

National Plan to End Violence Against Women and Children 2022-2032:

Second Action Plan Submission

Embedding Primary Healthcare in Australia's Response to Domestic, Family and Sexual Violence

About the Submitters

This submission is provided by Brisbane South Primary Health Network (BSPHN) and Hunter New England and Central Coast Primary Health Network (HNECC PHN), on behalf of Primary Health Networks currently delivering Australian Government funded Domestic, Family and Sexual Violence (DFS) initiatives under the National Plan to End Violence Against Women and Children 2022–2032. Across Australia, 18 of the 31 Primary Health Networks (PHNs) deliver one or more DFS initiatives spanning prevention and early intervention, crisis response, recovery and healing, workforce development and system integration. See Appendix A for a list of PHNs.

PHNs are independent organisations funded by the Australian Government to improve the efficiency, effectiveness and coordination of primary healthcare services and to improve health outcomes for local communities. As regional commissioners and system integrators, PHNs work across general practice, mental health, alcohol and other drug services, hospitals, Aboriginal Community Controlled Health Organisations, community services and other sectors to address local health needs and strengthen service coordination.

Over the past six years, participating PHNs have partnered with the Department of Health, Disability and Ageing, specialist DFS services, primary healthcare providers, Aboriginal Community Controlled Health Organisations, researchers and community organisations to strengthen the role of primary healthcare in preventing, identifying and responding to domestic, family and sexual violence.

Through this work, PHNs have developed and implemented a nationally unique suite of integrated healthcare responses spanning prevention and early intervention, crisis response, recovery and healing, workforce development and system integration. These initiatives are currently being delivered across metropolitan, regional, rural and remote Australia and are generating a growing evidence base demonstrating the contribution primary healthcare can make to Australia's response to violence.

This submission draws on the experience of PHNs delivering these initiatives and demonstrates the critical role PHNs can play in strengthening connections between healthcare, specialist DFS services and community organisations to create a more coordinated and effective response to domestic, family and sexual violence.

Acknowledgements

We acknowledge the Traditional Owners of Country throughout Australia and their continuing connection to land, waters and community and pay respects to Elders past and present. We recognise the strength and resilience of Aboriginal and Torres Strait Islander people, especially those affected by domestic, family and sexual violence.

We wish to acknowledge those with a lived and living experience of domestic, family and sexual violence and of the Australian domestic, family and sexual violence specialist sector. Primary Health Networks' work at the intersection of health and DFS would not be possible without their significant ongoing contributions and their willingness to partner with PHNs and the primary health care sector. Their wisdom, expertise and knowledge have significantly shaped our work to date and will continue to do so.

This submission also acknowledges the Australian Government Department of Health, Disability and Ageing, whose system partnership and funding ensures that locally designed and integrated health solutions are possible.

Executive Summary

Primary healthcare services are often the first, and sometimes only services accessed by people experiencing domestic, family and sexual violence (DFSV). General practice, mental health services, alcohol and other drug services, urgent care settings, maternal, child and family health services and other community-based healthcare providers regularly encounter people affected by violence, often before specialist support is accessed. Despite this, Australia's primary healthcare system has historically lacked a nationally coordinated mechanism to build workforce capability, strengthen referral pathways and integrate healthcare services with specialist DFSV responses. Research consistently demonstrates that health professionals report limited confidence, knowledge and access to specialist support when responding to violence, contributing to missed opportunities for identification, intervention, recovery and healing.

The Australian Government's investment in PHN-led DFSV initiatives has begun to address this gap. Through workforce development, system integration, specialist referral pathways and commissioning of innovative service responses, PHNs have demonstrated that the primary healthcare sector can play a significantly larger role in Australia's response to domestic, family and sexual violence. PHNs have engaged and trained thousands of healthcare professionals, established stronger connections between healthcare and specialist DFSV services, improved access to trauma-informed care and developed new pathways for victim-survivors, children and families affected by violence.

