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31 July 2026

Second Action Plan Consultation team
Department of Social Services
GPO Box 9820
Canberra ACT 2601

Submitted to: https://engage.dss.gov.au/second-action-plan/submissions/

Dear Second Action Plan Consultation team,

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

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to inform the development of the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032 (the National Plan).

The APS is the leading professional association for psychologists in Australia. Our members work across health, mental health, community, education, family, justice and specialist service systems, and frequently support individuals, families and communities affected by domestic, family and sexual violence (DFSV). Psychological expertise is critical to understanding the impacts of violence, coercive control and trauma, and to supporting effective prevention, risk assessment, recovery and behaviour change.

The attached submission responds to the priority areas identified in the consultation paper. It draws on psychological evidence, previous APS submissions and reports, and insights from APS members with expertise in DFSV, trauma, suicide risk, children and young people, prevention, perpetrator intervention, and workforce capability.

We consent to this submission being made publicly available. Should further information be required, please contact me at the APS National Office on (03) 8662 3300 or via email at z.burgess@psychology.org.au.

Yours sincerely,

Dr Zena Burgess FAPS AICD
Chief Executive Officer

APS response

The APS agrees with the Consultation Paper's assessment that violence against women and children in Australia remains unacceptably high. Domestic, family, and sexual violence (DFSV) is one of the most significant health and welfare challenges facing Australia, with profound impacts on victim-survivors, children, families, communities and the systems that support them[1].

We welcome the Consultation Paper's focus on victim-survivors, prevention and early intervention, people who use violence, and system integration and workforce. In addition, we commend the focus on children and young people in their own right. These priorities align closely with psychological expertise in trauma, coercive control, behaviour change, risk assessment, prevention, recovery and workforce sustainability.

Given the breadth of the consultation, the APS has provided a targeted response to selected questions and issues where we identified gaps, risks, or opportunities to add value to the Second Action Plan.

Priority Area 1: Victim-Survivors

What service or system responses would make the biggest difference to victim-survivors' safety, wellbeing, healing and recovery?

Improved measurement of DFSV to facilitate more integrated risk identification

The APS has previously identified that DFSV related data are held across multiple systems that are often poorly integrated, with differences in legislation, data definitions and reporting practices limiting the ability to conduct consistent national analysis[2]. We, therefore, support recommendations outlined in the Consultation Paper to improve the measurement of DFSV which may facilitate more integrated risk identification and information sharing across jurisdictions. These recommendations aim to strengthen DFSV data systems to better capture the experiences of high-risk populations, emerging forms of abuse and patterns of harm.

Jurisdictional reforms demonstrate the potential for more integrated approaches to risk identification and information sharing[2]. Victoria's Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)[3], for example, establishes a system-wide approach to identifying, assessing, and managing family violence risk across multiple sectors, supported by legislated information-sharing arrangements[4,5]. The New South Wales (NSW) Government also recently funded the development of the Domestic and Family Violence Common Risk Assessment Framework (DFVCRAF), which aims to ensure timely and consistent risk identification and management across government agencies, non-government and community organisations[6]. The NSW Government will use the DFVCRAF Implementation Insights Report[7] to help inform next steps for implementation of this framework.

Inclusion of key professionals in coordinated risk management

Important contextual information about DFSV victimisation may be identified within psychology practices but is rarely captured within administrative datasets. Individuals may present to psychologists with symptoms such as anxiety or depression, with the underlying context of DFSV emerging gradually through therapeutic work. Because psychology services, particularly in private practice, operate largely within therapeutic settings outside existing data linkage systems, this information rarely contributes to national reporting processes.

As we have previously asserted[2], multidisciplinary responses are widely recognised as best practice in high-risk DFSV cases[8], yet current funding arrangements such as the Medicare Better Access Initiative[9] do not support psychologists to participate in case coordination meetings with other services.

As a result, professionals who may hold important information about an individual's experience of violence are often absent from the forums where risk is assessed and managed across systems.

These limitations highlight the need for more integrated approaches to risk identification, information sharing and coordinated intervention across systems.

Timely access to trauma-informed psychology services

Victim-survivors may seek the care of a psychologist when determining whether a relationship is abusive, as support while planning to leave an abusive relationship, and at various points throughout their recovery.

We reiterate our recommendation that the Australian Government enable victim-survivors direct access to Medicare-funded psychology services without requiring a GP referral or mental health diagnosis[10,11].

