of model was not meeting the needs of most of the parents with disability. There is diversity amongst parents with disability, and also within the types of disability.

McConnell, Aunos, Pacheco and Hahn (2021) highlight the error of assuming all women with intellectual disability present with the same needs or abilities, stating that in fact there are very few generalisations that can be made about women with intellectual disability. Dyson, Frawley and Robinson (2017) found attitude changes were needed in relation to how disability was perceived, including redress of persistent stereotypes, to ensure best practice in family violence service provision. A study of mental health services (Maddox et al., 2019) found clinicians assumed all people with neurodiversity displayed aggressive behaviours, which led to barriers to accessing mental health services.

There is diversity in how people experience their disability that is affected by intersectional factors. The literature (Dyson, Frawley & Robinson 2017; Libesman et al., 2023) shows an intake process must consider women's unique combination of strengths, abilities, needs, challenges and resources, which can be achieved by asking questions about the person and their life, not just their disability status.

Previous negative experiences with disclosure

Some people with disability who are seeking family violence services, whether victim survivors or perpetrators, note previous negative experiences when disclosing disability and relationship status. In some cases, these negative experiences include being denied service – usually on the incorrect presumption that there is a more appropriate service elsewhere – or experiencing discrimination, such as the refusal to deliver an accessible service. They may also receive responses from police or service providers negatively judging their capacity to sustain a healthy relationship (Rowe, Dowse, Baldry & Baker, 2021).

These experiences relate to the perception of women with disability created by the medical model of disability. Women with disability are seen as asexual and in need of protection and often denied choices in regards to sexual and reproductive health as a result. If family violence occurs, women with disability are scared that if they disclose disability it will be seen by service providers as confirming that women with disability shouldn't have relationships. Women fear disclosing disability status due to being judged by others as not having the capacity to keep themselves safe in relationships (Dyson, Frawley & Robinson, 2017).

An Australian survey (CREDH, 2021) conducted on attitudes towards disability showed over half the people surveyed thought that people with disability were easier to exploit or take advantage of. The survey shows Australians hold stereotypes about disability as a weakness and make assumptions about capacity. Assumptions about the vulnerability of people with disability can be used against people to limit their independence and ability to choose and seek services. They also place the carer in a hero status, which has significant impacts on people with disability accessing support when the carer is a perpetrator of violence.

Focusing on a person's disability as a deficit when planning intervention arises from the medical model of disability. It ignores that disability is a social structure, and can lead to victim blaming. Mays' (2006) study found considering

disability within inclusive approaches is empowering, and putting in place appropriate accommodations can support women to develop skills in service seeking and advocating for their needs to be met.

Historical experiences of support systems

Historical representations of disability influence current disability services and lead to segregation of people with disability from their peers without disability. Australian legal and policy frameworks support the othering of disability, seeing disability as a problem arising from a person's body or mind being outside the normal range (Harpur & Douglas, 2014; Libesman et al., 2023). The characteristics attributed to disability in this context, of disability making a person faulty or needing to be fixed, is disempowering for people with disability and can be a reason why they do not want to disclose disability to agencies (Libesman et al., 2023).

Historical experiences of disability can contribute to real fears of disclosing either disability or family violence when the risks are institutionalisation, sterilisation or isolation (Harpur & Douglas, 2014). Historically, in Australia, people with disability have been segregated in institutions, frequently experiencing physical, sexual or psychological abuse. In some cases, this abuse was legitimised as being appropriate practice, such as through isolation in the name of 'behaviour modification'. Reproductive rights or health choices, such as choosing to have a baby or to have choices in contraception, were not available to people with a disability leaving a disturbing legacy of fear of authority in those with a disability (Harpur & Douglas, 2014).

In addition, women with disability, psychosocial disability in particular, experience long-standing gendered stereotypes of instability and hysteria. If women with a psychosocial disability report family violence, they may have real concerns their fears requiring protection and police assistance will be misconstrued by practitioners or police as them having a mental health episode. When combined with tactics by the person using violence describing them as crazy or the one using violence, or using systems against them (systems abuse), there is a real risk of not being believed or being held for involuntary mental health treatment (Harpur & Douglas, 2014).

Inaccessible service systems

There are few accessible and inclusive services for people with disability, including family violence services. Services are often siloed: for example, in the case of parents with disability seeking support, disability support services are unable to provide family violence supports, and family violence supports are unable to meet the specific, but also diverse, needs of parents with disability. Parents with disability are frequently invisible in the design of community-based services and expected to fit into existing services that do not work for them, leaving them over represented in mandatory government services (Libesman et al., 2023).

Service accommodations that are available to people with a disability rely on self-disclosure of disability, a problematic approach given the fears of being reported to child protection or being discriminated against. In addition, some

people with disability may not fit the strict criteria services use to establish eligibility, leaving people such as those with chronic illness or ADHD without services (Libesman et al., 2023).

Self-determination and colonisation

Aboriginal and Torres Strait Islander people have very high rates of disability according to the Australian Bureau of Statistics – usually about twice that of other Australians. However, First Nations people, depending on their background, may not identify with western ideas of disability, and may reject the language of ‘disability’.

Being labelled by perceived deficits – as some interpret ‘disability’ to be – is considered offensive for some First Nations communities and may even raise memories of the experiences of institutionalisation associated with the Stolen Generation (Gilroy et al., 2013). Support for people with disability, for many First Nations people, is found naturally within the local community. Seeking outside support may be understood as questioning the capacity of the community to provide for that person.

In many cases, First Nations approaches to discussing and responding to what white Australia calls ‘disability’ focuses on fulfilling additional needs for support, rather than on the source of that need (Damian Griffis, 2013). Research (Gilroy, Donnelly, Colmar, & Parmenter, 2013; Liberman et al., 2023) on First Nations communities finds diverse interpretations of disability across communities, and that colonisation and the social structures that come with it are disabling for people.

The approach outlined briefly by Damian Griffis in his discussion of Aboriginal and Torres Strait Islander approaches to discussing disability has inspired the approach taken in this project (2013). The project team thank him for his insights and for his generosity in sharing them.

Child removal risk

Women with disability often fear having their children removed by child protective services. It is important to note that the risk of child removal is not just a perceived risk; rather, the research demonstrates this is an ongoing reality for parents with disability that they deal with from pregnancy onwards. Libesman et al., (2023) in research for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, has documented the risk, finding child protection has a lower threshold for removal of children when the mother lives with disability.

Disability in parents is assumed to contribute to higher risk of harm to children, which is related to entrenched perceptions of disability, including assumptions of reduced capacity leading to reduced parenting capability. These assumptions regarding disability dominate risk assessments, with assessments not representing strengths and real capacity of parents with disability. Parents with disability who seek support from services have found that their support seeking actions were construed as being unable to look after their children due to disability.

Once parents with disability report family violence, they are at increased risk of being reported to child protection (Libesman et al., 2023). From there, once they are involved in the child protection system, they are more likely to have children removed from their care, **and** having that removal become permanent and extended to other children (including future children). The risk of child removal increases further if the parent with disability was First Nations or if they have psychosocial disability (Libesman et al., 2023).

Parents with disability seeking family violence services have a real fear of having their children removed if they seek help from support services or disclose they have a disability due to ingrained negative stereotypes about parenting with disability. In order to manage or avoid the risk of child removal, parents with disability are less likely to disclose disability status, or will avoid needed services altogether (Libesman et al., 2023, Maher et al., 2018). Further, victim survivors are resistant to explore brain injury diagnosis due to the potential risk of losing custody of their children, and the stigma attached to having a brain injury (Brain Injury Australia et al., 2018).

Not identifying as disabled

Definitions of disability vary by context, and it can be difficult for people to understand whether they are included within them. Libesman et al. (2023) discusses how disability definitions are created by institutions or professionals without the input of those with disability or understanding of how those definitions miss people who don't fit in the boxes. People with disability whose disabilities are not obvious, or who can 'pass' as not disabled, or who are acquiring disability over time (such as through aging), may not know whether they should self-identify as having a disability.

