



THE
AUSTRALIAN
CENTRE FOR
SOCIAL
INNOVATION

Formal Submission

Consultation on the Second Action Plan (National Plan to End Violence against Women and Children 2022–2032)

Executive Summary

We welcome the opportunity to contribute to the consultation for the Second Action Plan under the National Plan to End Violence against Women and Children 2022-2032. Our submission draws on 16 years of experience working alongside Family, Domestic and Sexual Violence (FDSV) and social health practitioners, victim-survivors and community leaders to ensure the plan reflects what actually works on the ground and ensuring policy evolves with and alongside the realities of community safety and self-determination.

As the Commonwealth advances the National plan, we recognise two critical gaps:

1. the vital, often invisible and unfunded work that is required to integrate multi-sector efforts and;
2. peer-to-peer and in-community responses, which continue to remain under-resourced and unrecognised in policy design.

FDSV prevalence will only ever be overcome when the parts of our broadest social and human service health system are intrinsically connected. Service integration must be better resourced, not assuming it will happen off the back of diverse service delivery contracts. When primary care, justice, housing and specialist FDSV sectors are given dedicated time and clear pathways to collaborate, systemic gaps close and victim-survivors experience more seamless support.

Peer and in-community responses must be a part of the National plan as they are best placed to fill support gaps that formal parts of the service system are unable to fill. Peer and in-community responses must be centred as legitimate, funded pillars of the national response that activate local capability, contributing to a stronger and broader FDSV response network. These responses can thrive when policy explicitly recognises lived expertise, removes bureaucratic barriers to community leadership and invests in scaffolding the system to support these responses in new and innovative ways.

We invite the Department to embed structural funding for cross-sector integration and establish a dedicated funding stream for peer-to-peer and in-community responses. The government can further enable these outcomes by commissioning the mapping of existing responses and integration efforts, making the current complexity, strengths and gaps of the system response visible.

Our submission is informed by rigorous evidence and integrated response design. A [Quasi-experimental evaluation](#) of [Family by Family](#) (a family-led peer support program) shows that families seeking support are significantly more likely to have experienced multiple government service contacts, highlighting the urgent need for coordinated, trauma informed pathways. Similarly our partnership in supporting the scaling of the [Supporting Primary Care to respond to FDSV pilot](#) shows how primary care has effectively integrated with FDSV responses when supported by clear infrastructure, collaborative practices and trust-based relationships.

By prioritising investment in a better connected service system and enabling communities to be a part of the response, the National Plan can shift from reactive coordination to proactive community-wide prevention and response. To turn these insights into lasting change, the National Plan must move beyond siloed funding and embed relational work that keeps communities (and front line practitioners) safe. We invite the Department to enable 3 actionable policy and implementation recommendations, drawing on our lessons learnt in sector capability building and community-led design.

1. Invest in building new infrastructure: implementation and innovation partnerships
2. Strengthen the role of adjacent sectors in the National Response
3. Embed Peer and in-community response core infrastructure

Ending violence requires investment in integration

FDSV does not occur in isolation from other forms of disadvantage. Evidence from TACSI's partnership with BetterStart, Adelaide University, demonstrates that families engaging in Family by Family often experience multiple and intersecting forms of system contact, including child protection, mental health, alcohol and other drug services, homelessness and the prison system. Children in seeking families were almost four times more likely than their peers to have experienced all five indicators of government service contact associated with disadvantage. These findings have important implications for policy design. Families navigating multiple forms of disadvantage rarely experience their lives through boundaries of specialist service systems. Their needs, spanning parenting, safety, housing, wellbeing, relationships, financial stress and community connection highlight that families most likely to experience vulnerability are already interacting with multiple service systems, often simultaneously. Responses that are organised around individual service sectors can struggle to adapt to this complexity, often requiring victim-survivors to repeatedly navigate fragmented pathways.

