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The Hidden Cost: Disabled Children, Adverse Childhood Experiences, and the Prevention Economics Case Against This Bill

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Inquiry into the NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026

Executive Summary

This submission addresses five provisions of the Bill: the legislating of parental responsibility obligations and informal supports under proposed section 17B and the amended reasonable and necessary criteria (Schedule 1, Part 6); the revised functional capacity access test (proposed subsection 9B(1), Schedule 1, Part 1); the requirement to exhaust all appropriate treatment before accessing the NDIS (proposed subsections 24(5)(a) and 25(1B)(a)); eligibility restrictions based on access to other service systems (proposed section 25B); and the Ministerial determination enabling a 50% reduction in social and community participation funding (proposed section 34A). It argues that these provisions, taken together, will predictably increase disabled children's risk of exposure to adverse childhood experiences (ACEs) and generate long-term costs across health, child protection, and mental health systems that far exceed any projected NDIS savings. The Bill's framing of sustainability is fiscally incomplete. Preventing harm to disabled children is not just a welfare argument. It is also a prevention economics argument, supported by five federal or national evidence bases (National Mental Health Commission, 2021; Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, 2023; Australian Child Maltreatment Study, 2023; Parenting Research Centre, 2026; Productivity Commission, 2020). Sixty-seven percent of current NDIS participants are aged 15 or under (Children and Young People with Disability Australia, 2026), and parliamentary debate has noted that 160,000 Australians are at risk of losing NDIS access under these reforms (House of Representatives, Hansard, 14 May 2026). These provisions will disproportionately affect children.

The five Bill provisions addressed:

- Proposed section 17B and amended section 34(1): Legislating parental responsibility obligations
- Proposed subsection 9B(1): Functional capacity access criteria
- Proposed subsections 24(5)(a) and 25(1B)(a): Requirement to exhaust all appropriate treatment
- Proposed section 25B: Eligibility exclusions based on access to other service systems
- Proposed section 34A: Ministerial determination enabling 50% reduction in social participation funding

67%
of NDIS participants are aged 15 or under

160,000
Australians at risk of losing NDIS access

62.2%
of Australians have experienced child maltreatment (ACMS)

Five federal and national evidence bases support this submission:
National Mental Health Commission (2021) | Disability Royal Commission (2023)
Australian Child Maltreatment Study (2023) | Parenting Research Centre (2026)
Productivity Commission (2020)

1. About the Submitter

Dr Kate Renshaw is a Registered Play Therapist-Supervisor (RPT-S™/APPTA), researcher, and Founding Director of Play & Filial Therapy. She holds registration with APPTA, and memberships with BAPT, APT and IC-PTA. Dr Renshaw has held lecturing positions at Deakin University, Roehampton University London, and Ikon Institute of Australia. She is currently a casual lecturer on the BAPT-accredited MSc Play Therapy at the University of South Wales. She completed her PhD in 2022 positioning her evidence-based Teacher's Optimal Relationship Approach (TORA) within Victoria's multi-tier mental health framework. Dr Renshaw presented her research at the International Congress on Evidence-Based Parenting Support (I-CEPS) in 2025 and has an accepted abstract at the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) 2026 World Congress in Melbourne (August 2026). She has provided oral and written evidence to parliamentary inquiry, including to the Joint Select Committee on Australia's Thriving Kids Inquiry. She co-authored the 'Play Therapy and the NDIS: How Play Therapists can support NDIS child participants and their families' (2024) and 'Play Therapy Evidence Summary' (2025), both submitted to the Independent Review of NDIS Funded Music and Art Supports, led by Dr Stephen Duckett.

10.4%
of the child population has disability

25.9%
of maltreatment allegations (29.0% of substantiated)

3×–4×
higher risk of violence, abuse and neglect

2. Disabled Children Face Compounded Vulnerability Under These Provisions

Children with disability: 10.4% of child population
25.9% of maltreatment allegations | 29.0% of substantiated allegations
3× higher risk of physical violence | 4× higher risk of emotional abuse and neglect
1 in 3 primary school students with mental health difficulties are disabled

The evidence on maltreatment and mental health risk for disabled children is unambiguous. Although children with disability make up approximately 10.4% of the child population, they represent 25.9% of children with a maltreatment allegation and 29.0% of those with a substantiated allegation. A WHO-commissioned systematic review found children with disability face more than three times the risk of physical violence, nearly three times the risk of sexual violence, and over four times the risk of emotional abuse and neglect compared to non-disabled peers (Jones et al., 2012). South Australian data cited in the Australian Government's own National Children's Mental Health and Wellbeing Strategy (National Mental Health Commission, 2021) found that 1 in 3 primary school students experiencing mental health difficulties are disabled. Yet that same federal Strategy concluded that for children under 12 years of age there is no real 'system' of affordable, integrated care delivered on the basis of need. The NDIS has been, for many disabled children under 12, the primary mechanism filling that gap.

