



Submission

Second Action Plan to End Violence Against Women and Children 2022-2032

Date: 31 July, 2026

Our Commitment to First Nations Wellbeing, Culture, and Self-Determination

We stand in strong support of First Nations Australians, affirming their inherent right to self-determination, cultural preservation, and sovereignty over their land and traditions. We acknowledge that for First Nations peoples, mental health is inseparable from cultural, emotional, physical, and spiritual wellbeing—a holistic understanding maintained through tens of thousands of years of continuous culture.

The Gayaa Dhuwi (Proud Spirit) Declaration Framework and Implementation Plan, launched in Meanjin/Magandjin (Brisbane) on the lands of the Turrbal and Yuggera/Jagera peoples where our office stands, provides a crucial 10-year roadmap. QAMH fully endorses this community-led approach to integrating First Nations leadership, cultural knowledge systems, and healing practices into Australian mental health frameworks.

QAMH is committed to supporting truth-telling as a process of acknowledging the histories, lived experiences, and ongoing strengths of First Nations peoples, particularly in the context of mental health. By confronting the impacts of colonisation, intergenerational trauma, and ongoing systemic injustices, we can better address the historical and contemporary factors affecting the mental wellbeing of First Nations individuals and communities.

In this submission, we emphasise the importance of holistic and healing approaches to mental health that incorporate the cultural knowledges, connection to Country, and spiritual practices of First Nations peoples. We are dedicated to ensuring that the principles of self-determination, cultural safety, truth-telling, and holistic health are central to the mental health initiatives and recommendations we propose. Our goal is to help build a future where mental health systems respect and respond to the unique needs and strengths of First Nations Australians.

Acknowledgement of Country



QAMH acknowledges and pays deep respect to Aboriginal and Torres Strait Islander peoples as the Traditional Custodians of the lands and waters across Australia. We honour their Elders past and present, whose knowledge, leadership, and cultural practices have sustained these lands for millennia.

Who is QAMH?

The Queensland Alliance for Mental Health (QAMH) is the peak body for community-based mental health and wellbeing services delivered by non-government organisations (NGOs) in Queensland. We represent more than 146 members and stakeholders, involved in the delivery of these services.

Our purpose is to strengthen, promote, and advocate for community-based mental health and wellbeing service delivery for all Queenslanders, through direct engagement with our members, collaboration with government and statutory bodies, and active participation in policy reform at state and national levels.

QAMH maintains a formal collaboration with Community Mental Health Australia and contributes to the work of Mental Health Australia. We also work with both the National and Queensland Mental Health Commissions.

Our membership gives us direct insight into the experience of people living with mental health challenges, their families, carers, and kin, and the organisations that support them.

Recognition of Lived and Living Experience and Expertise

QAMH honours and affirms the lived and living experience of those who have experienced mental health and wellbeing challenges, suicide, and alcohol and other drug use, and the essential contributions they make to the community mental health sector. We equally recognise the lived and living experience of family, carers, and kin, acknowledging their unique perspectives and contributions.

We acknowledge the courage and strength of those who bring their Lived and Living Expertise into professional spaces and affirm that expertise as an essential foundation for a responsive, effective, and human-centred sector.

Throughout this submission, we use the term "lived and living experience" to reflect that mental health challenges are often ongoing rather than historical, and "Lived and Living Expertise" where we refer to the knowledge, skills and insights that people develop through that experience. Both terms recognise that experiential knowledge is a genuine and valuable form of expertise, not simply a personal characteristic.

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Definitions

Psychosocial supports are non-clinical, trauma-informed, recovery-oriented services that support people experiencing mental health challenges to live independently and safely in the community. They enable people to stay well, avoid crisis and participate in community life. By strengthening wellbeing and social participation, they also reduce pressure on hospitals and emergency services, making them a cornerstone of a sustainable mental health system.

Community-Based Mental Health Services

This sector occupies a unique and critical position within the broader mental health system. These services address the complex realities of distress shaped by trauma, poverty, isolation and other social determinants, providing practical support with housing, relationships, employment and social inclusion. These services are critical for:

- People who are eligible for the NDIS and those who are not
- Individuals facing barriers to accessing mainstream mental health services
- People whose needs are significant but not primarily clinical.

Recovery is the person's journey and outcome.

Psychosocial support is the service or intervention that helps enable recovery.

Introduction

Queensland Alliance for Mental Health welcomes the opportunity to provide feedback on the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032.