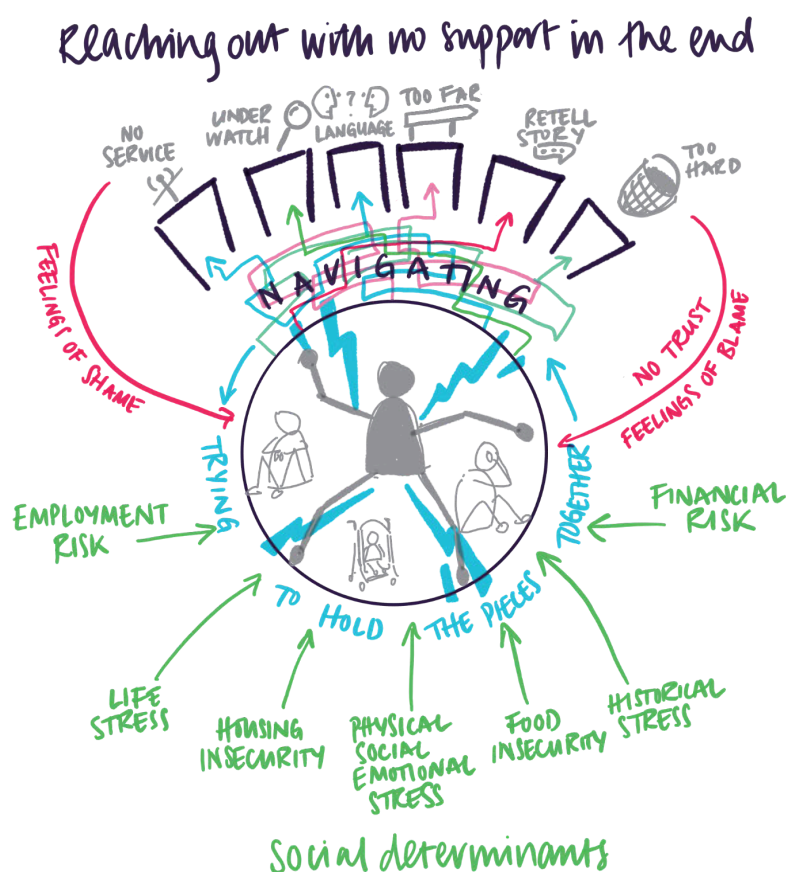


Image: Co-designed with a woman with lived experience of FDSV. This illustration maps the reality of navigating multiple disconnected services while trying to keep a family together. Repeatedly retelling traumatic experiences, managing different eligibility criteria and attending countless appointments creates a significant emotional and practical burden. Rather than experiencing a coordinated response, many people find themselves navigating fragmented systems that can compound stress, financial hardship and isolation at a time when support is needed most.

This complexity is also felt by frontline practitioners. Many enter the work with a commitment to support people holistically, yet are often constrained by narrowly defined service scope. Practitioners frequently find themselves trying to respond to the realities of people while navigating systems that

shoehorn their interconnected challenges into separate services, creating frustration for both the workers and those seeking support. As a result, workers can find themselves acting as informal systems navigators, investing significant effort in connecting victim-survivors across fragmented services while knowing that this support will remain difficult to access in the long-term. For victim-survivors, this can mean spending the majority of time being referred or assessed, minimising precious time focussed on what people actually need. We have heard this described to us as the ‘trauma of the system.’

We also know that many current contracts expect integration and partnerships between services, however the time and permission to invest in building this is not resourced. Most of the integration efforts we see today are often invisible and are achieved as a result of the goodwill and unpaid efforts of already stretched practitioners and their organisations.

This reality requires a national response that genuinely supports the FDSV sector to collaborate with adjacent sectors, to bring together their collective expertise, to support each other and to activate and sustain a broader and fundamentally ‘FDSV-informed’ integration response. It is efforts like these that will foster a unified approach that upholds dignity, safety, care, and respect across the entire social and human services sector.

Our experience supporting the development and national scaling of the Supporting Primary Care to respond to FDSV pilot alongside our long term partners at Brisbane South PHN and the 11 other PHN’s who have implemented the pilot, demonstrates the return on investment for integrated approaches. The model was designed to strengthen the capability of primary health care practitioners to identify and respond to FDSV as part of a broader systems response. The work recognised that while general practice is often one of the first places people disclose violence, practitioners frequently face barriers including limited training, unclear referral pathways, time constraints, a lack of knowledge around safety and a lack of confidence and capacity approaching FDSV as a public health issue. Addressing these barriers required more than workforce training alone. It required investment in system integration, shared pathways, cross-sector relationships and ongoing collaborative infrastructure that connected primary care to specialist services.