This work has been delivered via four complementary PHN-led DFSV pilots under or aligned with the First Action Plan of the National Plan to End Violence Against Women and Children, 18 of the 31 PHNs deliver one or more of these programs, which span the continuum from identification and early intervention through to recovery and healing.

Activities under First Action Plan:

- **Supporting Primary Care to Respond to DFSV** strengthens the ability of primary healthcare providers, including general practices, to recognise, respond and refer people affected by violence through workforce development, specialist DFSV Local Link support and strengthened referral pathways.
- **Supporting Outreach Healthcare** delivers multidisciplinary healthcare directly into DFSV refuge and crisis accommodation settings, improving access to healthcare for women and children experiencing violence and reducing barriers associated with cost, transport and safety.
- **Supporting Recovery** provides long-term, trauma-informed mental health and care coordination support for victim-survivors and their families, addressing a previously unmet gap between crisis services and recovery and healing.

Activity aligned with First Action Plan:

- **Hope in Healing** is developing Australia's first dedicated primary healthcare response to domestic and family violence-related mild traumatic brain injury and non-fatal strangulation, addressing an emerging and often overlooked health consequence of violence.

Further information about these programs has been included in Appendices A and B.

Importantly, PHNs have not simply delivered programs. They have provided the system integration function within the primary healthcare response to domestic, family and sexual violence, bringing together general practice, mental health services, alcohol and other drug services, hospitals, specialist DFSV services, child and family services, Aboriginal Community Controlled Organisations, community organisations and other local partners to create coordinated responses to violence. Emerging evaluation findings demonstrate that sustainable change occurs when healthcare providers are supported through specialist expertise, clear referral pathways, integrated models of care and strong local partnerships rather than standalone training initiatives.

Through six years of implementation and evaluation, PHNs have demonstrated their ability to activate the primary healthcare system as part of Australia's response to domestic, family and sexual violence. The First Action Plan established proof of concept. The Second Action Plan presents an opportunity to move beyond pilot implementation and formally embed PHNs as a key delivery mechanism within the National Plan to End Violence Against Women and Children 2022–2032. Doing so would support the national scale-up of proven approaches, strengthen workforce capability consistently across regions, improve integration between health and specialist DFSV sectors, establish nationally consistent operating models and create a shared framework for measuring outcomes, benchmarking performance and driving continuous improvement.

Without PHNs, implementation of DFSV-related health reform remains dependent on individual services, local relationships and fragmented regional approaches. PHNs provide the Australian Government with an existing national infrastructure capable of translating policy into practice across primary healthcare settings while retaining the flexibility to work with local specialist DFSV organisations, Aboriginal Community Controlled Organisations and community partners to deliver place-based responses that reflect local needs.

What PHNs have demonstrated

Since 2020, participating PHNs have demonstrated the ability to strengthen the health system response to domestic, family and sexual violence through workforce development, service integration and innovative models of care.

PHN-led initiatives have:

- Engaged 1,839 general practices, delivered 989 workforce development sessions and built DFSV capability among 5,451 healthcare professionals, strengthening the capacity of primary healthcare providers to recognise, respond and refer people affected by violence.
- Supported 11,946 engagements between primary healthcare professionals and specialist DFSV Local Link workers and facilitated 1,763 referrals to specialist DFSV services, strengthening pathways between healthcare and the specialist DFSV sector.
- Improved collaboration between healthcare, specialist DFSV services, mental health providers and community organisations through integrated models of care, Communities of Practice and coordinated referral pathways. Evaluation findings consistently identify PHNs as playing a critical role in facilitating local system integration.
- Demonstrated innovative healthcare responses for women and children experiencing violence through refuge-based multidisciplinary healthcare, improving access to primary care, paediatric assessment, developmental screening, mental health support and specialist services at the point of highest need.
- Addressed a previously unmet gap between crisis services and long-term recovery by providing trauma-informed mental health care and care coordination that supports victim-survivors and families through recovery and healing. Early evaluation findings report improved access to care, strengthened recovery outcomes and improved collaboration between services.
- Demonstrated nationally unique models supporting children affected by violence across the continuum from crisis and identification through to recovery and healing, recognising children and young people as victim-survivors in their own right.