Extending the Medicare Benefits Schedule (MBS) to streamline victim-survivors' access to psychological services would enable items to be claimed based on the psychologist forming a reasonable belief, based on their clinical judgment and expertise, that the patient is experiencing, or has experienced, DFSV[10]. This is particularly important for victim-survivors experiencing coercive control, financial abuse or surveillance, where attending a GP appointment may be unsafe or impractical. Another benefit in enabling direct access to psychological care for victim-survivors is that it may reduce the risk that needing to obtain a mental health diagnosis from a GP as part of the Mental Health Treatment Plan unfairly characterises their experience as a mental health disorder[10].

The APS also recommends increasing the number of Medicare-funded psychology sessions available to victim-survivors, recognising that recovery from trauma and coercive control often requires longer-term support[2].

What current or emerging issues should the Second Action Plan address, including in relation to coercive control and technology-facilitated abuse?

The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFSV

The Second Action Plan should address the use of suicide and threats of suicide as a tactic of coercive control. Threats of suicide or self-harm may be used to compel compliance, discourage disclosure, prevent a victim-survivor from leaving, or regain control during separation, legal proceedings or other periods of heightened risk[12–14]. Australian research suggests this is not uncommon, with one study finding that approximately 39% of women who experienced coercive control reported being subjected to threats of suicide or self-harm by a partner[15].

Importantly, coercive intent and genuine suicide risk may coexist[14,16]. If suicide threats are treated only as a mental health crisis, the coercive function of the behaviour may be missed, and victim-survivor safety deprioritised. Conversely, dismissing threats as purely manipulative may fail to identify genuine suicide risk[14]. Psychologists are well placed to help determine the coercive dynamics and genuine suicide risk which requires complex professional judgement.

The APS recommends that the Second Action Plan support nationally consistent guidance for practitioners to assess DFSV risk and suicide risk together, including practical guidance on responding to suicide threats that may function both as indicators of distress and tactics of control[2].

Technology-facilitated abuse

The Consultation Paper appropriately recognises technology-facilitated abuse as a form of violence. The Second Action Plan should build on this by setting out the practical systems, responsibilities and supports needed to prevent and respond to technology-facilitated abuse as a mainstream aspect of DFSV and coercive control.

This should include clear scope and examples, including stalking, monitoring, location tracking, spyware, repeated unwanted contact, impersonation, fake accounts, image-based abuse, AI-generated sexualised images or videos, threats to share intimate images, doxxing, and abuse through shared parenting apps, banking apps, school communication apps and children's devices.

The Second Action Plan should also set expectations across prevention, frontline capability, justice responses, platform accountability, specialist technology-safety support, children and young people, and data and evaluation. This includes:

- embedding digital consent, image-based abuse, online misogyny, dating-app abuse and coercive control within respectful relationships education;
- building capability across police, courts, health, mental health, child protection, family law, schools, banks and specialist services;
- ensuring protection orders, family law processes and perpetrator interventions explicitly address digital abuse; and
- improving national data on technology-facilitated abuse, including repeat victimisation, severity and cumulative impacts.

Victim-survivors should not be left to manage technology-facilitated abuse alone. The Second Action Plan should support access to specific technology-safety advice, safe evidence preservation, rapid reporting pathways and coordinated responses between police, eSafety[17], DFSV services, legal services and online platforms. Technology companies should also have clear responsibilities to prevent foreseeable harm, design for safety and privacy, respond rapidly, reduce repeat abuse and provide escalation pathways for victim-survivors and advocates.

What gaps remain in addressing the needs of diverse communities, including Aboriginal and Torres Strait Islander people?

Aboriginal and Torres Strait Islander peoples experience heightened vulnerability to DFSV due to intersecting structural and historical determinants[18]. Experience of DFSV occurs within broader contexts of social disadvantage, which increase exposure to trauma and limit access to culturally safe supports. Colonisation, dispossession and the Stolen Generations have contributed to intergenerational trauma linked to cycles of violence and family disruption[19].

The APS has long championed the importance of cultural safety being at the heart of DFSV prevention and response initiatives and for these initiatives to be genuinely co-produced with First Nations Australians[20].