Additionally, they may feel they are not worthy of seeking disability accommodations or services, despite a need for them, potentially even internalising the ableism that sees particular adjustments such as reminders for appointments or additional support with filling in forms as 'enabling' or 'lazy'. This sense of not being entitled to accessible services can also be communicated or affirmed, sometimes through unconscious bias, by practitioners.

Too early to know/undiagnosed

There is a cohort of people who access family violence services that are not aware they have a disability. There are many reasons for this. For some, they may have some cognitive impairment that was identified during childhood, but that was insufficient to meet diagnostic criteria at the time. However, an instance of comorbidity (such as the impacts of trauma) may significantly reduce their cognitive functioning.

Another example is the underdiagnosis of neurodiversity (including but not limited to ADHD and Autism) especially amongst girls in the 1980s and 90s. A recent Senate Community Affairs References Committee report (2023) found access to Attention Deficit Hyperactivity Disorder (ADHD) diagnosis in Australia is inadequate. Part of the reason can be due to the high cost related to diagnosis, which is not covered by Medicare and becomes a private cost to the individual that is often unaffordable. In addition, as there are limits on which professionals

can diagnose ADHD and are willing to, services have long wait times and are often limited in regional and remote areas. These factors all lead to underdiagnosis of ADHD in Australians (Senate Community Affairs References Committee, 2023).

Some people with disability also mask the indicators of their disability so that they have missed identification through school or previous service delivery episodes. Additionally, many community services do not understand their role to involve identification of signs or symptoms of disability, or that they may need to refer someone for diagnosis, so people can have multiple service delivery episodes without being identified as having disability.

Additionally, it may be too early in the diagnosis process for service users to identify their disability needs. In the case of Acquired Brain Injury, the symptoms may not be obvious yet, or may be indistinguishable from the trauma impacts associated with family violence. Therefore, when asked they will say they don't have a disability despite requiring alterations to the service to make it appropriate for them. For many, the existing approach to disability leaves many of their needs unmet, reduces engagement and represents a lost opportunity.

Acquired and Traumatic Brain Injury

Acquired Brain Injury (ABI) is a term used to encompass all types of brain injury that occur after birth, including Traumatic Brain Injury and Non-Traumatic Brain Injury. Traumatic Brain Injury (TBI) is a type of ABI caused by an external force to the head that causes damage to the brain – the damage can be short term or permanent – whereas Non-Traumatic Brain Injury is caused by other factors, for example strangulation and related lack of blood flow and oxygen to the brain (Brain Injury Australia et al., 2018).

Acquired Brain Injury from family violence may occur via blows to the head or strangulation. While this area is under-researched, it is increasingly identified as a key issue. Many brain injuries remain undiagnosed and untreated, even following hospitalisation for the injury. Clients may remain unaware of their disability for extended periods, and unaware that future family violence injuries can compound symptoms (Brain Injury Australia et al., 2018).

Victim survivors who access family violence services may not yet suspect they have an ABI or may be too early in the diagnostic process to know. Despite the severity of injuries, the majority are undiagnosed. There are now positive outcomes in the treatment of mild TBI, which results in the reduction of symptoms over the long term, yet few family violence brain injuries are addressed (Brain Injury Australia et al., 2018). Brain Injury Australia recommends family violence practitioners improve their skills at screening for potential brain injury in victims of family violence and support them to seek diagnosis and treatment for best recovery outcomes.

Brain injury can relate to higher rates of perpetration of family violence. People who use violence may have symptoms of brain injury but not understand that those symptoms are related to having a brain injury. Symptoms of brain injury may take time to emerge and after initial supports, such as medical supports for injury, few opportunities to screen for and diagnose brain injury exist, except in the justice system (Brain Injury Australia et al., 2018).

This research also shows the overrepresentation of brain injury in prison populations, often diagnosed only after incarceration. This suggests that other services, including community services, may be failing to identify this invisible disability in their clients. Without awareness around brain injury and the associated higher risk of perpetrating violence, risk assessments lack vital information and in many cases the associated risk remains unaddressed.

Asking questions about needs and adapting service provision without requirement of diagnosis can help support screening for those with undiagnosed brain injury. Questions about needs and challenges noted can assist clients and practitioners in reflecting on potential signs of brain injury and provide an opportunity to provide further information and guidance if required (Brain Injury Australia et al., 2018).

Key insights this project has used

The *Designing Disability-Responsive Intake Processes project* has designed an intake model that combines all of the best practice recommendations, investment of time for appropriate planning, a reduced focus on disability or diagnosis and more time on presenting issue, input from experts by experience with a real influence on intake process and a list of potential accommodations that suit a wide range of people with a wide range of needs.



How we went about our project

Hearing directly from people with disability was vital to the success of this project. Although there is research about the experiences of people with disability in services, there appears to be a lack of exploration of the intake process. Additionally, there is a distinct absence of explorations of how disability is approached in practice within services. We sought to ensure that we understood more about the experiences of people with disability in intake processes, as well as ensuring that the intake process the project produced reflected their lived experiences, priorities and concerns, their 'wishlist' for how intake processes should work, as well as their understanding of and solidarity with other people with disability.

Codesign

This project used a codesign approach, which means that we sought to bring together the insights and expertise of the Service User Input Group participants with the capability of the project team to support the creation of the intake process. Designed to be participatory, successful codesign must include strategies to address the power imbalance that frequently occurs between lived experience and expertise.



Implement and learn

What messages are we getting?
How are we learning from them?



Build the conditions

Are we the right people for the work?
What's in it for other?
Who are we working with?
What matters to them?
Who can take part?



Test and refine

What appears promising?



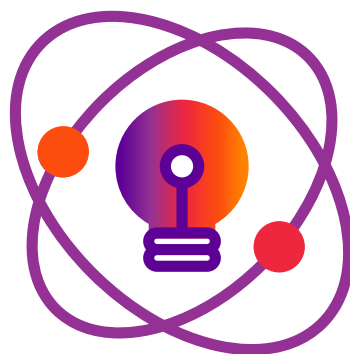
Immerse and align

Should we be doing this?
What do we already know?
Who should we partner with?
Where are the gaps?



Design

How do we build on what is already strong?



CoDesign



Discover

What is happening in the context?
What is already strong?
What are people longing for?

Adapted from Beyondstickynotes' image accessible here:
<http://www.beyondstickynotes.com/what-is-codesign>

The project team drew on the expertise of the Project Advisory Group, made up of representatives of service providers, peak bodies and academics, to help finesse the approach. This, along with insights gathered through previous work CHIFVC had undertaken in consulting with the sector, supported the identification of an approach, including the importance of codesigning the intake process with people with disability via the Service User Input Group.

As part of the 'building the conditions' element of the process, the project team recognised that they could contribute their own expertise to the operation of the Service User Input Group with the aim of 'representing' the service system and making the intake process easier for agencies to use. However, this would obscure the hard-won insights of the people with disability who participated in the project. Additionally, it would deny family violence services the opportunity to explore and consider whether their service delivery could be modified to reflect the needs identified by the Service User Input Group. In this project, the project team's strategy was to understand their role as:

- capturing the insights generously offered by the participants
- framing up their insights into a series of questions that could form part of an intake process
- testing this with participants until they were satisfied that it would enhance their own experiences of services and those they imagined that other people with disability might have.

The project team, guided by the PAG, developed three sessions, broadly framed around the following key tasks:

1. **Sharing experiences (the 'building the conditions,' 'immerse and align' and 'discover' elements)**
2. **Imagining what could be (the 'discover' and 'design' elements)**
3. **Checking our working (the 'test and refine' element)**

A draft intake process, developed by the project team from the feedback provided in sessions one and two was taken to the third session for checking and confirmation. This also enabled us to draw together the insights derived from the two groups (see below for details) and unify them.

It is worth noting that participants routinely drew on the experiences of others in their contributions, sometimes comparing and contrasting different experiences and the impacts of different impairment types, and sometimes giving voice to those whose voices could not be heard because participation in the project would have been too personally costly. Participants were careful to acknowledge the diversity of experiences within the population of 'people with disability' and the specificity and diversity of their own experiences. The intake process thus reflects this.

