

Submission to the Consultation on the Second Action Plan (2025–2028)

National Plan to End Violence Against Women and Children 2022–2032

The Burnet Institute and the National Drug Research Institute (NDRI) welcome the opportunity to provide feedback on the Second Action Plan under the National Plan to End Violence Against Women and Children 2022–2032. This joint submission is made with Access Health (The Salvation Army), Peer-Based Harm Reduction Western Australia and the Australian Injecting & Illicit Drug Users League, representing research, specialist AOD primary health care, harm reduction and peer-led drug user organisations.

Burnet Institute and NDRI are recognised leaders in public health, harm reduction, AOD research, and the health and wellbeing of people who use drugs. Collectively, our organisations have decades of experience in research, policy and service engagement with people affected by substance-use-related stigma, criminalisation and domestic, family and sexual violence (DFSV), including team members with lived and living experience.

Our longstanding partnerships with health, community and peer-led organisations include trusted relationships with criminalised women, women who use drugs, and men who have used violence and use drugs—a priority population for the Australian Government and Australia’s National Research Organisation for Women’s Safety (ANROWS), given their critical role in preventing and ending DFSV.

This expertise gives us a detailed understanding of the intersecting drivers of violence and substance use, the structural harms that compound DFSV, and the barriers many women face when seeking safety, support and services.

Overview

This joint submission draws on recent mixed-methods research with women who inject drugs, criminalised women who have experienced violence, and criminalised men who have used violence, alongside our broader research and engagement with frontline, peer-based and lived-experience communities¹⁻³. This evidence highlights a major gap in current violence policy: women who use drugs experience high levels of violence but are often excluded from effective support because of stigma, criminalisation and fear of punitive service responses. This submission builds on our previous policy briefings and research by identifying practical opportunities for the Second Action Plan to strengthen responses to DFSV, and other forms of violence, for women who use drugs, particularly women who inject drugs and women who are criminalised.

Key evidence

Our research found very high levels of violence against women who inject drugs: by 2019, 82% had experienced assault, 38% had experienced sexual assault, one in four had presented to an emergency department with a suspected assault-related injury, and one in five had been admitted to hospital where assault was formally diagnosed³. These findings align with broader evidence showing disproportionately high rates of intimate partner violence among women who use drugs and increased frequency, severity and lethality when drugs are used within violent relationships⁴⁻⁹.

Our ANROWS-funded research similarly found that criminalised women who use drugs described violence as an almost universal feature of their lives, extending beyond intimate partner violence to include violence by family members, acquaintances, police and prison officers¹.

Despite this burden, many women avoid health, social and specialist support services because disclosing drug use when seeking DFSV support can trigger punishment rather than protection. Reported risks include criminal penalties, mandatory reporting, parole revocation, retaliatory partner violence, police violence, forced family separation, housing loss and incarceration. Although ANROWS' Australian National Research Agenda (ANRA) acknowledges the role of drug use and criminalisation in women's experiences of DFSV, recent reviews continue to identify substance use coercion as an area where evidence and practice remain underdeveloped^{4,5}.

Without recognising and responding to the needs of women who use drugs, national strategies are unlikely to reach some of the women at greatest risk of violence and victimisation. The Second Action Plan presents an important opportunity to address this gap by incorporating our key recommendations.

Key Recommendations

- Explicitly recognising women who use drugs, including criminalised women, as a priority population and invest in understanding their unique needs;
- Investing in integrated, multi-disciplinary responses that address violence, substance use, health, housing, and justice needs; and
- Reducing stigma associated with substance use and criminalisation, and challenging the "perfect victim" narrative that can exclude women from recognition, protection, and support.

Recommendation 1: Recognise women who use illicit substances, particularly women who inject drugs, as a priority population under the National Plan.

