

Submission to the consultation for the Second Action Plan of the National Plan to End Violence against Women and Children 2022–2032

Prepared by the Childlight East Asia and Pacific Hub and the Gendered Violence Research Network, University of New South Wales

The Childlight East Asia and Pacific Hub is a partnership between the University of New South Wales, the University of Edinburgh and the Human Dignity Foundation. Established in 2024 in the UNSW School of Social Sciences, the Hub conducts research and knowledge translation on child sexual exploitation and abuse in Australia and across the East Asia and Pacific region. Childlight has created [Into the Light](#), the first global index of child sexual exploitation and abuse, and [Searchlight](#), a data platform designed to make research evidence accessible to policy-makers and the public.

The UNSW Gendered Violence Research Network brings together researchers from across the university working to understand, prevent and respond to gendered violence. The network supports interdisciplinary collaboration, strengthens partnerships with government and the community sector, and translates research into policy and practice to improve safety, justice and wellbeing. Its work spans domestic, family and sexual violence, violence against children, technology-facilitated abuse and the social and structural conditions that enable violence across the lifespan.

We welcome the opportunity to contribute to the Second Action Plan. Our submission draws on research into violence against women, children and diverse communities; the co-occurrence of violence against women and child maltreatment; technology-facilitated abuse; harmful sexual behaviours; the long-term and intergenerational impacts of trauma; and the overlapping social and commercial determinants of violence against women and children.

Executive summary

The central organizing proposition of our submission is that the Second Action Plan should adopt a lifespan and intergenerational approach to gender-based violence. Australia's policy architecture has tended to divide violence against children from violence against women, and childhood from adulthood. These divisions do not reflect victim-survivors' lives or the epidemiology of violence. Gender-based violence often begins in childhood; changes across adolescence and adulthood and older age; and affects relationships, health, parenting and safety across generations.

The submission advances nine connected priorities:

1. adopt a lifespan and intergenerational approach to gender-based violence;
2. broaden prevention and strengthen accountability for reducing violence and harm;
3. centre children as victim-survivors within a lifespan approach;
4. recognise child and family safety, support and recovery as prevention;
5. strengthen perpetrator and system accountability and the material conditions for safety;
6. position women's and children's health and recovery as foundations for safety;
7. use men's health settings for prevention and early intervention;
8. regulate the commercial determinants of gender-based violence; and
9. strengthen governance, workforce, data and investment to deliver reform.



Summary of recommendations

1. A lifespan and intergenerational approach

Recommendation 1.1: Embed a lifespan, intersectional and intergenerational framework across the Second Action Plan that recognises children as victim-survivors of gender-based violence in their own right; identifies changing risks, needs and intervention opportunities across childhood, adolescence, adulthood and older age; and invests in safety, material security, recovery and culturally responsive support to prevent harm from recurring or accumulating across generations.

2. A broader and more accountable definition of prevention

Recommendation 2.1: Adopt a comprehensive prevention framework that combines universal, selective and indicated interventions across the lifespan. The framework should explicitly recognise the preventive contribution of early intervention, perpetrator accountability, safety and material support, therapeutic care, recovery and regulation to reducing the incidence, recurrence and severity of gender-based violence.

Recommendation 2.2: Establish a national framework for the independent evaluation and regular review of prevention policy, expenditure and practice. The framework should require significant prevention investments to have an explicit theory of change, baseline measurement and appropriate comparison strategies where feasible, behavioural and safety outcomes, sufficient follow-up to assess sustained effects, and transparent publication of positive, null and adverse findings. Regular investment reviews should use this evidence to determine which interventions should be sustained, adapted, expanded or discontinued and to ensure that prevention funding responds to emerging evidence and unmet need.

3. Centring children within a lifespan approach

Recommendation 3.1: Through National Cabinet and the relevant ministerial councils, establish national minimum standards for responding to children affected by gender-based violence, including child-specific safety and needs assessment, accessible information, independent advocacy, therapeutic support and safe, developmentally appropriate participation in decisions affecting them.

Recommendation 3.2: Fund and evaluate demonstration pilots of child-and-family advocacy models for cases involving co-occurring domestic and family violence and child sexual abuse, bringing together safeguarding, forensic assessment, health, therapeutic care, legal assistance and practical support. Models should include specialist secondary consultation for complex child protection and family-law matters and be co-designed and governed with Aboriginal Community Controlled Organisations.

Recommendation 3.3: Establish and resource a specialist multidisciplinary evidence-gathering mechanism for family-law matters involving complex or unresolved concerns about abuse and violence. This capability should provide timely assessment, specialist advice to the Court, coordinated assistance to children and caregivers, and continuity of therapeutic support during and after proceedings.



Recommendation 3.4: Commission independent evaluations of the Magellan pathway and Evatt List, examining access, timeliness, assessment quality, procedural fairness, coordination with state and territory agencies, children's participation, parenting orders and longer-term child safety and wellbeing outcomes.

Recommendation 3.5: Establish a transparent family-law research and accountability framework, including regular publication of de-identified data on high-risk matters, pathways through the Court, use of specialist assessments, duration and outcomes of proceedings, and post-order safety and wellbeing.

Recommendation 3.6: Develop a national best-practice framework for school and education-sector responses to peer and sibling sexual harm. The framework should address immediate safety, information sharing, referral thresholds, educational continuity, procedural fairness, support for affected children, intervention with children displaying harmful behaviours, and access to specialist secondary consultation.

Recommendation 3.7: Establish nationally consistent data collection on harmful sexual behaviours and child-on-child sexual abuse across child protection, education, health, policing and specialist treatment services, including the nature and context of behaviours, service access, intervention outcomes and recurrence.

4. Child and family safety, support and recovery as prevention

Recommendation 4.1: Seek agreement across the Commonwealth, states and territories on a nationally accessible child-and-family safety, support and recovery continuum. The continuum should encompass early family support, perinatal and infant mental health, child and caregiver therapy, specialist trauma treatment, advocacy, case coordination and flexible practical assistance.

5. Perpetrator and system accountability

Recommendation 5.1: Lead the development of a national perpetrator-accountability framework covering early intervention, behaviour-change programs, health and therapeutic intervention, monitoring, disruption and justice responses. The framework should establish common principles for matching interventions to assessed risk, need, context and responsivity, while prioritising victim-survivor and child safety.

Recommendation 5.2: Establish an ongoing cross-portfolio program to identify and prevent the weaponisation of Commonwealth systems, including family law, child support, taxation, social security, immigration, superannuation, government payments and digital government services.

