



Consultation Paper
**Supporting the Second Action
Plan to Eliminate Domestic
Family and Sexual Violence
against Women and Children**

Designing Systems for Real Lives

Submitted on behalf of the Specialist Family
Violence Advisor Capability Building Program (AOD)

Contact



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Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.



About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body representing alcohol and other drug (AOD) services across Victoria.

VAADA strengthens, champions and amplifies the voice of AOD services, advocating for policy, funding and system improvement. We work with members, government, and cross-sector partners to improve access to high-quality, person-centred AOD care.

Our vision is that everyone in Victoria has equitable access to a quality AOD system of care, when, where and how they want it.

VAADA is committed to collaboration, evidence-informed practice, Aboriginal self-determination and ensuring lived and living experience informs policy, practice and sector development.

VAADA seeks to achieve this through:

- Advocating for accessible, person-centred AOD services
- Influencing policy, funding and system reform
- Supporting a capable, connected and sustainable AOD workforce
- Bringing together members, stakeholders and partners to strengthen collaboration across the health and human services sectors
- Promoting evidence-informed policy and practice
- Amplifying the voices of people, families and communities with lived and living experience
- Supporting Aboriginal self-determination through partnerships with Aboriginal Community Controlled Organisations and Aboriginal-led approaches

VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

Background

The Victorian Alcohol and Drug Association (VAADA) welcomes the opportunity to contribute to the Second Action Plan under the *National Plan to End Violence against Women and Children 2022–2032*.

Alcohol and other drugs occur across a spectrum of use. People use substances in different ways, for different reasons and with different outcomes. This submission does not seek to speak about all alcohol and other drug (AOD) use. Rather, it brings the unique perspective of the AOD sector, comprising AOD treatment and harm reduction services. Particularly, it brings the expertise of services working alongside people experiencing dependence, significant substance-related harms and other intersecting health and social needs.

This distinction matters because people accessing AOD treatment and harm reduction services are not simply a subset of the general population who use substances more frequently. They may be navigating dependence and recovery alongside domestic, family and sexual violence (DFSV), mental distress, homelessness and housing insecurity, criminalisation, poverty, parenting and child protection systems, and other forms of structural and systemic inequity¹. These experiences are not separate problems occurring alongside one another. They are shaped by the social, economic and institutional conditions in which people live and by the systems through which they must seek safety and support.

VAADA recognises that the intersections between DFSV and substance use are diverse and can be shaped by gender, sexuality, race, disability, age, socioeconomic position, migration status, criminalisation and other social and structural conditions². Our contribution to the Second Action Plan is therefore grounded in what becomes visible from within AOD treatment and harm reduction settings, while recognising that no single service system can, or should, be expected to respond to the whole context of a person's life.

Our sector works alongside people experiencing DFSV and people using DFSV, including people who may not be engaged with family violence services or other health or human services systems. Through sustained and trusted relationships, AOD treatment and harm reduction services can support health, recovery, safety, connection, parenting and self-determination, while creating opportunities to recognise violence, including DFSV, respond to escalating harm and support accountability and change.

Research demonstrates substantial intersections between substance use and DFSV among people accessing AOD treatment, while qualitative evidence identifies multiple and interacting relationships between substance use, intoxication, withdrawal, dependence, power and control, and the context in

¹ Australian Government. (2022). *National Plan to End Violence against Women and Children 2022–2032*. Department of Social Services

² Campbell, E., Fernando, T., Gassner, L., Hill, J., Seidler, Z., & Summers, A. (2024). *Unlocking the prevention potential: Accelerating action to end domestic, family and sexual violence. Report of the Rapid Review of Prevention Approaches*. Australian Government.

which DFSV occurs and is experienced.^{3,4} These relationships are neither singular nor linear. Substance use does not fully explain patterns of DFSV, and most people who use substances do not use DFSV. However, neither can substance use be treated as incidental where dependence and significant substance-related harms intersect with DFSV, safety, recovery and lethality.

Executive Summary

People experiencing AOD dependence and significant substance-related harms are disproportionately affected by DFSV. AOD treatment and harm reduction services also engage with people using DFSV, including people who may not be engaged with family violence services, behaviour change programs or other parts of the response system. This places the AOD sector at a critical point for early recognition, safety, harm reduction, risk management and behaviour change.

The relationships between substance use and DFSV are diverse, interactive and non-linear. People may use substances for enjoyment, to manage trauma, fear, pain or other impacts of violence; substances, medication or treatment may be controlled or exploited within a pattern of family violence; and intoxication, withdrawal, toxicity or dependence may be relevant to escalation, severity and lethality. Substance use does not fully explain a broader pattern of controlling behaviour, for which the person using DFSV remains responsible.

Stigma, criminalisation and structural inequities affect who is believed, whose parenting is scrutinised and who can access safety, treatment and support. When policy and service responses focus on substance use alone, they may miss family violence, discourage honest disclosure and unintentionally reproduce punishment, surveillance, power and control.

The Second Action Plan should move beyond referral pathways and equip the services people already access with the capability, authority, relationships and resources to recognise intersecting risk and respond. Effective crisis responses and continuity of treatment and harm reduction can prevent escalation and ongoing experiences of DFSV, overdose, treatment disruption, housing loss and compounding harm, including for children and young people.

VAADA recommends that the Second Action Plan:

1. **Recognise substance use exploitation** within national family violence policy, practice guidance and risk assessment frameworks.
2. **Build integrated AOD and DFSV capability** across treatment, primary health, outreach and harm reduction settings.
3. **Strengthen responses for people using family violence** through accessible, integrated, culturally responsive, child-centered and youth-

³ Curtis et al. (2021), Identified support needs for intimate partner violence engagement in an alcohol and other drug treatment sample, *Journal of Substance Use*.

⁴ Gilchrist et al. (2019), The interplay between substance use and intimate partner violence perpetration: A meta-ethnography, *International Journal of Drug Policy*

responsive interventions that address substance use and family violence risk together.

4. **Prevent and correct misidentification** through nationally consistent identification, correction, notification, information-sharing governance and review processes.
5. **Design systems around intersectional risk across the lifespan**, by embedding the social, structural and systemic conditions that shape safety, risk, recognition and access to support within national policy, implementation and service integration, with young people recognised as a distinct population requiring age- and developmentally appropriate responses.
6. **Reform policy settings that influence safety and disclosure**, recognising AOD treatment and harm reduction services as essential to family violence safety and prevention.
7. **Align national strategies through reciprocal integration** of the National Plan to End Violence against Women and Children and the forthcoming National Drug Strategy.
8. **Strengthen national evidence systems** by bringing together research, practice expertise, implementation evidence and lived and living experience.

The AOD sector is a critical part of Australia's prevention and response to DFSV. Investment in workforce capability, family violence expertise, harm reduction and integrated responses can strengthen safety, sustain engagement and support meaningful change without reproducing the power, control and structural inequities these systems are intended to address. It will also help build systems that respond to the realities of people's lives without reproducing the power, control and structural inequities they are intended to address.

1. An Effective Crisis Response is Prevention

A central proposition of this submission is that effective crisis response is also prevention: what systems do at a point of crisis can materially alter the conditions in which further harm becomes more or less likely.

For a person experiencing DFSV, an effective, immediate, practical response that prioritises safety, at the point they seek support should not depend on which service they first engage with. Every service that identifies family violence risk should be equipped to respond in ways that prioritise safety. Such a response can create immediate safety while also changing what happens next. It can reduce the likelihood of further escalation and compounding harm, maintain connection to housing, healthcare and AOD treatment, and create greater possibilities for healing and recovery. For children and young people, an effective crisis response can support safety, stability and important relationships, while reducing the likelihood that the effects of DFSV and associated housing, health and social disruption continue to compound across childhood and into adulthood.⁵ For a

⁵ Watson, J; Theobald, J; Haylett, F; Hooker, L; Murray, S., (2024). You're in the Right Spot. Responding to Pregnancy and Homelessness: Evaluation of the Cornelia Program. RMIT University. Report. <https://doi.org/10.25439/rmt.27859674.v1>

person using DFSV, timely and sustained intervention can create opportunities to interrupt further harm, strengthen accountability and support meaningful change.^{6,7}

This is not an argument that crisis response is a substitute for primary prevention. Rather, it recognises that *prevention cannot be separated from the quality of our response once harm, risk or crisis becomes visible*. Effective crisis response can be preventative because it can change the conditions in which further harm becomes more or less likely.