Consistent with recommendations from the recent Missing and Murdered Indigenous Women and Children Roundtable[21], we advocate for DFSV initiatives to be led by Aboriginal and Torres Strait Islander women and communities and for long-term, equitable investment that prioritises Aboriginal Community-Controlled Organisations and supports prevention, healing, and culturally safe, community-led responses.

Gaps also remain for migrant and refugee communities, people with disabilities, people from culturally and linguistically diverse (CALD) backgrounds, LGBTQA+ people, people living in rural, regional and remote communities and mothers[22](see also Additional Comments section). Other barriers encountered by these communities may include social isolation, communication barriers, power imbalances and dependency on others for care and material resources, and fear of consequences when seeking support. We advocate for sustained funding for community-led and accessible supports that contribute to reducing discrimination and stigma about DFSV disclosure.

Priority Area 2: Prevention and Early Intervention

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

The APS supports the Consultation Paper's comprehensive framing of prevention, including its focus on gender inequality as a core driver of violence and shifting the attitudes, behaviours, systems and structures that allow violence against women and children to occur.

The biggest difference in preventing and ultimately ending violence would come from sustained implementation of this prevention agenda over decades, supported by structural reform and properly resourced systems. Prevention cannot rely on short-term funding cycles, isolated programs or one-off awareness campaigns. It requires long-term, whole of population attitude and behaviour change across schools, workplaces, media, online environments, communities and institutions.

The Second Action Plan should also make clear that prevention depends on the structural conditions that enable safety. Safe and affordable housing, women's economic security, wage equity, superannuation equity, access to childcare, income support and financial safety mechanisms should be treated as prevention infrastructure, not only as crisis responses. Leaving and recovering from violence should not be made financially impossible. This is consistent with the Australian Human Rights Commission's recent recommendations to address gender equity and safety, including action on intersectional data collection, workplace inequality, pregnancy and family responsibilities discrimination, unpaid labour, the undervaluing of female-dominated industries, and adequately funded, community-led prevention efforts[23].

Finally, prevention must be connected to early intervention and response systems. Community education will have limited impact if DFSV services, housing, legal assistance, health, mental health, child protection and justice systems remain under-resourced or fragmented. The biggest difference will come from a prevention system that is sustained, constantly evaluated, structurally supported and connected to practical pathways to safety, accountability and recovery.

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

The APS supports sustained, evidence-informed prevention and early intervention approaches, including respectful relationships education, public awareness about DFSV and coercive control, and early intervention with people using or at risk of using violence. The Consultation Paper rightly notes that long-term, consistent prevention programs beginning in primary school are most effective, and that one-off or poorly contextualised programs can risk backlash.

Psychologists have expertise in behaviour change, bias, motivation, developmental learning and the social and cognitive processes that shape attitudes and behaviours.

This expertise can support the design, implementation and evaluation of prevention initiatives that seek to shift entrenched beliefs, challenge harmful attitudes and behaviours and build respectful relationship skills from early childhood and school settings.

To strengthen and expand these approaches, governments should invest in sustained funding, workforce capability, rigorous evaluation, and clear safeguards so that early intervention with people using or at risk of using violence remains accountable and centred on victim-survivor safety.

The APS previously commended the Australian Government for investing in the 'Stop it at the start' campaign[24] which raised awareness about the potential negative influences of social media on respect (particularly towards women)[25]. We also support age-appropriate prevention and early intervention programs in educational settings which help children and young people to recognise DFSV, coercive control, unsafe relationships, grooming, technology-facilitated abuse and safe help-seeking pathways. These programs could be delivered by psychology teams, school wellbeing teams or appropriately trained mental health professionals.

Children and young people, however, cannot carry the burden of prevention knowledge alone. As the Consultation Paper identifies, young people can experience a profound contradiction when they are taught about consent and respect in the classroom yet return to homes and communities where the adults around them use violence or normalise its use. Parent and carer education should sit alongside school-based programs, and include recognising coercive control, responding to disclosures and supporting children without blame, shame or minimisation.

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

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

The APS commends the Consultation Paper's recognition that children and young people must be understood as victim-survivors in their own right, not only as witnesses to adult violence or dependants of an adult victim-survivor.

Children and young people are profoundly affected by DFSV, either as direct victims or through displays of violence within the home[26]. Exposure to family violence during childhood is associated with increased risk of suicidal ideation, suicide attempts, and long-term psychological harm, including vulnerability to future interpersonal violence[27–29]. A study of children exposed to DFSV in Western Australia found that by age 18, children who had been exposed to domestic and family violence were 79% likely to have had contact with mental health services, compared with 16% of those who had not been exposed[30].