Recruitment

Originally, we intended to have only one codesign group of service users with disability. With the advice of the Project Advisory Group, we developed criteria for inclusion that would promote the safety of those participating.

This meant that we focussed on women victim survivors of family violence who had accessed services. We sought individuals who either had recovered from their experiences enough that they could explore their experiences of service delivery and manage any emotional responses they might have themselves, or who had sufficient ongoing supports around them to ensure their safety. We committed to seeking to address any support needs that a potential participant might have in order to maximise accessibility. This included an openness to revising the approach developed if required.

During the recruitment phase of this project, the team utilised contacts within the Central Highlands specialist family violence service system to identify and engage with potential participants. To support this process, the team created promotional material (flyers, one-pagers, FAQs) to circulate through their networks and contacted local disability organisations to engage participants.

In total, five core participants volunteered to take part in the Service User Input Group meetings. The participants had a varied range of backgrounds and experiences, both in their personal lives, in their impairment types and in their interactions with the service system. They were split over two separate groups to maintain pre-existing relationships between some of the participants and to ensure equity. One of the participants disclosed that she is Aboriginal and her adolescent daughter also made valuable contributions to the second session. The daughter is frequently included in this group, so it was deemed rapport was sufficiently strong to tolerate these changes in membership.

Onboarding, consent and compensation

We ensured that the onboarding process was respectful of each participant's individual needs by creating an engagement needs form (see Appendix 1) using the Safe and Equal My Engagement Needs and Expectations guidelines that outlined how we could best facilitate the meetings and discussions to meet the needs of participants. In some cases, this form was filled out by the project team during phone calls or by workers familiar with and supporting participants. The project team consulted these forms as they developed and designed each session.

Although the project was focussed on codesign rather than a research project, we developed a robust consent process using the World Health Organisation Informed Consent Form Template for Qualitative Studies as a guideline to develop a consent and information form (see Appendix 2) that was provided to each participant ahead of or at the first meeting for signing. The form was read aloud in full and discussed in detail prior to signatures being sought.

Following CHIFVC's evolving model of compensation for lived experience, participants received a \$50 gift card for each session they participated in and the project also covered associated costs such as transport when required. We further offered to fund support workers if required, but this was not an option taken up by any participants.

What we learned

Experiences of services

There were diverse experiences amongst our Service User Input Groups, and some over extended periods of time and numerous different engagements. Although we were focussed on family violence service delivery, many of the experiences that were shared in the focus groups reflected experiences in a diversity of different services. This reflects that distinctions between agency, services and programs are not necessarily experienced as such by service users. Supporting accountability across all agency and service types in relation to accessibility is therefore vital.

Negative experiences

There were many disappointing experiences recounted. Stigma, discrimination, refusal to accommodate, disbelief of victim survivor experiences and more were part of the experiences for the service users. However, some expressed difficulty with identifying discriminatory experiences at the time, especially when discussing experiences they had as young people or when they first came into contact with the service system. They also expressed that practitioners responded with uncertainty or anxiety to their expression of their support needs. It is therefore important to support practitioners with adequate policy and practice guidance in the delivery of disability-responsive practice.

Advocacy and the Responsibility for Accessible Services

Many of our conversations explored service delivery broadly and the majority of participants highlighted that ongoing self-advocacy and negotiation was part and parcel of their experience of service delivery. Difficulties faced in relation to accessing services that met their needs (i.e. that were responsive to their needs as a person with disability) was the primary reason given for disengagement.

Self-advocacy is a term used within the disability sector and the disability community to refer to the process used to ensure that a service user gains access to the services they require, in the ways that they require them. It is often an extensive and ongoing process involving education and often confrontation, frequently balanced with significant relationship management. It can result in people with disability being understood as difficult, demanding or 'too much', which can in turn impact on the relationship with the practitioner supporting them.

In the vast majority of cases, the difficulties associated with self-advocacy are avoidable. They often result from services developing program models without the input of people with disability and without recognising that in order to deliver a service that is disability-responsive, flexibility must be built into the model. If this work is not done, people with disability usually wind up doing extensive unrecognised and undervalued labour within their service engagement to ensure that they receive a service that meets their needs. Services should

be proactive in designing (preferably codesigning) and delivering disability-responsive services.

Using intake processes to undertake a comprehensive exploration of *how* people would prefer their services delivered would therefore increase efficiencies, increase engagement and ensure that victim survivors with disability received the services they are entitled to. It supports ongoing engagement, supports improved assessment and planning (including of risk), and enables all agencies – including those receiving a case management allocation or a referral – who engage with a client to be disability-responsive from their first interaction. Intake is the first opportunity to shape future engagement and ensure that people with disability receive the service they are entitled to.

Characteristics of positive experiences

There were positive experiences highlighted and discussed by the Service User Input Groups as well. Although a few were thoroughly positive, the majority identified positive elements mixed in with difficulties or requiring significant advocacy to achieve. Importantly, neither of the Service User Input Groups thought that specialist knowledge was required to achieve a positive service engagement. Although practitioners frequently feel that they need to ‘know more about disability’, it is interesting to note that the following characteristics are not dependent on additional education or knowledge, but are about how the relationship with the specific client is approached.

The provision of services that are ‘trauma-informed’ has become such a mainstay of the community services system, and many of the characteristics of positive experiences reflected trauma-informed service delivery. Unfortunately, however, participants in the Service User Input Groups highlighted that these were the exception rather than the rule in the experiences they recounted, and that they frequently felt misunderstood, misheard or like a problem in their encounters with practitioners.

Taking time

The most important element identified in service delivery was taking time with people. People with disability identified often feeling rushed by practitioners and that there wasn’t time to raise or explore their needs in service delivery. Interestingly, when a practitioner did take time to work with a client, to fully hear what they needed to say and responded to it, it rapidly built trust and rapport.

Service users highlighted that even if a practitioner was unable to meet their support needs, taking time both to hear out the need, to ensure they understood the parameters of the need and to explore what might be involved in meeting that need (for example raising the issue with their team leader) made a significant difference to their experience.

Empathy

Empathy was identified by participants as the defining factor in positive interactions with practitioners. The Service User Input Groups highlighted that empathetic responses helped to build trust and rapport, and that it was vital not only in service delivery but during intake as well. Those who received an empathetic response from services, especially on intake, were far more likely to remain engaged even when there were problems in delivering a disability-responsive service. They were also far more likely to disclose and continue to disclose their needs and their experiences, which is vital to disability accessibility as well as accurate risk assessment and management.

It is important to underscore that empathy was seen as a very rare occurrence in the experiences of service system we heard. This may mean that what is experienced as empathy by those receiving a service differs from what practitioners believe is empathetic engagement. As a result, we asked participants to share some of the key facets of empathy with us. They included:

- Listening
- Taking time
- Being curious (about the right things)
- Sympathising with the difficulties clients were navigating
- Identifying barriers experienced by the client and coming up with solutions
- Being ready and willing to deviate from their usual processes if this is what is needed to deliver services
- Not treating their needs as frustrating, annoying, difficult, 'too much' or fabricated
- Recognising the impacts of trauma and not taking them personally
- Demonstrating trust.

Being taken seriously/being believed

There were a range of examples of service users not being believed, both in relation to their experiences of violence and in relation to their disability. It made a significant difference to their service engagement when practitioners accepted rather than doubted their experiences, needs or their story. Many participants in the Service User Input Groups identified not being believed or not being trusted as a major barrier to successful rapport-building and disability-responsive service delivery; many were sensitive to any indicators of disbelief or distrust on the part of their practitioners.

What we designed

Although the Service User Input Groups worked hard with us to codesign the Disability-Responsive Intake Process, they emphasised that it would be insufficient on its own to achieve disability-responsive service delivery.

