

Response to The National Plan to End Violence against Women and Children 2022-2032

July 2026

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non-government alcohol and other drugs sector in NSW. We represent 93 organisational members that provide services in over 150 locations across NSW, employing over 1,000 staff. They provide a broad range of services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Together, we improve the health and wellbeing of people who use, or have used, alcohol and other drugs across the NSW community.

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ABOUT NADA

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for non-government alcohol and other drug (AOD) services in NSW. We lead, strengthen and advocate for the sector. Our decisions and actions are informed by our members' experiences, knowledge, and concerns.

We represent over 90 organisational members that provide services in over 150 locations across NSW, employing over 1,000 staff. Our members are diverse in their structure, philosophy, and approach to service delivery. They provide a broad range of alcohol and other drugs services, including health promotion and harm reduction, early intervention, treatment and continuing care programs.

We provide a range of programs and services that focus on sector and workforce development, data management, governance and management support, research and evaluation, sector representation and advocacy, and actively contribute to public health policy.

Together, we improve the health and well-being of people with living and lived experience of alcohol or other drug use across the NSW community.

NADA has award-level accreditation as reviewed by Quality Innovation and Performance (QIP), under the Australian Service Excellence Standards (ASES).

To learn more, visit www.nada.org.au.

PREPARATION OF THIS SUBMISSION

This submission is informed by consultation with the NSW NGO alcohol and other drugs (AOD) sector.

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Response to the National Plan to End Violence against Women and Children 2022-2032 Consultation Questions

Alcohol and other drug (AOD) use does not cause domestic, family and sexual violence (DFSV). However, substance use frequently intersects with violence, coercive control, trauma and social disadvantage. As a result, the AOD sector is uniquely positioned to identify risk, support victim-survivors, engage people who use violence and contribute to integrated, whole-of-system responses.

Key Messages

1. **Integrated responses are essential.** Women and children affected by DFSV often experience intersecting issues including substance dependence, homelessness, mental health, child protection involvement and justice system contact. Governments should invest in integrated, multidisciplinary and person-centred service models.
2. **The AOD sector is a critical but underutilised part of the DFSV response system.** Both victim-survivors and people who use violence regularly access AOD services, creating significant opportunities for earlier identification, intervention, risk assessment and referral.
3. **Workforce development and cross-sector capability building are urgently needed.** Comprehensive DFSV, trauma-informed care and AOD training should be embedded across health, AOD, child protection, housing, justice and specialist DFSV services.
4. **Women with multiple needs require greater access to housing and family-inclusive treatment.** Investment is needed in gender responsive services that support women alongside their children, particularly residential treatment, withdrawal management and post-crisis recovery supports.
5. **Stronger focus is required on Aboriginal women, women leaving custody, and children experiencing both DFSV and parental substance use.** These cohorts face significant barriers to accessing coordinated, culturally safe and effective support.

Priority Area 1: Victim-Survivors

- 1.1 What service or system responses would make the biggest difference to victim-survivors' safety, wellbeing, healing and recovery?
- 1.2 What helps people access support earlier, and what barriers prevent people from seeking help or engaging with systems and services?
- 1.3 What current or emerging issues should the Second Action Plan address, including in relation to coercive control and technology-facilitated abuse?
- 1.4 What gaps remain in addressing the needs of diverse communities, including Aboriginal and Torres Strait Islander people?

NADA Position:

1.1 Improved integration across services and systems is essential to strengthening victim-survivors' safety, wellbeing, healing and recovery, particularly for women experiencing multiple and intersecting forms of system involvement. A coordinated, person-centred response would better address the full range of an individual's needs and reduce the burden of navigating fragmented service systems.

[Recommendation 1.5](#) from the 2024 NSW Drug Summit provides a clear basis for appropriately funding integrated health and social service models that respond to clients' co-occurring needs. While integrated care models exist, there are further opportunities to strengthen connections between health and social services, including primary care, child protection, housing, justice, disability, domestic and family violence, and neglect services. The commitment to invest in and build on successful multi-agency and multidisciplinary models should be progressed in ways that place the person's needs at the centre, support collaborative and coordinated practice, and reduce the barriers created by complex system navigation.