The APS recommends that the Australian Government work with state and territory governments to address barriers preventing children from accessing psychology services in DFSV contexts, including situations where perpetrators withhold consent for treatment. Children exposed to DFSV may experience significant psychological distress and trauma-related impacts, including increased risk of self-harm, suicidal ideation and later suicidal behaviour. These responses should be understood in the context of violence, coercive control and disrupted safety rather than treated only as individual mental health concerns. Early and timely access to trauma-informed psychology services is therefore critical and should be recognised as a core prevention, early intervention and recovery strategy.

We also recommend investment in digital prevention approaches, recognising the important role that online environments play in shaping attitudes, behaviours and relationships.

The Second Action Plan should also respond more directly to online harms affecting children and young people and provide clearer guidance to schools and communities regarding how to respond to these issues without blaming or shaming children.

Priority Area 4: People who use violence

What more can be done to promote healthy, safe relationships and strengthen accountability for people who use violence?

The APS supports the consultation paper's focus on people who use violence and its recognition that earlier identification, accountability and behaviour change are essential to ending violence against women and children. This area could be strengthened by making the gendered pattern of perpetration more visible throughout the Second Action Plan. Inclusive language such as "people who use violence" is appropriate but should be used alongside clear recognition that violence against women and children is most commonly perpetrated by men[1,31,32].

Perpetrator accountability and intervention should be central to the Second Action Plan. The APS supports the Consultation Paper's focus on identifying opportunities to encourage or compel people who use violence to seek support, take responsibility and change their behaviour, particularly given that most men who use violence do not seek formal support to change their behaviour.

The Second Action Plan should strengthen early intervention and accountability pathways, including through health and mental health services, GPs, psychologists, workplaces, schools, family law, police and courts. However, expansion of perpetrator interventions, including men's behaviour change programs, should only be supported where programs are evidence-informed, linked to victim-survivor safety services, delivered by appropriately trained practitioners, subject to clear standards, and evaluated for effectiveness and safety outcomes. This is particularly important because therapeutic work with people who use violence can be complex and potentially unsafe if treated as ordinary counselling. APS resources on therapeutic work with perpetrators highlights the need to prioritise the safety of others, build accountability into treatment, avoid inadvertent validation of abusive narratives, and recognise that some people who use violence may minimise, manipulate or resist change[26,33].

Long-term prevention should begin early, be developmentally appropriate, and be embedded in sustained whole-school and community-based approaches rather than delivered as isolated one-off sessions. The Second Action Plan should support prevention initiatives that build emotional regulation, empathy, accountability, respectful relationships, consent, healthy help-seeking, safe bystander skills and non-violent ways of responding to conflict, rejection, shame and distress. While the Consultation Paper addresses harmful gender norms, online misogyny and the influence of the manosphere, the Second Action Plan

could more explicitly address norms of masculinity as part of prevention and early intervention[34]. This should include specific engagement with boys and young men to challenge harmful norms associated with entitlement, dominance, control, aggression, emotional restriction and peer reinforcement of disrespect, while promoting healthy and respectful masculinities, emotional literacy, accountability and non-violent behaviour.

Priority Area 5: System integration and Workforce

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

The APS supports the Consultation Paper's focus on system integration and workforce capability. The Second Action Plan should strengthen integration across DFSV, health, mental health, child protection, family law, housing, justice, education and specialist service systems. This should include clearer national expectations for risk identification, referral, information sharing, professional roles and cross-sector collaboration, while preserving victim-survivor privacy, autonomy and choice[2].

As outlined in the DFSV Commission's 2025 Yearly Report[35], there have been multiple major inquiries and reviews into DFSV over the past fifteen years. These major reviews have made similar recommendations, indicating that the Second Action Plan needs to prioritise strengthened national collaboration and improved governance arrangements across all Australian jurisdictions. Further, adoption of the updated National Risk Assessment Principles and Risk Factors for family and domestic violence[36] will facilitate shared understanding and application of risk assessment practices across Australian jurisdictions.

An appropriately skilled and funded DFSV workforce is essential to delivering consistent and high-quality prevention and response services. However, significant workforce shortages and suboptimal working conditions within the sector contribute to work safety risks and workforce attrition[37]. Secure, long-term funding and improved remuneration and working conditions would facilitate better support and retention of the DFSV workforce, which is mostly female[37].