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2019–2023) estimated the total economic cost of disability-related maltreatment at $46 billion per year and made 222 recommendations to reduce it. Key risk factors for maltreatment of disabled children include parental stress, economic hardship, and limited access to formal supports. Each of these is directly amplified by the provisions discussed below.

3. Specific Bill Provisions and Their Child Safety Implications

3.1 Proposed section 17B and amended section 34(1): Legislating parental responsibility

Proposed section 17B introduces planning principles that require the CEO to recognise the role of community and informal supports and fund only supports arising directly from qualifying impairments. The amended section 34(1) reasonable and necessary criteria now requires consideration of what families, carers, and informal networks can reasonably be expected to provide. Section 17B(3) further provides that participants should be responsible for their day-to-day living costs, including living costs incurred whether or not a person has a disability. For disabled children, whose daily living and disability-related needs are inseparable, this principle creates a structural ambiguity that risks eroding funded support on the basis that a need is characterised as ordinary living rather than disability-related. Proposed subsection 34(1J) provides that the CEO must not approve a support if its primary or substantial purpose is 'reducing burden on parental time, below what is reasonably expected of any parent' (Bill, s 34(1J)(a)). Proposed subsection 34(1K) further requires the CEO to consider whether relying on informal and community supports would be reasonable before approving funded supports.

Section 34(1K)(a) contains a limited exception (a 'carve-out'): the CEO must consider whether relying on informal supports would expose a participant or another person to a material risk of harm, abuse or neglect that cannot be mitigated through informal or lower cost supports. This carve-out is inadequate for the child protection purpose it appears designed to serve. It places the burden of demonstrating harm risk on the family, without any proactive assessment mechanism, and without accounting for the cumulative parental stress that the evidence identifies as a precursor to harm. The ACMS found that harm risk escalates as family adversity accumulates, well before harm occurs. A threshold requiring demonstrated material risk of harm will not capture the families most at risk until it is too late.

This provision creates a legal threshold for parental obligation without any corresponding assessment of parental capacity. The Parenting Research Centre's 2026 national survey of more than 10,000 Australian parents (Parenting Today Insight Brief 2, Day et al., April 2026) found that 45% of Australian parents experience moderate psychological distress and a further 12% experience high distress including serious anxiety or depression. The proportion of Australian parents reporting high distress has nearly tripled over the past decade, rising from 4% in 2016 to 11% in 2025. The strongest predictor of high distress was loneliness, with lonely parents having 3.6 times higher odds of high psychological distress. Parental distress was directly associated with harsher parenting behaviours including smacking, arguing, and yelling. The report explicitly identifies parents of children with disability, complex needs, or chronic health conditions as facing heightened loneliness, self-doubt, and reduced opportunities for rest. Australian research confirms that approximately 27% of primary carers of people with disability already experience high psychological distress, significantly above the general population (Wang & Du, 2019).

> **Parenting Research Centre 2026 survey (10,000+ parents): 45% moderate distress, 12% high distress.**
> Parental distress directly associated with harsher parenting behaviours.
> Parents of disabled children face heightened loneliness, self-doubt, and reduced rest.

The Australian Child Maltreatment Study (ACMS, 2023) found that family-related adversities including parental mental illness and family economic hardship each double the risk of multi-type maltreatment. Entrenching in law an expectation that parents absorb more care, without assessing whether they have the capacity to do so, directly amplifies these known risk factors. This provision risks placing families under the kinds of pressures the evidence associates with elevated maltreatment risk, rather than strengthening the supports that protect them. It is important to note that this risk does not diminish as disabled children grow older. The child protection literature, and recent cases reported in Australia, make clear that carer breakdown under inadequate formal support is associated with serious harm to disabled children and young people across the full age range to 18. Restricting the age of protection in any recommendation to this submission to children under 12 would be inconsistent with the evidence on when and how carer-related harm occurs.