Recommendation 5.3: Assess Commonwealth housing, social-security, taxation, child-support, childcare, employment, migration and financial-service policies against their effects on victim-survivor safety, economic security and the capacity to leave and remain separated from violence.



6. Women's and children's health and recovery as foundations for safety

Recommendation 6.1: Examine how Commonwealth responsibilities for Medicare, Primary Health Networks and Commonwealth-funded health programs can expand affordable, long-term recovery pathways for survivors of childhood and adult gender-based violence.

Recommendation 6.2: Fund long-term, community-led prevention and healing initiatives that enable communities to identify local manifestations of gender-based violence, strengthen collective efficacy and protective relationships, and develop culturally grounded solutions. Initiatives should be evaluated against safety, service access, community capability and recovery outcomes rather than attitudes alone.

Recommendation 6.3: Develop the specialist trauma workforce required to deliver these pathways, including capability in complex trauma, dissociation, childhood and adult sexual violence, domestic and family violence, disability, culturally safe care and child- and adolescent-specific treatment.

7. Men's health as a setting for prevention and early intervention

Recommendation 7.1: Establish a national health-system response to people who use violence, including practice guidance, workforce development, specialist consultation and supported referral pathways across general practice, emergency care, mental health, suicide prevention, alcohol and other drug services and men's health programs.

Recommendation 7.2: Fund and evaluate prevention and early-intervention programs that strengthen boys' and men's emotional regulation, help-seeking, healthy relationships and recovery from childhood trauma, using behavioural and victim-safety outcomes rather than attitudinal measures alone.

8. Regulating the commercial determinants of gender-based violence

Recommendation 8.1: Establish a cross-portfolio regulatory prevention workstream to implement the Rapid Review's recommendations concerning systems and industries. It should include published actions, responsible ministers and regulators, implementation timelines, measurable harm-reduction objectives and independent evaluation.

Recommendation 8.2: Through National Cabinet and relevant ministerial councils, seek agreement on complementary state and territory reforms to liquor licensing, alcohol availability and delivery hours, electronic gaming machines and other jurisdictionally regulated products and venues.

Recommendation 8.3: Develop a comprehensive pornography harm-reduction framework extending beyond age assurance to provider responsibility, performer age and consent verification, content governance, recommender systems, payment services, accessible complaints, rapid removal and prevention of repeat uploads.



9. Delivering reform: governance, workforce, data and investment

Recommendation 9.1: Establish a formal cross-plan governance mechanism linking the National Plan, the National Strategy to Prevent and Respond to Child Sexual Abuse, Safe and Supported, and Our Ways – Strong Ways – Our Voices, supported by a published implementation schedule with named lead agencies, timeframes, funding commitments and shared outcomes.

Recommendation 9.2: Establish a ten-year national investment plan aligned with the lifespan and intergenerational framework, with recurrent funding, jurisdictional contributions, population- and needs-based allocation principles, and dedicated investment in Aboriginal Community Controlled Organisations.



1. A lifespan and intergenerational approach

Australian policy and funding have often reproduced a binary between violence against children and violence against women. Child maltreatment and child protection are generally addressed through one set of strategies and systems, while domestic, family and sexual violence against adults is addressed through another. This division obscures continuity as well as change: the ways childhood victimisation can shape later vulnerability and health, the ways risk contexts change across adolescence and adulthood, and the opportunities to intervene with children and families before harms compound (Salter et al., 2020; Salter, Woodlock et al., 2025).

Gender-based violence is not confined to adult relationships. Children experience sexual abuse, domestic and family violence, coercive control, physical and emotional abuse, financial abuse and technology-facilitated violence. These forms of maltreatment are frequently gendered in their prevalence, perpetration, dynamics or impacts, and often arise from the same inequalities and social determinants that underpin violence against women (World Health Organization, 2024).

Child sexual abuse illustrates the limitations of dividing policy according to age or administrative responsibility. We support maintaining a dedicated national strategy with specialist child safeguarding expertise. However, child sexual abuse is common, gendered and closely connected to matters within the National Plan, including domestic violence, coercive control, harmful sexual behaviours, technology-facilitated abuse, family law, mental health and long-term recovery (Salter et al., 2026).

For the last decade, most victims of sexual assault recorded by Australian police were under 18 at the time of the incident (Australian Bureau of Statistics, 2025). The Australian Child Maltreatment Study found that 28.5 per cent of people experienced child sexual abuse, including 37.3 per cent of women and 18.8 per cent of men (Mathews et al., 2024). Child sexual abuse also commonly co-occurs with other forms of maltreatment, including domestic and family violence, and encompasses forms of harm such as sibling sexual abuse that sit uneasily across existing policy and service systems (Olejníková et al., 2025; Salter et al., 2026).

The consultation paper includes child sexual abuse only where it occurs in a family and domestic violence context. This does not fully resolve the policy gap. Familial child sexual abuse cannot be adequately addressed simply by declaring it within scope when the National Plan's principal prevention frameworks were not designed to prevent or respond to child sexual abuse or harmful sexual behaviours by children and adolescents. Conversely, separating child sexual abuse from the National Plan obscures its gendered dynamics, its co-occurrence with domestic and family violence and its consequences for adult health, relationships and safety. A lifespan approach would preserve specialist strategies while making their interfaces, shared responsibilities and gaps explicit.

The experiences of LGBTIQ+SB people provide a further example of why age-bounded frameworks are inadequate. In the National Survey of LGBTIQ+SB Experiences of Sexual Violence, more than half of participants reported sexual violence in both childhood and adulthood (Salter, Breckenridge, et al., 2025a, 2025b). These experiences were often cumulative and connected, although their contexts and dynamics changed across the



lifespan. Sexism, homophobia and transphobia—intersecting with racism, ableism and socioeconomic inequality—shaped exposure to violence as participants moved from families of origin into intimate relationships, community settings, educational institutions, workplaces and online environments.

Treating LGBTIQ+SB people principally as an adult population obscures childhood experiences of abuse, family rejection and homelessness, as well as transitions between child, youth and adult service systems. At the same time, treating them as a single population can conceal important differences in the forms and drivers of violence experienced by women, men, trans and gender-diverse people, First Nations Sistersgirls and Brotherboys, people with disability and culturally diverse communities. A lifespan and intersectional approach would make these changing contexts visible and support age-appropriate, identity-affirming and culturally safe responses.