If the National Plan is to achieve transformational change, it must recognise integration and sector capability building as essential infrastructure rather than add-on activities. Dedicated investment in cross-sector coordination, workforce capability and shared learning can strengthen early intervention pathways, reduce system fragmentation and ensure victim-survivors receive timely and connected support regardless of where they first seek help.

“It helps me to be hopeful about change when many aspects of the system are involved in such proactive and respectful approaches to improve the support available to those families and children experiencing DFV.” - GP

“The two victim-survivors I spoke with in the month had been in relationships with their husbands for 20+ years, and had both been experiencing significant DFV over that time. Both had never spoken to anyone, especially not support services, about their experiences of DFV and were extremely grateful for their GP in asking them about DFV then referring them to a Local Link.” - GP

“It’s quite groundbreaking, building these bridges and bringing these sectors together for the first time.... It’s a culture shift, so the different sectors are not seeing each other as the enemy anymore” - Key stakeholder

High-Level Model

Six Influencing Activities

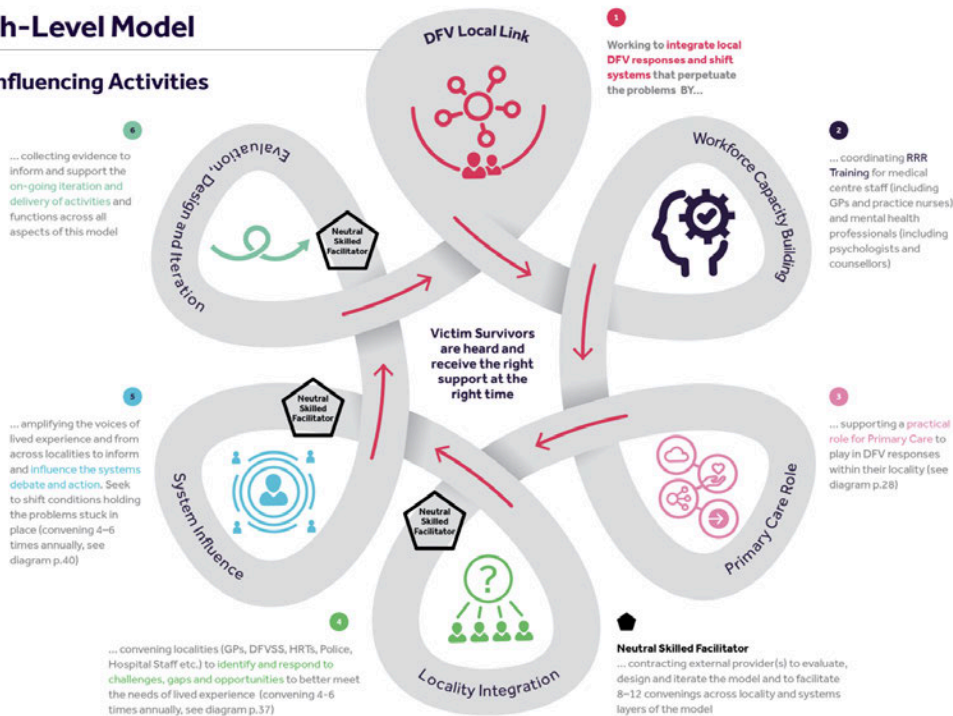


Image: The six influencing activities of the Supporting Primary Care to respond to FDSV pilot. 1. Local Link (integrated worker) 2. Workforce Capability Building 3. The Practical Role of Primary Care 4. Locality integration 5. Systems Influence 6. Evaluation, Design and Integration.

Our Lessons from working in integrated ways that can be actioned:

TACSI believes the Supporting Primary Care to respond to FDSV pilot offers lessons that extend well beyond primary health care. Its impact and effectiveness has been captured in a [National evaluation](#) conducted by the Sax Institute. While originally designed to strengthen the role of general practice within the FDSV response, the core architecture of the model is not health specific. At its heart, it is a systems integration and capability building model that creates the conditions for adjacent sectors to recognise their role, build confidence and capability, strengthen referral pathways, and become active contributors to a coordinated response.

