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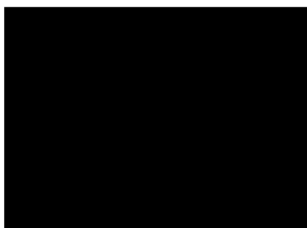
To whom this may concern

Thank you for the opportunity to provide a submission to the Second Action Plan to End Violence against Women and Children. The Queensland Network of Alcohol and other Drugs (QNADA) submission is attached.

QNADA represents a dynamic and broad-reaching specialist network of non-government alcohol and other drug (NGO AOD) treatment and harm reduction services across Queensland. We have over 60 member organisations, representing the majority of specialist NGO AOD providers. This submission is made following consultation with QNADA members.

QNADA is pleased to provide further information, or discuss any aspect of this submission. Please do not hesitate to contact me at [REDACTED] or by calling [REDACTED]

Yours sincerely



CEO



Submission to the Second Action Plan to End Violence against Women and Children

July 2026

This submission has been prepared by the Queensland Network of Alcohol and Other Drug Agencies (QNADA). Its content is informed by consultation with QNADA member organisations providing alcohol and other drug (AOD) treatment and harm reduction services across Queensland, as well as a review of relevant research and reports.

It is important to note at the outset that the vast majority of people who use substances do not experience problematic use and never come into contact with services around their use. Globally, specialist alcohol and other drugs treatment is necessary for 11-12% of people who use drugs.¹

A recent survey of the AOD workforce in Queensland undertaken as part of QNADA's work to support sector capability to respond to domestic and family violence found workers frequently encountered people experiencing violence: around one third indicated more than once per week, with a further third indicating 1-3 times per month. Additionally, the workforce reported encountering people who use violence: around 10% reported more than once per week, with a further 20% reporting 1-3 times per month. These findings confirm the AOD workforce have a role to play in recognising and responding to violence against women and children, including working to reduce men's use of violence.

This submission covers elements of the five priority areas for the second national plan to end violence against women and children², with a particular focus on:

- AOD use within family and domestic violence contexts,
- how AOD services can support people who have experienced, or are at risk of experiencing violence
- the significant institutional stigma and discrimination experienced by people who use drugs and its impact on accessing services and support

The intersection between substance use and violence can heighten the risk of harm in some situations, when gendered and intersectional drivers of violence are present³. This pattern of violence is experienced both commonly and uniquely to women, children and young people, First Nations peoples, multicultural people, and LGBTQIA+ SB communities, and people who are structural disadvantaged^{4,5}.

Some people's pattern of violence may include substance use coercion. Substance use coercion involves manipulating or controlling their partner's use of substances as a tactic of abuse. This type of behaviour might include withholding access to substances, forced injection, treatment interference,

¹ United Nations Office on Drugs and Crime, 'World Drug Report Booklet 2: Global Overview of Drug Demand and Supply: Latest Trends, Cross-Cutting Issues' World Drug Report 2018 (Vienna: United Nations 2017).

² ANROWS, 2026. "Evidence to action: informing direction for the Second Action Plan (2026)" <https://engage.dss.gov.au/wp-content/uploads/2026/05/second-action-plan-consultation-paper.pdf>.

³ VAADA, 2025. "Position Paper - Strengthening the Role of the Alcohol and Other Drug (AOD) Sector in Responding to Gendered Violence" https://www.vaada.org.au/wp-content/uploads/2026/04/PP_Strengthening-AOD-sector-response-to-gendered-violence_FINAL-2025.pdf.

⁴ ANROWS, 2026. "Evidence to action: informing direction for the Second Action Plan (2026)" <https://engage.dss.gov.au/wp-content/uploads/2026/05/second-action-plan-consultation-paper.pdf>.

⁵ VAADA, 2025. "Position Paper - Strengthening the Role of the Alcohol and Other Drug (AOD) Sector in Responding to Gendered Violence" https://www.vaada.org.au/wp-content/uploads/2026/04/PP_Strengthening-AOD-sector-response-to-gendered-violence_FINAL-2025.pdf.

substance facilitated sexual assault and financial abuse, which serve to increase the vulnerability and potential for substance dependence for the person experiencing violence⁶.

This may also extend to threatening to disclose their use to service providers (such as police or child safety services), to reduce the likelihood the person experiencing violence will report abuse due to fears of diminished credibility based on substance use prejudice. Widespread societal stigma around drug use can complicate how victimisation is perceived and responded to by police and child safety services.

We undertook a DFV Capability Project across 2024 and 2025, funded by Queensland Health to implement Recommendation 19 of the Women's Safety & Justice Taskforce Hear Her Voice Report (2021) and previous recommendations from the Queensland Domestic and Family Violence Death Review and Advisory Board. The project was conducted in two phases. Phase one of the project commenced with an environmental scan of DFV capability work previously undertaken in the AOD sector and broader health sector, as well as consultation on the development of a capability assessment tool. A supported assessment process was then trialled with mental health and alcohol and other drugs (MHAOD) services on the Gold Coast and Cairns. Phase one concluded with two roundtable discussions, which brought together family and domestic violence, mental health and alcohol and other drugs services to discuss the findings of the pilot assessments and ways to improve service responses. Phase two extended the offer of supported assessments to mental health, alcohol and other drugs services across Queensland.