Women who use illicit substances, particularly women who inject drugs, experience very high levels of violence yet remain largely invisible within national strategies to prevent and respond to violence against women. This exclusion risks leaving a vulnerable population without tailored policy, funding, services or workforce responses, despite substantial barriers to safety and support, including refuge exclusion, child protection intervention, criminalisation and discrimination across health, social service and justice systems.

In our Melbourne cohort of 431 women who inject drugs in our cohort in Melbourne, 16% were Aboriginal or Torres Strait Islander, 93% were living in public or private housing, and had been injecting for approximately 17 years. We found that more than 80% had experienced assault (i.e. attacked or suffered any kind of violence) and 38% had experienced sexual assault³. The violence was often severe: one in four women presented to an emergency department following suspected assault and one in five had an assault-related hospital admission, as per formal diagnosis. Among women who primarily smoked methamphetamine, two-thirds reported recent assault between 2016 and 2023 and 16% were hospitalised due to assault². These rates substantially exceed those observed in the general Australian population and demonstrate the need for tailored policy and service responses.

This burden of violence is inseparable from the social and structural conditions in which many women live. Poverty, housing instability, homelessness, criminalisation, child protection involvement, poor physical and mental health, and substance use stigma can increase exposure to violence while reducing access to safety and support ^{3,6-10}.

Violence and substance use can be mutually reinforcing, with people who use violence weaponising drugs, alcohol and dependence as tools of coercive control^{1,4,5,11}. This can include controlling access to substances, preventing treatment or support, facilitating violence or sexual assault, undermining women's credibility, and threatening disclosure to police, child protection authorities, family or services. Women also described navigating a "hierarchy of risk", in which seeking help could create new risks such as misidentification as the primary or predominant aggressor¹. Recognising these forms of coercion in the National Plan is critical to strengthening prevention and response services.

Importantly, violence against women who use drugs extends beyond DFSV. While current and former partners were commonly identified as people using violence, almost half of the women who inject drugs in our cohort study had experienced violence from a stranger and nearly one-third reported violence perpetrated by people who deal or use

drugs³. These findings highlight the need for prevention and response frameworks that recognise not only intimate partner violence and DFSV, but also the broader community violence used against these women.

Women who use substances, particularly those who are criminalised, frequently encounter stigma and discrimination and may be viewed as less credible because they do not fit dominant notions of the “perfect” or “ideal” victim¹². These biases contribute to women being disbelieved, blamed, excluded from services, and in some cases, misidentified as primary aggressor, particularly within policing, criminal legal and child protection systems^{1,13,14}. Without explicit commitment to understand and respond to the needs of these women in the National Plan, these systemic biases are likely to persist.

Recognising women who use illicit substances, particularly women who inject drugs, as a priority population would help ensure that national policies, funding, services and workforce development respond to the severity of violence experienced by this group and the specific barriers they face in accessing safety.

Recommendation 2: Address the unique barriers that prevent women who use drugs from seeking support

Many women who use illicit drugs, particularly women with histories of injecting drug use and criminalisation, do not access specialist violence services or formal support after victimisation. In our research, only around one-third sought some form of healthcare after assault (largely counselling and the emergency department), underscoring a critical disconnect between women experiencing violence and the systems intended and funded to support them³.

Women consistently described multiple barriers to seeking help from any service about the violence they have experienced^{1,3}. These included:

- stigma and discrimination related to their drug use, including concerns that they would be blamed for the violence, viewed as undeserving of support, or excluded from services;
- fear of child protection involvement and child removal;
- lack of trust in service providers and previous experiences of punitive, dismissive, or ineffective responses;
- fear of criminal legal penalties, including breaches of orders, parole revocation, or further criminalisation if drug use was identified;
- the burden of repeatedly recounting traumatic experiences across multiple services; and
- practical barriers such as housing instability, limited transport, and lack of access to a phone or phone credit.

These fears are well founded. Australian evidence demonstrates that women who use drugs often avoid seeking help because they fear increased scrutiny from child protection services and the possible removal of their children^{3,13,14}. Our research similarly found that women's reluctance to engage with services was grounded in previous experiences of seeking help that resulting in surveillance, punishment, or other unintended harms rather than safety and support¹.