The six influencing activities of the model are equally relevant to sectors such as housing, mental health, alcohol and other drug services, community services, education and employment, all of which are often critical touchpoints for people experiencing violence and disadvantage.

As governments seek to strengthen integrated responses to FDSV there is an opportunity to adapt and apply the model across a broader range of service systems. Doing so would support a more coordinated and responsive ecosystem in which practitioners across multiple sectors are better equipped to identify needs early, respond appropriately and connect people to the support they require. Rather than relying on specialist services alone, this approach builds capability throughout the broader service system, recognising that effective responses to complex social challenges require many parts of the system working together.

The successful scaling to date demonstrates that integration is not an abstract aspiration but a practical and replicable capability. With appropriate adaptation to local contexts and sector specific needs, the model provides a tested foundation for strengthening collaboration, capability and coordinated responses across the wider social and human services system.

Adaptive Peer and In-Community Infrastructure

The National Plan should invest in a national demonstration and scaling pathway for peer and in-community responses as a core component of Australia's response to FDSV. There remains a significant opportunity to move beyond consultation and participation towards investing in the peer and community infrastructure that can strengthen all four pillars of the National Plan - preventing violence before it occurs, supporting earlier intervention, complementing formal responses, and enabling long-term healing and recovery.

Evidence suggests that peer approaches can successfully engage people experiencing significant and intersecting disadvantages, including those navigating multiple forms of adversity and service contact. The long term evaluation of Family by Family highlighted that it is possible for peer-to-peer models of family support to successfully engage with families with significantly high and more complex needs. Reinforcing the importance of designing family support programs that are responsive, flexible, and trauma-informed. In the past 12 months alone, analysis of our own program data showed that 50% of our peer volunteers drew on a lived experience of FDSV to support 53% of families seeking support associated with FDSV.

Despite this complexity, participation in Family by Family was associated with a 44% relative reduction in the likelihood of children entering out-of-home care over a two year period. These findings demonstrate that peer-to-peer approaches are not limited to supporting people with low-level needs; when appropriately scaffolded, they can work effectively alongside families experiencing significant adversity and complexity.

The strength of peer approaches lies in their ability to respond to people as whole individuals rather than through the lens of a particular service system. Unlike formal services, peers are not constrained by organisational mandates or sector boundaries. They are often able to adapt to what matters most in a person's life at a given moment - whether that relates to safety, parenting, housing, wellbeing, relationships, financial stress or community connection. This flexibility allows peer responses to complement specialist services and help people navigate the complexity that often accompanies experiences of violence and disadvantage.

Emerging practice in the recovery space further highlights this opportunity. In 2025, the Hunter New England Central Coast Primary Health Network commissioned the adaptation of the [Virtual Village](#) model to expand its support offerings within the [Supporting Healing and Recovery pilot](#). The model responds directly to the Recovery pillar of the National Plan by providing peer-led, trauma-responsive support that recognises healing as a relational process. Through flexible digital and telecommunications platforms, the Virtual Village connects individuals, including those in rural and remote communities, with trained peer supporters who can walk alongside them through recovery, reduce isolation and strengthen connection. Building on more than a decade of learning from peer-to-peer approaches, the model demonstrates how lived experience can be mobilised as a source of support, hope and healing in ways that complement formal services.

Across both Family by Family and the Virtual Village, a consistent pattern emerges: peer support is most effective when it is supported by strong scaffolding. Coaching, safeguarding, supervision, coordination, learning systems and connections to formal services create the conditions that enable community capability to flourish safely and sustainably. The question for policy is therefore not whether communities can support one another, but how governments can invest in the infrastructure that enables these responses to operate at scale while maintaining quality, safety and impact.