A lifespan approach also makes gender-based violence against older women more visible. Violence may continue from earlier relationships, begin or intensify in later life, or be perpetrated by partners, adult children, other relatives, carers or institutional staff. Ageism can obscure the gendered dynamics of this abuse by recasting coercive control, sexual violence, financial exploitation and neglect as undifferentiated “elder abuse” or family conflict (Meyer et al., 2020). Older women’s safety may also be affected by disability, cognitive change, caring responsibilities, bereavement, social isolation, insecure housing and dependence on others for income, transport, communication or personal care. Responses must therefore connect domestic, family and sexual violence systems with aged care, health, disability, guardianship, housing and financial services, while preserving older women’s autonomy, supported decision-making and access to specialist gender-based violence support.

A lifespan approach must therefore attend to both common patterns and important differences. It should not collapse child maltreatment, domestic violence, sexual violence and other forms of abuse into an undifferentiated category or replace specialist strategies and services. Its purpose is to ensure that policy boundaries do not create gaps in prevention, safety and care and that responses are adapted to developmental stage, community context and intersecting inequalities.

An intergenerational perspective is also necessary. Violence can affect attachment, parenting, health, housing, education and economic security, with consequences extending across families and generations (Salter, Woodlock, et al., 2025). These pathways are neither uniform nor inevitable. Safety, material support, culturally responsive family services, therapeutic care and accountability for people and institutions that cause harm can interrupt the accumulation and transmission of disadvantage. Prevention must therefore include investment in the conditions that enable children, adults, families and communities to recover, alongside action on the social, institutional and commercial conditions that produce or intensify violence.

Recommended action: Embed a lifespan, intersectional and intergenerational framework across the Second Action Plan that recognises children as victim-survivors of gender-based violence in their own right; identifies changing risks, needs and intervention opportunities across childhood, adolescence, adulthood and older age; and invests in safety, material security, recovery and culturally responsive support to prevent harm from recurring or accumulating across generations.



2. A broader and more accountable definition of prevention

The Second Action Plan should not equate prevention with universal education or population-wide attitudinal change. Universal initiatives - including respectful relationships education, public campaigns and efforts to advance gender equality - remain important, but they are only one component of a comprehensive prevention system.

Public health models distinguish between universal interventions delivered across a population, selective interventions directed towards groups and settings experiencing elevated risk, and indicated interventions where risk factors or harmful behaviours are already evident (Gordon, 1983). The World Health Organization similarly recognises that violence prevention should operate across the lifespan and at multiple levels, with targeted interventions for people and groups facing greater risk (Krug et al., 2002). Applying this approach to gendered violence requires investment to be calibrated to the distribution and intensity of risk rather than spread uniformly across the population.

Prevention should therefore encompass interventions with children and families experiencing adversity; responses to emerging harmful behaviours; targeted engagement with people at risk of perpetration; disruption and accountability measures for known perpetrators; therapeutic care and recovery; and regulatory action addressing environments and industries that increase the likelihood or severity of violence. Although some of these measures occur after violence has begun, they have preventive effects when they stop violence recurring, prevent further victimisation, reduce its severity or interrupt its intergenerational transmission. Their contribution to prevention should be explicitly recognised, coordinated and resourced (Hill & Salter, 2024).

Prevention responsibilities should also be proportionate. Individuals, institutions, governments and industries do not contribute equally to risk and do not possess equal power to reduce it. Responsibility should reflect an actor's contribution to harm, its capacity to prevent or mitigate that harm, and its influence over the social, institutional or commercial environments in which violence occurs. A comprehensive prevention framework must therefore assign responsibilities not only to individuals and communities, but also to the institutions and industries whose policies, products and business practices shape exposure to violence.

Recommended action: Adopt a comprehensive prevention framework that combines universal, selective and indicated interventions across the lifespan. The framework should explicitly recognise the preventive contribution of early intervention, perpetrator accountability, safety and material support, therapeutic care, recovery and regulation to reducing the incidence, recurrence and severity of gender-based violence.

2.1. Accountability for preventive impact

Gender equality, respectful relationships education and improvements in community attitudes remain important objectives, but they should not be treated as sufficient evidence that violence has been prevented. These are intermediate outcomes whose preventive value



depends on whether and under what conditions they lead to sustained changes in behaviour, institutions and exposure to violence.

A major meta-analysis of sexual violence prevention programs found that interventions frequently improved knowledge, attitudes and beliefs without producing corresponding reductions in perpetration or victimisation (Porat et al., 2024). Reviews of the behavioural impacts of educational interventions in dating and domestic violence have produced more promising but mixed findings, identifying reductions in some forms of adolescent dating violence while also finding inconsistent effects across victimisation, perpetration, programs and settings (De La Rue et al., 2017; Lee & Wong, 2022; Russell et al., 2021). The broader evidence therefore supports continued investment in well-designed educational interventions, but not the assumption that educational exposure or attitudinal improvement necessarily translates into reduced violence.

Prevention investments should therefore be supported by an explicit theory of change identifying how each activity is expected to influence behaviour, exposure to risk and, ultimately, the incidence and severity of violence. Evaluation should examine outcomes appropriate to the intervention, including changes in perpetration and victimisation, recurrence, escalation, service access, safety, recovery and institutional practice. Knowledge, attitudes, intentions and bystander confidence may be legitimate intermediate outcomes, but should be clearly identified as such rather than presented as direct measures of reduced violence.

Regular independent review is also essential. Prevention policy must be capable of learning from implementation, identifying interventions that are ineffective or produce unintended consequences, and expanding, adapting or discontinuing programs according to evidence. As Australia's response to HIV illustrates, effective public health systems retain the capacity to revise established strategies when outcome data demonstrate the need for different or more targeted interventions (Hill & Salter, 2024). The lesson here is that effective prevention systems must change their investment mix when outcome data show that established approaches are insufficient.

Recommended action: Establish a national framework for the independent evaluation and regular review of prevention policy, expenditure and practice. The framework should require significant prevention investments to have an explicit theory of change, baseline measurement and appropriate comparison strategies where feasible, behavioural and safety outcomes, sufficient follow-up to assess sustained effects, and transparent publication of positive, null and adverse findings. Regular investment reviews should use this evidence to determine which interventions should be sustained, adapted, expanded or discontinued and to ensure that prevention funding responds to emerging evidence and unmet need.