Aligning the National Plan with harm minimisation principles would better support violence responses for women who use drugs. This would help specialist violence services respond to the realities of women's lives and encourage intersecting systems, including police, child protection and the criminal legal system, to adopt more evidence-informed and trauma-informed approaches. It would also support harm reduction services, such as needle and syringe programs, community healthcare, supervised injecting centres and drug treatment services, to respond to violence as part of the broader risks women face. Because these services are often trusted points of contact for women who inject drugs, investment in women-centred and peer-led models, including women-only harm reduction spaces with violence-response expertise, can improve safety, increase engagement and create opportunities for earlier intervention¹⁵.

Recommendation 3: Invest in multi-disciplinary responses to violence

Many violence support services and crisis accommodation programs remain difficult to access for women who use drugs, despite Australia's broader harm minimisation approach to drug use. Abstinence-based policies, criminalisation and policing of drug use, limited workforce capacity, and concerns about intoxication can exclude women from support. These barriers are compounded for women who are criminalised, for whom contact with police or statutory services may increase the risk of further criminalisation, incarceration or remand for non-violent offences^{14,16}.

In practice, many women who use drugs have more frequent contact with low-threshold health and harm reduction services than with specialist family violence services. Needle and syringe programs, community health services, opioid agonist treatment providers and outreach services are often trusted points of contact and, increasingly, are responding to disclosures of violence and immediate safety concerns. However, these services are rarely funded or resourced to provide comprehensive family violence responses, despite regularly supporting women experiencing active violence and coercive control. As can be seen in the following excerpt from a case study from an unidentified AOD service, where Sophie (pseudonym) is experiencing coercive control and has limited safety access points:

Sophie is a forty-three-year-old woman who presents with multiple co-occurring conditions and psychosocial challenges, including opiate dependence, chronic disease, chronic pain, post-traumatic stress disorder, and recurrent wound care needs associated with injecting drug use. At Sophie's initial orientation with the nurse, an ongoing and high-risk intimate partner family violence (IPFV) situation was identified.

Over the duration of Sophie's engagement at The Service, Sophie has identified several evidence-based high-risk factors in her IPFV situation. Consistent throughout Sophie's disclosures, are omnipresent and exhaustive tactics of coercive control and fear-based manipulation. This includes consistent and fixated attempts to be present and included in clinical consultations and treatment plans, an intense feeling of loss of control when Sophie engages with healthcare professionals alone, and psychological and emotional and financial abuse. Additionally, Sophie has disclosed that verbal abuse has transitioned to more frequent physical acts of violence, including the perpetrator shaking her violently by the scruff of her clothing. Sophie has also recently disclosed that the perpetrator has recommenced using methamphetamine, removed Sophie's access to transport, and is monitoring phone and internet use. ... Due to the level of coercive control, fear and violence experienced, Sophie has identified The Service and hospital emergency departments as her primary and only safety plan.

The Second Action Plan should prioritise integration between AOD services and the full range of services that support people where and when violence occurs. A “no wrong door” approach would allow women to access violence support regardless of where they first seek help, including through AOD or family violence services. This requires shared referral pathways, co-located services where appropriate, and workforce development across both sectors. Integration must also preserve trust, safety and accessibility by allowing service independence and avoiding unnecessary involvement of statutory systems.

Integration between violence and AOD services should also extend to people who use violence. AOD use are commonly present in family, domestic and sexual violence incidents and can contribute to the severity, frequency and complexity of violent behaviour¹⁷⁻¹⁹. However, as with abstinence-based policies for victim survivors, removing substances does not necessarily remove the risk of violence. AOD services

are often one of the few systems with regular contact with people who are at risk of using violence, placing them in a position to identify risk, support early engagement and facilitate referral to specialist perpetrator intervention programs^{20,21}.