3.2 Proposed subsection 9B(1): Functional capacity access criteria

The Bill introduces a definition of 'functional capacity' in proposed section 9B and enables Rules to set standardised assessment criteria and tools. Section 9B defines functional capacity as a person's ability to undertake an activity without assistance, assessed in a context that explicitly excludes 'the impact of the person's environmental and personal circumstances' (Bill, s 9B(1)(b)). For disabled children, this definition is clinically problematic. Developmental context is not incidental to a child's functional capacity; it is inseparable from it. A child's ability to function cannot be meaningfully assessed in isolation from their developmental stage, their family environment, and their support history. Standardised capacity assessments applied under this definition risk excluding children whose needs are genuine but not yet formally categorised, particularly children with autism spectrum disorder, intellectual disability, and sensory disabilities, precisely the groups with the highest maltreatment risk. A child denied access on a functional capacity threshold who then loses family-level protective factors faces compounded vulnerability with no system-level safety net.

3.3 Proposed subsections 24(5)(a) and 25(1B)(a): Appropriate treatment exhaustion

The Bill requires children and young people to try all 'appropriate treatment' before they can access the NDIS (proposed subsections 24(5)(a) and 25(1B)(a)). Appropriate treatment is defined as evidence-based treatment that can reliably be expected to materially improve the impairment and is regularly undertaken in Australia. Children and Young People with Disability Australia (CYDA, 2026) has identified this as creating a postcode and wealth test for access, noting that a family in regional Australia may be expected to travel or pay privately for treatment before receiving NDIS support. CYDA further notes the provisions could pressure families to explore harmful restrictive practices to prove all options have been exhausted.

The Minister's second reading speech states that 'the NDIS was never intended to replace health, rehabilitation and treatment services which play a critical role in preventing lifelong disability' (Butler, House of Representatives, 14 May 2026). This submission does not dispute that principle. It argues that the mechanism the Bill uses to give effect to it, requiring all appropriate treatment to be exhausted before NDIS access is granted, makes no provision for whether that treatment is developmentally appropriate, neuro-affirming, or validated for use with children. Many interventions that meet the Bill's definition of 'evidence-based and regularly undertaken in Australia' have been developed for adults and retrofitted for children without age-specific evidence or paediatrically credentialed practitioners. For autistic children and children with intellectual disability, treatments that nominally satisfy the Bill's threshold may include compliance-based behavioural approaches that contemporary evidence, neuro-affirming clinical practice, and lived experience advocates identify as harmful, particularly for children. A family navigating this process in good faith may find their child is exposed to approaches that are not appropriate for them, with no recourse and no recognition of the burden this places on them.

In practice, particularly in regional, rural, and remote Australia, the services that nominally exist and satisfy the 'regularly undertaken in Australia' criterion are frequently designed for adults. A child referred to a speech pathology, occupational therapy, or psychology service with no paediatric specialisation, no neurodevelopmental training, and no capacity for child-centred or play-based approaches is not receiving appropriate treatment in any clinically meaningful sense. But under this Bill's framework, having accessed that service may be recorded as having exhausted the option. The Bill provides no mechanism to assess the developmental appropriateness, neuro-affirming practice standards, or paediatric evidence base of a treatment before requiring a child to undergo it.

From an ACEs and prevention economics perspective, the period during which a family is required to navigate, fund, and exhaust inappropriate treatments before NDIS access is granted is precisely the high-stress, low-support window in which ACE risk is elevated. The ACMS found that parental stress and limited access to formal support are primary risk factors for maltreatment. This provision creates a period of reduced support during which families face elevated stress and reduced access to protective factors, with no guidelines on how long it may last and no guarantee that the treatments required are appropriate for the child in question. CYDA's Recommendation 2b is directly relevant: children and young people aged 0 to 25 should not be included in reductions to capacity building funding, to protect access to therapeutic supports as part of early intervention and during significant life transitions.