The AOD sector works alongside people at precisely these points.

People enter AOD services carrying different experiences, strengths, relationships, responsibilities and hopes for change. Some are experiencing DFSV. Some are using DFSV. Some may have experiences of both across different relationships and contexts. Many are parents, partners, family members and community members. They may be seeking support with substance dependence while also navigating housing insecurity, poverty, criminalisation, mental distress, grief, trauma, pregnancy, parenting and other forms of structural inequality.

People's lives do not align with service boundaries. Effective responses therefore depend on recognising the whole context of a person's life rather than responding to a single presenting issue.

The interrelation between substance use and DFSV is similarly diverse. Substance use may be connected to coping with the impacts of DFSV; be introduced, controlled or exploited within a pattern of violence including DFSV; affect health, dependence and withdrawal; or be relevant to the frequency, severity, lethality and impacts of DFSV used by another person. For a person using DFSV, substance use may be relevant to escalation and risk without fully explaining the broader pattern of controlling behaviours for which they remain responsible. Research examining the co-occurrence of substance use and intimate partner violence has consistently identified the need for responses capable of working with both rather than treating them as unrelated service issues.^{8,6}

The AOD sector therefore represents an important point of contact with people, families and communities who may not be reached, recognised or sustained within other parts of the DFSV response system.

An effective crisis response requires the service that the person is seeking support from have the capability, relationships, authority and resources to act. Victoria demonstrates what becomes possible when AOD services are included in the DFSV response.⁹

⁶ Helps, N., McGowan, J., & Meyer, S. (2026). Victim-Survivors Accounts of Men's Change: Findings From a Combined Alcohol and Other Drug Use and Domestic Violence Intervention. *Research on Social Work Practice*, 36(1), 73-84.

⁷ Meyer, S., et al. (2023). *Domestic Violence and Alcohol and Other Drug Use: Australian Pilot Intervention Findings*. Research on Social Work Practice

⁸ Meyer, S., McGowan, J., Helps, N., & Williamson, H. (2021). Evaluation of the TaskForce Early Intervention for Family Violence Program (U-Turn).

⁹ Victorian Government. (2021). *MARAM practice guides: Foundation knowledge guide*. Family Safety Victoria. <https://www.vic.gov.au/maram-practice-guides-foundation-knowledge-guide> [1, 2]

Through the Multi-Agency Risk Assessment and Management Framework (MARAM), which includes the Information Sharing Schemes (Family Violence Information Sharing Scheme (FVISS), Child Information Sharing Scheme CISS) AOD services are prescribed with responsibility to identify, assess and manage family violence risk and to participate in collaborative information sharing and risk management.^{10,11}

The Specialist Family Violence Advisor (SFVA) Capability Building Program is a critical part of this architecture, embedding specialist DFSV expertise within the AOD service system and creating a bridge between practice, organisational change and broader systems reform. SFVAs provide secondary consultation, workforce capability development, organisational and systems leadership, and support the implementation of Victoria's family violence reforms.¹² Importantly, the program also creates capacity for reform to be informed by the systems that embed it. Through understanding of AOD practice, systems, service structures, workforce capability and the experiences of people accessing AOD services, the SFVA capability building program identifies system barriers, implementation challenges and unintended outcomes, and contributes to the development and adaptation of reforms, policies and practice approaches at a statewide level. This helps avoid reform being retrospectively fitted to service systems that do not have the structures, resources or ways of working required to implement it sustainably and effectively.

This matters because AOD practitioners are not simply making referrals to a separate DFSV system. They are already identifying and responding to DFSV within therapeutic relationships that may be sustained over time, with an understanding of the broader context of people's lives. As a result, AOD practitioners may recognise changes in substance use or treatment engagement alongside escalating DFSV risk. They understand the relevance of intoxication, withdrawal, dependence, treatment disruption and recovery to a person's circumstances, including the conditions in which agency, choice and free will are exercised, while upholding the person's dignity. They may hold information about health, parenting, housing and relationships that has become visible gradually, through sustained engagement and trust, rather than through a single crisis presentation.

They may also be working with a person who uses DFSV. This is a critical and under-recognised contribution of the AOD sector.^{13,12} People using DFSV do not exist only within police, courts, corrections or dedicated behaviour-change programs. They also attend health and human services. They seek treatment for substance use and substance dependence. They are parents, partners and family members. They may want aspects of their lives and relationships to change while

¹⁰ Victorian Government. (2024). *Family Violence Information Sharing Guidelines: Guidance for information sharing entities*. State of Victoria.

¹¹ Victorian Government. (2024). *Child Information Sharing Scheme: Ministerial guidelines*. State of Victoria.

¹² Department of Health. (2024). *Specialist Family Violence Advisor program in mental health and alcohol and other drug services: Guidelines*. State Government of Victoria. <https://www.health.vic.gov.au/specialist-family-violence-advisor-program-mental-health-alcohol-other-drug-services>

¹³ Victorian Alcohol and Drug Association. (2025). *Strengthening the role of the alcohol and other drug (AOD) sector in responding to gendered violence* [Position paper].

not yet recognising, disclosing or taking responsibility for the full impacts of their behaviour.

Much like there is no “perfect victim” of DFSV, there is no single or “perfect” archetype of a person who uses DFSV. People who use violence have diverse identities, experiences and circumstances, and may themselves experience structural oppression, trauma, substance dependence, mental health distress or violence. Acknowledging this complexity does not diminish accountability for the harm a person causes. Understanding context is not the same as excusing violence; rather, it enables systems to understand risk more accurately and create more meaningful opportunities for safety and change. Acknowledging complexity is not the opposite of accountability, it is often necessary to achieve it.

¹³

Our systems will miss opportunities for safety and intervention if they are designed only to recognise people who conform to the categories through which services expect them to appear, or if we remain fearful of working with context and complexity because acknowledging either may be mistaken for diminishing accountability.¹³

A person experiencing DFSV may not present to a DFSV service. A person using DFSV may never present to a men’s behaviour change program. Both may already be sitting within an AOD service, and engagement can both increase safety, and reduce risk. Victoria’s family violence reforms create an important opportunity for risk to be identified within the context of someone’s life, rather than through a single presenting issue. The SFVA model adds specialist capability and consultation to support, strengthen and embed this work in practice, and within our systems.^{6,13}

Victoria’s family violence reforms have established important architecture for shared responsibility, information sharing and more consistent approaches to identifying, assessing and managing family violence risk. The five-year legislative review of the Family Violence Information Sharing Scheme (FVISS), Central Information Point (CIP) and Multi-Agency Risk Assessment and Management (MARAM) Framework recognised the significant progress achieved through these reforms, including greater information sharing, service coordination and consistency in risk identification and management. However, the review also identified substantial limitations in how the reforms operate in practice, including persistent misidentification and significant concerns about the capacity of MARAM and its associated tools to adequately recognise and respond to risk across diverse communities.¹⁴

The experience of AOD practice within harm reduction services demonstrates how policy settings can improve safety and reduce opportunities for ongoing harm. By providing access to health care, sterile injecting equipment, overdose

¹⁴ Family Violence Reform Implementation Monitor. (2023). *Legislative review of family violence information sharing and risk management: Reviewing the effectiveness of Parts 5A and 11 of the Family Violence Protection Act 2008 (Vic)*. State of Victoria.

prevention, peer support and integrated health responses, these services reduce the risks associated with criminalisation and unregulated drug supply.