Intake can never just be a process

They recommended the following context to support delivery of the intake process:

1. **Ensure empathetic engagement at all times.**
2. **Ensure that enough time is available to fully address the service user's needs.**
3. **Focus on what is needed to deliver services to this specific person in front of you (rather than on organisational process or diagnostic categories).**
4. **Offer intake in a range of ways so that individuals are not required to fill out a form or use a phone (both of which may be a barrier).**
5. **If face-to-face engagement is requested,**
 - a. ensure you provide a safe environment which is easily adapted to high-sensory or low-sensory needs.
Suggested strategies include the provision of weighted blankets, toys or pillows, kinetic sand, slime, fiddle toys, tablets with basic games on them.
 - b. ensure you provide communication strategies and devices to support non-verbal or alternative communication if required.
Suggestions include provision of tablets with Symbotalk or similar apps installed, communication boards (including violence and abuse images/ words), or a chosen communication professional or interpreter as needed.
 - c. ensure you can provide an on-site experience that is safe (that is, adapted to their specific needs), including providing an adapted welcome/greeting process, an adaptable waiting area and so on.
Suggestions include asking about someone's preferences on arrival (see the intake process for more detail), providing a waiting room that is either high sensory or low sensory, that the welcome process greet them by name if needed, that the practitioner is immediately on hand to welcome the client if needed, that someone can be assigned to support them in the waiting area (with a cup of tea or similar) if required, that the space is modified for easy access if needed and so on.
4. **Ask about mental health, especially suicidality, during the intake process. Treat this as a need that must also be addressed, potentially immediately. Remember that heightened or dampened affect may both be indicators of a mental health emergency.**

About the intake process

In light of the research undertaken and the experiences highlighted by the Service User Input Groups, co-design led to the creation of the Disability-Responsive Intake Process outlined below.

Although the project team, including the Service User Input Groups, has done our best to be as inclusive as possible, there may be additional adjustments or accommodations that your organisation can and does provide to people with disability or that you discover service users identify that they need on a regular basis. These should be added to the Intake Process – and we encourage you to contact us as part of the continual learning and improvement elements of the codesign process outlined in the ‘How we did it’ section above.

An individual choosing to take up any of the accommodations or adjustments offered throughout the Disability-Responsive Intake Process does **not** necessarily mean that that person has disability, identifies as having disability or would be diagnosed with disability. However, it will ensure that all people receive a service that is adjusted to their specific needs and will promote increased engagement. It is important to note that unless the provision of accommodations or adjustments is **relevant** information within the definitions of the relevant Information Sharing Schemes, it may only be shared with permission from the service user.

The Intake Process may assist in identification of factors such as issues with executive function, which may support diagnosis if required. In many circumstances, however, family violence service delivery is engaging with traumatised people who may be experiencing **temporary** debility, especially with executive function, that will resolve over time when they are no longer experiencing family violence. Again, delivering a service that meets their needs will promote service engagement and efficacy and thus recovery.

The Intake Process will require organisational policy modification to support practitioners to implement it, including identifying those adjustments, accommodations and amendments to service delivery that may not be possible within the agency. The project team encourages agencies to recognise that they may need to modify the intake process and/or policies and practices within their agency to make it practicable in their own contexts.

However, our codesign approach recognises the power imbalance that exists between us as experts and people with disability, and between agencies and people with disability. In this context, the project team identified that the most valuable contribution we could make in this space was to support participants to develop the best possible intake process for people with disability. It is then incumbent upon agencies to play their role in the codesign process by exploring what strategies they may need to put in place, or be worked towards, to realise its use.

The Disability-Responsive Intake Processes Project is designed to support practitioners in the use of the tool, and so includes brief practice guidance. It is included in a ‘tear out’ format in Appendix 3.

Intake process

Practice Support

It is a requirement under human rights and discrimination law that services meet the needs of people with disability. This process is designed to help you ensure your services meet the varied needs of your clients.

For people with disability, disclosing disability may be a risk, which is why these questions are structured to clarify their needs independently of disclosing disability status. People with disability may:

- have experienced discrimination during previous engagements
- have had their disability status used against them as part of the violence they are experiencing
- be seeking to manage the risk of their children being removed.

Disability is not always visible and you will not always be able to tell. These questions are designed to help both you and your client clarify how you can modify service delivery to meet their needs. Clients may not share their disability status with you. This does not mean that they do not have disability support needs. For all of the reasons above, people with disability may require significant rapport to be developed before they will share their disability status with you.

Of all of the attributes a worker may display, empathy is most important to ensuring a good experience for clients. Curiosity and a lack of assumptions is vital.

For some people, this may be the first time they have had the opportunity to share their preferences about how their services should be delivered. You may be helping them find the language to articulate their needs to others (and 'self-advocate' for accessible services). If you think you may have identified a need that has not been raised by the client, you may wish to offer the support you think they need.

Please note it is your responsibility to ensure that your service can meet any of the needs that are disclosed through this process. Where needs cannot be met, you should take care to ensure the client does not feel shut down, rejected or like a burden. Avoid knee-jerk reactions. Although a request may be unusual, it may not be impossible to meet that need.

You may need to find out whether a need can be met and you should share that with the client as part of this process. As their worker, you may be able to advocate for a policy to be changed or suspended, or you may be able to seek alternative services that offer other choices. Where you cannot meet a need, apologise, note the deficit in your service's capacity to meet their needs and provide that feedback to your team leader.

Suggested script for workers

We want to provide you with a service that meets your needs. I've got a series of questions here that will help us to do this. You will always be informed of how your information will be used and we will seek to follow your wishes wherever possible. At the end of this discussion, we will have a talk about whether you want me to share this information with other workers who might work with you. You do not have to tell us anything you don't want to tell us, but whatever you can share will help us provide the kind of service that will work for you.

Meetings

1. How would you prefer to have meetings with us?

Offer: phone call, Zoom, face to face, options about length, breaks, location (consider confidentiality), frequency, best time of day, presence of children (childcare? public space?), etc.

2. Is there anyone you would like to be present during meetings?

Support person or therapy or assistance animals should be welcomed; clarify whether an interpreter is required additionally as community members should not be relied on for interpretation. Offer communications professional or communications strategies; National Relay Service? Communications app? Support access to a therapy animal if required.

Online Meetings

3. Do you prefer to speak with your voice or type in the chat?

4. Do you require captions?

5. Do you need to use headphones?

6. Would you prefer having your video/the other persons video, on or off?

7. Any other preferences for an online call?

Service delivery

8. How are you going with remembering things at the moment? Can we help you with reminders?

Frequency of reminders – 3 weeks, 1 week, day before? Via email? Text message?

9. Are there any parts of working together that you already know you'll need help with?

Offer: help with reading, help with filling in forms, help with contacting other services, help with documenting services, workers and meetings; emphasise that you're open to amendments to service delivery, that it's OK if the client doesn't know right now; provide some context about what service delivery is likely to involve.

Communication

10. How do you prefer that we communicate with you?

Offer: email before or after, written notes or summary sent afterwards, recording meetings, repetition in meetings, text messages afterwards, plain language, Symbotalk, keep checking in.

11. How do you prefer to communicate with us?

Offer: email, phone call, text message, Symbotalk, communication boards, communications professionals.

12. How would you prefer we address misunderstandings?

How could we best deal with situations where I misunderstand you or you misunderstand me?

Help with trauma

13. How can we help you feel safe/cope if you feel overwhelmed or upset?

Offer: space, a cup of tea, distraction, a quiet presence, breathing exercises, mindfulness strategies (5 things you can see etc.), fresh air, a cushion or a soft toy, option to reschedule to another time, tablet games, weighted blankets/toys available, sensory toys (slime, kinetic sand), or contact with a therapy animal if available

Physical environment (only if face to face meetings)

14. What would make you feel safe and comfortable on arrival at a/this service?

Offer: someone to greet them – should that be the worker? Greeted by name? Preference to be left alone until the worker is available? Offering a non-alcoholic drink; offering to sit with them; offer volunteer; fidget toys, waiting rooms, worker ready at door; warning about wait times and nature of waiting room (perhaps images of room sent through to client).