The APS acknowledges that Ahpra, the National Boards and Accreditation Authorities have committed to building the capability of the health workforce to recognise and respond to DFSV[38]. We reiterate our previous recommendations that the Australian Government support initiatives that both strengthen workforce capability and sustainability[2,11]. Health professionals working with people experiencing DFSV are frequently exposed to critical risk situations, distressing material, and high levels of responsibility for safety planning. The complexities of this work are heightened by the presence of suicide risk. Without appropriate support, health professionals who provide DFSV services can experience burnout, vicarious trauma, and workforce attrition[2].

The APS has previously proposed an Australian Government funded APS-led national professional support network for practitioners working with DFSV victim-survivors[39]. The network would consist of specifically trained psychologists available to undertake voluntary individual support for other psychologists and professionals working in the DFSV sector. This initiative would have the capacity to help mitigate the effects of vicarious trauma which can occur in DFSV support workers and other health professionals who are working with victim-survivors[39].

Investing in workforce skills development, however, does not negate the need for appropriately funded services that form part of a whole-of-government and cross-jurisdictional approach.

Additional comments

The National Plan appropriately takes an intersectional approach, recognising that violence and gender inequality exist in relation to multiple and intersecting structural and systemic forms of discrimination[40]. This approach also recognises that the drivers, dynamics and impacts of violence women experience can be compounded by their experience of other forms of oppression and inequality, resulting in some groups of women experiencing higher rates and/or more severe forms of violence, or facing barriers to support and safety that other women do not experience[40].

Mothers[*] are subjected to multiple and intersecting forms of discrimination, including as females and as caregivers for their children[42]. They often navigate harmful societal norms and experience disproportionate socioeconomic burdens[43–45]. This discrimination might be further compounded where mothers are migrants, single, adolescent, gender diverse or living with a disability. Their experiences may also be affected by factors such as their age, labour status, sexual orientation, economic status, religion, belief or race. These factors often shape the nature and extent of institutional responses and the inaccessibility of services for mothers[42].

The United Nations (UN) Special Rapporteur on violence against women and girls, its causes and consequences, recently published a report focused on violence and discrimination faced by women and girls globally due to their status as mothers, and in connection with other grounds of discrimination[42]. The report found that violence manifests in several ways, including economic, reproductive, physical and psychological, and that policies often neglect mother-specific needs, leading to inadequate healthcare, legal protections, and social support[42].

The Special Rapporteur's recommendations include, but are not limited to:

- Recognise mothers as a distinct category with specific rights and protections;
- Address violence through targeted prevention, legal reforms, and accountability measures;
- Improve healthcare quality, ensure informed consent, protect mothers' reproductive rights including freedom from obstetric violence;
- Strengthen data collection, monitoring, and reporting on violence and discrimination; and
- Promote community awareness, gender equality, and shared caregiving responsibilities[42].

We urge the Australian Government to consider explicitly addressing the multiple manifestations in which mothers are subjected to violence in the Second Action Plan and to consider them a priority population group.

[*]We recognise that there is a growing recognition of the importance of gender inclusive language. The APS understands that transgender men and gender diverse (such as non-binary) people may carry pregnancies and give birth[41]. Given this, birthing parents may not identify as mothers but may still experience some of the above-described discrimination and socio-economic burden.

Conclusion

In summary, the APS supports the Consultation Paper's priorities and emphasises that DFSV remains a major national health and welfare issue. We recommend improving DFSV data collection, risk assessment and information sharing across systems, increasing access to trauma-informed psychological support for victim-survivors, and strengthening responses to coercive control, including suicide threats and technology-facilitated abuse. We also advocate for culturally safe, community-led services for Aboriginal and Torres Strait Islander peoples and better support for other diverse priority population groups.

The APS also highlights the importance of long-term prevention through gender equality, respectful relationships education, economic security, and early intervention programs. We support recognising children as victim-survivors in their own right, strengthening accountability and evidence-based interventions for people who use violence, and improving system integration, workforce sustainability and national coordination. Overall, the APS argues for a well-funded, trauma-informed and integrated approach to prevent violence, support recovery and improve safety outcomes.

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time, knowledge, experience and evidence-based research to the development of this submission.

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