Case study: DFSV Prevention in Crisis and Harm Reduction Settings

The Service is a Melbourne-based, crisis-responsive, specialised Alcohol and Other Drug (AOD) Primary Health Care and Harm Reduction service that supports people who are using substances (primarily injecting drug use), experiencing primary homelessness, or engaged in survival sex-work, street-based sex-work and/or independent sex work in unsafe settings. Particularly, it seeks to employ a trauma-informed social model of healthcare to individuals who cannot engage meaningfully in mainstream, appointment-based and specialist healthcare services and service pathways. As part of this model, three social workers manage The Service access point day-to-day and, in addition to facilitating access to internal health services and clinicians, support clients navigating a range of complex, intersectional and high-risk biopsychosocial challenges. Central to this are frequent disclosures by women of intimate partner family violence and community-based male-violence.

Sophie (pseudonym), commenced engaging with The Service in 2023 in the context of wanting to restart Opioid Agonist Treatment (OAT), also known as Medically Assisted Treatment for Opioid Dependence (MATOD). In addition to Sophie disengaging with her previous General Practitioner, this was against a broader backdrop of sectoral changes whereby OAT prescribing practices, particularly for this cohort, were operating at reduced capacity or closing due to retiring clinicians, funding and political associated challenges.

This is important context as it demonstrates that the drop-in based nature of The Service responds to a cohort that have limited-service options and pathways to care, including reduced capacity to maintain appointment-based settings or feel unsafe, unwelcomed or stigmatised at mainstream health services.

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

Over the duration of Sophie's engagement at The Service, Sophie has identified several evidence-based high-risk factors in her DFSV experience. Consistent throughout Sophie's disclosures, are omnipresent and exhaustive tactics of coercive control and fear-based manipulation. This includes consistent and fixated attempts to be present and included in clinical consultations and treatment plans, an intense feeling of loss of control when Sophie engages with healthcare professionals alone, and psychological and emotional and financial abuse. Additionally, Sophie has disclosed that verbal abuse has transitioned to more frequent physical acts of violence, including the perpetrator shaking her violently by the scruff of her clothing. Sophie has also recently disclosed that the

perpetrator has recommenced using methamphetamine, removed Sophie's access to transport, and is monitoring phone and internet use. Based on Sophie's opinion, secondary consultation with Specialist Family Violence Practitioners and information and recommendations handed down via the Royal Commission into Family Violence (2016), the evidence-based risk factors Sophie continues to experience presents significant risk of lethality.

The level of risk Sophie experiences, in conjunction with the responses provided by social workers and other clinicians, speaks to the level to which crisis-based responses to disclosures of high-risk DFSV are deeply entrenched in prevention work and strategy. Since presenting to The Service, the social work and clinical teams have undertaken three years of skilled crisis-based responses that undoubtedly seek to prevent further harm and violence. These responses and their preventative nature have taken many forms. Due to the level of coercive control, fear and violence experienced, Sophie has identified The Service and hospital emergency departments as her primary and only safety plan. Disclosures in these contexts have prompted extensive crisis-based interventions and safety planning to take place. This has included liaising with hospital, detox and rehabilitation services under the MARAM agreement, the development of case-specific safe words, numerous team case conferences, extensive secondary consults with family violence services and specialists, sitting in immense risk due to service engagement barriers, disclosure documentation and dynamic and skilled psychosocial and clinical strategies aimed to promote safety and prevent harms.

This case study presents an evidence-based example of how crisis-based intervention and responses to DFSV are preventative and should be considered as a central component of DFSV prevention work, strategy and planning. Considering crisis-based intervention as a separate function to broader prevention work ultimately poses significant risk to vulnerabilised women who cannot access other mainstream services, whether family violence specific or otherwise.

In this instance, Sophie has identified that the only services she is able to access without being victim to further violence is The Service and an emergency department. Sophie has specifically identified that due to the level of violence, coercive control, and surveillance experienced, accessing mainstream DFSV services is not a viable option. This, in conjunction with existing barriers to other mainstream appointment-based services, positions The Service, emergency departments and other drop-in crisis-based models at a crucial point in safely and responsively engaging with high-risk DFSV disclosures.

Sophie's case study is a pertinent example that drop-in crisis services are often the only environment where victim-survivors can disclose their level of risk and speaks to the gap in [DFSV] prevention work that often dismisses the role, place and responsibility of crisis-based responses in the DFSV sector.

Sophie has specifically identified that the skilled responses and management of her DFSV situation at The Service and broader crisis-based services have contributed towards her remaining alive, and the only pathway

to accessing supports when able and required. There must be a focus on resourcing the co-location of family violence practitioners within these settings.

Safe systems recognise the people they were designed to serve.

2. Creating the Conditions for Safety, Honesty and Change

One of the core strengths of the AOD sector is that our work begins with people as they are, while remaining clear about where responsibility for family violence harm sits. Change is rarely linear, and sustained change is more likely where people can remain connected to care, speak honestly about what is happening in their lives and access support capable of responding to the context in which change must occur.

Supporting a person who uses DFSV to address substance use, substance related harms and/or dependence does not remove accountability for their use of DFSV. Equally, accountability should not require us to reduce a person to the harm they have caused or abandon the possibility of change. The AOD sector is experienced working within this tension. Practitioners support people to identify patterns, understand impacts, strengthen motivation and make sustained changes over time while maintaining attention to the safety and wellbeing of partners, children and families. This creates opportunities to explore the relationship between substance use and behaviour without allowing substance use to become an explanation that displaces responsibility.

Safety should not be contingent on becoming sufficiently uncomplicated to fit the service system. A person should not have to resolve substance use/dependence before they can access safety from DFSV, just as they should not have to leave their experience of DFSV at the door of an AOD service in order to access treatment.

If the National Plan is serious about supporting people to stop using DFSV, it must invest in the systems where people are already seeking help and where relationships capable of supporting sustained change already exist. The task for the Second Action Plan is therefore larger than improving pathways between services. It is to create the conditions in which safety, honesty, accountability, healing and change are possible.

2.1 Building Systems that Support Honesty and Accountability

Victoria's MARAM reforms have significantly strengthened workforce capability across prescribed services to identify, assess and respond to domestic, family and sexual violence. This work remains essential and should continue. However, workforce capability alone is not enough.

The next phase of reform should focus on ensuring that broader policy settings create the conditions in which people can safely disclose what is happening in

their lives, and services have the practical capability to respond effectively. Building workforce capability without addressing the structural barriers that discourage honest disclosure risks limiting both safety and accountability.

For a person experiencing DFSV, disclosing substance use may carry valid fears extending far beyond the substance use itself: policing and criminalisation, heightened surveillance, scrutiny of parenting, family separation or child removal, loss of housing or other supports, and being considered less credible when seeking help.¹³ Effective responses to people using DFSV require practitioners to understand what is actually happening: patterns of substance use, treatment engagement, intoxication, withdrawal, parenting, relationships and risk. Where policy settings increase the costs of honest disclosure, they can reduce the quality of information available for assessment, accountability and intervention.⁷ These experiences are not equivalent and should not be merged. Responsibility for DFSV remains with the person using it. Effective systems must nevertheless understand both the circumstances in which a person experiences DFSV and those in which another person can be supported to stop using it.^{2,7}

Seen from this perspective, drug policy is not separate from DFSV policy. The question is whether our policy settings create the conditions in which people can safely tell us what is happening, and which services can respond effectively when they do. Accountability requires greater clarity about behaviour and its context, not less. Substance use may increase the frequency, severity, lethality or impacts of DFSV without fully explaining the broader pattern of controlling behaviours in which it occurs.¹³ Effective intervention requires the capacity to hold both realities at once.

2.2 Building intervention capability within AOD settings

Creating the conditions for safety and accountability also requires investment in the settings where people are already seeking help. While reform has largely focused on improving referral pathways between AOD and DFSV services, comparatively little investment has been directed towards developing and scaling interventions for people using family violence within AOD treatment settings.