"I would love to meet and give her a big hug. she has been down herself but she was always there for me. She helped me to split with the kids' dad when I was having a tough time...she was there. My mental health is up and down but the down side seems to be dissolving. She has helped me to look at the bad things and the grief and loss in my life and the anger I held for people, she helped me to see that I can be a bit selfish and concentrate on myself and that was ok." Connected individual Virtual Village

"It's good to know that we are not a service that could create a feeling of being judged. I've seen everything that people might share with me and I tell them that and that they won't shock me. Instead of telling, I just ask What do you want to do? How can I help?" Peer Volunteer the Village

Our Lessons from activating peer to peer, in-community infrastructure that can be actioned:

Our experience across Family by Family, the Virtual Village and other peer-led initiatives suggests the opportunity is not simply to replicate individual programs, but to adopt and adapt the patterns that make these approaches effective. Across diverse contexts, we consistently observe that people respond positively to support that is relational, strengths-based, flexible and grounded in lived experience. Peer supporters are often able to engage with the whole person, rather than a single issue, helping individuals and families navigate the complexity of their lives in ways that complement formal services.

These approaches also demonstrate that community capability does not emerge by chance. Effective peer responses are supported by clear safeguards, coaching, supervision, pathways to specialist support and ongoing learning. Together, these elements create the conditions for people with lived experience to contribute safely and meaningfully to prevention, early intervention, response, healing and recovery.

Importantly, enabling peer responses requires shifts not only in community capability, but also in system capability. Practitioners, intake workers and service leaders often need support to understand how peer approaches complement formal services and where their role sits within that ecosystem. This can involve moving beyond a traditional case management mindset towards seeing their role as creating the conditions for connection, building confidence in community-based supports, and helping people access both formal and informal sources of support. Rather than being solely responsible for holding and managing every aspect of risk, practitioners can play an important coaching and enabling role, supporting people to build trusted relationships, strengthening natural support networks and guiding connections into peer responses where appropriate.

For peer approaches to thrive, the broader system must also develop confidence in recognising lived experience as a legitimate source of support and in understanding how risk, safeguarding and accountability can be shared across a broader ecosystem of care. This includes supporting intake and frontline practitioners to identify when peer support may be beneficial, make warm referrals and actively connect people to community-based responses. When systems are equipped to work alongside peer approaches in this way, peer support is no longer positioned at the margins of the response but becomes an integrated and valued part of how communities prevent harm, respond to adversity and support healing and recovery.

The opportunity for the National Plan is to work with these repeatable patterns and create mechanisms for their adaptation across different communities, sectors and settings. Rather than scaling a single model, the next phase of reform should focus on scaling the underlying conditions that enable peer and in-community responses to thrive, recognising lived expertise, investing in relational approaches, building local capability and strengthening connections between community

and formal systems. In doing so, the National Plan can harness the strengths that already exist within communities and embed them more intentionally within Australia's response to FDSV.

Overarching Lessons from building peer to peer, in-community and integration into systems that can be actioned:

Drawing on our experience walking alongside sectors to translate complex challenges and the resources we have into practical, place-based solutions (including; integrated, in-community and peer-led), our approach has always required us to be systemic in nature simultaneously centring community voice, with practical realities and systems priorities.

TACSI has demonstrated the importance of intermediary support doing more than merely connecting stakeholders, but rather actively weaving relationships to bridge gaps and unrealised potential between government, organisations, and community. Our lessons emphasise that effective intermediaries act as dynamic systemic facilitators, driving authentic collaboration and innovation across the sector.

This work has enabled us to show leadership in:

- Supporting government in cross-agency collaborations
- Helping organisations design for scale
- Building prevention into every response opportunity
- Providing and discerning clear value-add's, ensuring resources generate cohesion and social capital rather than duplicating effort.
- Enabling Community Leadership
- Embedding in-community roles and networks to foster genuine self-determination.
- Prioritising the voices of people with lived and living experience
- Supporting the broadening of service roles to integrate peer-to-peer practices
- Building capacity in, allyship, deep listening, and sitting with complexity .
- Advisory partner mindsets and practices
- Translating insights into actionable policy interventions and service redesigns.
- Developing capability-building frameworks that enable people to problem-solve and implement change with confidence.
- Modelling what it takes to strengthen the ecosystem for all partners.

