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<https://engage.dss.gov.au/second-action-plan/submissions/>

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Introduction and Background to this Consultation

We welcome the opportunity to provide this submission to the Consultation and wish to thank the Department of Social Services for this work on the Second Action Plan (National Plan to End Violence against Women and Children 2022-2032). The following information is provided and adapted from the consultation documents to help inform our national network of the context for this consultation.

The Second Action Plan is an important opportunity to strengthen implementation, improve coordination across systems, and focus national effort where it can have the greatest impact. This consultation process is central to that work.

The National Plan makes clear that ending violence against women and children requires coordinated, evidence-informed action across governments, sectors and communities. It requires us to ask difficult questions, listen carefully to the experiences of people across Australia, and remain responsive to emerging evidence and changing conditions.

Building on the First Action Plan, progress in the National Plan requires coordinated action across the domains of prevention, early intervention, response, and recovery and healing.

Aboriginal and Torres Strait Islander peoples, children and young people, and people who use violence against women and children and other forms of gender-based violence are identified as priority populations that need to be better understood in the research. The Consultation Paper identifies where progress has been made, where harms persist or are growing, and where outcomes are not equal. Further information is available here (<https://engage.dss.gov.au/second-action-plan/consultation-paper/>)

It identifies 5 priority areas for the next plan:

1. **Victim-survivors of violence against women and children and other forms of gender-based violence:** strengthening a whole of society /life-course approach to prevention, early intervention, response, recovery and healing with a focus on victim-survivors from all communities/backgrounds.
2. **Prevention and early intervention:** embedding initiatives where people live, work, learn and connect to address the gendered drivers of this violence; address substantive influences on perpetration and risk such as harmful substance use, gambling, and adverse childhood experience; support attitudinal and behavioural change to prevent harm before it occurs; and to prevent escalation. It also requires collaboration and integration across sectors to strengthen primary prevention and early intervention approaches.
3. **Children and young people in their own right:** centring children and young people's voices, rights, and safety across prevention, early intervention, response and recovery, and providing tailored, age and developmentally appropriate support for children and young people. This includes young people who use violence (in home and/or intimate partner relationships, including use of sexual violence).
4. **People who use violence:** advancing prevention, early intervention, response, and recovery and healing throughout the life course on both family and domestic violence and sexual violence,

supporting earlier identification, and multi-sector approaches to accountability and behaviour change, for example (but not limited to) strengthening policing and justice sector responses.

5. **System integration and workforce:** safe and effective prevention, early intervention, response and long-term recovery including justice and health-sector responses, drawing on an integrated system and a connected and capable workforce that utilises trauma and violence-informed approaches across multi-sector services and programs.

Our Response to the Consultation Questions

1. **Prevention.** What actions can governments, workplaces, industries, schools, families and individuals take to stop violence before it starts?

There are many valuable lessons that can be drawn from people with lived experience of mental health challenges that can help inform and address the issues that contribute to violence against women and children. We know well how structural stigma and discrimination work to stereotype, define, have power over, and 'other' certain groups in order to maintain that control and legitimacy. We also recognise and experience first-hand how most of social inequalities relate to who has power and influence to define who has control of and access to resources and rulemaking. We also understand the pervasive gendered nature of social and political relations. We also recognise that mental health trauma and violence towards women and children have many intersections in their causes and consequences.

Recommendations framed around social justice for addressing the social determinant of mental health¹ may offer some useful parallels to inform action here, particularly for prevention. Below Table adapted from that source:

1. Make social justice central to all interventions designed to address violence against women and children. Patterns of violence are inequitably distributed between and within these populations, principally arising from systemic structural inequalities.
2. Invest in interventions that pay off in multiple domains. Few social determinants solely affect one issue. Investing in interventions that target key social determinants will improve physical, mental and social outcomes for individuals and communities.
3. Invest in interventions that target critical windows of the lifecourse to interrupt intergenerational transmission of violence. Providing good-quality, accessible parental and familial support early in life can interrupt intergenerational transmission of disadvantage, negative stereotypes that perpetuate violence and can give or perpetuate tacit permission within families or communities.
4. Prioritize interventions that focus on poverty alleviation. Any comprehensive public health approach to reduce violence against women and children must include efforts to provide women (and children) the means to escape violence, and to build agency and autonomy to leave (or not enter in the first place) environments where violence and coercive control are more likely.
5. Strengthen research on social determinants of violence against women and children, and the evidence arising from primary, secondary and tertiary prevention.

¹ Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Soneson E, Steare T, Wright T, Griffiths SL. The social determinants of mental health and disorder: evidence, prevention and recommendations. World Psychiatry. 2024 Feb;23(1):58-90. doi: 10.1002/wps.21160.

The above recommendations include addressing socioeconomic disadvantage related to education, finance, housing, employment, and so forth. They also include addressing early life adversity to prevent cycles of disadvantage and challenge stereotypes that position women and children within structures where violence is more likely, condoned, minimised, and seen as a private matter within individuals and families, rather than as a crime.

2. **Services and support.** How can services and supports work better for people who have experienced, or are at risk of experiencing, family, domestic or sexual violence?

On any and all levels, whether it is from insidious microaggressions to explicit violence, respect and safety of all people to live within their homes and communities free from discrimination, coercion and violence is a basic human right.