AOD services engage people over extended periods and often at times when they are actively reflecting on substance use, relationships, parenting and future goals. These settings provide unique opportunities to recognise family violence earlier, support accountability, strengthen parenting and facilitate sustained behaviour change alongside recovery.

Australian models already demonstrate what is possible. Programs such as **U-Turn**,⁷ alongside emerging interventions delivered within residential rehabilitation settings, show that integrating specialist family violence practice within AOD treatment is both feasible and effective. YSAS identifies a related gap for young people using intimate partner violence, who may experience a “referral with no hope” where adult behaviour change programs are not developmentally appropriate and trusted youth services are not funded to provide specialist intervention.¹⁵ National investment in evaluating, strengthening and scaling these approaches would enable the AOD sector to contribute more fully to

implementation of the National Plan and improve opportunities for earlier intervention, safety and accountability.

In AOD practice, a lifespan approach contributes to prevention of intersectional harms by identifying and responding to changing family violence risk before harm escalates or become further entrenched. YSAS emphasises that this requires young people to be recognised as a distinct population, with strengths, forms of agency, developmental needs and social positioning that differ from those of both younger children and adults.¹⁵ Maintaining access to treatment and harm reduction, recognising when biological, psychological, therapeutic, social, structural, and systemic conditions are being exploited, supporting the safety and wellbeing of children, young people and other family members, and intervening with people using violence can interrupt opportunities for further harm. Continuity of care across life stages and service transitions can also reduce isolation, treatment disruption, overdose risk and reliance on unsafe relationships, while strengthening safety, health, connection and opportunities for sustained behaviour change.

3. The Gaps in Intersectional Risk Our Systems Miss

3.1 Systems do not respond to substance use neutrally

Australian research with women and gender diverse people who use drugs (prescribed and prohibited) found that more than three-quarters had experienced negative treatment from health workers because of their use.^{16,17} These experiences include fear of disclosure of drug use, delayed access to health care and non-attendance at follow-up appointments.³ These findings are consistent with VAADA's consultation with women for its submission to the Victorian Inquiry into Women's Pain, where women described being disbelieved, disregarded and stigmatised within healthcare settings, including experiences of inadequate pain treatment and reluctance to seek care because of anticipated judgement or punitive responses.⁴ Australian research also locates gendered substance use stigma as a form of structural violence, including through social expectations attached to femininity and motherhood.¹⁸

While this evidence specifically reflects research and consultation with women, VAADA recognises that gender and sexuality diverse people who use substances, can experience distinct and intersecting forms of DFSV, gendered stigma, discrimination and exclusion.¹⁹ Policy and service responses must be capable of recognising these experiences without assuming that gendered harm is experienced uniformly.

These experiences occur within a broader social and policy environment in which people who use illicit substances can be positioned as less deserving of care,

¹⁵ Youth Support and Advocacy Service, YSAS Submission to Consultation on Second Action Plan (2027-2032)

¹⁶ Brener et al. (2024), *Experiences of stigma and subsequent reduced access to health care among women who inject drugs*, Drug and Alcohol Review

¹⁷ Victorian Alcohol & Drug Association (VAADA). (2024). *Submission to the Inquiry into Women's Pain*.

¹⁸ Dertadian et al. (2023), *The gendered violence of injecting-related stigma among relatively affluent, suburban women who inject drugs*, Drug and Alcohol Review.

¹⁹ Ison, J., Hindes, S., & Fileborn, B. (2026). LGBTQ+ adult sexual violence critical scoping review: Victimization risk factors. *Trauma, Violence, & Abuse*, 27(2), 319–330. <https://doi.org/10.1177/15248380241311930>

credibility and protection. Criminalisation does not operate only through arrest or prosecution. It forms part of a broader system of surveillance, regulation and punishment through which some people and communities are made disproportionately visible to state systems while the harms they experience remain under-recognised. Critical scholarship evidences that these systems do not operate equally: surveillance, criminalisation and incarceration are distributed differently across communities and are inseparable from histories and continuing structures of colonisation, racism, gendered inequality and socioeconomic oppression.^{20, 21, 22, 23}

Australian research on gendered substance-use stigma further demonstrates that these structural conditions extend beyond formal contact with carceral systems.^{5,6,7} The result is not simply stigma at the point of service access. It is an unequal distribution of visibility, credibility and protection. Systems can make a person's substance use highly visible through policing, healthcare records, child protection involvement, surveillance and criminalisation, while simultaneously failing to recognise the DFSV, coercion, structural inequity or other harms shaping their circumstances. A person can therefore become **hypervisible as someone who uses substances while remaining invisible as someone experiencing DFSV**.

This is particularly consequential in the context of DFSV. VAADA has previously highlighted evidence that people experiencing DFSV were more likely to have charges brought against the person using DFSV when they were perceived by law enforcement to be sober.²⁴ This raises important questions about how perceived substance use shapes institutional credibility and the recognition of DFSV, and about whose behaviour becomes the focus of systemic intervention.^{13, 25}

This points to a central concern of this submission: whose substance use becomes visible can shape whose experience of DFSV becomes visible, but visibility itself does not occur on equal terms. The question for the Second Action Plan is therefore not only whether services recognise the intersection between substance use and DFSV. It is whether the systems responsible for providing safety, care and accountability are themselves reproducing the structural conditions through which some people are more readily surveilled, criminalised and assessed than they are believed, supported or protected.

²⁰ Cunneen, C., Baldry, E., Brown, D., Brown, M., Schwartz, M., & Steel, A. (2013). *Penal Culture and Hyperincarceration: The Revival of the Prison* (1st ed.). Routledge. <https://doi.org/10.4324/9781315599892>

²¹ Baldry, E., Carlton, B., & Cunneen, C. (2014). Abolitionism and the paradox of penal reform in Australia: Indigenous women, colonial patriarchy, and co-option. *Social Justice*, 41(3), 168–189. Retrieved from <http://www.jstor.org/stable/24361638>

²² Anthony, T. (2019). Settler-colonial governmentality: The carceral webs woven by law and politics. In *Questioning indigenous-settler relations: Interdisciplinary perspectives* (pp. 33–53). Singapore: Springer Singapore.

²³ Nethery, A. (2021). Incarceration, classification and control: Administrative detention in settler colonial Australia. *Political Geography*, 89, 102457. <https://doi.org/10.1016/j.polgeo.2021.102457>

²⁴ Victorian Alcohol & Drug Association. (2024a). *Submission to the Legislative Assembly Legal and Social Issues Committee: Inquiry into capturing data on adults who use family violence in Victoria*. VAADA.

²⁵ Evans, A. (2020). Towards an integrated response to the complex interplay of domestic and family violence, alcohol and other drug use and mental health in Western Australia. Western Australian Network of Alcohol & Drug Agencies

VAADA therefore approaches the intersection of substance use and DFSV as a systems issue as well as a practice issue. Our focus is not on locating risk or deficit in people experiencing substance dependence. It is on understanding how systems can recognise the whole context of people's lives, build on their strengths, knowledge and existing strategies for safety and recovery, and provide equitable access to safety, healing, recovery and opportunities for change.

These findings are important to the Second Action Plan because they demonstrate that outcomes are shaped not only by a person's individual circumstances, but by the systems through which they must seek support. Substance use can influence who is believed, whose experience of violence is recognised, whose parenting is scrutinised, who can access housing and safety, and whose behaviour becomes the focus of intervention.

3.2 Gaps in who and what our systems recognise

Despite the breadth of Victoria's family violence reforms, significant gaps remain in the relationships, communities and forms of risk that our systems are equipped to recognise. Further work is required to strengthen responses to the diversity of relationships and contexts in which family violence occurs, including familial family violence and adult family violence,²⁶ and to ensure that intersectional risk is visible within the standardised frameworks and tools used across the multidisciplinary and multiagency service system.