3. Centring children within a lifespan approach

Recognition of children as victim-survivors in their own right should lead to concrete changes in funding, service design, professional practice and accountability. Children are not merely witnesses to violence against a parent, extensions of an adult victim-survivor or secondary clients of adult services. Perpetrators may directly subject children to coercive control, physical and sexual violence, grooming, technology-facilitated abuse and exploitation. They may also use children to monitor, intimidate or punish another family member, undermine relationships with a protective caregiver, or continue abuse after separation (Dragiewicz et al., 2022).

Violence and adversity in childhood are common and have cumulative effects across the lifespan. Australian research indicates that almost two-thirds of the population have experienced at least one form of child maltreatment, while nearly two in five have experienced multiple forms (Mathews et al., 2023). Adverse childhood experiences are associated with poorer physical and mental health, substance dependence, homelessness, educational disengagement, contact with criminal justice systems, revictimisation and, for a minority, increased risk of using violence (Hilton et al., 2019; Lawrence et al., 2023; Scott et al., 2023).

These outcomes are neither inevitable nor explained by childhood adversity alone. They reflect the interaction of trauma with gender, poverty, racism, disability, family and community resources, and access to timely support. Nonetheless, preventing childhood adversity and supporting children and families to recover are essential to reducing gendered violence and its health and social consequences across generations.

Centring children requires every child affected by gendered violence to have access to an individual safety and needs assessment, developmentally appropriate and accessible information, independent advocacy where required, specialist therapeutic care, and meaningful participation in decisions affecting them. Children should not lose access to support because violence against them is classified as secondary to violence against a parent, because responsibility is disputed between service systems, or because their protective caregiver is unable to navigate fragmented services.

Recommended action: Through National Cabinet and the relevant ministerial councils, establish national minimum standards for responding to children affected by gender-based violence, including child-specific safety and needs assessment, accessible information, independent advocacy, therapeutic support and safe, developmentally appropriate participation in decisions affecting them.

3.1. Co-occurring coercive control, domestic violence and child sexual abuse

Domestic violence and child sexual abuse can occur within the same family and may be perpetrated by the same person (Olejníková et al., 2025). However, they are often investigated and assessed through different systems, evidentiary frameworks and professional lenses. Our research found that child sexual abuse concerns may be more difficult to substantiate than



domestic violence, creating an evidentiary gap with serious consequences (Salter et al., 2026). Protective parents and caregivers may be blamed for failing to protect a child while also being penalised for acting on concerns that authorities cannot conclusively substantiate. Perpetrators may exploit this gap by grooming and coercively controlling protective adults, undermining their confidence, isolating them from support and discrediting them to professionals.

Grooming and coercive control are both cumulative and relational processes. Domestic and family violence policy has moved beyond treating physical assaults as isolated incidents to examining patterns of manipulation, surveillance, isolation and control. Assessment of grooming should similarly consider the perpetrator's pattern of behaviour towards the child and the wider network of caregivers, professionals and institutions around them. A shared pattern-based approach would strengthen identification, risk assessment and intervention where domestic violence and child sexual abuse co-occur.

The Second Action Plan should fund integrated child-and-family advocacy models that can navigate child protection, policing, sexual assault services, family law, health, mental health and therapeutic care. Child Advocacy Centre models provide useful foundations for coordinated, child-centred responses that minimise repeated retelling and bring forensic, medical, therapeutic, legal and practical assistance together (Herbert & Bromfield, 2016; Salter et al., 2026). Any Australian model should be adapted to local legal and service systems and designed with Aboriginal Community Controlled Organisations.

Recommended action: Fund and evaluate demonstration pilots of child-and-family advocacy models for cases involving co-occurring domestic and family violence and child sexual abuse, bringing together safeguarding, forensic assessment, health, therapeutic care, legal assistance and practical support. Models should include specialist secondary consultation for complex child protection and family-law matters and be co-designed and governed with Aboriginal Community Controlled Organisations.

3.2 Family law and unresolved child sexual abuse concerns

The Federal Circuit and Family Court of Australia frequently determines parenting matters in which domestic violence is documented yet concerns about child sexual abuse remain contested, incompletely assessed or inconclusive. A failure to substantiate an allegation does not establish that abuse did not occur. Nevertheless, evidentiary uncertainty may be interpreted in ways that expose children and protective caregivers to further risk.

These cases frequently involve fragmented assessments across police, child protection, family consultants, independent children's lawyers and privately engaged experts. Relevant information may not be shared, no agency may hold responsibility for an integrated assessment, and children may be repeatedly interviewed without receiving ongoing support. Judicial education is necessary but cannot remedy deficiencies in the evidence and specialist services available to the Court.

The Court therefore requires timely access to independent, multidisciplinary and child-focused expertise. Children and protective caregivers also require coordinated legal, therapeutic and practical support during proceedings and after parenting orders are made. Children's

experiences following orders should be monitored to determine whether arrangements secure their safety, stability and wellbeing over time.

Recommended action: Establish and resource a specialist multidisciplinary evidence-gathering mechanism for family-law matters involving complex or unresolved concerns about abuse and violence. This capability should provide timely assessment, specialist advice to the Court, coordinated assistance to children and caregivers, and continuity of therapeutic support during and after proceedings.

Recommended action: Commission independent evaluations of the Magellan pathway and Evatt List, examining access, timeliness, assessment quality, procedural fairness, coordination with state and territory agencies, children's participation, parenting orders and longer-term child safety and wellbeing outcomes.

Recommended action: Establish a transparent family-law research and accountability framework, including regular publication of de-identified data on high-risk matters, pathways through the Court, use of specialist assessments, duration and outcomes of proceedings, and post-order safety and wellbeing.

3.3 Adolescent sexual violence and harmful sexual behaviours

A significant form of child sexual abuse sits uneasily across the boundaries of the National Plan and the National Strategy: sexual harm caused by children and adolescents. Children of all genders may display harmful sexual behaviours or be affected by them, and abuse may occur between siblings, peers, intimate partners or other children known to one another. However, there has been a notable increase in Australia of sexual violence perpetrated by adolescent boys against adolescent girls (Mathews et al., 2024).

Within gendered violence prevention frameworks, these behaviours may be articulated as sexual violence by “young people” and attributed primarily to gender norms and attitudes. Within child protection and therapeutic practice, sexual behaviour that is developmentally inappropriate, coercive, abusive or harmful is understood as requiring safeguarding, assessment and specialist intervention. Both perspectives contribute important insights, but they are not interchangeable.