15. Is there anything we should change in the physical environment?

Ground floor meeting room, space for mobility aids, guidance for low vision or Deaf/hard of hearing people, preferred seating, smaller waiting room, quiet space, sensory toys etc.

16. Are there any needs we should address during the meeting?

Do you need to be able to stand and move around regularly during meetings? Regular food or drink?

17. If things change while you're waiting, how would you like that communicated to you?

If your worker is running late; if your worker can't make it and has been replaced; if something else has changed.

18. What would help you feel safe as you leave the service?

Do we need to have a casual discussion to help you transition? Would it be best for someone to walk you out? Check in post-meeting/did you get home OK? Transport? Waiting with you/seeing you off?

Sharing your information

19. Would you prefer for us to share your story with others as you move through the system, or would you like to share your story yourself with new workers?

Ensure client is aware that although their preference will be given due weight, some information may be shared in some circumstances without their consent in alignment with the Family Violence Information Sharing Schemes. It may be worth revisiting the Information Privacy and Consent to Share documents.

20. Would you prefer to talk to others about the needs we've discussed here, or would you prefer that we pass the details on to other workers or agencies?

If you would be more comfortable, we can provide these details to other services that may be working with you. Alternatively, you may prefer to discuss them with any new worker yourself.

Note: ideally this would be an opportunity to share with clients that this intake process is common across all Central Highlands services. It is also a good chance to provide a clear explanation on the client's privacy and how their information may be used and shared.

Great, we will implement these as discussed and I'll come back to you with any further questions. I've made a note to follow up on the queries you had about <x, y, z>. If anything changes or you have any other ideas about how our service could best meet your needs, please feel free to let me or future workers know.

Disability

I'm now going to ask you about your disability status. This will have no impact on anything we've discussed so far. You do not have to disclose anything to me that you don't want to. If you tell us you have disability, this information will be stored on our systems and is subject to the same consent conditions which means that there may be situations where we share it with others.

21. Do you want to share any information about any disability?

22. Do you have any support needs we should know about that we haven't discussed already?

ABI identification

A range of tools have been developed, modified or enhanced through this project to support identification of Acquired Brain Injury (ABI) indicators. These include:

1. Acquired Brain Injury: Practice Support and Research Snapshot
2. Modified MARAM Adult Victim Survivor Comprehensive Risk Assessment Form
3. Acquired Brain Injury Indicator Screening Tool

Acquired Brain Injury: Practice Support and Research Snapshot

Throughout this project, the issue of the identification of ABI came up over and over. To support practice in this space, the project team has developed a practice support sheet for inclusion in the CHIFVC Guide to the Family Violence Service System in Central Highlands. It is designed to support specialist family violence practitioners in responding to indicators of ABI. It can be found at Appendix 4.

MARAM Adult Victim Survivor Comprehensive Risk Assessment Form

Brain Injury Australia, as part of their landmark report on family violence and ABI, "The Prevalence of Acquired Brain Injury Among Victims and Perpetrators of Family Violence," (2018) developed a basic identification tool designed to be used during family violence service delivery. Although this tool doesn't 'screen'

for ABI, it does identify key indicators of a potential ABI and so can support practitioners in making meaningful referrals for potential diagnosis.

However, although this tool is included in the MARAM Practice Guides, it is separated from risk assessment. Consultation with specialist family violence practitioners revealed they most commonly use the Adult Victim Survivor Comprehensive Risk Assessment Tool, which is included in the MARAM Practice Guides as Appendix 11, or its online version in the Tools for Risk Assessment and Management (TRAM). This means that there is no prompt during the use of the form to explore potential brain injury indicators. Practitioners do not often have the expertise to identify potential signs or symptoms of ABI, especially mild ABI, so it is important they are supported to screen routinely.

To help address this issue, the project team has lightly modified the relevant section of the MARAM Adult Victim Survivor Comprehensive Risk Assessment Form, highlighting the added elements. An agency can use this to modify the MARAM Adult Victim Survivor Comprehensive Risk Assessment Form for practitioners, to support them in routinely checking for ABI indicators. It can be found at Appendix 5.

The project team also advocate for the inclusion of the Acquired Brain Injury tool developed by Brain Injury Australia to be incorporated into the TRAM Comprehensive Risk Assessment in order to support practitioners using routine screening for indicators of ABI.

Screening Tool for Acquired Brain Injury

Building on the tools included in both the MARAM Victim Survivor and Perpetrator Practice Guides (which are different), the project team has also developed a stand-alone screening tool for ABI indicators, which may be used with children or adults where the MARAM Adult Victim Survivor Comprehensive Risk Assessment Form is not in use. This tool can be found at Appendix 6.



Where to from here?

This report represents the completion of Phase 1 of the *Designing Disability-Responsive Intake Processes Project*. Phase 2 is intended to be a pilot undertaken with a specialist family violence service in Central Highlands and will be subject to its own report.

However, the project team is committed to ongoing codesign work and we welcome the opportunity to collaborate with more and other services. We are providing this report and the associated tools to support the increased accessibility of specialist family violence services more broadly.

It is the hope of the project team (including the Service User Input Groups) that the Intake Process developed here will be adapted and utilised across Central Highlands, and indeed beyond. We welcome feedback, communication and especially ideas for improvement arising from the use of the Intake Process, understanding this to be an opportunity for the sector to participate in the ongoing codesign process required for continual improvement.



Recommended change management steps

Introducing a new Intake Process does require a change management process that addresses organisation factors as well as practice factors. The project team recommends that organisations follow the steps outlined below to implement it:

1. **Gain support of senior leadership for the implementation (potentially through inclusion in a Disability Inclusion Action Plan or similar).**
2. **Convene a working group to support implementation.**
3. **Audit internal resources to ensure that all adjustments and accommodations offered through the Intake Process and in the 'Intake can never be just a process' section above are able to be delivered by the organisation. This process should:**
 - a. consider the likely impact of delivery of these adjustments and accommodations on practitioners, including work and case load impacts
 - b. consider how to mitigate these (e.g. reducing caseloads where the provision of accommodations and adjustments may require a higher workload)
 - c. consider how to gather data about the use of the Intake Process that will support ongoing improvement.
4. **If there are adjustments and accommodations that cannot immediately be delivered:**
 - a. identify a strategy for the organisation to work towards their delivery (potentially via the Disability Inclusion Action Plan or similar)
 - a. modify the Intake Process to reflect these limitations.
2. **Socialise the Intake Process with staff via a series of staff meetings, emails or similar, setting a date for beginning its use.**
3. **Track data at regular intervals to consider improvements that may be required, using codesign with service users, especially those with disability, wherever possible.**

References

- Australian Bureau of Statistics. (2021-22). Personal Safety, Australia. ABS. <https://www.abs.gov.au/statistics/people/crime-and-justice/personal-safety-australia/2021-22>.
- Centre of Research Excellence in Disability and Health, (2021). Attitudes Matter: Findings from a national survey of community attitudes toward people with disability in Australia. Centre of Research Excellence in Disability and Health, The University of Melbourne.
- Clark, C., Kusevskis-Hayes, R., & Wilkinson, M (2018) Enhancing Student Disclosure: Australia's Invisible Equity Students and Reasons for Nondisclosure in Australia's Tertiary Sector. *Journal of the Australian and New Zealand Student Services Association*, 26(1), 28-41.
- Disability Discrimination Act 1992 (Cth)
- Disability Act 2006 (Vic)
- United Nations. (2006). Convention on the Rights of Persons with Disabilities. *Treaty Series*, 2515, 3
- Dyson, S., Frawley, P., & Robinson, S. (2017). "Whatever it takes": Access for women with disabilities to domestic and domestic violence services: Final report (ANROWS Horizons, 05/2017). Sydney: ANROWS.
- Gabbe, B., Ayton, D., Pritchard, E. K., Tsindos, T., O'Brien, P., King, M., Braaf, S., Berecki-Gisolf, J., & Hayman, J. (2018). The Prevalence of Acquired Brain Injury Among Victims and Perpetrators of Family Violence. *Brain Injury Australia*.
- Gilroy, J., Donnelly, M., Colmar, S., & Parmenter, T. (2013). Conceptual framework for policy and research development with Indigenous people with disabilities. *Australian Aboriginal Studies*, 2013(2), 42-58.
- Griffis, D. (Presenter). (2013 April 15). Damian Griffis talking about some of the challenges Indigenous people with disability face. [vodcast] Department of Social Services. last accessed 22/11/2023 <https://www.youtube.com/watch?v=l1Xg9kFQirs>
- Harpur, P & Douglas, H. (2015). Disability and domestic violence: protecting survivors' human rights. *Griffith Law Review*. 23(3). 405-433.
- Kreider, C., Bendixen, R., & Lutz, B. (2015). Holistic needs of university students with invisible disabilities: A qualitative study. *Physical & Occupational Therapy in Pediatrics*, 35(4),426–441.
- Libesman, T., Gray, P., Chandler E., Briskman, L., Didi A & Avery, S., (2023). Parents with disability and their experiences of child protection systems, Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability.
- Maddox, B., Crabbe, S., Beidas, R., Brookman- Frazee, L., Cannuscio, C., Miller J., Nicolaidis, C & Mandell, D (2019) "I wouldn't know where to start": Perspectives