The five-year review documented concerns about the suitability of components of MARAM for diverse communities, including migrant and refugee communities, older people, people with disability, LGBTIQ+ people and male victim survivors, as well as significant concerns about the cultural safety and responsiveness of MARAM for Aboriginal people and communities.¹⁴

Project Respect²⁷ has identified similar limitations in the recognition of risk for people with experience in the sex industry and people who have experienced sexual exploitation. Stigma, criminalisation, migration and housing insecurity, and assumptions about sex work and consent may affect whether violence is recognised and whether people can access appropriate support. These experiences reinforce the need for implementation and evaluation to examine outcomes for priority communities, rather than assuming that generally improved information sharing produces equitable safety outcomes.

The effectiveness of any risk assessment or information-sharing framework depends not only on what information is shared, but on what information is recognised as relevant, whose experiences are considered credible, and whether inaccurate information can be challenged and corrected. Systems do not simply record reality; they shape it.

²⁶ Phillips. Alicia., (2026) Specialist Family Violence Advisor Showcase, Gateway Health.

²⁷ Project Respect Consultation Paper, 2026, 2nd Action Plan to Eliminate Violence Against Women and Children.

3.3 Recognising Substance Use Exploitation

One significant gap within current family violence policy and practice is the limited recognition of the ways substance use, dependence, treatment and the systems surrounding them can become relevant within patterns of domestic, family and sexual violence (DFSV). VAADA has consistently highlighted these dynamics through its submissions to the Parliamentary Inquiry into the Relationship between Domestic, Family and Sexual Violence and Suicide (2026)²⁶ and the Victorian Inquiry into Women's Pain (2024).

VAADA uses the term *substance use exploitation* to describe behaviours that exploit a person's current or past experiences of substance use, including dependence, treatment, recovery, history of substance use, stigma and anticipated institutional responses, as a means of increasing power and control. The framework recognises that people's experiences of substance use are diverse and may include enjoyment, connection, coping, symptom management, stabilisation, dependence, recovery or abstinence/harm reduction across one's life.

The object of exploitation is rarely the substance itself; it is the person. Substance use, a person's history of substance use, and the biological, personal, social and institutional circumstances surrounding it become mechanisms through which power and control can be exercised. For people experiencing DFSV, control over access to substances, treatment or pharmacotherapy may become another means through which autonomy is constrained. People may be deliberately supplied with substances, prevented from accessing them, pressured to use in unsafe ways or denied access to treatment.^{13,13} As VAADA argued in its Submission to the Inquiry into Women's Pain, stigma associated with prescribed and other substance use frequently limits access to care, undermines credibility and compounds barriers to safety.³¹

Substance use exploitation may also intersect with sexual exploitation. Project Respect has highlighted that a person using violence may introduce, control or exploit substances to facilitate sexual exploitation, constrain consent, increase reliance or make violence more difficult to disclose. These dynamics may occur within intimate relationships, the sex industry or other contexts, including sham relationships established for the purpose of exploitation. Recognising this intersection must not conflate consensual sex work with sexual exploitation: the distinction rests on consent, choice and the presence of coercion, deception or control.

Accordingly, VAADA's framework shifts the analytical focus away from substance use as the defining feature of exploitation, and towards the ways substances, their biological effects, and the circumstances surrounding them may be deliberately weaponised within broader patterns of DFSV.

Substance use coercion represents one mechanism through which substance use exploitation may occur. It involves behaviours that seek to override or limit another person's bodily autonomy, agency, liberty and/or decision-making in

relation to substances, treatment or recovery. This may include pressuring, compelling or manipulating someone to use substances, discouraging or preventing treatment, interfering with prescribed medications, making substance use or abstinence a condition of the relationship, or otherwise attempting to control decisions relating to substance use. Many forms of substance use exploitation, however, do not involve direct coercion. Instead, they exploit existing dependence, withdrawal, treatment engagement, recovery, history of substance use, parenting concerns, criminalisation, stigma or anticipated institutional responses to increase isolation, dependency, surveillance or control.³⁵

Emerging research increasingly reflects these broader patterns. Studies examining chemical control have documented the non-consensual administration or manipulation of prescribed and non-prescribed substances within coercive and controlling intimate partner violence.²⁷ Other qualitative research has identified behaviours including sabotaging recovery, making substance use a condition of the relationship, exploiting parenting concerns, reinforcing stigma and increasing social isolation.^{28,29} Collectively, this evidence demonstrates that substances, their pharmacological effects, and the broader conditions surrounding their use can all become mechanisms through which power and control are exercised within patterns of DFSV.

To address this gap, VAADA has developed the substance use exploitation framework, which synthesises emerging evidence and practice-based expertise to support the identification and response to behaviours that exploit substance use, dependence, treatment, recovery, history of substance uses and anticipated institutional responses. The framework provides a practical model for strengthening policy, workforce capability and practice, and is available to support future implementation across service systems.

The framework does not suggest that all substance use occurring within a relationship where DFSV is present is itself a tactic. Instead, it asks a different question:

How is substance use relevant to the pattern of DFSV, and how are the behaviours and conditions surrounding substance use being used to expand dominance and constrain another person's choice?

This question matters because substance use exploitation can be enabled not only by the behaviour of a person using DFSV, but also by the predictability of institutional responses. Where a person using DFSV can reasonably anticipate that another person's substance use will make them less likely to be believed, more likely to be scrutinised or less able to access safety, those structural conditions can themselves become tools of control. A threat does not require direct control over a system to be effective. It requires only a credible expectation about how that system is likely to respond.

Recognising Substance Use Exploitation therefore requires action at two levels: responding to the behaviour of the person using DFSV and addressing the policy and systemic conditions that make substance-related stigma, criminalisation and

exclusion effective mechanisms of control. The Second Action Plan must recognise substance use exploitation as an emerging area for policy, practice, research and workforce development and support further implementation, capability building and evaluation in partnership with cross partner sectors.

3.4 Misidentification

Misidentification provides one of the clearest examples of what can occur when systems fail to recognise context. Information-sharing systems are only as safe as the information they contain. Where inaccurate or decontextualised information is routinely shared across systems without effective mechanisms for review and correction, misidentification becomes not an isolated practice issue, but a predictor of systems failure.

Djirra (2024) demonstrates how inaccurate police records may persist even after judicial findings have corrected the record. Once inaccurate information enters government systems, it can continue to inform future information sharing, risk assessment and statutory decision-making, creating ongoing opportunities for criminalisation, family policing, child removal and systems abuse. Djirra further warns that inaccurate data can itself create new opportunities for people using violence to continue systems abuse through institutional responses.²⁸

This is fundamentally a governance issue. Victoria has established robust legislative frameworks requiring family violence information to be collected and shared. However, there remains no equivalent, transparent or consistently regulated mechanism requiring prescribed entities to review, correct and communicate inaccurate family violence information once misidentification has been identified. Until this gap is addressed, systems will continue to reproduce preventable harm through the routine sharing of inaccurate information.

The Five-Year Review similarly found that fear of misidentification can discourage people experiencing family violence from seeking assistance from police and statutory services, particularly people with criminal records, alcohol and other drug (AOD) concerns, or previous mental health treatment. It also identified the difficulty of correcting an inaccurate identification once it has entered service systems.¹⁴ YSAS identifies related risks for young people, whose resistance to DFSV, substance use, distress, disability or neurodivergent presentations may be misidentified and met through adult legal and policing responses. Misidentification is known to increase surveillance and judicial-system involvement while obscuring experiences of violence, developmental context and need for safety and support.¹⁵

One practitioner described the consequences in this way:

"I wasn't being protected anymore. I was being watched. My substance use became the story, while the violence he used against me and our children disappeared into the background. The more the system watched me, the less it watched him. He didn't have to keep controlling us, the system did it for him."