Increased access to safe, stable and affordable housing for women and children is critical to improving safety and recovery outcomes. Housing insecurity can increase vulnerability to violence, constrain choices, and limit the practical options available to victim-survivors seeking safety and long-term recovery.

Longer-term, recovery-focused support beyond crisis intervention is needed to promote sustained safety and wellbeing. Recovery commonly requires coordinated responses to trauma, substance dependence, parenting, mental health, housing, social connection and other factors that influence a person's capacity to heal and rebuild their life.

The availability of **services that can support women alongside their children should be expanded**, recognising that safety, recovery, parenting and family reunification are closely connected. There are currently seven residential AOD programs in NSW that can provide treatment for women and their children. These services are predominately in Sydney, unable to respond to the demand and women currently experience significant wait times to access services. Further investment is required to increase options for women with children, including those accessing withdrawal management, so that safety is prioritised and treatment is coordinated across relevant systems.

1.2 Survivor healing and recovery are significantly strengthened when experiences of DFSV are identified and addressed as part of responses to substance use. **Integrated and co-located DFSV and AOD service models** have proven to support more timely identification, coordinated care and safer pathways to recovery.

Women are more likely to seek and remain engaged with support when services are trauma-informed, non-judgemental, culturally safe and focused on building trust and respectful relationships. Fear of child protection involvement, including the possibility of child removal, remains a significant barrier to disclosure and help-seeking, particularly for women who are parenting, pregnant or experiencing substance dependence.

International and Australian sector data indicate that between 41% and 80% of women in AOD programs have a history of experiencing DFV¹. Anecdotally, data from NSW women only residential services indicate this can be as high as 90% of women accessing treatment.

Gender shapes patterns of substance use, including initiation, access, consumption, experiences of dependence, AOD-related risk behaviours and treatment outcomes. Gender-responsive treatment has been shown to reduce barriers and improve outcomes, as outlined in the practice guide, [NADA Working with Women Engaged in AOD Treatment](#).

Stigma associated with AOD use can prevent women from disclosing violence or seeking support, delaying access to services and increasing the level and duration of harm. Many women first disclose domestic and family violence to a GP, health professional, AOD worker or other frontline worker. **Strengthening AOD workforce capability to identify DFSV**, document concerns and facilitate referrals to appropriate supports helps reduce stigma and improve access to timely and appropriate care.

[Recommendation 4.1](#) from the NSW Drug Summit highlights the need for all health professionals receive AOD education and training that includes trauma-informed care and addresses stigma and discrimination. AOD service delivery is underpinned by clinical care standards and a [Care Charter](#), which recognise the impacts of stigma and discrimination and the importance of trauma-informed, person-centred care. These documents provide an important foundation for sector training and capability development.

Practical barriers, including housing instability, transport limitations, childcare responsibilities, financial hardship and complex service systems, can further prevent women from accessing support and sustaining engagement with services.

- 1.3** Coercive control remains a significant concern for women presenting to AOD services and may manifest through financial abuse, social isolation, surveillance, threats relating to children, and continued intimidation following separation.

People who use violence may also misuse legal processes, parenting arrangements, child protection reports and other service systems to perpetuate patterns of coercion and control after a relationship has ended. One of the clearest findings from the NSW Coroner into the murder of Lilie James found that risk does not end when a relationship ends (ANROWS). Post-separation abuse can escalate quickly, through coercive control and technology-facilitated harassment.

Technology-facilitated abuse is increasingly reported by women accessing AOD services. **Frontline workers, police and justice agencies require targeted training** to identify these behaviours, support women to document concerns, and provide effective, coordinated responses.

The Second Action Plan should give greater attention to women during periods of heightened vulnerability, including pregnancy, early parenting and transition from custody to community,

¹ Nicholas, R., White, M., Roche, AM., Gruenert, S. & Lee, N. (2012). Breaking the Silence: Addressing family and domestic violence problems in alcohol and other drug treatment practice in Australia. National Centre for Education and Training on Addiction (NCETA). Flinders University, Adelaide, SA.

when risks of violence, homelessness, substance use relapse and social isolation may be elevated. According to the AIHW, 1 in 7 women who experienced violence by a current partner and were pregnant during the relationship, experience violence during their pregnancy.