Community-based mental health services delivered by NGOs are an important partner in achieving the objectives of the National Plan, but one that is not yet consistently recognised or embedded within Domestic, Family and Sexual Violence (DFS) responses. People affected by DFS present to our services with the psychological, social, and functional impacts of trauma. The Second Action Plan provides an opportunity to strengthen this role by embedding long-term psychosocial support, early identification, and integration between the community-based mental health sector and specialist DFS services.

Accordingly, rather than addressing every aspect of the National Plan, this submission focuses on the areas where community-based mental health services can add the greatest value to improving outcomes for victim-survivors. QAMH understands that recovery from violence is rarely linear, and that support needs often continue well after the crisis has passed, requiring coordinated, flexible, rights-based, and person-led care. This contribution is one part of a broader, integrated response that also relies on effective collaboration with police, child protection, corrections, housing and specialist DFS services.

Priority Area 1: Victim Survivors

Consultation Question

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

1.1 Recognising recovery as more than crisis response

The National Plan identifies recovery and healing as integral to Australia's response to DFSV, recognising that recovery is often difficult and long-term, extending well beyond the immediate crisis, with many victim-survivors requiring dedicated and tailored support over time.¹ Consistent with this, the Productivity Commission identifies psychosocial support as a key facilitator of recovery, helping people build social connections, maintain housing, develop daily living skills, and participate in community.² Community-based mental health services are well placed to provide this support as a complement to specialist DFSV services, offering ongoing, recovery-oriented care that helps people rebuild confidence, strengthen relationships and reconnect with their communities as they recover and rebuild their lives.

Long-term psychosocial support is not consistently recognised within service pathways or funding models. Crisis responses remain essential, but they should connect people into flexible, recovery-oriented support that lasts as long as it is needed. As the Productivity Commission observes, psychosocial supports play "a vital role in enabling those living with mental illness to live well, to recover in their communities" and empower people to achieve "independence, increase control over daily life, and promote self-determination" (Mental Health, Productivity Commission Inquiry Report Volume 3, p. 831).

The Second Action Plan should explicitly recognise the role of long-term, recovery-oriented psychosocial support in helping victim-survivors recover and heal beyond the immediate crisis period.

1.2 Community-based mental health services as a trusted point of support

Evidence shows that trust, continuity of care, empathy and positive relationships with practitioners are among the strongest facilitators of disclosure,³ the very conditions that relationship-based, recovery-oriented community-based mental health services are structured to build. For many victim-survivors, these services are also a low-barrier and non-stigmatising point of contact, one that does not require a person to name their experience as DFSV before support can begin.

Some people disclose only once they feel safe and ready, often well into an existing support relationship and long after they first presented for anxiety, depression or distress. Others are already engaged with community-based mental health services when violence occurs, or while receiving support from specialist DFSV services.

Recognising community-based mental health as an integral partner in the broader service system would strengthen coordination and ensure victim-survivors get timely access to specialist support when they need it, alongside the ongoing psychosocial support that recovery depends on.

1.3 Recognising violence as the driver of mental distress

People affected by DFSV frequently present with anxiety, depression,⁴ psychological distress, self-harm or suicidality.^{5,6} These responses are real and often need support, but reading them only as mental ill-health risks missing the violence driving them. Without recognising DFSV as a possible underlying cause, an understandable response to trauma can be treated as a condition to manage rather than a signal that harm may still be happening.⁷

This is particularly relevant in the context of coercive control and technology-facilitated abuse, where patterns of harm may be cumulative, difficult to identify and not immediately recognised by either the person experiencing violence or the services supporting them.

Strengthening the capability of community-based mental health practitioners to recognise the mental health dimensions of DFSV would support earlier identification, safer responses and clearer pathways to specialist services.

Recommendation 1

The Second Action Plan should embed community-based mental health as a core partner in recovery and healing by:

- recognising long-term, recovery-oriented psychosocial support as a part of the DFSV service response, available to victim-survivors well beyond the crisis period,
- establishing referral and shared-care arrangements between specialist DFSV services and community-based mental health services, so people move between them without falling through the gap,
- building practitioner capability to recognise when a person's distress may stem from violence, including coercive control and technology-facilitated abuse, the forms hardest to see,
- resourcing community-based mental health practitioners to contribute safely to existing risk assessment processes and cross-agency information-sharing arrangements, so relevant information keeps pace with a person's circumstances.