Harmful sexual behaviours arise through diverse developmental pathways. Associated factors may include exposure to domestic and family violence, child abuse or neglect, disrupted caregiving, peer and family environments, social isolation, neurodevelopmental or cognitive disability, exposure to pornography or other harmful sexual material, and broader norms supporting gender inequality and sexual entitlement (McKibbin, Green, et al., 2024; McKibbin, Humphreys, et al., 2024). No single factor is present in every case, and a universal educational response is insufficient to the prevention or response to sexual violence by adolescents.

Schools are critical settings for prevention, identification and response, but they should not be expected to manage serious harmful sexual behaviour without specialist assistance. Despite the national focus on respectful relationships and consent education, there are significant inconsistencies between state and territory frameworks in responding to sexual violence that occurs in schools, particularly where a student reports abuse or assault by another student. In these circumstances, schools can lack clarity on their legal obligations and available



mechanisms to address the safety and wellbeing of the victim alongside due process for the accused student, including where police investigations may be ongoing. Educational programs that promote gender equality and respect are likely to be undermined in institutional environments where schools lack the requisite guidance and policy framework to respond in a holistic way to sexual violence between students.

Recommended action: Develop a national best-practice framework for school and education-sector responses to peer and sibling sexual harm. The framework should address immediate safety, information sharing, referral thresholds, educational continuity, procedural fairness, support for affected children, intervention with children displaying harmful behaviours, and access to specialist secondary consultation.

Recommended action: Establish nationally consistent data collection on harmful sexual behaviours and child-on-child sexual abuse across child protection, education, health, policing and specialist treatment services, including the nature and context of behaviours, service access, intervention outcomes and recurrence.



4. Child and family safety, support and recovery as prevention

Childhood maltreatment, exposure to domestic violence, disrupted attachment, family stress and other forms of adversity can shape vulnerability and, for a smaller group, pathways to later violence (Fulu et al., 2017; Li et al., 2020; Papalia & Widom, 2024). These pathways are not deterministic, but they nevertheless identify powerful opportunities to prevent harm, support recovery and interrupt the accumulation of disadvantage across the lifespan and between generations.

A lifespan and intergenerational approach requires investment in the systems that protect children, strengthen safe caregiving relationships and enable recovery from violence. This includes child safeguarding and protection, early childhood and family support, perinatal and infant mental health, parenting programs, specialist therapeutic care, material assistance and support for protective caregivers. These systems should be recognised as part of Australia's gender-based violence prevention infrastructure rather than treated as adjacent social services.

Trauma-informed and gender-transformative prevention should be understood as complementary rather than competing approaches. Childhood maltreatment, disrupted attachment and other forms of adversity have a powerful impact on gender norms and attitudes (Howell, 2002). Research suggests that family-related adverse childhood experiences can reinforce anti-feminist gender-role beliefs among some boys, which in turn increase the likelihood of intimate-partner violence perpetration in adulthood (Wenigmann et al., 2024).

This indicates that interventions addressing gender norms may be less effective for some children and adolescents if they do not also respond to trauma, emotional regulation, family violence, peer relationships and other developmental needs. Conversely, therapeutic interventions that address trauma without attending to gender, power, entitlement and social context may leave important drivers of violence unaddressed.

Recognising these services as prevention does not imply that victim-survivors cause later violence, are responsible for their own re-victimisation, or that recovery services are justified only by their effects on future prevalence. Safety, healing and wellbeing are important outcomes in their own right. However, leaving children and families without effective therapeutic, practical and material support allows the effects of violence to accumulate and may increase vulnerability to further harm.

4.1. Support children and protective parents together

Children's safety and wellbeing are closely linked to the safety and wellbeing of their caregivers. Violence can damage attachment, undermine parental confidence and produce behaviours—withdrawal, aggression, dissociation, sexualised behaviour, school refusal and self-harm—that distressed caregivers may struggle to understand. Child–parent psychotherapy and related dyadic approaches demonstrate the value of supporting the child-



caregiver relationship rather than treating children or mothers in isolation (Hooker et al., 2021).

Therapeutic care alone may be insufficient when a family is experiencing insecure housing, financial hardship, disrupted schooling, disability-related barriers or ongoing legal proceedings. Safety and recovery require material foundations. Protective caregivers may need assistance with housing, income, transport, childcare, schooling, legal costs and the practical work of navigating police, child protection, health services and courts.

Services must not make a child's access to support wholly dependent on the capacity of an overwhelmed caregiver to identify, fund and coordinate multiple services. Children should have a direct entitlement to assessment and therapeutic care. At the same time, protective caregivers should receive case coordination, psychoeducation, therapeutic support and practical assistance to strengthen their capacity to support the child. Assistance should be flexible and sustained for as long as required, rather than ending when an immediate crisis or statutory intervention concludes.

4.2. Build a national service continuum

Access to specialist services for children and adults exposed to violence remains geographically inconsistent. The Second Action Plan should establish a nationally accessible continuum ranging from universal and early family support through to specialist assessment and intensive therapeutic intervention. This should include clear referral pathways, supported transitions between services, specialist secondary consultation and mechanisms for children and families whose needs cross multiple systems. National consistency should establish an entitlement to appropriate care without imposing a single service model on every community.

Recommended action: Seek agreement across the Commonwealth, states and territories on a nationally accessible child-and-family safety, support and recovery continuum. The continuum should encompass early family support, perinatal and infant mental health, child and caregiver therapy, specialist trauma treatment, advocacy, case coordination and flexible practical assistance.

5. Perpetrator and system accountability

Prevention includes stopping people who have used violence from harming the same victim-survivor again, harming children, escalating their behaviour or carrying abuse into subsequent relationships. This requires responses that address the diversity of perpetration, interrupt continued and cross-system abuse, and strengthen the material conditions that enable victim-survivors and children to achieve safety.

Accountability should be assessed by its outcomes: increased safety and freedom for victim-survivors and children, sustained changes in perpetrator behaviour, and reductions in recurrence, escalation and further victimisation.

5.1. Differentiated responses to perpetration

Perpetrators differ in their patterns of violence, motivation, level of risk, capacity to change and use of institutions. A single intervention model will not be appropriate for every perpetrator or every form of violence.

Accountability should operate as a continuum: clear expectations and opportunities to change; proportionate behavioural, therapeutic and justice interventions; monitoring and disruption where risk persists; and enforceable consequences for continued abuse. Assessment and intervention should be matched to risk, need and context and responsive to developmental stage, culture, disability, sexuality, family circumstances and the nature and severity of the abuse, without compromising victim-survivor safety.