AOD services are already responding to violence against women as trusted points of contact, but their role is not recognised within the National Plan. These access points as prevention has been reflected in the 2025 Report of the Rapid Review of Prevention Approaches and the Victorian Government's Royal Commission in Family Violence^{22,23}. However, a more explicit role for the AOD sector in the National Plan, with commensurate funding and workforce capacity building, could enhance coordination and connections in the existing system. Strengthening partnerships between AOD services, family violence services and perpetrator intervention programs, where men who use drugs are often excluded, could support earlier intervention and more comprehensive responses. Because evidence on integrated responses for people who use violence remains limited, future policy should be informed by dedicated evaluation and implementation research.

Recommendation 4: Address substance use and criminalisation stigma and challenge narratives that exclude women who use drugs from being recognised as legitimate victim survivors.

Stigma associated with alcohol and other drug use remains a major barrier to preventing and responding to violence against women. Women who use illicit substances frequently encounter judgement and discrimination across healthcare, family violence, social services, child protection, policing and criminal legal systems^{15,24-29}. These experiences shape whether women feel safe seeking help, the quality of support they receive, and whether their experiences are recognised within violence prevention frameworks such as the National Plan³⁰.

Recent Australian research highlights the extent of stigma experienced by people who inject drugs, with 78% reporting injecting-related stigma in the previous 12 months and 71% reporting negative treatment from healthcare workers²⁹. Many delayed care, withheld information about drug use, missed follow-up appointments or sought care elsewhere because of stigma and discrimination. Our research similarly found that women avoided seeking support after violence because they anticipated judgement, disbelief, inferior care or punitive responses such as child removal^{1,3}. These concerns can delay testing, disclosure and treatment, contributing to poorer health outcomes and greater health-system costs³¹⁻³³.

Stigma towards women who use drugs is often reinforced by ideas of the “perfect” or “ideal” victim³⁴. Women who experience violence are frequently expected to conform to social expectations of innocence, respectability and vulnerability before their experiences are recognised as legitimate³⁴. Women who use drugs are often perceived

as holding a lot of the responsibility for the harms they experience, making them more likely to be disbelieved, treated punitively or feel discouraged from seeking and staying connected with support services¹.

Stigma informs the policing that women who use drugs experience and these attitudes have serious consequences for safety and justice¹. Emerging Australian evidence suggests that women who use substances may be at increased risk of being misidentified by police as primary or predominant aggressors rather than victim survivors¹⁴, particularly where violence, substance use, trauma and child protection involvement intersect. This can criminalise women seeking help, intensify existing criminalisation and undermine future trust in services. Our own research with criminalised women highlighted such experiences¹:

“It’s a white male system, so white males are taken aside and questioned and if they say ‘oh she started it’ well, then, they’re believed, because when police turn up it’s usually the female that’s like... all flustered and, you know, maybe screaming... because she’s been abused... the male will often calm down straight away... and she’s just a drug user and she’s just a menace and all the rest of it.”

“‘This person is presenting or looking like they are heightened or unhinged or upset or confused and so I’ll just call them a perpetrator and charge them. My job here is done. I don’t need to look into anything further.’ It’s just really lazy policing.”

Such responses can further entrench disadvantage, discourage future help-seeking and leave women exposed to ongoing violence. Women report never really recovering from these experiences as their criminal record follows them throughout their lives¹.

We strongly support measures in the Second Action Plan that address stigma, discrimination and misogynistic narratives towards women who experience violence. The Plan should explicitly recognise the intersecting stigma experienced by women who use illicit substances and those who are additionally criminalised, who are often judged against narrow ideas of the “perfect victim” and may be misidentified, disbelieved, arrested, stripped of access to housing and children, criminalised or treated punitively when seeking support. Women who use drugs cannot benefit from family violence, health, housing or justice responses if they anticipate judgement, punishment, child removal or further violence as a consequence of help-seeking.

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