Priority Area 2- Prevention and Early Intervention

Consultation Question

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

Community-based mental health is not primary prevention, and this submission does not claim it to be. Its contribution to this priority area is early intervention: recognising DFSV sooner, responding safely, and connecting people to specialist support before harm escalates and before crisis becomes the only remaining option. Primary prevention initiatives remain critical to reducing DFSV, and community-based mental health works best alongside them, not in their place.

2.1 Earlier recognition through community-based mental health

The Second Action Plan provides an opportunity to strengthen prevention and early intervention by supporting the earlier identification of DFSV and connecting people with appropriate support before their needs escalate. While specialist DFSV and justice responses remain essential, community-based mental health services also have an important role in recognising violence earlier and facilitating timely access to specialist support.

2.2 Recognising intersecting circumstances

Community-based mental health services routinely support people experiencing complex and intersecting challenges, including housing instability, financial hardship, substance use and social isolation. While these circumstances do not cause DFSV, they can increase vulnerability, influence help-seeking, and complicate recovery. Considering these broader circumstances enables practitioners to recognise when violence may be contributing to a person's experience and respond in a safe, coordinated and trauma-informed way.

Supporting community-based mental health services to recognise DFSV across the whole system would strengthen prevention and early intervention.

Recommendation 2

The Second Action Plan should position community-based mental health services within its early intervention response by:

- building practitioner capability to respond safely when someone discloses, and to act on early signs before a situation escalates,

- establishing formal referral secondary consultation arrangements between community-based mental health and specialist DFSV services,
- resourcing early intervention so people can be connected to specialist support before their situation escalates to crisis.

Priority Area 5 – System Integration and Workforce

QAMH supports the proposed Priority Area on system integration and workforce. Safe and effective responses across prevention, early intervention, recovery and healing require an integrated service system supported by a connected and capable workforce. From the perspective of community-based mental health, the Second Action Plan provides an opportunity to strengthen how services work together, build workforce capability and create funding arrangements that support coordinated, person-centred care.

5.1 Coordinating services across sectors

The National Plan identifies clearly established referral pathways, coordination and integration across sectors as essential features of a person-centred service system. The Second Action Plan should explicitly include community-based mental health within these arrangements to strengthen continuity of care and improve access to coordinated support for victim-survivors.

Community-based mental health services support people alongside specialist DFSV services. However, collaboration is often dependent on local relationships rather than formal expectations or system design. This can result in inconsistent referral pathways, limited opportunities for secondary consultation and fragmented care.

Establishing formal collaboration, referral and consultation mechanisms between community-based mental health and specialist DFSV services would strengthen continuity of care and support more coordinated responses throughout prevention, early intervention, recovery and healing.

5.2 Building a connected and capable workforce

A safe response to DFSV depends on the specialist and non-specialist workforces working as one, not in parallel. Community-based mental health is a large part of that non-specialist workforce, and the value comes from knowledge moving in both directions. Specialist DFSV expertise flowing into community-based mental health sharpens how workers recognise and respond to violence. An understanding of the mental health and psychosocial impacts of violence flowing the other way makes specialist DFSV support more recovery-oriented. Building this shared capability, should be grounded in evidence, in trauma and violence informed practice, and in the meaningful involvement of people with Lived and Living Expertise. It also must be sustained. Supervision, mentoring, debriefing and measures that address vicarious trauma are what keep a workforce capable rather than burnt out, and they are what turn individual skill into a system that holds.

5.3 Supporting community-based mental health services to respond safely

As part of the broader non-specialist workforce, community-based mental health services require the practical supports needed to respond safely and confidently to DFSV. This includes access to clear practice guidance, specialist consultation, established referral pathways and organisational systems that support safe, trauma-informed practice.

Community-based mental health services are already founded on rights-based, trauma informed, person-led and recovery-oriented practice. Realising their contribution to the Second Action Plan requires services to be appropriately resourced to build trusted therapeutic relationships, recognise when DFSV may be contributing to a person's circumstances, and work confidently within their role as part of an integrated service system. This includes understanding when specialist DFSV expertise is required and ensuring people can be connected to the right support through timely, coordinated referral pathways.

Embedding these practical supports within community-based mental health services would strengthen the broader service system by ensuring people receive safe, coordinated and trauma-informed care, while enabling specialist DFSV services and community-based mental health services to contribute their respective expertise.