²⁸ Djirra. (2024, May 27). *Submission to the Legislative Assembly Legal and Social Issues Committee: Inquiry into capturing data on family violence perpetrators in Victoria*. Parliament of Victoria.

I wasn't escaping the violence. I was carrying it from service to service. Every report, every assessment and every file that recorded my substance use without the context of his abuse gave the system another reason to watch me, question my parenting and fear for my children, while he remained free to continue the violence."

This reflection is not hypothetical. It reflects a pattern repeatedly encountered across practice. When inaccurate information is accepted as fact and routinely shared across systems, surveillance is redirected towards the person experiencing family violence while the person using violence becomes progressively less visible to the very systems intended to hold them accountable. Substance use becomes evidence of risk rather than part of the context requiring a response.^{6,14}

The longer inaccurate information remains uncorrected, the more deeply it becomes embedded across systems, influencing future assessments, statutory intervention and structured professional judgement. Each repetition reinforces the appearance that the original assessment was correct. Families become subject to escalating surveillance, children are removed, parents are criminalised, treatment is disrupted, trust in services is eroded and opportunities for safety are lost. For some, the consequences are irreversible.^{6,11,14}

This is not simply a failure of information sharing. It is a predictable governance failure. Information sharing is only as safe as the governance surrounding the information being shared. A system that legislates the sharing of information, but not the correction of inaccurate information, should expect to reproduce misidentification. The resulting harm is foreseeable, preventable and cumulative.¹⁴

3.5 When Systems Weaponise Substance Use

Substance use is one of the most visible aspects of many people's lives within health and statutory systems.

Substance use is not a single risk factor. It may serve many different functions within the context of DFSV, and those functions are directly relevant to understanding risk, safety and intervention.²⁹ People may use substances for enjoyment, to manage trauma symptoms, reduce hypervigilance, cope with chronic pain, survive homelessness, remain awake to protect children, manage withdrawal, or navigate the cumulative impacts of violence and social exclusion.³⁰ Equally, substance use may be deliberately encouraged, controlled or exploited by the person using family violence as part of a broader pattern of domination and control. Without understanding the function that substance use is serving, systems risk responding to the behaviour rather than the circumstances producing it.³¹ The presence of substance use alone therefore provides limited

²⁹ Dudgeon, P., Gibson, C., Walker, R., Bray, A., Agung-Igusti, R., Derry, K., ... & Gee, G. (2025). Social and emotional wellbeing: A review. *Lowitja institute*.

³⁰ Anthony, T., Bhatia, M., Pillay, K., & Williams, J. M. (2026). Introduction: Racial Injustice and the Global Crisis of State Violence. In *The Palgrave Handbook of Racial Injustice and Resistance* (pp. 1-11). Cham: Springer Nature Switzerland.

³¹ Anthony, T., & Blagg, H. (2021). Biopower of Colonialism in Carceral Contexts: Implications for Aboriginal Deaths in Custody. *Bioethical Inquiry*, 18(1), 71–82. <https://doi.org/10.1007/s11673-020-10076-x>

information. What matters is its risk relevance, how, why and in what ways substance use is influencing a person's experience of violence, safety and recovery.

The need to strengthen assessment in this area has already been recognised through the Five-Year Family Violence Reform Implementation Monitor, which identified that existing MARAM risk assessment tools do not consistently support practitioners to assess the relevance of alcohol and other drug use within family violence risk assessment for people experiencing family violence.¹⁴ The Second Action Plan provides an opportunity to build on this work by ensuring national assessment guidance supports practitioners across prescribed services to determine the risk relevance of substance use and substance-related harm as part of understanding family violence.¹³

These limitations are not peripheral to the effectiveness of the reforms. The design of our systems shapes who becomes recognisable to them, what information becomes legible as risk, and what responses become possible. The five-year review found that people who do not access family violence support through first responder/family violence pathways may receive different service responses because of unequal access to consolidated risk information, specifically identifying Aboriginal people, people who use substances, culturally diverse communities, LGBTIQ+ people and older people among those who may be less likely to seek assistance through mainstream, government-led services.¹⁴

People do not experience DFSV from equal social positions, nor do they arrive at services with equal access to housing, financial security, healthcare or social support.^{32,33} Systems designed around standardised pathways therefore produce inequitable outcomes when they fail to account for the structural conditions shaping people's lives.^{22,34}

A commitment to equity requires systems to be designed around the communities experiencing the greatest barriers to safety, rather than those whose circumstances most closely align with existing service models. This includes people experiencing the intersections of DFSV, substance use, homelessness, disability, criminalisation, racism, poverty and other forms of structural oppression.³²

The more pressing challenge is no longer whether family violence can be identified, but whether the broader service system is designed and resourced to respond equitably once it is. Despite significant investment in reform, people who use substances continue to encounter stigma, service exclusion, fragmented referral pathways and inconsistent access to practical family violence support. Too often, substance use continues to be interpreted as a reason to delay, limit or refuse a family violence response, rather than as part of the context requiring that response.¹³ *Safety should be available through the services that people can*

³² Theobald, J., Watson, J., Haylett, F., & Murray, S. (2023). Supporting pregnant women experiencing homelessness. *Australian Social Work*, 76(1), 34-46.

³³ Ison, J., Hindes, S., & Fileborn, B. (2026). *LGBTQ+ adult sexual violence critical scoping review: Victimization risk factors*. *Trauma, Violence, & Abuse*, 27(2), 319-330. <https://doi.org/10.1177/15248380241311930>

³⁴ Ablaza C, Kuskoff E, Perales F & Parsell C. (2023). *Responding to Domestic and Family Violence: The Role of Non-Specialist Services and Implications for Social Work*. British Journal of Social Work.

actually access, not only through the services our systems assume they should access. If a person meets the substantive criteria for a family violence response, access to safety should not depend on where risk was first identified. This requires systems to move beyond referral-based models towards responses that are available through the practitioners and services already working alongside people, including AOD services.^{134,25}

This requires AOD services, alongside other prescribed services responding to family violence, to have equitable access to the practical resources needed to support an effective intervention. This includes access to:

- the Housing Establishment Fund (HEF) and emergency material assistance;
- priority access to social housing and the Priority Access Housing Register applications;
- rental assistance and private rental brokerage;
- crisis and transitional accommodation;
- equitable access to Family Violence Flexible Support Packages (FVFSPs);
- practical safety measures and brokerage; and
- integrated referral pathways that enable timely access to DFSV services, housing and interdisciplinary services.

As a community committed to eliminating DFSV, we must continue examining whether our frameworks, tools and systems reflect the realities encountered by communities, practitioners and service systems. This requires ongoing learning from Aboriginal community-controlled organisations, people with lived and living experience, diverse communities and the sectors working alongside people whose experiences may not yet be fully reflected within existing family violence architecture.

DFSV cannot be the responsibility of one service system. The systems already working alongside people must be equipped, resourced and connected to respond safely and equitably. Identification without access to an effective response is not an effective response.

4. Policy settings that shape safety, accountability and Substance Use Exploitation

4.1 Decriminalisation of Personal Drug Use

The criminalisation of personal drug use and possession creates outcomes that extend well beyond contact with the criminal legal system. In the context of DFSV, it can become relevant to safety, intervention and opportunities for change.³⁵

For people experiencing DFSV, fear of policing, criminalisation, family policing, child removal, heightened surveillance, dispossession and diminished credibility can constrain disclosure and help-seeking. These anticipated system responses

³⁵ Victorian Alcohol and Drug Association. (2024). *Submission to the Inquiry into Women's Pain*. Victorian Alcohol and Drug Association.

may themselves become tools of systems abuse, exploited by a person using DFSV to reinforce control and reduce a person's willingness to seek support.³⁵

For people using DFSV, effective intervention depends on practitioners being able to understand the relationship between substance use, behaviour and risk.