Recommendations for Inclusion in the Second Action Plan

To build on the evidence generated through six years of implementation of PHN-led domestic, family and sexual violence initiatives, and to support the transition from pilot implementation to a mature, nationally consistent primary healthcare response, we recommend the following actions be included in the Second Action Plan:

Recommendation 1: Embed DFSV as a Core PHN Function

Embed domestic, family and sexual violence as a core PHN commissioning, workforce development and system integration function, and continue investment in proven PHN-led DFSV models across all 31 PHN regions.

Recommendation 2: Establish a National PHN DFSV Framework

Transition PHN-led DFSV initiatives from pilot implementation to a nationally scaled program model in all 31 PHNs. This should include establishing a National PHN DFSV Framework that builds on the experience of PHNs and their partners to date. This could include national program guidance, implementation resources, workforce capability standards, Communities of Practice, commissioning guidance and an embedded national PHN led coordination function including designated State Lead PHNs. This should maintain flexibility for place-based delivery through partnerships with the primary health care sector, specialist DFSV organisations, Aboriginal Community Controlled Organisations and local communities.

Recommendation 3: Establish a National DFSV Outcomes and Evaluation Framework

Develop a nationally consistent outcomes, evaluation and reporting framework that enables PHNs to measure, benchmark and continuously improve DFSV responses at local, state and national levels. This should include agreed outcome measures, minimum data requirements, service integration indicators and workforce capability measures, supporting the development of a mature evidence base.

Recommendation 4: Scale Proven Models and Build Evidence for Emerging Priorities

Expand evidence-informed responses for victim-survivors, children and young people across all PHN regions, while supporting PHNs to pilot, evaluate and build the evidence base for emerging priority areas, including responses for people who use violence and integrated early intervention models.

The Health System Gap

Domestic, Family and Sexual Violence is a Health Issue

Domestic, family and sexual violence (DFSV) is not only a justice and social issue; it is a significant health issue with impacts across the lifespan. Victim-survivors regularly access healthcare services before, during and after experiences of violence, often presenting with physical injuries, chronic health conditions, mental health concerns, substance use issues, reproductive health concerns, developmental challenges and trauma-related symptoms. Primary healthcare services are therefore uniquely positioned to identify violence, provide early intervention, support recovery and connect people with specialist services.

Health services are often among the few universal systems that interact with individuals and families across the continuum of violence, from prevention and early intervention through to crisis response, recovery and healing. General practice, mental health services, alcohol and other drug services, urgent care settings, child and family services, allied health providers and community-based healthcare services all play an important role in recognising and responding to violence and its impacts.

Pregnancy, infancy and early childhood represent particularly important opportunities for intervention. Evidence demonstrates that pregnancy and the early postnatal period are times of heightened risk for the onset or

escalation of domestic and family violence, while children exposed to violence experience increased risk of poor health, developmental and wellbeing outcomes throughout their lives. These critical life stages reinforce the importance of healthcare services as a platform for prevention, early intervention, identification, recovery and healing.

A Critical Gap in the Health System Response

Despite the recognised role of healthcare services in responding to DFSV, Australia's primary healthcare system has historically lacked a nationally coordinated mechanism to support healthcare professionals to identify and respond to violence effectively.

Research consistently demonstrates that primary healthcare professionals report:

- limited confidence in responding to disclosures of violence
- uncertainty regarding referral pathways and available supports
- limited access to specialist advice and consultation
- concerns about managing risk and safety planning
- insufficient integration between healthcare and specialist DFSV services.

As a result, opportunities for early identification, intervention, referral and recovery support are frequently missed. Individuals experiencing violence often move between healthcare, specialist DFSV, child and family, housing, justice and community services with limited coordination between sectors. This fragmentation places additional burden on victim-survivors and can result in delayed access to support, inconsistent service responses and poorer outcomes.