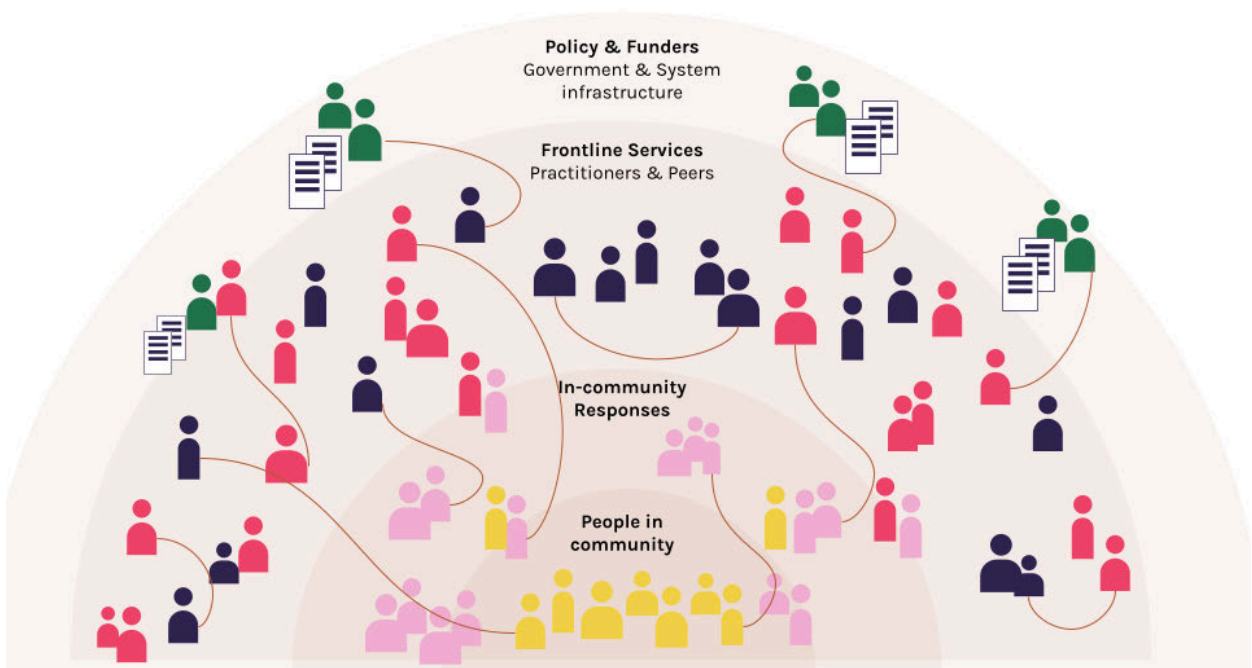


Image: Bridging gaps and unrealised potential between government, organisations and community enables us to reach holistic outcomes that no one single service, sector or policy can serve alone.

3 Actionable Recommendations

Ending violence requires more than specialist responses. It also requires adjacent sectors and communities to be recognised, equipped and connected as active contributors to the response. There is a critical need to have policy makers, funders, specialist organisations, frontline workers and community work together in a co-ordinated way. We invite the Department to enable 3 actionable policy and implementation recommendations into the Second Action plan as follows:

1. Invest in building a new scaffolding infrastructure: Implementation and innovation partners.

We invite policy makers and funders to invest in building implementation and innovation capability through the creation of a new scaffolding infrastructure in order to enable the expanse of community, government and sector responses to thrive. This new infrastructure will enable time to be invested in relationship brokering, developmental partnerships and capacity building and the confidence for the current service system to act in new and responsive ways.

At the system level, this scaffolding infrastructure will play a vital intermediary role, connecting funders, specialists, organisations and community networks through Communities of Practice and co-design processes. These groups require long-term investment to sustain systems leadership, learning, and coordination.

At a community level, this new infrastructure would enable frontline workers and community members to co-create practical tools, learning opportunities, and trusted warm referral pathways. This would also provide recognition that communities are in fact active partners in the FDSV response rather than just passive service recipients.

TACSI has learnt that the role of an implementation and innovation partner can be a critical intermediary role when introducing new and emerging practice. A support that enables the scaling of effective patterns, practices and mindsets rather than isolated programs that often stifle shared and sustainable change.