Where criminalisation discourages honest disclosure about substance use, intoxication or withdrawal, it reduces opportunities for meaningful assessment, accountability and sustained behaviour change.⁷ If the Second Action Plan seeks earlier intervention and meaningful accountability, it must also consider the policy settings that discourage the very disclosure on which effective assessment and response depends. Drug decriminalisation will not, by itself, prevent DFSV. Nor is it a substitute for gendered and intersectional analysis, risk assessment, accountability or DFSV responses.

Its relevance lies in the way criminalisation can shape patterns of power and control. Where substance use is criminalised, disclosure carries significant legal and social consequences. These consequences can themselves become tools of abuse. A person using family violence may threaten to report another person's substance use to police or child protection, expose them to employers or family members, or exploit fears of criminalisation, child removal, housing loss or stigma to increase compliance and prevent help-seeking.³⁵

The criminalisation of personal drug use creates conditions in which threats become more credible, disclosure becomes more dangerous, and institutional responses themselves may become mechanisms of control.³⁵ Those assumptions influence how people are believed, whether they are considered deserving of support, how parenting is assessed, and whether substance use is understood as contextual information or evidence of personal irresponsibility. These institutional assumptions can make disclosure more consequential for a person seeking safety. They can also reduce opportunities for honest engagement, meaningful assessment and effective intervention where both substance use and the use of DFSV require a response.⁶

Australian qualitative research demonstrates that the impacts of drug policy are shaped by people's lived experiences of criminalisation, incarceration and exclusion. International evidence, including from Portugal, shows that removing criminal penalties for personal drug use and possession did not produce the substantial increases in drug use predicted by opponents of reform and can form part of a broader public health response.³⁶ *A system cannot meaningfully support safety, healing or accountability while making honesty more harmful and dangerous.*

Decriminalisation, however, addresses only one part of the policy environment.

4.2 Safe, Regulated Supply

Even where criminal penalties are removed, people who use substances may still be required to rely on an unregulated market characterised by uncertain composition, potency, availability and cost.^{7,34} Within the context of DFSV,

³⁶ Hughes, C. E., & Stevens, A. (2010). What can we learn from the Portuguese decriminalization of illicit drugs? *The British Journal of Criminology*, 50(6), 999-1022. DOI:[10.1093/bjc/azq038](https://doi.org/10.1093/bjc/azq038)

dependence created by an unregulated market may increase opportunities for *substance use exploitation* by increasing reliance on others for access to substances, treatment, money, transport or housing. These are not simply consequences of substance use. They are manifestations of family violence occurring within the context of an unregulated drug market.^{7,13}

For children, families and communities, the harms associated with an unregulated drug supply may also compound existing family violence.^{9,16,21} Periods of escalating DFSV may coincide with increased overdose risk, health crises, housing instability, bereavement and repeated involvement with statutory systems, creating cumulative harms that extend well beyond the DFSV itself.³⁵

Drug law reform advocates support the development of evidence-informed models of safe, regulated supply as part of a broader public health, harm reduction and human rights response. The case for regulated supply is not that it will prevent or eliminate DFSV. Rather, it seeks to reduce preventable harms, sources of instability and opportunities for substance use exploitation that compound existing harms.

While international experience, including Portugal, demonstrates the benefits of shifting from punitive approaches towards integrated health responses, Australian reform should be designed, implemented and evaluated within the Australian policy, health and family violence context.

4.3 Connect the policy systems that shape people's lives

Governments organise health, alcohol and other drug, housing, justice and domestic, family and sexual violence responses through separate portfolios, funding streams, legislation, workforce strategies and outcomes frameworks. While administratively necessary, these divisions do not reflect how safety, health, behaviour change and recovery occur in people's lives. Public systems should be designed to respond to the whole person, rather than the single issue through which they first become visible. Where a person first enters the system should not determine which aspects of their life become visible, which risks are recognised or which opportunities for safety, accountability and change become available.

Policy settings determine what information becomes visible, what risk becomes recognisable, which sectors are equipped and resourced to respond and, ultimately, whose safety and whose accountability become possible. Governments therefore have a responsibility to ensure that legislation, policy and public systems are responsive to the realities of people's lives, particularly those experiencing the greatest structural barriers to safety, health and justice. Systems designed to respond safely to substance use, disability, racism, colonisation, poverty, homelessness, gender diversity and domestic, family and sexual violence are not specialist systems for a small number of people, they are better systems for everyone.

Every person should be able to access health care, support and opportunities for change regardless of where they first enter the system. Whether someone presents to an alcohol and other drug service, a hospital, family violence service,

homelessness service, general practice, child and family service or justice setting should not determine how their safety, parenting, substance use, health needs or opportunities for accountability are recognised. Systems should be designed to recognise intersecting risk wherever it presents, rather than assuming responsibility begins only after a person reaches a specialist service.

The Second Action Plan should therefore promote deliberate alignment across government portfolios that shape safety, health, justice and wellbeing. Alignment must extend beyond policy language to shared governance, investment, workforce development, implementation, data and evaluation. Rather than concentrating family violence capability within a single portfolio, governments should build capability wherever meaningful opportunities for safety, accountability and behaviour change arise. This requires sustained investment in workforce capability across systems, including sectors that routinely encounter intersecting risks but have not historically been recognised as central to the family violence response.

Alcohol and other drug services are one example of this broader principle. These services routinely encounter the intersections between substance use, trauma, parenting, health and family violence and often engage with people long before family violence becomes visible to specialist or statutory responses. Strengthening family violence capability within these settings increases opportunities for earlier recognition of risk, safer responses, accountability, referral and behaviour change without requiring people to first enter specialist family violence systems. YSAS demonstrates that the same principle applies to youth and youth AOD services, while also emphasising that service integration cannot substitute for access to safe housing, healthcare, material assistance and youth-specific DFSV support. Coordination cannot create safety where the practical resources required for safety are unavailable.¹⁵

Implementation of the Second Action Plan should require reciprocal recognition of intersecting risks across national and jurisdictional strategies. This should include reciprocal alignment between the National Plan to End Violence against Women and Children and the forthcoming National Drug Strategy, alongside relevant state and territory strategies.

Drug and alcohol strategies should explicitly recognise DFSV including substance use exploitation, misidentification, parenting, suicide and overdose, as relevant to their implementation. Likewise, domestic, family and sexual violence strategies should explicitly recognise substance dependence, withdrawal, harm reduction, treatment access, criminalisation and the unregulated drug supply as relevant to safety, accountability and recovery.

This reciprocal integration should be supported through joint governance and accountability, aligned outcomes and evaluation, shared research priorities, compatible and risk-relevant data systems, reciprocal workforce capability, joint commissioning of integrated responses, and mechanisms for translating learning across jurisdictions.

The purpose is not to collapse distinct areas of expertise into a single system. It is to ensure that governments stop organising policy and services as though people experience one form of harm, one service system or one need at a time. Instead, governments should design systems capable of recognising and responding to the realities of people's lives, particularly where structural barriers to safety, health and justice are greatest. Systems designed around the whole person are better able to recognise intersecting risks, strengthen equitable access to safety, maintain accountability, reduce preventable harms and create more opportunities for recovery and lasting change.

Effective responses should not be viewed as separate from prevention. Systems that recognise risk earlier, respond safely, support accountability and reduce preventable harms also reduce opportunities for violence to escalate, recur and become entrenched. Designing systems capable of responding to people experiencing the greatest structural barriers to safety is therefore not only good crisis response; it is an essential foundation for prevention.

Project Respect also recommends sustainably funding and evaluating integrated responses across Commonwealth and state-based systems, rather than assessing individual programs in isolation or transferring responsibility for trafficking and modern slavery responses to under-resourced specialist services and workers.

Systems and policy settings are not merely the backdrop against which DFSV occurs. They shape the conditions in which safety, accountability, healing and change become more or less possible.

4.4 Enabling Responses Designed for Real People

Just as policy settings shape what risks become visible, service systems also shape whose experiences are recognised, believed and responded to.