Historically, domestic, family and sexual violence responses have largely been concentrated within specialist DFSV services, while healthcare services have often lacked the structures, relationships and support required to operate as an integrated part of the response system. The result has been a gap between the healthcare system's potential contribution to violence prevention, identification, response and recovery, and its actual capacity to do so consistently across the country.

The Role of Primary Health Networks

A key lesson from the First Action Plan is that effective health system responses to DFSV require a dedicated system integration function. PHNs have demonstrated that they can perform this role at a regional level. As regional commissioners and system integrators, PHNs work across primary healthcare, mental health, alcohol and other drug services, hospitals, specialist DFSV organisations, child and family services, Aboriginal Community Controlled Organisations and community organisations to strengthen coordination, referral pathways and service integration. Further information about PHNs and their role in the Australian healthcare system is included in Appendix C.

PHNs have demonstrated their ability to strengthen the health system response to DFSV by:

- building workforce capability across primary healthcare and commissioned services
- establishing referral pathways between healthcare and specialist DFSV services
- creating local partnerships and Communities of Practice
- commissioning responses to identified service gaps
- improving coordination between health, community and specialist sectors
- supporting providers to recognise, respond and refer people affected by violence.

Importantly, PHNs have demonstrated that sustainable change requires more than training alone. Effective responses occur when workforce development is accompanied by specialist support, referral pathways, integrated models of care, shared governance and strong partnerships between healthcare and specialist DFSV services. Evaluation findings consistently identify PHNs as playing a critical role in facilitating and sustaining these relationships across local systems.

Building a Mature National Response

The evidence generated through PHN-led DFSV initiatives demonstrates that Australia now has a scalable model for embedding domestic, family and sexual violence responses within primary healthcare nationally.

The First Action Plan established proof of concept. PHNs have demonstrated that primary healthcare can play a significantly greater role in prevention, early intervention, crisis response, recovery and healing when supported through coordinated system reform. The opportunity for the Second Action Plan is to build on this foundation by transitioning from pilot implementation to a mature, nationally coordinated model that embeds domestic, family and sexual violence capability across the primary healthcare system while retaining flexibility to respond to local community needs.

PHN-Led Initiatives Across the DFSV Continuum

PHN DFSV initiatives collectively provide a continuum of primary healthcare responses spanning crisis support, identification, early intervention, recovery and healing. The models demonstrate how primary healthcare can contribute across multiple priorities of the National Plan and provide a practical blueprint for embedding domestic, family and sexual violence capability within Australia's health system.

Table 1 outlines how current PHN-led initiatives align with the National Plan, Rapid Review recommendations and the Second Action Plan Priority Areas.

Violence stage	Setting	Primary care response	ANROWS priority area	Alignment to National Plan and Rapid Review
Crisis	Crisis accommodation and refuge	Supporting Outreach Healthcare Pilot	Response and Early Intervention — <i>Holistic integrated health and social care at the point of highest vulnerability.</i> • Priority Area 1 – Victim Survivors • Priority Area 2: Prevention and Early Intervention • Priority Area 3: Children and Young People • Priority Area 5: System Integration and Workforce	National Plan: Operationalises early intervention, response and recovery through integrated health and FDSV frontline responses; person-centred coordination in trusted settings. Rapid Review: Responds to the call to better support children's experiences of FDSV and strengthen crisis and recovery systems.