Interventions must be evaluated through behavioural and safety outcomes, including recurrence, escalation, abuse of children and abuse in subsequent relationships. Referral, attendance and program completion are measures of service activity, not evidence that violence has stopped.

Recommended action: Lead the development of a national perpetrator-accountability framework covering early intervention, behaviour-change programs, health and therapeutic intervention, monitoring, disruption and justice responses. The framework should establish common principles for matching interventions to assessed risk, need, context and responsivity, while prioritising victim-survivor and child safety.

5.2. Preventing and disrupting systems abuse

Perpetrator accountability depends on system accountability. Child support, social security, taxation, family law, banking, housing, health, policing, education and digital platforms can be manipulated to continue coercive control during and after separation. A perpetrator may exploit several systems simultaneously or repeatedly while each institution sees only an isolated incident, application or transaction.

Government agencies and regulated industries should be responsible for identifying and interrupting patterns of systems abuse. Accountability cannot be outsourced to victim-survivors through repeated reporting, evidence-gathering and self-navigation across fragmented agencies.



System accountability must also encompass harm caused or prolonged by institutional action or inaction. Agencies and regulated industries should audit whether their policies, products and administrative processes facilitate coercive control or financial abuse. Complaints and review mechanisms should be accessible, trauma-informed, timely and capable of producing corrective action.

Recommended action: Establish an ongoing cross-portfolio program to identify and prevent the weaponisation of Commonwealth systems, including family law, child support, taxation, social security, immigration, superannuation, government payments and digital government services.

5.3. Material security as safety infrastructure

Safety requires material resources. A victim-survivor's capacity to leave violence, remain separated, protect children and recover is shaped by access to secure housing, adequate income, childcare, legal assistance, healthcare, transport and employment protections. Poverty, debt and housing insecurity can prolong exposure to perpetrators, facilitate post-separation coercion and force women and children to choose between violence and destitution (ANROWS, 2019; Summers, 2022).

Material insecurity may also be deliberately produced and exploited through interference with employment, withholding child support, manipulation of debts and accounts, property damage, vexatious legal proceedings and misuse of government payments (Breckenridge et al., 2020). Strengthening material security therefore both supports victim-survivors and reduces perpetrators' capacity to maintain control.

Housing, social security, taxation, child-support, childcare and employment settings should be assessed for their effects on the capacity to leave and remain separated from violence. Reforms should provide rapid access to crisis and transitional assistance, minimise requirements for continued interaction with perpetrators, and identify and remedy debts or liabilities arising from coercive control.

Recommended action: Assess Commonwealth housing, social-security, taxation, child-support, childcare, employment, migration and financial-service policies against their effects on victim-survivor safety, economic security and the capacity to leave and remain separated from violence.

6. Women's and children's health and recovery as foundations for safety

Health is not merely an outcome of safety; it is also a resource through which safety can be created and sustained. Gender-based violence is a major cause of injury, illness, disability, psychological distress, self-harm and suicide among women and children. Its health effects may persist long after immediate danger has passed and can affect education, employment, relationships, parenting, social participation and the capacity to navigate further threats and institutional systems. Accessible, sustained health and recovery support can reduce distress, strengthen relationships and parenting, and assist women and children to establish and maintain safety.

Recovery and healing are sometimes treated as the final domain of policy: what occurs after prevention has failed. A lifespan and intergenerational framework recognises that recovery is an important objective in its own right and can also have preventive effects. Effective support may reduce revictimisation and suicidality, improve engagement with education and work, strengthen safe family relationships and prevent the health and social consequences of violence from accumulating across the lifespan and generations. Effective trauma care can reduce distress, improve quality of life and support safety, attachment, parenting and recovery. It should therefore be understood as part of public-health and prevention infrastructure, not solely as a downstream clinical response (Ford, 2015; Salter & Hall, 2022; Salter, Woodlock et al., 2025).

Intergenerational effects do not arise through a simple or inevitable “cycle of abuse.” They emerge through interactions between trauma, family relationships, material and social disadvantage, community responses and institutional systems. Prevention must therefore address trauma at individual, family, community and institutional levels rather than locating responsibility within victim-survivors or their parenting (Isobel et al., 2019; Salter, Woodlock et al., 2025).

Health and social services will encounter many people whose needs are shaped by childhood and adult gender-based violence, whether or not they disclose it or identify themselves as victim-survivors (Dolezal & Gibson, 2022; Israel et al., 2023). Mental health, alcohol and other drug, homelessness, disability, sexual and reproductive health, suicide-prevention and primary-care services must be capable of recognising trauma-related needs while also assessing current safety. Symptoms should not be treated in isolation from the violence and social conditions that may have produced or sustained them.

6.1. Long-term pathways, not episodic crisis responses

The Second Action Plan should establish affordable, long-term recovery pathways for survivors of childhood and adult gender-based violence. Care should be trauma-informed, shame-sensitive, culturally safe and capable of responding to complex trauma and dissociation. It should include peer support, social and practical assistance, and community-led healing alongside clinical care.



Access should be determined by need rather than an arbitrary timeframe, a requirement to participate in criminal proceedings or the presence of a narrowly defined psychiatric diagnosis. Victim-survivors should not have to repeatedly retell their experiences to establish eligibility as they move between crisis, health and recovery services.

Children require developmentally appropriate pathways that can change as their needs change. Services must be capable of responding to developmental trauma, disability and communication needs, supporting safe caregiving relationships and maintaining continuity across child, adolescent and adult health systems. Transitions between services should not result in the loss of therapeutic relationships or the need to begin again.

Services should enquire safely about childhood and adult trauma where relevant, while mental-health and trauma services should assess current exposure to violence and coercive control. Enquiry must be supported by clear response and referral pathways: identifying violence without being able to provide meaningful assistance may increase distress without improving safety.

Recommended action: Examine how Commonwealth responsibilities for Medicare, Primary Health Networks and Commonwealth-funded health programs can expand affordable, long-term recovery pathways for survivors of childhood and adult gender-based violence.

Recommended action: Fund long-term, community-led prevention and healing initiatives that enable communities to identify local manifestations of gender-based violence, strengthen collective efficacy and protective relationships, and develop culturally grounded solutions. Initiatives should be evaluated against safety, service access, community capability and recovery outcomes rather than attitudes alone.

Recommended action: Develop the specialist trauma workforce required to deliver these pathways, including capability in complex trauma, dissociation, childhood and adult sexual violence, domestic and family violence, disability, culturally safe care and child- and adolescent-specific treatment.