1.4 Women experiencing DFSV alongside substance dependence, homelessness, child protection involvement and contact with the criminal justice system continue to face significant gaps in coordinated, accessible and trauma-informed support. These intersecting needs increase the risk that women will fall between service systems, particularly where eligibility criteria, referral pathways and information-sharing arrangements are fragmented or poorly aligned. Women leaving custody remain an under-recognised cohort with high and complex support needs, including heightened vulnerability to violence, homelessness, substance use relapse, child protection involvement and social isolation. A significant service gap remains at the point of transition from custody to community, when risks are often acute and access to coordinated housing, AOD treatment, DFSV support, health care and family services may be limited or delayed. Stansfield et al (2020) reviews literature confirming risk is heightened post-release from custody.²

Aboriginal and Torres Strait Islander women continue to experience unmet needs and systemic barriers when engaging with statutory and mainstream service systems, including concerns about racism, previous negative service experiences, and fear of child removal. These barriers can prevent earlier disclosure, reduce trust in services, and limit sustained engagement. The Second Action Plan should **prioritise culturally safe, community-controlled and strengths-based responses** that address these gaps, support earlier access to treatment and safety, and improve continuity of care across AOD, DFSV, housing, child protection and justice systems.

Priority Area 2: Prevention and Early Intervention

2.1 What would make the biggest difference in preventing and ultimately ending violence?

2.2 How can existing efforts to prevent violence be strengthened or built upon at the individual, community, organisational, institutional and societal levels?

2.3 How can governments, communities, schools, workplaces, online platforms and others better support people to recognise and respond to harmful attitudes and behaviours?

2.4 What prevention and early intervention approaches appear most promising or effective, and what is needed to strengthen or expand them?

2.5 What emerging issues should the Second Action Plan address in relation to primary prevention and early intervention?

NADA Position:

2.1 DFSV screening through AOD services should be prioritised as a key mechanism for earlier identification and response. Routine screening is already undertaken in specialist women's

² Stansfield, Richard & Semenza, Daniel & Napolitano, Laura & Gaston, Melanie & Coleman, Megan & Diaz, Maria. (2020). The Risk of Family Violence After Incarceration: An Integrative Review. *Trauma, Violence, & Abuse*. 23. 476-489. 10.1177/1524838020957986.

services and should be strengthened across AOD settings to support consistent identification of domestic, family and sexual violence, including risk associated with people who use violence. Consideration should be given to approaches such as the [MARAM](#) framework in Victoria, alongside existing NSW Health requirements for Domestic Violence Routine Screening across Local Health District AOD services for women over the age of 16.

2.2 Earlier access to coordinated treatment and support for the whole family should be prioritised when conflict first emerges. Where appropriate, stronger coordination between AOD services, services working with people who use violence, and specialist DFSV services would support earlier intervention, improve risk identification and strengthen safety for victim-survivors and children.

Research indicates that children living with DFSV, parental substance use, or both, are at increased risk of experiencing violence, using violence in adulthood, and developing patterns of harmful substance use. This cohort should therefore be recognised as a priority group for secondary intervention, with support available before harms escalate or before children and young people later present to AOD services.

Priority Area 3: Children and young people in their own right

3.1 What would make the biggest difference to improving safety, recovery and wellbeing outcomes for children and young people affected by this violence?

3.2 How can governments, services, education settings, families, communities and others better recognise and respond to children and young people experiencing violence or harm?

3.3 What approaches are most effective in supporting children and young people who are using violence or displaying harmful sexual behaviours to take accountability, change behaviours, and reduce harm?

3.4 How should the Second Action Plan respond to current or emerging forms of harm affecting children and young people, including technology-facilitated abuse, harmful online content, and violence within peer and dating relationships?

3.5 How can children and young people be meaningfully involved in shaping the policies, programs and services that affect them?