First Contact and Disclosure	Primary health care settings including general practices and ACCHOs and PHN-commissioned services — AOD, mental health, aged care, Headspace, Urgent Care Clinics	Supporting Primary Care to Respond to DFSV	Response and Early Intervention — <i>Strengthening primary care capacity to recognise, respond and refer.</i> • Priority Area 1 – Victim Survivors • Priority Area 2: Prevention and Early Intervention • Priority Area 5: System Integration and Workforce	National Plan: Advances early intervention, response and person-centred coordination; victim-survivors often engage with health services before specialist DFSV support. Rapid Review: Responds to Recommendation 11a (equipping GPs, mental health and AOD services) and Recommendation 14c (capability uplift across health workforces).
Recovery	FDSV frontline services, ACCHOs and community mental health — no wrong door approach	Supporting Recovery	Prevention and Recovery — <i>Sustained, trauma-informed therapeutic support for the whole family.</i> • Priority Area 1 – Victim Survivors • Priority Area 2: Prevention and Early Intervention • Priority Area 3: Children and Young People • Priority Area 5: System Integration and Workforce	National Plan: Operationalises Recovery and Healing through long-term therapeutic support, family-centred care and life course coordination. Rapid Review: Responds to the priority of addressing children's experiences of violence and the DFSV Commission's call for sustained integrated recovery beyond crisis intervention.
Response and Recovery	General practice, refuge and community settings	Hope in Healing — mTBI and concussion clinics	Response and Recovery — <i>Identifying and treating sub-acute concussion and strangulation injuries.</i> • Priority Area 1 – Victim Survivors • Priority Area 2: Prevention and Early Intervention • Priority Area 5: System Integration and Workforce	National Plan: Aligns with Response, Recovery and Healing — person-centred coordination, workforce strengthening and addressing long-term impacts of violence. Rapid Review: Responds to the call to strengthen health system responses and the DFSV Commission's recommendations to reduce fragmentation for victim-survivors with complex needs.

Priority Area 1: Victim Survivors

Primary healthcare services are often the first, and sometimes only, services accessed by victim-survivors of domestic, family and sexual violence. General practice, mental health services, alcohol and other drug services, urgent care settings and community-based healthcare providers frequently encounter people affected by violence before disclosure occurs and throughout recovery and healing. Despite this, many healthcare professionals report limited confidence, knowledge, referral pathways and access to specialist support when responding to violence. This has historically limited the health system's ability to consistently identify, respond to and support victim-survivors.

PHNs have demonstrated that the healthcare system can play a significantly stronger role in supporting victim-survivors when workforce capability, referral pathways and specialist support are embedded within local service systems. Through the Supporting Primary Care initiative, PHNs have engaged 1,839 general practices, delivered 989 training sessions and built capability among more than 5,400 healthcare professionals, strengthening the ability of providers to recognise, respond and refer people affected by violence. Specialist Local Link models have further strengthened connections between healthcare and specialist DFSV services, supporting almost 12,000 engagements between healthcare professionals and specialist workers.

Importantly, PHNs have also demonstrated that victim-survivors require access to healthcare and specialist support beyond the point of disclosure. Through the Supporting Outreach Healthcare initiative, PHNs have brought multidisciplinary healthcare directly into refuge and crisis accommodation settings, improving access to healthcare for women and children experiencing violence at the point of highest vulnerability. These models have reduced barriers associated with cost, transport and safety while strengthening connections between healthcare and specialist DFSV services.

PHNs have also demonstrated that recovery and healing are critical components of the victim-survivor journey. Through the Supporting Recovery initiative, PHNs have established long-term, trauma-informed mental health and care coordination responses that address a previously unmet gap between crisis services and recovery. Early evaluation findings indicate improved access to trauma-informed care, stronger service coordination, improved mental health outcomes and enhanced recovery and healing for victim-survivors and their families.

Collectively, these initiatives demonstrate how primary healthcare can contribute across the full continuum of care for victim-survivors, from identification and referral to crisis response, recovery and healing. They also demonstrate the critical role PHNs play in connecting healthcare, specialist DFSV services and community supports around victim-survivors to reduce fragmentation and improve access to coordinated support.

The Second Action Plan should build on this evidence by strengthening the role of healthcare as a core component of the victim-survivor response system and embedding PHN-led approaches nationally.