The Second Action Plan also provides an opportunity to examine the assumptions embedded within our service systems. Just as criminalisation shapes how substance use is interpreted, service systems frequently make assumptions about how a person experiencing DFSV should present in order to be recognised as credible, deserving of support and ready to engage. Too often, these assumptions reflect an imagined "perfect victim", rather than the realities of people's lives.

This imagined person is expected to disclose DFSV early, disengage from the relationship, abstain from substance use, comply with multiple service requirements, consistently engage with treatment, protect children from every impact of DFSV, and make decisions that systems consider rational and safe. They are expected to navigate fragmented service systems while managing trauma, housing insecurity, poverty, parenting responsibilities, criminalisation and other forms of structural oppression.

This is not how domestic, family and sexual violence is experienced for most, nor how recovery, safety or behaviour change occur.

There is no "perfect victim" of DFSV because there is no perfect context in which violence occurs. People experiencing DFSV may use substances, return to relationships, miss appointments, be ambivalent about statutory involvement,

prioritise immediate survival, experience withdrawal, protect a person who has harmed them, fear child removal or make decisions within severely constrained circumstances. These responses do not diminish the seriousness of the DFSV they experience, nor do they reduce their entitlement to safety, dignity or support.

These assumptions do not operate only in relation to people experiencing violence. Service systems can also hold implicit assumptions about who uses DFSV. People using DFSV are often imagined as immediately identifiable, consistently violent, highly visible to statutory systems or already engaged with specialist interventions. In reality, many people using DFSV remain embedded within families, workplaces and communities while also engaging with health, alcohol and other drug, mental health and other universal services.⁷ Effective accountability therefore depends on building capability wherever opportunities exist to recognise risk, respond safely and support behaviour change.¹³

When systems are designed around idealised archetypes of how people should experience, disclose or respond to domestic, family and sexual violence, people whose lives do not fit those constructions are more likely to be characterised as non-compliant, unreliable, difficult or unsuitable for support. Strategies developed to survive unsafe conditions may themselves become evidence against the person using them. Avoiding calls from an unknown number may be interpreted as disengagement, rather than a rational response to debt collection, fear, surveillance or safety concerns. Substance use may be interpreted as moral failure rather than contextual information. Returning to, or remaining in, a relationship may be interpreted as evidence that the DFSV is less serious, rather than a response to financial abuse, homelessness, parenting responsibilities, fear, controlling behaviour or the cumulative impacts of structural oppression. The result is not simply individual exclusion; it is a system that fails the people experiencing the greatest structural barriers to safety.

Fragmented systems continue to place responsibility for navigating complexity onto the person seeking support, requiring repeated disclosure, repeated assessment and repeated retelling of traumatic experiences. The burden of integration too often sits with the community rather than the system.^{6,13,23,24}

Practice should be grounded in curiosity rather than compliance. Rather than asking why a person has not engaged in the way a system expected, practitioners should ask what structural, relational or contextual factors are shaping that person's choices, opportunities and safety.

Ultimately, effective practice reflects the realities in which safety, accountability and change occur. Complexity is not an exception to be managed; it is the ordinary condition of human lives. Responses designed around that reality, rather than idealised assumptions about how people should present, recover, heal or engage, are better able to reduce systems abuse, strengthen equitable access to safety and create the conditions for accountability, recovery and healing.

Conclusion

The Second Action Plan presents an opportunity to strengthen Australia's response to DFSV by recognising that people's lives do not fit neatly within policy

portfolios, service systems or professional scope of practice. Safety, accountability, recovery and behaviour change are shaped by the interaction of structural conditions, public policy and service responses. Effective implementation therefore requires governments to design systems capable of recognising and responding to these realities.

For people who use substances, DFSV is frequently experienced alongside stigma, criminalisation, trauma, poverty, homelessness, parenting responsibilities and other forms of structural oppression. These intersecting experiences should not be understood as barriers to effective responses, but as the contexts within which effective responses must occur. Systems that recognise complexity without losing sight of accountability create more opportunities for safety, earlier intervention and meaningful change.

The recommendations within this submission provide practical opportunities to strengthen Australia's DFSV response through integrated policy, workforce capability, recognition of substance use exploitation, equitable service design and greater investment in sectors that routinely encounter intersectional risk. These reforms will strengthen responses for people who use substances while improving safety and accessibility across the broader service system for both people who use DFSV, and people who experience DFSV.

Ultimately, systems and policy settings are not merely the backdrop against which DFSV occurs. They shape whether risk is recognised, whether support is accessible, whether accountability is strengthened and whether opportunities for healing and lasting change become possible. Designing systems around the realities of people's lives is therefore not only good public policy, but also an essential foundation for ending DFSV.

Recommendations

VAADA recommends that the Second Action Plan strengthen Australia's response to DFSV and substance use by addressing the structural, policy and practice conditions that shape safety, accountability and equitable access to support.

1. Embed Substance Use Exploitation: within national family violence policy, practice guidance and risk assessment frameworks.

- Embed the Substance Use Exploitation Framework within national DFSV policy, risk assessment and practice guidance, supported by implementation resources, workforce development and evaluation.

2. National Workforce and System Capability for Integrated AOD and DFSV Responses

- Expand the Specialist Family Violence Advisor Capability Building Program.
- Develop shared practice standards.
- Invest in implementation support, secondary consultation and communities of practice.

- Ensure AOD services have equitable access to practical family violence responses, including brokerage, housing supports and integrated referral pathways.

3. Strengthen Responses for People Using Family Violence: Invest in evaluated integrated interventions, such as Windana's U-Turn program, and embed developmentally and culturally appropriate family violence interventions across AOD treatment pathways, including community-based services, withdrawal programs and residential rehabilitation. These interventions should address family violence alongside substance use and other intersecting risks.

Access should not depend on abstinence or completion of AOD treatment. Outcomes should include changes in family violence behaviour, partner and child safety, harm reduction, treatment continuity and sustained engagement.

4. Prevent and Correct Misidentification: Establish nationally consistent processes for regulating, preventing, identifying and correcting misidentification, including notification, information-sharing governance, review and oversight.

5. Design Systems Around Intersectional Risk Across the Lifespan: Design national policy, implementation and service integration around the intersecting social, structural and systemic conditions that shape safety, risk, recognition and access to support across the lifespan. Ensure responses are age- and developmentally appropriate and support YSAS's recommendations that young people be recognised as a distinct population, with needs and experiences that differ from those of younger children and adults, and that integrated prevention, early intervention, response, recovery and healing be available through the services young people already access.

6. Reform Policy Settings that Influence Safety and Disclosure: Review policy settings that discourage disclosure, enable systems abuse or increase surveillance and punishment, and recognise AOD treatment and harm reduction services as essential DFSV partners.

Recognise reducing opportunities for substance use exploitation as a family violence safety and prevention outcome. This includes maintaining treatment continuity, preventing overdose, supporting safer use and sustained engagement, enabling access to a regulated and safer supply, and reducing reliance on an unregulated supply or a person using DFSV who controls access to substances.

7. Align National Strategies: Fund and ensure reciprocal integration between the National Plan to End Violence against Women and Children and the forthcoming National Drug Strategy through shared governance, implementation, research and evaluation, including explicit attention to the intersections between youth AOD use and DFSV, sexual exploitation, trafficking and modern slavery, and the interfaces with state-based policies and strategies.

8. Strengthen national evidence systems: by recognising research, practice expertise, implementation evidence and lived and living experience as

complementary sources of evidence for policy development, service design and reform.

- Invest in rigorous multidisciplinary research and implementation evaluation that considers intersectional risk across a lifespan.
- Embed practitioners, researchers, and people with lived and living experience of intersectional risk in setting national research priorities and designing research.
- Establish mechanisms for emerging practice issues to inform national policy, research and practice guidance, including funding specialists in intersectional risk.
- Support continuous evaluation and learning across policy, practice and service systems.⁷