NADA Position

3.2 Strengthen ongoing education in schools by embedding age-appropriate, evidence-informed and continuous learning about respectful relationships, personal safety, healthy communication, consent, social cohesion and positive conflict resolution. Single-session education is unlikely to achieve sustained attitudinal or behavioural change. Consistent learning across the school years can support children and young people to develop respectful attitudes, recognise harmful behaviours and build the skills needed for safe and healthy relationships from an early age.

Increase funding for youth facilities and community-based youth programs that provide safe, structured and accessible environments outside school hours. Young people benefit from positive social connection, mentoring, recreation and community engagement in settings that are free from violence, substance-related harms and other unsafe influences. These spaces can contribute to modelling healthy relationships, strengthening resilience and fostering belonging.

Reduced investment in youth services, particularly in rural and regional areas, has contributed to increased isolation and reduced access to early intervention supports for young people.

Expand access to alcohol and other drug treatment for young people in both community-based and residential withdrawal and rehabilitation settings. Timely access to assessment, treatment, withdrawal management, rehabilitation and longer-term recovery supports can reduce the impacts of harmful substance use on children, young people, families and communities. Given the relationship between substance use and the severity of DFSV, greater investment in prevention, treatment and recovery services should form part of a comprehensive early intervention strategy.

Promote a coordinated community response that connects schools, youth services, health providers, family support services and specialist DFSV services. Strengthened local coordination would support earlier identification of risk, improve referral pathways and ensure children, young people and families can access appropriate supports before risks escalate.

3.3 Ensure inclusive, safe and purposeful participation of children and young people in policy and service design through age-appropriate mechanisms such as youth forums, workshops, peer-led discussions, youth advisory groups and youth peak bodies. Participation should be ongoing, supported and meaningful, with young people engaged as genuine co-design partners rather than consulted only at isolated points. Barriers to participation should be addressed through practical supports such as transport, technology access, flexible scheduling and culturally safe engagement. This approach is consistent with the NSW Government's commitment under Recommendation 6.1 of the Drug Summit to embed co-design principles in newly funded or expanded youth services.

Priority Area 4: People who use violence

4.1 What would make the biggest difference in preventing and responding earlier to the use of violence?

4.2 How can services, families, communities, workplaces, institutions and others better recognise and respond safely to people using violence or at risk of using violence?

4.3 What approaches are most effective in supporting people who use violence to take accountability, change behaviours, and reduce the use of violence, while focusing on victim-survivor safety?

4.4 How can governments and services, among others, strengthen culturally safe, accessible and evidence-informed responses for a range of communities and cohorts?

NADA Position

Evidence indicates that a significant proportion of men presenting to AOD services have used domestic, family and sexual violence, or sexual violence outside the context of intimate relationships. International studies suggest that approximately 30–40% of men participating in AOD interventions report such behaviours. This underscores the importance of recognising AOD treatment settings as a key point of engagement with people who use violence, as highlighted in the [NADA Practice Resource, *Engaging Men who perpetrate domestic and family violence in alcohol and other drugs treatment context*](#). Given the scale and complexity of this issue, a broader and more sustained

investment is required to support comprehensive, coordinated and evidence-informed approaches across the continuum of intervention.

4.1 Consistent screening and identification of people who use violence should be embedded across AOD, corrections, health and related service settings to support earlier identification, safer intervention and coordinated referral pathways. This should include screening for DFSV risk prior to release from custody, strengthened post-custodial programs, and consistent transfer-of-care processes that identify violence-related risk and connect people to appropriate behaviour-change, AOD and specialist DFSV responses. Embedding cross-sector protocols and practice guidance would strengthen AOD sector capacity and ensure risk is identified and managed more consistently across systems.

Community awareness and education should be strengthened to improve community-level recognition of behaviours associated with DFSV, coercive control and patterns of harm. Locally led and culturally grounded approaches are particularly important, including Aboriginal community-led education and practice approaches that support workers, families and communities to recognise risk and respond safely.

Targeted workforce development is required to address specific skills gaps across AOD, DFSV, corrections, justice and related service systems. Priority areas include non-collusive engagement, groupwork skills, understanding selective empathy, recognising risk, responding to Apprehended Domestic Violence Orders, and applying relevant legislative provisions including sections 13A and 16A. Strengthened understanding of information sharing, legal obligations and cross-system risk management is essential to improving safety for victim-survivors and children.