3.4 Proposed section 25B: Eligibility exclusions based on access to other systems

The Bill overrides the Federal Court's decision in National Disability Insurance Agency v Sutherland [2026] FCA 3 and enables Ministerial Rules to exclude people who receive certain supports from other systems. For disabled children, this creates a direct access risk. The National Children's Mental Health and Wellbeing Strategy (National Mental Health Commission, 2021) found that only 51.1% of children with mental illness had seen any health professional in the past 12 months, and just 6.9% attended even a single visit. Around 30% of Australian children aged 0–14 live in rural areas where the nearest services may require a round trip of 200km or more. Excluding disabled children from the NDIS on the basis of nominal access to services that are not practically available removes their only realistic support without providing a meaningful alternative. The Government's primary justification for redirecting children away from the NDIS via section 25B is the existence of Thriving Kids as an alternative pathway.

The Explanatory Memorandum confirms that Thriving Kids covers only children aged 8 and under with low to moderate Autism and Developmental Delay. It does not cover children aged 9 to 17, children with higher support needs, children with intellectual disability without autism, or children with sensory disabilities. The children most at risk in the evidence base this submission draws on are precisely those Thriving Kids does not cover. Further, budget analysis of Budget Paper 2 confirms that of the $2 billion Commonwealth Thriving Kids contribution, $1.4 billion flows to states and territories to design their own service models with no nationally mandated therapeutic content. The named Commonwealth components are: a national phone line and autism information helpline ($120.9 million), parent skills programs and a digital health record ($99.5 million), workforce development ($60.8 million), a public awareness campaign ($21.6 million), and implementation support ($36.7 million). Direct therapeutic support, including play therapy, art therapy, music therapy, speech pathology, and occupational therapy, is not a named component of Thriving Kids at the federal level. Each state and territory is designing its own model with no nationally agreed minimum therapeutic standard. Section 25B therefore rests on an assumption of therapeutic access that Budget Paper 2 does not support (Renshaw, 2026).

> **Thriving Kids covers only children aged 8 and under with low to moderate Autism and Developmental Delay.**
> It does not cover children aged 9–17, higher support needs, intellectual disability without autism, or sensory disabilities. Budget Paper 2 confirms direct therapeutic support — play therapy, art therapy, music therapy, speech pathology, occupational therapy — is not a named federal component.

3.5 Proposed section 34A: 50% reduction in social and community participation funding

The proposed section 34A support determination mechanism has been specifically flagged by the Minister as enabling a 50% reduction in social and community participation funding from October 2026. Social connection and community belonging are well-established protective factors against ACEs and mental ill-health. For disabled children, funded social participation is frequently the only structured peer contact available. Reducing it by 50% diminishes a key protective factor for the children the evidence identifies as most vulnerable to the isolation associated with elevated adversity and maltreatment risk.

4. The Prevention Economics Argument

$46B/yr
disability-related maltreatment costs (Disability Royal Commission)

$200B/yr
mental health disorders and suicide (Productivity Commission)

$15.2B/yr
cost of late intervention in children's lives (National Children's MH Strategy)

> **The $37.8 billion in projected NDIS savings does not account for what Centrelink, Medicare,** state mental health services, child protection, and the justice system will spend absorbing what the NDIS no longer funds for these children.

The Bill is framed around financial sustainability. This submission does not dispute that sustainability matters. It argues that the Bill's cost modelling is incomplete because it does not account for the downstream expenditure these provisions will generate in other systems. The Government's own Budget Paper 2 projects $37.8 billion in NDIS savings over four years, with the primary driver being the removal of children with mild to moderate needs from the scheme (Renshaw, 2026). This submission invites the Committee to set that figure against the downstream costs those children will generate in other systems: $46 billion per year in disability-related maltreatment costs (Disability Royal Commission), $200–220 billion per year in mental health and suicide costs (Productivity Commission), and $15.2 billion per year in late intervention costs (National Children's Mental Health Strategy). The $37.8 billion in projected savings does not account for what Centrelink, Medicare, state mental health services, child protection, and the justice system will spend absorbing what the NDIS no longer funds for these children.

The Australian Government's own evidence establishes the prevention economics case clearly. The National Children's Mental Health and Wellbeing Strategy identified the cost of late intervention in Australia at $15.2 billion per year, and found that early childhood programs return $2.40 for every $1 invested. The Productivity Commission (2020) estimated the annual cost of mental health disorders and suicide at $200–220 billion, with child maltreatment contributing substantially. The Disability Royal Commission estimated $46 billion per year in costs from disability-related maltreatment. None of these costs appear in NDIS expenditure. They fall across health, child protection, housing, family violence, and justice systems.