TACSI has been a leading intermediary introducing innovative practices into service systems since 2010. In this time, we have created principles, plans and policy for truly groundbreaking models. Our success stories are most often aligned with a practice of walking alongside service and system innovations over a period of time as an ecosystem of funders, services and communities increase their awareness, understanding and readiness for change.

Even the most rigorously co-designed and values-aligned service models cannot predict every bump in the road – especially if the road is previously untrodden. In addition, people learn and adopt innovative practice not at the outset, but largely through experience. The role of the implementation partner therefore is to walk alongside over rough ground and through all the ups and downs of the implementation journey, to learn, collaborate and embed innovative practice over time.

During the ups and downs of this journey, we often encounter:

- Novel contracts and expectations mismatched with old mindsets and behaviours
- Challenges with historical power dynamics between funder, providers and community
- Surges of momentum and progress followed by snap backs in moments of pressure
- Strong learning and capability development hampered by changes in leadership and key staff
- Openness to new ways of doing on the frontline constrained by ceilings of organisational risk
- Inconsistency of technical readiness, workplace culture and practice agility between providers

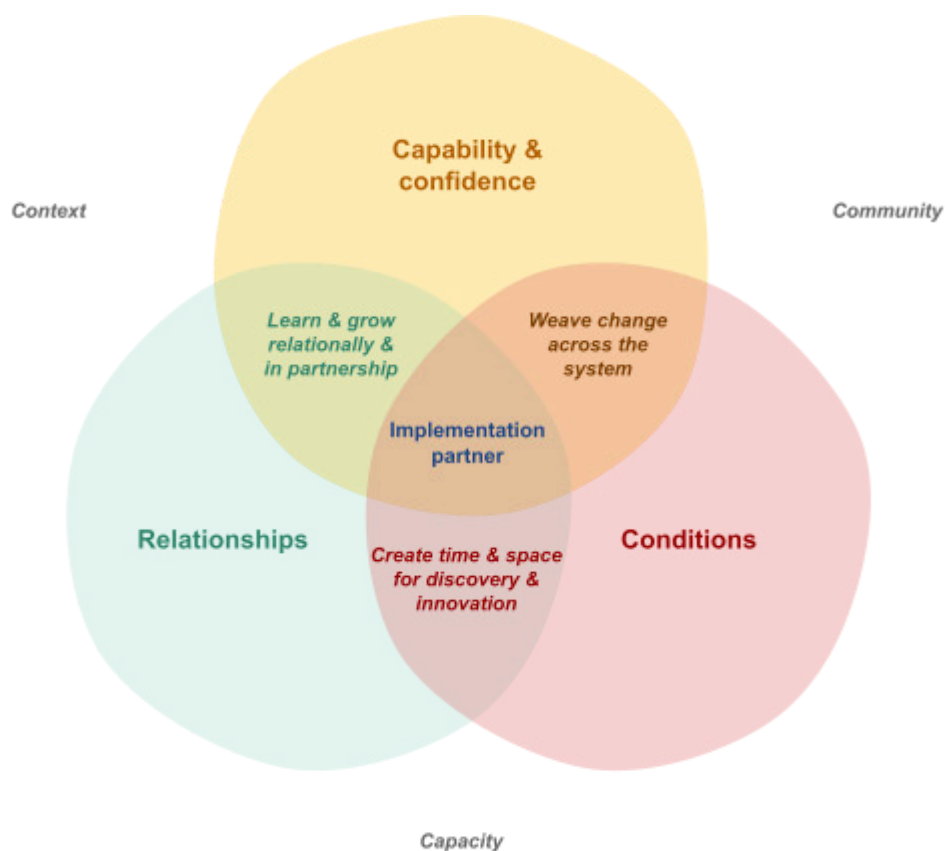


Image: shows three broad and expected outcomes of implementation support, Capability and confidence to implement the change, Conditions to embed the change and Relationships to support and empower people to deliver the change. Our following two recommendations demonstrate how this could be implemented across the layers of the system.