Priority Area 2: Prevention and Early Intervention

Prevention and early intervention cannot rely solely on specialist DFSV services. Many individuals affected by violence present to healthcare services long before engaging with specialist support and frequently present with physical, mental health, developmental and social impacts of violence before violence itself is identified.

Healthcare services therefore represent one of Australia's largest opportunities for early intervention.

Primary healthcare providers regularly encounter indicators associated with domestic, family and sexual violence, including anxiety, depression, substance use, trauma symptoms, chronic pain, pregnancy-related concerns and child developmental issues. Yet without dedicated capability-building and referral pathways, opportunities for early identification and intervention may be missed.

PHNs have demonstrated the ability to strengthen prevention and early intervention through workforce development, implementation support and stronger integration between healthcare and specialist services. This role extends beyond general practice. PHNs commission and support mental health, suicide prevention, alcohol and other drug services, community health services and other programs where domestic family and sexual violence is highly prevalent yet frequently under-recognised.

Importantly, prevention should also be viewed through the lens of recovery and healing. For children, young people and families affected by violence, timely access to trauma-informed support can help prevent the long-term impacts of trauma, poor mental health outcomes, developmental delay and intergenerational cycles of violence. Through the Supporting Recovery initiative, PHNs are delivering therapeutic support, family-centred healing and interventions for children and young people, including boys, during critical developmental periods when emotional regulation, relationship skills and attitudes are still forming. These interventions demonstrate how recovery and healing can also function as a prevention strategy by supporting healthier life trajectories following experiences of violence.

Similarly, the Supporting Outreach Healthcare initiative demonstrates the value of early intervention at the point of crisis. By providing multidisciplinary healthcare directly within refuge and crisis accommodation settings, PHNs are supporting women and children to access developmental assessments, paediatric care, mental health support, chronic disease management, immunisations and other preventative healthcare that may otherwise be delayed or inaccessible. These early health interventions help prevent the compounding impacts of violence and improve longer-term health and wellbeing outcomes for families.

Beyond the DFSV-specific initiatives, many PHNs are already investing in early childhood, child development, family support and community-based programs that aim to identify developmental concerns, strengthen family wellbeing and improve outcomes for children aged 0–5 years. These settings provide an important opportunity to strengthen connections between healthcare, community services, education and specialist DFSV supports and to identify families requiring additional support earlier.

The Second Action Plan should recognise primary healthcare as a critical early intervention platform and support PHNs to embed domestic, family and sexual violence capability across existing Australian Government funded healthcare, child and family and community-based programs. Strengthening the ability of healthcare providers and community services to recognise, respond and refer earlier, and supporting recovery and healing following violence—represents a significant opportunity to reduce harm and prevent future adverse outcomes.

Priority Area 3: Children and Young People in Their Own Right

Children and young people experience domestic, family and sexual violence in their own right and require dedicated responses that recognise their unique developmental, health and wellbeing needs. Evidence demonstrates that exposure to violence during childhood can have lifelong impacts on mental health, physical health, education and social development. Australian research has also identified a significant delay between the identification of violence and the delivery of targeted health responses for children.

PHNs have demonstrated the capacity of primary healthcare to support children across the continuum of violence, from crisis through to recovery and healing. Through the Supporting Outreach Healthcare and Supporting Recovery initiatives, PHNs have tested child-centred models that integrate healthcare, mental health, developmental support, care coordination and specialist DFSV expertise. These initiatives recognise children as victim-survivors in their own right and demonstrate the value of coordinated responses that support both children and families throughout recovery and healing.

Early evidence from the Hunter New England and Central Coast PHN demonstrates the potential impact of these approaches. In a three-month period, the Supporting Outreach Healthcare model supported 96 children, who represented 64 per cent of the total caseload, with significant health, developmental and neurodevelopmental needs identified through integrated care models. Similarly, the Supporting Recovery model has supported 218 children and young people through trauma-informed therapeutic interventions, care coordination and family-centred support. While these figures reflect outcomes from a single PHN region, they demonstrate the scale of unmet need and the potential reach of integrated primary healthcare responses for children affected by violence.