The ACMS (2023) found that 62.2% of all Australians and 61% of young people aged 16–24 have experienced at least one form of child maltreatment (Mathews et al., MJA 2023). Almost half (48%) of those who experienced maltreatment met criteria for a mental health diagnosis, compared with 21.6% of those who did not. People with a maltreatment history were 3 times more likely to have seen a psychiatrist and 2.4 times more likely to have had a mental health hospital admission. These costs land in Medicare, state mental health services, and emergency departments, not in the NDIS. The provisions in this Bill that increase expectations on families, restrict access, and reduce protective supports for disabled children risk expanding this burden.

> **62.2% of Australians have experienced child maltreatment (ACMS, 2023).**
> Almost half (48%) met criteria for a mental health diagnosis, compared with 21.6% of those without a maltreatment history. These costs fall in Medicare and state mental health services, not in the NDIS.

The Committee is invited to ask what whole-of-government cost modelling has been undertaken. What does Treasury project that Centrelink, Medicare, state mental health services, child protection, and the justice system will spend absorbing what these provisions remove? If that modelling has not been done, the Bill's sustainability claim is incomplete.

5. Recommendations

The Committee is respectfully asked to make six recommendations:

1	Section 17B / 34(1) That proposed section 17B and the amended section 34(1) parental responsibility provisions be amended to require an independent assessment of parental capacity and wellbeing before any obligation threshold is assigned, with explicit protections for parents of disabled children under 18 and for parents who are themselves living with disability or chronic health conditions.
2	Section 9B(1) That proposed subsection 9B(1) access criteria explicitly protect children whose functional needs are developmental and fluctuating, and that standardised assessment tools be required to demonstrate validity and reliability across the disability profiles of children under 12 before implementation.
3	Sections 24(5)(a) / 25(1B)(a) That proposed subsections 24(5)(a) and 25(1B)(a) be amended to require that any treatment a child is required to exhaust before NDIS access is granted must be: (a) developmentally appropriate and validated for the child's age and neurodevelopmental profile; (b) neuro-affirming and consistent with contemporary child development evidence; and (c) practically accessible, with the NDIA required to consider cost, travel, and waitlist time as barriers.
4	Section 25B That proposed section 25B eligibility restrictions include a requirement that exclusions based on access to other services apply only where practical access (not nominal access) can be demonstrated, with specific protections for children in regional, rural, and remote areas and for children under 12 where the National Children's Mental Health and Wellbeing Strategy has confirmed no adequate system of integrated care exists.
5	Section 34A That proposed section 34A support determinations be explicitly prohibited from reducing social and community participation funding for children with disability, on the basis that such participation constitutes a primary protective factor against ACEs and mental ill-health for this cohort.
6	Whole-of-government modelling That the Government be required to table whole-of-government cost modelling, covering projected downstream expenditure across health, mental health, child protection, housing, and justice systems, before the Bill proceeds to a vote.

The six recommendations above address each provision in turn.
Taken together, they ask the Committee to ensure the Bill does not remove protections for the children the evidence identifies as most at risk: disabled children in families under stress, in regional areas, and without access to developmentally appropriate care.

The Bill's sustainability claim is incomplete.

The $37.8 billion in projected NDIS savings does not account for what Centrelink, Medicare, state mental health services, child protection, and the justice system will spend absorbing what these provisions remove. The Disability Royal Commission estimated $46 billion per year in disability-related maltreatment costs. The Productivity Commission estimated $200–220 billion per year in mental health costs. The National Children's Mental Health Strategy identified $15.2 billion per year in late intervention costs. None appear in the NDIS budget.

This submission is made in the public interest and with reference to the best available Australian evidence on childhood disability, adversity and maltreatment risk, and prevention economics. The author is available to provide further evidence to the Committee if required.

Note on preparation: This submission was drafted with the assistance of AI writing tools. In accordance with the committee's guidance, the author has independently verified all sources and statistics, and all clinical, policy, and legal analysis reflects the author's own expertise and professional judgement.