Joint cross-sector training should be expanded so that AOD and DFSV workforces have a shared understanding of substance use, DFSV risk, accountability, safety planning and referral pathways. While specialist consultation will remain necessary in complex and high-risk matters, a common baseline of knowledge would support safer, more consistent and more coordinated responses.

4.2 AOD services routinely engage with people who use violence and should be a component of Australia's response to DFSV. This includes individuals whose substance use, mental health, housing insecurity, criminal justice involvement and family circumstances may intersect with patterns of coercion, control and harm. With appropriate investment, practice guidance and specialist partnerships, AOD services can play a more systematic role in early identification, risk management, safety planning and accountability, while remaining within their clinical scope and working alongside specialist DFSV services.

Within AOD settings, this role may include structured, assessment-informed conversations with clients about their use of DFSV, not as a substitute for specialist behaviour change intervention, but to better understand the risk posed to family members and the relationship between violence, substance use and treatment goals.

AOD services can also incorporate identified DFSV risks into case planning and goal-setting processes, supported by secondary consultation with specialist DFSV practitioners, men's behaviour change providers, child protection, community corrections and other relevant services.

This includes prioritising immediate and short-term safety planning where a client's behaviour presents risk to family members, supporting violence-interruption strategies, and encouraging compliance with protection orders or other court-imposed conditions designed to promote safety.

Where clients are participating in men's behaviour change programs, AOD services can contribute to coordinated practice by liaising with program providers so that substance use, violence-related risk and accountability goals are understood and managed consistently across services.

More broadly, AOD services can contribute to collaborative risk assessment, safety planning, accountability planning and coordinated risk-management activities that reduce opportunities for further harm.

Realising this contribution requires dedicated investment in cross-sector integration, specialist consultation pathways, workforce capability and governance arrangements that formally recognise AOD services as part of the national DFSV response architecture.

- 4.3** Effective responses to people who use violence must address accountability while also recognising dynamic risk factors that can affect a person's capacity to choose non-violence, including substance use, mental health, housing insecurity, gambling harm, limited education and employment opportunities, and financial precarity. Evidence-informed practice should support people who use violence to take responsibility for their behaviour through non-collusive engagement, selective empathy, values-based reflection, safety planning and structured behaviour-change pathways. Increased investment is required to expand access to programs that build skills, strengthen accountability and operate alongside men's behaviour change programs, AOD treatment and specialist DFSV responses.
- 4.4** Governments can strengthen culturally safe, accessible and evidence-informed responses by investing in Aboriginal community-controlled approaches, strengthening governance arrangements, building cultural capability across mainstream services, and increasing Aboriginal workforce participation across AOD, DFSV, justice and related systems. These actions are necessary to ensure responses to people who use violence are locally appropriate, accountable, culturally safe and connected to broader family and community safety outcomes.

Priority Area 5: System Integration and Workforce

5.1 What would make the biggest difference in creating a more coordinated and connected system response for people affected by violence against women and children and other forms of gender-based violence and people using violence?

5.2 What workforce capabilities, supports, or conditions are most needed to strengthen prevention, early intervention, response and recovery?

5.3 What approaches or models appear most effective in improving collaboration, coordination and information sharing across services, systems and programs?

5.4 What supports do specialist and universal services need to provide inclusive, accessible and response services?

5.5 What evidence, workforce or system gaps should the Second Action Plan prioritise to strengthen implementation and improve outcomes over time?

NADA Position

AOD services are an essential part of a coordinated national response to DFSV, given their regular engagement with both victim-survivors and people who use violence. The intersection between substance use, trauma, coercive control, mental health, child protection, housing insecurity and justice system contact means that AOD services are often positioned at critical points of identification, intervention and referral. However, their contribution remains under-recognised within broader DFSV system architecture.