Beyond DFSV-specific initiatives, PHNs are already investing in programs that support families during pregnancy, early childhood and key developmental stages, including maternity, child development, family support and community wellbeing initiatives. Through commissioning and partnership arrangements, PHNs are often working in the same settings where developmental concerns, behavioural challenges, family stress and violence may first be identified. This creates an opportunity to strengthen connections between healthcare, education, community services and specialist DFSV services and improve early identification and intervention for children affected by violence.

The Second Action Plan should strengthen child-centred responses that recognise children as victim-survivors in their own right and support integrated pathways across health, education, child development, family support and specialist DFSV systems. Strengthening recovery and healing responses for children should also be recognised as a prevention strategy, helping to reduce the long-term impacts of trauma and interrupt intergenerational cycles of violence.

Priority Area 4: People Who Use Violence

Preventing domestic, family and sexual violence requires stronger responses to people who use violence. While specialist perpetrator interventions and men's behaviour change programs remain the foundation of Australia's response, there is growing recognition that primary healthcare, mental health and alcohol and other drug services are important settings for earlier identification and intervention.

The evidence base for health-sector responses to people who use violence is still emerging. Research suggests healthcare settings may play an important role in recognising violence, supporting accountability and facilitating referral to specialist interventions; however, further evidence is required regarding the most effective models of care in these settings.

PHNs are well positioned to support the development of this evidence through workforce development, commissioning, referral pathway development and system integration. Through existing work in general practice, mental health, alcohol and other drug services and other commissioned programs, PHNs have demonstrated their ability to build workforce capability, strengthen cross-sector partnerships and connect service providers with specialist supports.

Participating PHNs have already commenced exploring the role of primary healthcare in responding to people who use violence. Early work has focused on building workforce awareness and capability, strengthening relationships with specialist perpetrator intervention services, and identifying opportunities to safely embed responses within existing health and community service settings. This approach recognises that responses to people who use violence must be evidence-informed, integrated with specialist services and underpinned by a strong focus on victim-survivor safety and perpetrator accountability.

The Second Action Plan should support PHNs to test, evaluate and build the evidence base for health-sector responses to people who use violence while maintaining a strong focus on victim-survivor safety, accountability and collaboration with specialist perpetrator intervention services.

Priority Area 5: System Integration and Workforce

System integration and workforce capability represent the greatest opportunity to strengthen Australia's response to domestic, family and sexual violence.

Historically, healthcare, specialist DFSV services, child and family services, mental health services and community organisations have often operated as separate systems. This fragmentation has created challenges for victim-survivors navigating support, limited referral pathways between sectors and contributed to inconsistent responses across services. Healthcare professionals have also reported ongoing challenges relating to confidence, knowledge, referral pathways and access to specialist support.

The strongest evidence emerging from PHN-led initiatives is the role PHNs play as regional system integrators. Through workforce capability development, Communities of Practice, commissioning, care coordination and partnership-building, PHNs have connected primary healthcare, specialist DFSV services, mental health providers, child and family services, Aboriginal Community Controlled Organisations and community organisations around coordinated responses to violence. Evaluation findings consistently highlight the role of PHNs in facilitating collaboration, strengthening partnerships and improving local service integration.

In the context of the implementation of DFSV health reforms, PHNs are the federal government's equivalent of the state and territory governments' Local Hospital Networks. PHNs can implement nationally and jurisdictionally set policies and standards into practice within their local service systems.

PHNs can embed DFSV capability across the breadth of services they already fund, while strengthening integration between primary care, specialist DFSV services, hospitals, child and family services and other local support systems. With established regional infrastructure and national coverage, PHNs provide an existing mechanism to scale effective DFSV responses while maintaining flexibility to meet local community needs. They work closely with peak professional bodies, their local service system partners and their communities to ensure that the translation to the local context is appropriate and effective.