The findings from this project show that the sector is engaged and aware of domestic and family violence, yet the capability assessments revealed critical gaps that require attention. These gaps are particularly evident in understanding coercive control, managing risk escalation, and resisting collusion when working with people who use violence. Across services, indicators of DFV are often missed, with several service providers reporting cases where women had been misdiagnosed with mental health conditions, including psychosis or personality disorders for reporting behaviours related to a partner's coercive tactics. For example, a woman's report that she was being secretly recorded by her partner was misdiagnosed as delusion and the woman was placed on an involuntary treatment order. In another example, a woman was misdiagnosed with psychosis for reporting she thought her partner was tracking her phone and stalking her. Similarly, opportunities exist to improve responses where men present with suicidal ideation or following a suicide attempt, where relationship breakdown or conflict is a contributing factor. Current risk assessment approaches in these situations frequently fail to adequately consider the potential lethality to a partner or ex-partner, which can have serious consequences for safety planning and clinical decision-making around hospital admission.

It would be ideal if the second plan included specific action to build DFV capability in the mental health and alcohol and other drugs treatment and harm reduction sectors nationally. There are clear opportunities to strengthen service capability through targeted investment in contextualised workforce training, embedding specialist DFV roles in services, and the design of systems that support genuine collaboration. Services that have access to workers or clinicians with specialist DFV expertise consistently rated higher in the capability assessment than services without this expertise on the team. Almost all staff who participated in the workforce survey expressed strong interest in accessing

⁶ KODY Policy Stakeholder Group, 2023. "Policy Briefing Paper: Substance Use Coercion/Exploitation" <https://vawc.com.au/wp-content/uploads/2024/08/2024-02-Policy-Briefing-Paper-Substance-Use-Coercion.pdf>.

training focused on coercive control and working with people using violence. At the same time, services reported dissatisfaction with some existing training offerings, noting that stigmatising language and a superficial understanding of mental health and AOD issues limited the training's effectiveness. These findings point to a significant opportunity to develop contextualised, sector-specific training that addresses the types of client presentations most commonly encountered in the mental health and alcohol and other drug sector.

Collaboration across the MHAOD sectors and with multi-agency DFV responses also presents challenges. Multi-agency responses often treat the health system as a single entity, with network participation and engagement in high-risk teams typically managed through a single hospital and health service representative. This approach renders much of the activity invisible to other clinicians and excludes non government and Aboriginal and Community Controlled organisations (ACCOS) entirely. Strengthening connections between MHAOD services, ACCOs, and multi-agency DFV networks is therefore critical to ensuring a coordinated and effective response. By embedding specialist DFV workers within services, improving referral pathways, engaging more broadly with local networks, and establishing sector-wide communities of practice, the sector can more effectively identify and respond to DFV, while supporting both clients and staff.

As outlined in more detail in our [Stigma and Discrimination Position Paper](#), illicit drug dependence is one of the most stigmatised health concerns in the world and experiences of stigma and discrimination are a common occurrence in the lives of people who use drugs. These experiences are likely further heightened amongst victim-survivors of violence against women and children. For example, as a victim-survivor's substance use is often used to discredit them where they make a report by playing into harmful stereotypes, victim-survivors may feel discouraged to disclose their experience of violence or seek support. Stigma and discrimination, therefore, not only contribute to delayed access to treatment and supports but also extends the duration of harm a victim-survivor suffers.

This is particularly concerning, as victim survivors who do seek support often fall between sector gaps – AOD services are not yet well equipped to identify coercive control and other less overt acts of violence, and DFSV-services often exclude women based on their substance use. The effects of stigma and discrimination extend to people who use violence. As highlighted in the [Consultation Paper](#), most men who use violence do not seek men's behaviour change programs to stop their use of violence. For those who do seek such programs (voluntarily or by mandate), their substance use often renders them ineligible or is not specifically addressed. Therefore, in addition to the opportunities identified above to strengthen AOD service capability, strategies that address stigma and discrimination would improve service access and outcomes.

While it is critical that AOD and other non-specialist services are appropriately equipped to respond to domestic and family violence and support earlier intervention, there is also considerable benefit to enhancing other services' understanding of how to better respond to people who are affected by AOD. As outlined within our [Systemic Responses: Criminal justice system responses position paper](#) for many people who use drugs the greatest harms they experience come from contact with the police or other criminal justice sector agencies. In particular, the criminalisation of use and possession and the associated stigma and discrimination faced by people who use illicit drugs is a significant barrier to their engagement and participation with services. For victim-survivors it may result in a reluctance to report offences because of previous negative experiences with the criminal justice system and/or a fear of harmful consequences (particularly for those who use illicit drugs). Where victim-survivors who

use substances do report, they are also more likely to encounter (real or perceived) issues with respect to the credibility of their statements which may impede the investigation or successful prosecution of offences.

While we agree that intoxication should not excuse criminal behaviour, we wish to note the significant role stigma and discrimination towards people who use drugs may play within legal settings. We stress that serious consideration should be given to the significant role of institutional stigma and discrimination towards drug users in current legal and criminal justice settings. A Drug Policy Modelling Program [report](#) (2017) highlighted the impact of stigma and discrimination on people experiencing problematic alcohol and other drug use and found that experiences of stigma were common across health, justice, courts, welfare and child safety services, workplaces, family and friends and in the broader community⁷.

⁷ Lancaster, Kari., Seear, Kate., and Ritter, Alison. 2018. Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use: A report for the Queensland Mental Health Commission, Monograph 26.