from clinicians, agency leaders, and autistic adults on improving community mental health services for autistic adults, *Autism* 24(4), 919-930.

Maher, J., Spivakovsky, C., McCulloch, J., McGowan, J., Bevis, K., Lea, M., Cadwallader, J. & Sands, T. (2018). *Women, disability and violence: Barriers to accessing justice: Final Report*. ANROWS: Australia's National Research Organisation for Women's Safety

Mays, J. M. (2006). Feminist disability theory: Domestic violence against women with a disability. *Disability & Society*, 21 (2), 147 – 158.

McConnell, D., Aunos, M., Pacheco, L., & Hahn, L. (2021). Reconsidering sexuality, relationships, and parenthood for adults with intellectual disability. In L. M. Glidden, L. Abbeduto, L. L. McIntyre, & M. J. Tassé (Eds.), *APA handbook of intellectual and developmental disabilities: Clinical and educational implications: Prevention, intervention, and treatment* (pp. 383–417). American Psychological Association.

McConnell, D., & Phelan, S. K. (2022). Intimate partner violence against women with intellectual disability: A relational framework for inclusive, trauma-informed social services. *Health & Social Care in the Community*, 30(6), e5156–e5166. <https://doi.org/10.1111/hsc.13932>

Powers, L. E., Renker, P., Robinson-Whelen, S., Oschwald, M., Hughes, R., Swank, P., & Curry, M. A. (2009). Interpersonal violence and women with disabilities: analysis of safety promoting behaviors. *Violence Against Women*, 15(9), 1040-1069.

Riley, G., & Hagger, B. (2015). Disclosure of a stigmatized identity: A qualitative study of the reasons why people choose to tell or not tell others about their traumatic brain injury, *Brain Injury*, 29(12), 1480-1489.

Rowe S., Dowse L., Baldry E., & Baker M., (2021). *Police responses to people with disability*, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

Senate Community Affairs References Committee (2023). *Barriers to consistent, timely and best practice assessment of Attention Deficit Hyperactivity Disorder (ADHD) and support services for people with ADHD*

Women With Disabilities Australia (2007). *Forgotten Sisters - A Global Review of Violence against Women with Disabilities*. WWDA Resource Manual on Violence Against Women With Disabilities. Hobart, Tasmania: Women With Disabilities Australia.

Appendix 1

Engagement Needs and Expectations Form

Designing Disability-Responsive Intake Processes Project - Service User Input Group

Introduction

Name

Pronouns

Please outline a description of your family violence intake experience

(Please note: the focus of this project is not on detailing participants' experience of family violence, but on their experience of family violence intake processes and the service system.)

Accessibility/Safety

Please outline any accessibility and support requirements

(Auslan interpreter, preference around online or face-to-face meetings, meeting reminders, technology, breaks etc.)

Please outline any concerns/apprehensions regarding involvement in this project

(Legal/physical/emotional/cultural safety.)

Please outline ways we can uphold your safety, if needed

(First name only, use of a pseudonym, visibility of email address etc.)

Support

Would you like to bring anyone along with you?

Please outline your preferred supports if involvement becomes triggering

Please outline any additional costs that will support your engagement

(e.g. childcare, travel etc.)

Other

Anything else you'd appreciate us knowing prior to group engagement?

Appendix 2

Designing Disability-Responsive Intake Process Project Service User Input

Group – Consent and Information Sheet

This Informed Consent Form is for the participants of the Service User Input Group in the Designing Disability-Responsive Intake Process Project, who will be providing insight into the co-design of a family violence intake process.

Dr Jess Cadwallader – jess@chifvc.org.au
Central Highlands Integrated Family Violence Committee
Designing Disability-Responsive Intake Processes Project

This Informed Consent Form has two parts:

- Part I: Information Sheet (to share information about the study with you)
- Part II: Certificate of Consent (for signatures if you choose to participate)

You will be given a copy of the full Informed Consent Form.

Part I: Information Sheet

Introduction

The Service User Input Group exists to inform the co-design of the disability-responsive intake process for family violence. This will take place over three, 90-minute meetings. The group will share their experiences of family violence intake, offering feedback for a better alternative, and be the consultative group for the process being developed.

Attendees

The group will be made up of 2 individuals from across the Central Highlands region, with a diverse range of disability. The meetings will also be attended by the Project Officer and Project Support from CHIFVC.

Topics & themes

The meeting topics and themes will centre around the individuals' experience of family violence intake, highlighting the downfalls and opportunities for change, as well as the elements of intake that have worked well. The focus will be on the responsiveness, or lack thereof, to the individual's disability in service intake, and not on their experience of family violence.

Privacy & confidentiality/recording

All information shared throughout the meetings will be kept confidential, in both the process and documentation developed by CHIFVC, and by the others in the group. The individuals involved in the co-design aspect of this project agree to maintain the privacy of the others present and information shared at the meetings. Notes recorded in the meeting will centre around the experience shared, rather than the individual sharing it. All information recorded will be de-identified in any documentation or reporting shared at the conclusion of the project. The meetings will be audio recorded and the files will be transcribed by an external organisation. All files will be securely stored on the Women's Health Grampians F drive.

Influence & outcomes/feedback

The input from the group will be used to inform the recommended changes that should be made at family violence intake in order to better meet the needs of people with disability who are seeking a service. We will use the information shared through these meetings to develop an alternative intake process to pilot at intake services in our region. Each meeting will have time allocated for feedback of the process being developed and participants are welcome to contact the project team outside of the dedicated meeting to offer further suggestions where they may not feel comfortable in the meeting for whatever reason. The project team will report back to the group via email as to how their information has been used, highlighting the changes made to current intake processes.

Support

The project team recommends the services of 1800RESPECT if external support is needed outside of the project meetings. The project team also recommends that participants engage with their own support networks if needed outside of the project meetings. We are also happy to assist in this process if required.

1800RESPECT

Phone: 1800 737 732

Website: 1800respect.org.au

Part II: Certificate of Consent

I have read the above information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant

Signature of Participant

Date (day/month/year)

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:

1. The project team will endeavour to uphold the safety and security of all participants in this project
2. The project team will keep all information shared and accompanying files secure and confidential
3. The project team will be transparent and open with the participants in the project

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant

Print Name of Researcher/person
taking the consent

Signature of Researcher /person taking
the consent

Date (day/month/year)

Appendix 3

CHIFVC Disability-Responsive Intake Process (practice-ready layout)

Tailoring service delivery to meet the needs of clients

It is a **requirement under human rights and discrimination law** that services meet the needs of people with disability. This process is designed to help you ensure your services meet the varied needs of your clients.

For people with disability, **disclosing disability may be a risk**, which is why these questions are structured to clarify their needs independently of disclosing disability status. People with disability may:

- have experienced discrimination during previous engagements,
- have had their disability status used against them as part of the violence they are experiencing, or
- be seeking to manage the risk of their children being removed¹.