5.4 Funding an integrated service system

The effectiveness of the Second Action Plan will depend not only on the services it funds, but also on how those services are funded to work together. Achieving an integrated system and a connected and capable workforce requires funding arrangements that support collaboration, continuity of care and long-term recovery, rather than focusing predominantly on crisis response.

Community-based mental health services play an important role in supporting recovery and healing, but this contribution depends on stable funding that enables organisations to build and retain a skilled workforce, develop trusted therapeutic relationships and provide flexible, recovery-oriented psychosocial support over time. Funding models should support continuity of care and recognise that recovery from DFSV is often non-linear and extends beyond immediate crisis intervention.

Funding should also recognise the integration functions that enable coordinated care. Activities such as partnership development, referral coordination, secondary consultation and cross-sector collaboration are essential to an integrated service system, yet they are rarely funded explicitly. In many cases, these functions depend on the goodwill and commitment of organisations rather than dedicated investment, making collaboration difficult to sustain over time.

Flexible, place-based funding arrangements can further strengthen integration by enabling services to respond to local circumstances and community need. This is particularly important in rural, regional and remote communities, where thin service markets often require organisations to work collaboratively across traditional service boundaries to ensure people can access timely and appropriate support.

Recommendation 3

Fund the Second Action Plan so victim-survivors can reach long-term psychosocial support, and so services can afford to work together. To do this, governments should:

- commit dedicated, multi-year psychosocial support funding for victim-survivors on a term that matches the Action Plan period and is reviewed against the National Plan's 2032 horizon,
- fund coordination directly by attaching an integration loading to psychosocial and DFSV service contracts, ring-fenced for partnership development, referral coordination, secondary consultation and joint case work, so collaboration stops depending on organisations absorbing the cost,
- establish flexible, place-based pooled funding for rural, regional and remote communities, letting providers combine DFSV and psychosocial funding against local need, with a minimum viable service allocation so thin markets are not left with nothing,
- tie the funding to accountability by reporting against recovery and continuity-of-care outcomes not activity counts alone.

Concluding statement

The Second Action Plan is a chance to move beyond meeting violence only in the moment of crisis and towards supporting recovery over the long term. For many victim-survivors, healing is not measured by the day they leave a violent situation, but by their ability to rebuild relationships, regain confidence, reconnect with their community and live the life they choose. Community-based mental health services are part of what makes that recovery possible, working alongside specialist DFSV services to hold people through the long stretch after crisis has passed.

Realising that contribution takes two things: recognising community-based mental health as a partner in the DFSV service system, and funding it to do the work. Recognition without funding is an acknowledgement that changes nothing on the ground. Funding without integration leaves services working in parallel rather than together. The Second Action Plan can do both, and in doing so support not only safety but the longer work of recovery.

Ending violence is the goal of the National Plan. Making sure people have what they need to recover from its lasting impacts should be the enduring legacy of the Second Action Plan.

References

- ¹ Australian Government. (2022). *National Plan to End Violence against Women and Children 2022–2032*. Department of Social Services. <https://www.dss.gov.au/the-national-plan-to-end-violence-against-women-and-children-2022-2032>
- ² Productivity Commission. (2020). *Mental health* (Inquiry Report No. 95, Vols. 1–3). Australian Government. <https://www.pc.gov.au/inquiries/completed/mental-health/report>
- ³ Heron, R. L., & Eisma, M. C. (2021). Barriers and facilitators of disclosing domestic violence to the healthcare service: A systematic review of qualitative research. *Health & Social Care in the Community*, 29(3), 612–630. <https://doi.org/10.1111/hsc.13282>
- ⁴ Australian Government. (2022). *National Plan to End Violence against Women and Children 2022–2032*. Department of Social Services. (pg 38) <https://www.dss.gov.au/the-national-plan-to-end-violence-against-women-and-children-2022-2032>
- ⁵ Australian Institute of Health and Welfare. (2021, November 4). *New insights into suicide and self-harm in Australia, including potentially modifiable risk factors* [Media release]. <https://www.aihw.gov.au/news-media/media-releases/2021-1/november/new-insights-into-suicide-and-self-harm-in-austral>
- ⁶ Australian Institute of Health and Welfare (AIHW). Health outcomes. Family, domestic and sexual violence in Australia. Canberra: AIHW; accessed 27 July 2026. <https://www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/health-outcomes>
- ⁷ Australian Institute of Health and Welfare. (2024). *How do people respond to family, domestic and sexual violence?* <https://www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/how-do-people-respond-to-fdsv>