Our recent national project on 'Claiming Your Human Rights'² highlighted key themes that may resonate with the experiences of women and children within services and systems of support:

- Not being listened to - *feeling dismissed, talked over and being treated as irrelevant in their own care*
- Inadequate or inappropriate care – *diagnostic overshadowing, coercive practices, lack of trauma-informed care, and treatment that retraumatised rather than helped.*
- The power of having support - *When a support person, peer worker or advocate was present, the quality of care often changed, sometimes dramatically.*
- Barriers to accessing services - *Long waits, financial cost, geographic isolation, and complex fragmented systems blocking people from getting help.*
- Privacy, dignity & respect - *Breaches of confidentiality and a lack of basic dignity and respect caused significant distress.*
- Self-advocacy & knowledge - *System knowledge and communication skills helped the outcome, but many in a crisis couldn't access that capacity.*

Our 'Oral Health and Mental Health' national survey project³ identified the clear need for dentists and other dental staff to have great awareness of the impacts of trauma, particularly involving sexual violence experienced by women and children. This example of one sector of healthcare is pertinent to all areas of healthcare. The following excerpt from the report exemplifies the longstanding trauma impacts that must be understood (pp.27-28):

"Several consumers related this trauma to past experiences triggered during contact with the dentist:

Panic attack at going into the hospital and couldn't cope with the idea someone was going to stand over me for an hour.

I've been afraid of male dentist for a long time but improving with a female dentist.

The feeling of laying on my back, in a vulnerable position, unable to move or speak is really distressing to me. This has prevented me from visiting the Dentist to receive treatment many times in the past.

Childhood experiences have caused me to feel panic when I can't get away quickly when someone is bending over me.

Because of my status as a sexual abuse survivor, the entire dental experience is deeply triggering/

traumatic - as is the process of having to disclose, which means that choosing to go or not go is often incredibly difficult."

² <https://www.livedexperienceaustralia.com.au/research/human-rights>

³ <https://www.livedexperienceaustralia.com.au/research/oral-health>

3. **Children and young people.** How can communities and services best support children and young people to stay safe from violence?

More refuge options and identified informal and formal neighbourhood options for children (accessible afterhours and on weekends, as well as during the day) are needed.

Stronger school-based supports are needed. Teaching staff are important role models and mentors for children and young people in homes where family violence is present.

Community sporting and other clubs are important sources of connection and respite from violent home environments for children and young people. More support is needed for mentor programs that are embedded naturally into the flow of these grassroots organisations add value to children and young peoples' lived despite adversity.

4. **People who use violence.** What more can be done across the community to promote healthy, safe relationships and strengthen accountability for people who use violence?

Role-modelling affirming relationships and community expectations about respect and dignity, and challenging stereotypes that contribute to disempowerment, discrimination, coercion and violence towards women and children is needed at all levels and in all settings where people who use violence are located. This includes in workplaces, clubs, all forms of media, and in the community. Mobilise informal peer support to call out and support those who may use violence. Strengthen men's mental health programs and also mentor programs for boys.

Addressing alcohol and/or other drug (AOD) addiction with better treatment access and response, and more assertive justice requirements for undertaking AOD rehabilitation are also suggested.

5. **Recovery and healing.** What would make the biggest difference in helping people and families to recover and heal after being affected by family, domestic and sexual violence?

Secure employment, financial security, safety and protection from further coercion are important. These structures help rebuild self-worth that may have been eroded over time due to coercive control, in particular.

Rebuilding a life after FDSV often means negotiating and nurturing multiple new circumstances (housing, schooling, finances, relationships with family and friends), a new identity as a person, and the care of children who may also be traumatised.

Help with children to establish connections to positive adult female and male role models post-flight from family violence is also important, especially within the first 1-2 years.

6. **Access to support.** What makes it easier for people to access support or services related to family, domestic or sexual violence?

Similar to barriers to accessing mental health support, the common barriers are excessive bureaucracy, the adversarial nature of the legal system that disempowers victims, stigma and shame, and concern about actual safety. Hence, being believed is crucial, as is compassionate support without judgment, and on the person's terms so that further trauma is not inadvertently reinforced.

About Lived Experience Australia

Lived Experience Australia Ltd (LEA) is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. Our 'friends' include more than 13,500 people with lived experience of mental health concerns across Australia. This includes lived experiences with all parts of

the public and private mental health care system, NDIS, psychosocial disability support outside the NDIS, PHN commissioned services, and service provision across urban, regional, rural and remote Australia. Experiences of trauma related to violence and abuse are pervasive in the past and present of many people who experience lived and living experience of mental health challenges.

All LEA Board and staff have mental health lived experience as a consumer, family/carer/kin/supporter, or both. Our four pillars of activity are: Systemic Advocacy; Lived Experience and Codesign Research; Capability Building within services and communities; and Partnerships.

Lived Experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. We advocate for effective policies and systemic change to improve mental health care, suicide prevention, and psychosocial disability support services and support across the lifespan, across the Australian health and social care system, including within State and Territory jurisdictions. This includes how proposed reforms to health systems and structures impact individuals, families and communities that experience mental health challenges.

Contact

We thank ANROWS (Australia's National Research Organisation for Women's Safety) for their work on the consultation paper and the Department of Social Services for the opportunity to provide a submission to this important consultation. We wish you well with next steps and would be pleased to contribute our Lived Experience perspectives to any future discussions about this important topic. We look forward to the outcomes and sharing the final Plan with our national 'friends' network.

Your sincerely

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