Disability is not always visible, and you will not always be able to tell. These questions are designed to help both you and your client clarify how you can modify service delivery to meet their needs. Clients may not share their disability status with you. This does not mean that they do not have disability support needs. For all of the reasons above, people with disability may require significant rapport to be developed before they will share their disability status with you.

Of all of the attributes a worker may display, **empathy is most important** to ensuring a good experience for clients. Curiosity and a lack of assumptions is vital.

For some people, this may be the first time they have had the opportunity to share their preferences about how their services should be delivered. You may be helping them find the language to articulate their needs to others (and 'self-advocate' for accessible services). If you think you may have identified a need that has not been raised by the client, you may wish to offer the support you think they need.

Please note it is **your responsibility** to ensure that your service can meet any of the needs that are disclosed through this process. Where needs cannot be met, you should take care to ensure the client does not feel shut down, rejected, or like a burden. Avoid knee-jerk reactions. Although a request may be unusual, it may not be impossible to meet that need.

You may need to find out whether a need can be met, and you should share that with the client as part of this process. As their worker, you may be able to **advocate** for a policy to be changed or suspended, or you may be able to seek alternative services that offer other choices. Where you cannot meet a need, apologise, note the deficit in your service's capacity to meet their needs, and provide that feedback to your team leader.

¹ Please note that these are well-documented risks that people with disability frequently encounter. See Report for further information.

Suggested script for workers

We want to provide you with a service that meets your needs. I've got a series of questions here that will help us to do this. You will always be informed of how your information will be used, and we will seek to follow your wishes wherever possible. At the end of this discussion, we will have a talk about whether you want me to share this information with other workers who might work with you. You do not have to tell us anything you don't want to tell us, but whatever you can share will help us provide the kind of service that will work for you.

Meetings

How would you prefer to have meetings with us?

Offer: phone call, zoom, face to face, options about length, breaks, location (consider confidentiality), frequency, time of day, presence of children (childcare? public space?), etc.

Is there anyone you would like to be present during meetings?

Support person should be welcomed; clarify whether an interpreter is required additionally as community members should not be relied on for interpretation. Offer communications professional or communications strategies; National Relay Service? Communications app?

Online Meetings

Do you prefer to speak with your voice or type in the chat?

Do you require captions?	Yes	No
Do you need to use headphones?	Yes	No
Would you prefer having your video/the other persons video, on or off?	On	Off
Any other preferences for an online call?		

Service delivery

How are you going with remembering things at the moment?

Can we help you with reminders?

Frequency of reminders –3 weeks, 1 week, day before?

Are there any parts of service delivery that you already know you'll need help with?

Offer: help with reading, help with filling in forms, help with contacting other services, help with documenting services, workers and meetings; emphasise that you're open to amendments to service delivery – that it's OK if the client doesn't know right now; provide some context about what service delivery is likely to involve.

Communication**How do you prefer that we communicate with you?**

Offer: email before or after, written notes or summary sent afterwards, recording meetings, repetition in meetings, text messages afterwards, plain language, Symbotalk?, keep checking in.

How do you prefer to communicate with us?

Offer: email, phone call, text message, Symbotalk, communication boards, communications professionals.

How would you prefer we address miscommunications?

How best to make space for this?

Help with trauma**How can we help you feel safe/cope if you feel overwhelmed or upset?**

Offer: space, a cup of tea, distraction, a quiet presence, breathing exercises, mindfulness strategies (5 things you can see etc), fresh air, a cushion or a soft toy, option to reschedule to another time, tablet games, weighted blankets/toys available, sensory toys (slime, kinetic sand).

Physical environment (only if face to face meetings)

What would make you feel safe and comfortable on arrival at a/this service?

Offer: someone to greet them – should that be the worker? Greeted by name? Preference to be left alone until the worker is available. Offering a drink; offering to sit with them; offer volunteer; fidget toys, waiting rooms, worker ready at door; warning about wait times and nature of waiting room (perhaps images of room sent through to client).

Is there anything we should change in the physical environment?

Ground floor meeting room, space for mobility aids, guidance for low vision or Deaf/hard of hearing people, preferred seating, smaller waiting room, quiet space, sensory toys etc.

Are there any needs we should address during the meeting?

Do you need to be able to stand and move around regularly during meetings? Regular food or drink?

If things change while you're waiting, how would you like that communicated to you?

If your worker is running late; if your worker can't make it and has been replaced; if something else has changed.

What would help you feel safe as you leave the service?

Do we need to have a casual discussion to help you transition? Would it be best for someone to walk you out? Check in post-meeting/did you get home OK? Transport? Waiting with you/seeing you off?

Sharing your information

Would you prefer for us to share your story with others as you move through the system, or would you like to share your story yourself with new workers?

Ensure client is aware that although their preference will be given due weight, some information may be shared in some circumstances without their consent in alignment with the Family Violence Information Sharing Schemes. It may be worth revisiting the Information Privacy and Consent to Share documents.

Would you prefer to talk to others about the needs we've discussed here, or would you prefer that we pass the details on to other workers or agencies?

If you would be more comfortable, we can provide these details to other services that may be working with you. Alternatively, you may prefer to discuss them with any new worker yourself.

Suggested script for workers

Great, we will implement these as discussed and I'll come back to you with any further questions. I've made a note to follow up on the queries you had about <x, y, z>. If anything changes or you have any other ideas about how our service could best meet your needs, please feel free to let me or future workers know.

Disability

Suggested script for workers

I'm now going to ask you about your disability status. This will have no impact on anything we've discussed so far. You do not have to disclose anything to me that you don't want to. If you tell us you have disability, this information will be stored on our systems, and is subject to the same consent conditions which means that there may be situations where we share it with others.

Do you want to share any information about any disability?

Do you have any support needs we should know about that we haven't discussed already?

Appendix 4

CHIFVC Acquired Brain Injury and Family Violence

Practice Support

1. Screen for potential brain injury as a part of family violence risk assessment

Physical abuse, such as striking, shaking and strangulation, can result in ABI, including where victims sustain repeated mild injury or facial injuries. The MARAM Practice Guides contain details to support identification and response to ABI [Comprehensive guide, Section 7.10].

- Ask the screening questions listed in the **modified MARAM Risk Assessment (available via CHIFVC)** and/or **CHIFVC General ABI/TBI Screening Questionnaire**
- Use the **Disability-Responsive Intake Process**. Questions with * relate to memory, judgement or problem solving, and may indicate executive function is impaired (a symptom of ABI).
- Additional symptoms of ABI which may be spontaneously disclosed include: vomiting; persistent severe headaches; memory loss; affected vision or dizziness; seizure; signs of cognitive or behavioural deterioration over time.

2. What to do if you find indicators of ABI through screening and risk assessment

Through screening, you may find indicators of ABI. There may be other causes of the same or similar symptoms, including trauma. Your role is not to diagnose ABI, but consider the impact of symptoms as part of risk assessment. The indicators of ABI and associated symptoms should be noted and included in referral to a service that has capacity to further explore the symptoms over time.

3. Make appropriate referrals for exploration of ABI symptoms and formal diagnosis

Refer to GP or ABI clinic for further exploration of ABI symptoms, comprehensive brain injury diagnosis and specialist supports for recovery. With appropriate supports and early diagnosis, symptoms can be decreased, emotional impact reduced and positive outcomes increased in all facets of life.

4. Adapt family violence services and supports to suit the client's brain injury symptoms

A person with an ABI may need adjustments made to service delivery. We recommend using the **CHIFVC Disability-Responsive Intake Process** to support this. Otherwise, adjustment options may include assistance with remembering appointments, focusing on one task at a time, support with working out how to travel to a new place, financial costs, information around risk of repeat ABI and/or easy read documents to assist with information comprehension.

5. Consider increased risk posed by perpetrators with ABI during risk assessment

ABI can manifest with reduced emotional regulation and/or impulse control. This must be factored into risk assessment. It is vital that people who use violence who have indicators of ABI are rapidly referred for diagnosis. Early intervention and rehabilitation for ABI can reduce offending behaviours.