7. Men's health as a setting for prevention and early intervention

Men's health services and men's contact with mainstream health care provide underused opportunities to prevent and intervene in violence. Men who use domestic and family violence have, on average, higher rates of depression, anxiety, suicidality, post-traumatic stress and alcohol and other drug problems than men who do not use violence (Oram et al., 2014; Sesar et al., 2018). Longitudinal evidence indicates that some mental disorders are associated with an increased risk of subsequent intimate-partner violence perpetration, although risks vary substantially by diagnosis and most men experiencing mental illness do not use violence (Yu et al., 2019). Co-occurring health needs may also impede engagement with behaviour-change and justice interventions if left untreated.

These associations do not establish that illness causes violence. Some men who use violence have no identifiable health disorder, while most men experiencing mental illness, trauma or adversity do not harm their partners or children. Gender inequality, coercive control, entitlement and individual agency remain central. The policy opportunity lies in recognising how gendered norms, developmental adversity, mental and physical health, substance use, gambling and social conditions interact in particular pathways - and intervening without medicalising abuse or displacing responsibility.

Men who use violence may be less likely than women to seek welfare or specialist family-violence support, but many are visible to general practice, emergency departments, mental-health, suicide-prevention and alcohol and other drug services. These contacts provide opportunities to recognise indicators of coercive control and violence, respond to disclosures, assess immediate risks and make supported referrals to appropriately matched interventions (Hegarty et al., 2016, 2022).

Health practitioners should not be expected to conduct specialist perpetrator risk assessment without training, protocols and access to consultation. Nor should identification rely on universal questioning unsupported by evidence or referral capacity. A safe health-system response requires clinically appropriate enquiry, clear escalation pathways, careful management of confidentiality and information sharing, and specialist advice where risks to partners or children are identified.

7.1. Childhood trauma, gender and pathways to violence

Childhood maltreatment and exposure to domestic and family violence are associated with an increased risk that some boys will use violence later in life, but the relationship is probabilistic rather than deterministic. Potential pathways include difficulties regulating distress, learned use of aggression, substance use, unsafe peer environments and the reinforcement of rigid or anti-feminist gender beliefs. Services for boys and men who have experienced abuse should support disclosure and recovery in ways that challenge restrictive masculinity without stigmatising male survivors as future perpetrators. Where boys or men use violence, interventions should address relevant trauma, health and developmental needs while maintaining clear responsibility for harmful behaviour. Understanding the circumstances shaping violence does not remove agency, accountability or the obligation to change.



7.2. Mental health, suicidality and coercive control

Suicidality requires particular attention. Intimate-partner violence can precede suicide, and men who use high-risk or high-harm violence have elevated rates of suicidal thoughts and behaviours (Kafka et al., 2022). In some cases, threats of suicide are used to frighten a partner, prevent separation, suppress disclosure or make a woman responsible for a man's survival. Responses must be capable of treating genuine suicidal distress while recognising the potential coercive use of threats, assessing risks to partners and children, and maintaining perpetrator accountability.

Mental-health and suicide-prevention services should not manage a man's distress in isolation from potential risks to others. In high-risk cases, suicide prevention must incorporate assessment and management of homicide and homicide–suicide risk. At the same time, confidential health care must not become a source of unsafe disclosure, information or pressure directed towards a victim-survivor. Clear protocols, specialist consultation and lawful information-sharing arrangements are required.

7.3. A health-system prevention agenda

The health system's role should extend from universal health promotion to targeted early intervention and specialist treatment. Universal initiatives can strengthen boys' and men's emotional literacy, help-seeking, social connection and capacity to manage distress without control or violence. These initiatives should be distinguished from targeted responses for people displaying warning signs and from specialist intervention with men already using violence.

Health services should be equipped to identify and respond to men using violence and connect them with interventions matched to risk and need. Men's behaviour-change and other perpetrator interventions should, in turn, be capable of addressing co-occurring mental-health, trauma, substance-use and gambling problems. Clinical treatment must not replace behavioural accountability, risk management, partner contact or specialist victim-survivor support.

Referral alone is insufficient. A supported pathway should confirm whether the receiving service is appropriate and accessible, address barriers to engagement and specify what occurs when a man declines treatment or risk escalates. Health services also require feedback mechanisms that respect confidentiality while enabling coordinated risk management.

Recommended action: Establish a national health-system response to people who use violence, including practice guidance, workforce development, specialist consultation and supported referral pathways across general practice, emergency care, mental health, suicide prevention, alcohol and other drug services and men's health programs.

Recommended action: Fund and evaluate prevention and early-intervention programs that strengthen boys' and men's emotional regulation, help-seeking, healthy relationships and recovery from childhood trauma, using behavioural and victim-safety outcomes rather than attitudinal measures alone.



8. Regulating the commercial determinants of gendered violence

Prevention policy has focused heavily on changing individual attitudes and social norms. Those efforts remain important, but violence is also shaped by products, services, markets and commercial infrastructures. Alcohol, gambling, pornography, financial products and digital technologies can increase the incidence or severity of violence, enable coercive and exploitative practices, and create commercial incentives that conflict with safety.

The Rapid Review of Prevention Approaches recognised this gap and called for “prevention through systems and industries,” including stronger regulation of alcohol, gambling, media and pornography and application of Safety by Design principles to government and commercial systems (Rapid Review Expert Panel, 2024). This represents an important shift: responsibility for prevention should not rest principally with individuals expected to modify their behaviour while governments leave the products and environments shaping that behaviour largely unchanged.

The Australian Government has accepted this direction and begun implementing relevant measures on age assurance, social-media access, doxxing, online industry codes, nudification and stalking tools, and financial abuse within some Commonwealth systems. However, implementation remains uneven. Substantial recommendations concerning alcohol availability and advertising, gambling advertising and electronic gaming machines, pornography, financial services and enforceable technology-sector accountability remain incomplete.

The Second Action Plan should move from identifying harmful industries to establishing a coherent regulatory prevention agenda. Regulation should be based on the contribution of products and business practices to harm, the capacity of an industry to prevent or mitigate that harm, and the degree of control it exercises over relevant environments and infrastructure. Voluntary action may complement regulation but should not substitute for enforceable duties, independent oversight and transparent reporting.

Safety by Design offers a useful organising principle across industries. It places responsibility on providers to anticipate and reduce foreseeable misuse; protects user autonomy and safety; and requires transparency and accessible accountability. Applied to gender-based violence, it means designing products and systems so that abuse is harder to perpetrate, easier to detect and disrupt, and less burdensome for victim-survivors to report and address.