2. Strengthen the role of adjacent sectors in the National Response:

Through the work of Supporting Primary Care to respond to the FDSV pilot, we are confident that the adoption and adaptation of the underpinning model, will fast track adjacent sectors taking on a greater role in prevention, early intervention, response and healing and recovery. Many will require support to bridge the gap between their core practice and specialism to a new set of relationships and pathways needed to respond as partners of an integrated system. To support this often steep learning curve it will require a new set of conditions to be enabled across the system and newly defined roles to be played from funders and policy makers to community members and community organisations.

The role of policy and funders:

- Recognise cross-sector integration as a core systems infrastructure
- Give people in organisations time and permission to align on integration purpose, principles, practices, policies and processes
- Invest in systemic intermediaries to support the integration shifts and outcomes

- Make space for learning in order to build greater and more diverse workforce capability across the board
- Value and evaluate partnership health on the same par as episodes of care or caseload numbers
- Fund the time needed to form and sustain partnerships
- Support the development of alliances to pool resources in order to overcome siloed funding that keeps organisations swimming only in their lane
- Invest in co-ordination, capability-building and relationship brokering roles that connect FDSV specialists services with adjacent sectors
- Invest in publically visualising the efforts to integrate the system across the intersections of housing, justice, corrections, child protection, health, education, and beyond. Too often, reform efforts neglect to show the whole: its strengths, diverse practices, aims, hidden opportunities, and relationships. Supporting the system to see itself is foundational to clarity and coherence
- Act as learning partners, not auditors, supporting developmental approaches.

Condition: integration must be funded as an ongoing capability of the system rather than relying on local champions or short term efforts.

The role for new scaffolding implementation and innovation partner

- Act as a trusted partner between funders, organisations and community
- Support the activation of learning networks, Communities of Practice and broker relationships between FDSV specialists and Adjacent sectors
- Support the co-design and adoption of other successful and evidence based solutions, across sectors.

Condition: Organisations undertaking this role will require long-term investment to sustain systems leadership, learning and co-ordination.

The role of front-line and community:

- Recognition of their role in the response
- Give sectors the opportunity to unearth and agree on the collective value in working together differently, by understanding the strengths, similarities and differences between practices and responses
- Build confidence in their everyday roles to better recognise, respond and refer
- Develop cross sector relationships and warm referral pathways
- Participate in shared learning and Communities of Practice
- Contribute to learning and feedback loops to continuously improve integration.

Condition: People are equipped with practical tools, trusted relationships enabling them to support and respond confidently beyond narrow service boundaries.

3. Embed Peer and in-community response core infrastructure

There remains obvious data gaps related to peer to peer models and in-community responses within the context of FDSV. A strategic approach is needed that focuses on demonstration and legitimisation of these responses in order to build new evidence and spread effective peer and in-community strategies at scale.

The role of policy and funders:

- Recognise lived experience as a legitimate source of expertise and support
- Establish dedicated, policy and funding pathways for peer-led and in-community responses

- Invest in the infrastructure to enable peer approaches to operate safely and at scale
- Fund peer roles to support people to navigate the service system and be supported to transition between services
- Support demonstrations and evaluation of in-community approaches.

Condition: Funding models must explicitly value relational outputs, alongside traditional outputs.

The role for new scaffolding implementation and innovation partner

- Provide external coaching, supervision, safe-guarding and wellbeing support to peer supporters and their supervisors and managers
- Provide support to community to activate, spotlight and codify safe in-community response practice and models
- Develop training, practice frameworks and host Communities of Practice
- Build connections between different initiatives
- Support the adaptation and co-design of peer approaches and in-community responses in different contexts.

Condition: Sustainable investment is required to support the implementation journey, including time that enables the implementation and innovation partner to support organisations and communities to adopt new roles, navigate challenges, adapt approaches and embed new practices.

The role of front-line and community:

- Contribute lived expertise to the design, delivery and improvement of new peer responses
- Identify new opportunities to activate peer support
- Seek to match peer roles with other practitioner roles in order to work as partners, share risk, provide choice and and build trust
- Create local opportunities for connection and support.

Condition: Communities are seen as co-creators and partners rather than just service recipients.

Contact Us

We would welcome the opportunity to discuss any aspect of this submission with the Department further, including any of the previous work we have undertaken. Please do not hesitate to reach out; you can contact us at:

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