Research Snapshot

Acquired Brain Injury (ABI) is an impairment arising from damage to the brain acquired after birth. It includes Traumatic Brain Injury (TBI) from an external blow to the head and non-TBI from lack of oxygen, for example from strangulation. Symptoms vary depending on the area of the brain implicated, but there may be deterioration in cognitive, emotional, physical or executive functioning (Gabbe, et al., 2018).

Prevalence of family violence related brain injury

- 40% of victims of family violence attending Victorian hospitals over a ten year period sustained ABI.
- 57% of family violence related major trauma cases over the same period involved ABI.
- 82% of family violence related deaths of a ten year period were due to ABI (Gabbe, et al., 2018).

Who is at the highest risk of sustaining a brain injury?

- 60% attending hospital for family violence were female and 31% were children under 15.
- When the perpetrator of family violence is an intimate partner, the percentage of females attending hospital for family violence increases to 84%.
- 42% of people identifying as Aboriginal or Torres Strait Islander who attended Emergency for family violence, sustained an ABI (Gabbe, et al., 2018).

Perpetrators of family violence

- Perpetrators of family violence are twice as likely to have an ABI as the rest of the community.
- 60% of male perpetrators of family violence have an ABI.
- Having an ABI can increase the likelihood of perpetrating family violence, if the injury is to those parts of the brain that control emotions and regulate behaviour. However, it is not inevitable that a person with an ABI becomes a perpetrator of family violence, and they may also be more likely to be victimised (Rushworth, 2021).

Is brain injury being missed in family violence presentations?

- 80% of females attending hospital for intimate partner violence have facial injuries but mild brain injury is often missed.
- It is likely the incidence and prevalence of family violence ABI is underestimated due to underidentification.
- Most pathways to diagnosis currently depend on victims self-identifying, and may require significant advocacy with health professionals (Gabbe, et al., 2018).
- Why is brain injury an issue for family violence practitioners?
- The family violence system plays a vital role in the detection and diagnosis of ABI. Repeated mild brain injuries can accumulate into significant impairment. Early intervention is vital.

References:

Gabbe, B., Ayton, D., Pritchard, E. K., Tindos, T., O'Brien, P., King, M., Braaf, S., Berecki-Cisolf, & Hayman. (2018). *The Prevalence of Acquired Brain Injury Among Victims and Perpetrators of Family Violence*. Brain Injury Australia.

Rushworth, N. (2011) *Out of sight, out of mind: People with an acquired brain injury and the criminal justice system*. Australian Institute of Judicial Administration. Sydney: Brain Injury Australia

Appendix 5

Modified MARAM Comprehensive Risk Assessment (VS) Form

Please note that this is an excerpt to demonstrate where the modifications have been made; the full form is available on the CHIFVC website.

Has the adult victim survivor been asked screening questions? **Yes** **No**

If yes, please indicate if any of the following risk factors were identified in the screening assessment:

Factors relevant to adult victim survivor:

Self-assessed level of risk

Factors relevant to perpetrator:

Has ever harmed or threatened to harm victim or family members (including child/ren)

Factors relevant to perpetrator (cont):

Controlling behaviours*

Physical harm

History of family violence

Emotional abuse

If no, please ask the following questions about the perpetrator, in addition to the set of questions below:

Question	Yes	No	Comments (or not known)
----------	-----	----	-------------------------

Have they controlled your day-to-day activities (e.g. who you see, where you go) or put you down?*			
--	--	--	--

Have they physically hurt you in any way? (hit, slapped, kicked or otherwise physically hurt you)			
---	--	--	--

Is more than one person making you feel afraid? (Are there multiple perpetrators)			
---	--	--	--

The following risk related questions refer to the perpetrator:

RECENTY	Are they currently unemployed?*			
	Have they recently...			
	shown signs of a mental health condition?			
	threatened or attempted suicide or self harm?*			
	misused alcohol, drugs or other substances?* (specify substance)			
	followed you, repeatedly harassed or messaged/ emailed you?*			
	been obsessively jealous towards you?*			
	has any violence increased in severity or frequency?* (what and how)			

*May indicate an increased risk of the victim being killed or almost killed.

Question

Yes No Comments (or not known)

The following risk related questions refer to the perpetrator (cont):

PERPETRATOR ACTIONS	<i>Have they ever...</i>		
	controlled your access to money, or had a negative impact on your financial situation?		
	seriously harmed you?* (identify type of harm; if yes to head injury, go to sub-questions below 'tried to choke or strangle you?')		
	assaulted you when you were pregnant?*		
	threatened to kill you?*		
	threatened or used a weapon against you?*		
	tried to choke or strangle you?*		
	<i>If yes ...have you ever lost consciousness? For how long?</i>		
	<i>...how often has this kind of harm been experienced? (that is, what is the frequency or number of times this occurred?): over a 12-month period? over the course of the relationship? over the course of your life?</i>		
	<i>...do you remember how long you were unconscious in the most recent incident? In previous incidents?</i>		
	<i>...has the harm to the head or neck changed or increased/escalated in frequency or severity?</i>		
	forced you to have sex or participate in sexual acts when you did not wish to do so?*		
	been reported to police by you or anyone else for family violence?		
	breached or broken the conditions of an intervention order or a court order?		
	had a history of violent behaviour to previous partners, other family members or non-family members? (specify details)		
	harmed or threatened to harm a pet or animal?*		
	been arrested for violent or other related behaviour?		
	been to court or been convicted of a violent crime or other related behaviour? (specify details)		

*May indicate an increased risk of the victim being killed or almost killed.

Question

Yes No Comments (or not known)

The following risk related questions refer to the perpetrator (cont):

SELF-ASSESSMENT	Do they have access to weapons?*
	Do you believe it is possible they could kill or seriously harm you?*
	Do you believe it is possible they could kill or seriously harm children or other family members?*
	From 1 (not afraid) to 5 (extremely afraid) how afraid of them are you now? (enter number in space provided)
	Do you have any immediate concerns about the safety of your children or someone else in your family?
	Do you feel safe when you leave here today?
	tried to choke or strangle you?*
	Would you engage with police if you felt unsafe? (If no, discuss barriers to why not)
IMMINENCE	Have you recently separated from your partner?*
	Do you have pending family court matters?
	Are they about to be, or have they recently been, released from jail or another facility? (Specify when)
	Has a crime been committed? (Not to be asked directly of victim survivors. Criminal offences include physical abuse, sexual assault, threats, pet abuse, property damage, stalking and breaching IVOs)

*May indicate an increased risk of the victim being killed or almost killed.

Appendix 6

General A/TBI Screening Questionnaire

Person using violence/victim survivor (incl. children)

Acquired or Traumatic Brain Injury is overrepresented amongst victim-survivors and perpetrators of family violence, but identification can take a long time or may never occur.

This questionnaire identifies key indicators that *may* be connected with Acquired or Traumatic Brain Injury, and can inform your referral to other services for further exploration. It should not be taken to definitively diagnose Acquired or Traumatic Brain Injury.

This questionnaire should be used in conjunction with **CHIFVC's Acquired Brain Injury Practice Support and Research Snapshot**.

Question	Yes	No	Comments (or not known)
Have you ever had any injuries from...			
<i>Car or bicycle accidents?</i>			
<i>Being hit by something or someone?</i>			
<i>Falling down?</i>			
<i>Playing sport?</i>			
<i>Military service or work?</i>			
Have you ever had an injury to your head or neck, including strangulation?			
Have you ever gone to the hospital or emergency room?			
If not disclosed, stop ABI screening questions here. Otherwise continue:			
Were you ever knocked out or did you lose consciousness?			
If so, what was the longest time you were knocked out or unconscious?			
How old were you the first time you were knocked out or lost consciousness?			

Based on MARAM Practice Guidance and Brain Injury Australia (2018) *The Prevalence of Acquired Brain Injury among Victims and Perpetrators of Family Violence* page 2.