References

Children and Young People with Disability Australia. (2026). 'Submission on the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026'. CYDA. https://www.cyda.org.au

Day, N., Wilks, L., Lewis, K., & Wade, C. (2026). 'Parenting Today Insight Brief 2: Parent mental health and wellbeing'. Parenting Research Centre. https://www.parentingrc.org.au

Doidge, J. C., Higgins, D. J., Delfabbro, P., Edwards, B., Vassallo, S., Toumbourou, J. W., & Segal, L. (2017). Economic predictors of child maltreatment in an Australian population-based birth cohort. Children and Youth Services Review, 72, 14–25. https://doi.org/10.1016/j.childyouth.2016.10.012

Edwards, B., & Higgins, D. J. (2009). Is caring a health hazard? The mental health and vitality of carers of a person with a disability in Australia. Social Science & Medicine, 69(8), 1252–1259.

Emerging Minds. (n.d.). 'Adverse Childhood Experiences (ACEs) Toolkit'. https://www.emergingminds.com.au

House of Representatives. (2026, May 14). National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026, Second Reading. Commonwealth of Australia, Hansard. https://www.aph.gov.au/Parliamentary_Business/Hansard

Jones, L., Bellis, M. A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T., & Officer, A. (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. The Lancet, 380(9845), 899–907. https://doi.org/10.1016/S0140-6736(12)60692-8

Justice and Equity Centre. (2026, May 21). 'Explainer: National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026'. https://www.jec.org.au

Mathews, B., Pacella, R. E., Scott, J. G., Finkelhor, D., Meinck, F., Higgins, D. J., Erskine, H. E., Thomas, H. J., Lawrence, D., Haslam, D. M., Malacova, E., & Dunne, M. P. (2023). The prevalence of child maltreatment in Australia: Findings from a national survey. Medical Journal of Australia, 218(6 Suppl), S13–S18. https://doi.org/10.5694/mja2.51873

National Mental Health Commission. (2021). 'The National Children's Mental Health and Wellbeing Strategy'. Australian Government. https://www.mentalhealthcommission.gov.au

National Disability Insurance Agency v Sutherland [2026] FCA 3. https://www.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/FCA/2026/3.html

Pacella, R. E., Nation, A., Mathews, B., Scott, J. G., Higgins, D. J., Haslam, D. M., Dunne, M. P., Finkelhor, D., Meinck, F., Erskine, H. E., Thomas, H. J., Malacova, E., Lawrence, D. M., & Monks, C. (2023). Child maltreatment and health service utilisation: Findings from the Australian Child Maltreatment Study. Medical Journal of Australia, 218(6 Suppl), S40–S46. https://doi.org/10.5694/mja2.51892

Productivity Commission. (2020). 'Mental Health Inquiry Report'. Australian Government.

Renshaw, K. (2026). Australia's Children's Budget Statement 2026–27: A Shadow Statement. Play & Filial Therapy Press. ISBN: 978-0-6458952-4-7. https://www.playandfilialtherapy.com

Renshaw, K., & Scira, N. (2024). 'Play Therapy and the NDIS: How Play Therapists' support NDIS child participants and their families'. Play and Filial Therapy and Playroom Therapy. https://www.playandfilialtherapy.com

Renshaw, K., & Scira, N. (2025). 'Play Therapy Evidence Summary'. Play and Filial Therapy and Playroom Therapy. https://www.playandfilialtherapy.com

Parliament of Australia. (2026). National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026: Explanatory Memorandum. Circulated by the Hon Mark Butler MP. https://parlinfo.aph.gov.au

Parliament of Australia. (2026). National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026. https://parlinfo.aph.gov.au

Royal Commission into Victoria's Mental Health System. (2021). 'Final Report'. Victorian Government.

Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. (2023). 'Final Report' (12 vols.). Australian Government. https://www.disability.royalcommission.gov.au

Scott, J. G., Malacova, E., Mathews, B., Haslam, D. M., Pacella, R., Higgins, D. J., Meinck, F., Dunne, M. P., Finkelhor, D., Erskine, H. E., Lawrence, D. M., & Thomas, H. J. (2023). The association between child maltreatment and mental disorders in the Australian Child Maltreatment Study. Medical Journal of Australia, 218(6 Suppl), S26–S33. https://doi.org/10.5694/mja2.51870

Wang, J., & Du, W. (2019). Factors associated with high psychological distress in primary carers of people with disability. Australian Journal of General Practice, 48(4), 234–238. https://doi.org/10.31128/AJGP-07-18-4634