Recommended action: Establish a cross-portfolio regulatory prevention workstream to implement the Rapid Review’s recommendations concerning systems and industries. It should include published actions, responsible ministers and regulators, implementation timelines, measurable harm-reduction objectives and independent evaluation.

8.1. Alcohol and gambling

Alcohol does not cause gender-based violence, and most people who consume alcohol do not use violence. However, harmful consumption can increase the likelihood, frequency and severity of domestic, family and sexual violence and is a shared risk factor across violence



against women and children (Karriker-Jaffe et al., 2023; Willoughby et al., 2025). Alcohol policy can therefore reduce violence by addressing the price, availability, delivery, promotion and consumption contexts of alcohol—not merely by encouraging individuals to drink responsibly.

The Rapid Review recommended that preventing gender-based violence become an explicit objective of state and territory liquor regulation, alongside restrictions on alcohol sales, delivery timeframes and advertising. The Government's February 2026 update reports \$1 million to update the 2015 National Framework for Action to Prevent Alcohol-Related Family Violence (Australian Government Department of Social Services, 2026). This is a useful foundation, but a revised framework will have limited impact unless it leads to legislative, licensing and enforcement reforms.

Gambling can contribute to financial stress, debt, conflict, coercion and economic abuse and may increase the frequency or severity of violence where it co-occurs with domestic and family violence (Hing et al., 2024). Gambling products and providers may also facilitate post-separation financial abuse. The Rapid Review supported a total ban on gambling advertising and stronger regulation of electronic gaming machines and online gambling. The February 2026 update does not identify a commensurate regulatory response to these recommendations.

Recommended action: Through National Cabinet and relevant ministerial councils, seek agreement on complementary state and territory reforms to liquor licensing, alcohol availability and delivery hours, electronic gaming machines and other jurisdictionally regulated products and venues.

8.2. Pornography and online sexual services

Children and adolescents are growing up in online environments saturated with pornography, sexualised content, online misogyny, image-sharing pressures and algorithmically amplified harmful material. Education must address these realities frankly. However, it is unreasonable to expect children, parents and schools to counter massive commercial systems designed to maximise reach, engagement and consumption without effective regulation.

Pornography regulation should consider age assurance; performer age, identity and consent verification; upload and recommender systems; reporting and removal mechanisms; repeat upload prevention; payment services; and provider accountability for unlawful material. It should also examine regulatory responses to content that depicts, promotes or eroticises coercion, sexual violence, incest or child-like themes.

Recommended action: Develop a comprehensive pornography harm-reduction framework extending beyond age assurance to provider responsibility, performer age and consent verification, content governance, recommender systems, payment services, accessible complaints, rapid removal and prevention of repeat uploads.

9. Delivering reform: governance, workforce, data and investment

The eight substantive priorities above depend on implementation architecture capable of working across conventional policy, portfolio and service boundaries. Without clear authority, named responsibilities, sustained funding, workforce capability and shared measures of success, a lifespan and intergenerational framework will remain an aspiration rather than an operating model.

9.1. Cross-plan governance and accountability

The Commonwealth should establish a formal governance mechanism connecting the National Plan, the National Strategy to Prevent and Respond to Child Sexual Abuse, *Safe and Supported*, and *Our Ways – Strong Ways – Our Voices*. This mechanism should identify shared priorities, allocate responsibility across portfolios and jurisdictions, resolve gaps and duplication, and report publicly on delivery.

Areas requiring joint action include familial child sexual abuse; co-occurring domestic violence and child sexual abuse; peer and dating violence; harmful sexual behaviours; adult recovery from childhood trauma; technology-facilitated abuse; family law; perpetrator accountability; and workforce capability. Coordination should not dilute the specialist expertise or distinct responsibilities of each strategy. Its purpose is to make the interfaces between them visible and accountable.

Recommended action: Establish a formal cross-plan governance mechanism linking the National Plan, the National Strategy to Prevent and Respond to Child Sexual Abuse, *Safe and Supported*, and *Our Ways – Strong Ways – Our Voices*, supported by a published implementation schedule with named lead agencies, timeframes, funding commitments and shared outcomes.

9.2. Sustainable funding and accountable commissioning

A lifespan and intergenerational approach requires funding arrangements that match the duration and complexity of the problems being addressed. Short-term grants, fragmented commissioning and repeated competitive tenders undermine workforce retention, service continuity, partnerships and evaluation. They are particularly burdensome for Aboriginal Community Controlled Organisations, small specialist services and community-led organisations without substantial administrative infrastructure.

Commissioning should be based on population need, service gaps, geography, accessibility and the intensity of support required. It should recognise the additional costs of providing services in rural and remote communities, ensuring disability access, delivering culturally specific care, supporting children and families with complex needs, and participating in cross-sector coordination.

Funding should include the infrastructure needed for effective delivery: supervision, secondary consultation, workforce development, data collection, evaluation, partnership-building and



lived-experience participation. These functions should not be expected to emerge from already inadequate frontline service budgets.

Governments should also publish how expenditure is distributed across universal, selective and indicated prevention; crisis response; recovery and healing; perpetrator intervention; regulation; and enabling infrastructure. This would reveal whether stated priorities are reflected in investment and allow the prevention portfolio to be rebalanced according to evidence and unmet need.

Recommended action: Establish a ten-year national investment plan aligned with the lifespan and intergenerational framework, with recurrent funding, jurisdictional contributions, population- and needs-based allocation principles, and dedicated investment in Aboriginal Community Controlled Organisations.



10. Conclusion

The Second Action Plan is an opportunity to correct a longstanding fragmentation in Australia's response to gender-based violence. Violence does not begin at 18, and its impacts do not remain within the service system or policy category in which it is first recognised. Children experience gender-based violence directly; some children use harmful sexual behaviours and require specialist intervention; childhood trauma shapes health and vulnerability across adulthood; and healing can change trajectories for survivors, families and future generations.

A lifespan and intergenerational approach would not dilute specialist strategies. It would connect them at the points where people currently fall through gaps. It would combine gender-transformative prevention with child safeguarding and therapeutic expertise, treat health as a resource for safety, and address the industries and technologies that shape risk. With accountable implementation, workforce capability and shared outcomes, the Second Action Plan can move from parallel policy systems towards a coherent national effort to end violence across the life course.

Contact:



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