Approximately two-thirds of people accessing AOD services are male, and a proportion of these clients will have used violence. This creates an important opportunity for AOD services to identify and respond to DFSV risk as part of routine clinical practice, rather than limiting attention to victim-survivors alone. National AOD workforce development recommendations, including those developed by NCETA, reinforce the need to build AOD worker capability to raise DFSV safely, undertake screening and assessment, recognise risk, support safety planning and make appropriate referrals.

5.1 Specialist cross-sector advisory roles should be embedded across service systems to support integrated practice, strengthen consultation pathways and ensure there is no wrong door for people seeking support. This requires AOD specialist advisors within DFSV organisations and programs, as well as DFSV specialist advisors available to AOD services. Existing models, including Principal Strategic Practice roles funded by Family Safety Victoria to provide specialist family violence consultation to substance use and mental health services, demonstrate the value of formalised advisory roles in strengthening capability, improving risk recognition and supporting coordinated responses across sectors.

5.2 Cross-sector training and capability building are required to establish shared language, knowledge and practice expectations across AOD, DFSV, mental health, child protection, justice and related systems. Consultation with the NSW AOD sector identified the need for intersectional practice frameworks that address the relationship between AOD use, mental health, child protection involvement and the impacts of violence. Ongoing investment is also required for clinical supervision, reflective practice and workforce wellbeing supports to reduce vicarious trauma and sustain safe, high-quality practice across both specialist and universal workforces.

5.3 [Recommendation 3.4](#) from the NSW Drug Summit provides a relevant policy foundation for expanding learning and development across the AOD, child protection, mental health and domestic and family violence sectors. The NSW Government has recognised that cross-sector learning is an important enabler of integrated care, particularly for children and families with complex needs. A sustained focus on the intersections between mental health, violence, abuse, neglect and AOD use would support earlier engagement in treatment and improve the capacity of services to keep children and families safe and connected. Continued investment is required

to strengthen partnerships, create shared learning opportunities and build consistent cross-sector understanding of child and family needs in the context of parental substance use and DFSV.

Men's behaviour change programs and programs for fathers who use violence, including models such as Caring Dads, frequently require access to specialist AOD expertise. A more integrated system would support coordinated responses across sectors, including through co-location, secondary consultation and stepped models of care for people who use violence. AOD services can contribute to risk reduction by addressing substance use within the context of DFSV, supporting accountability goals and strengthening coordinated practice with specialist behaviour-change and DFSV services.

Priority Recommendations

Drawing on the issues identified across the priority areas, NADA recommends a coordinated package of reforms that recognises AOD services as an essential partner in Australia's response to DFSV. These recommendations focus on strengthening integrated service responses, improving early identification and risk management, expanding recovery-oriented supports for women and children, and building the cross-sector workforce capability required to deliver safe, culturally responsive and accountable practice.

Recommendation 1 Fund integrated AOD, DFSV, mental health, housing, child protection and justice responses that provide coordinated, person-centred support for people with complex needs.

Recommendation 2 Expand access to safe, stable and affordable housing for women and children experiencing violence, including women leaving custody, with housing linked to coordinated recovery, AOD treatment, DFSV services, health care and family support.

Recommendation 3 Increase investment in family-inclusive AOD treatment services, including residential treatment and withdrawal management programs that allow women to remain with their children.

Recommendation 4 Embed routine DFSV screening, risk assessment and referral pathways across AOD services, supported by nationally consistent practice frameworks and workforce training.

Recommendation 5 Establish specialist cross-sector advisory roles and co-located service models to strengthen collaboration between AOD, DFSV, child protection, mental health and justice services.

Recommendation 6 Invest in workforce development across sectors, including training on DFSV, coercive control, technology-facilitated abuse, trauma-informed practice, cultural safety and responding to people who use violence.

Recommendation 7 Strengthen early intervention for children and young people through school-based respectful relationships education, youth services and increased access to youth AOD treatment and support.

Recommendation 8 Improve responses for people who use violence by strengthening identification, assessment, behaviour-change pathways and coordinated risk management across AOD, Community Corrections and specialist DFSV services.

Recommendation 9 Prioritise culturally safe, Aboriginal community-controlled responses and increase Aboriginal workforce participation across AOD and DFSV systems.