The First Action Plan has demonstrated that PHNs can successfully build workforce capability, establish referral pathways and strengthen integration between healthcare and specialist DFSV services. The next stage of reform should focus on maturing and scaling this evidence through nationally coordinated, place-based implementation approaches that meet community needs whilst reducing duplication, improving efficiency and supporting equitable access to quality DFSV responses regardless of geographic location.

This should consider not only continuation and expansion of the current DFSV PHN-led programs but also how DFSV reforms are embedded across all PHN programs. Further information about PHNs and the Australian healthcare system can be found in Appendix C.

A key example of this is the considerable Australian government investment (over \$1B in 2022-23) in localised mental health, suicide prevention and alcohol and other drugs (MHSPAOD) services via PHNs (Department of Health, Disability and Ageing, 2024).

State-funded MHSPAOD services are being supported to better respond to FDSV and provide integrated responses with the FDSV sector via state government FDSV reforms, but PHN-funded and private MHSPAOD services sit outside of these supports. PHNs are ideally placed to implement FDSV-health reforms within these services.

Other examples of PHN commissioned programs that could have DFSV reforms embedded include Urgent Care Clinics, Pelvic Pain Clinics, Aged Care health services, homeless health services, multicultural health services, child and maternal health services and Aboriginal and Torres Strait Islander Integrated Team Care services.

These measures can be kept low cost by reorienting the existing funding going into these programs to allow PHNs to better tailor services to those experiencing DFSV alongside their other needs. Additionally, rolling out contractual requirements for all PHN-commissioned service providers to align with national and jurisdictional DFSV practice standards and to complete appropriate DFSV and trauma informed care training would require minimal investment.

A National PHN DFSV Framework that builds on the experience of PHNs and their partners to date, alongside a national PHN coordination function with State PHN leads, should be implemented to support these activities. This should include shared workforce capability standards, Communities of Practice, implementation support and national outcome measures that enable PHNs to continuously improve performance at local, state and national levels.

While the core model should be nationally consistent, PHNs should retain flexibility to respond to local community needs through partnerships with primary health care, specialist DFSV organisations, Aboriginal Community Controlled Organisations and local communities. This place-based approach to implementing an overarching program model has been a strength of the work to date, enabling it to be successfully implemented across metro, regional, rural and remote areas in all jurisdictions.

The Second Action Plan presents an opportunity to formally embed PHNs as a key implementation mechanism within the National Plan and build a nationally consistent, integrated and evidence-informed healthcare response to domestic, family and sexual violence. By strengthening system integration, reducing fragmentation and supporting healthcare providers to recognise, respond and refer people affected by violence, PHNs provide a scalable framework for embedding DFSV capability across Australia's primary healthcare system.

If PHNs are not utilised to implement DFSV health reform under the National Plan, then a large portion of the Australian healthcare system will not be appropriately activated to take up their role in a whole of society response to DFSV.

Appendix A: Current PHN-Led DFSV Pilots

There are 18 PHNs federally funded to deliver four PHN-led DFSV pilot under or aligned with the First Action Plan of the National Plan to End Violence Against Women and Children.

Activities under National Plan:

- [Supporting Primary Care DFSV Pilot Program](#)
- [Supporting Outreach Healthcare DFSV Pilot Program](#)
- [Supporting Recovery DFSV Pilot Program](#)

Aligns with Activities of National Plan:

- [Hope in Healing \(mTBI\) - Medical Research Future Fund Project](#)

PHN	SPC Pilot	SR Pilot	SOHC Pilot	HH Pilot
ACT PHN (Capital Health Network)	x			
Adelaide PHN	x			
Brisbane South PHN	x	x		
Central and Eastern Sydney PHN	x		x	
Country SA PHN	x			
Country WA PHN (WA Primary Health Alliance)		x		
Gippsland PHN		x	x	
Hunter New England Central Coast PHN	x	x	x	x
Nepean Blue Mountains PHN	x			
Northern Territory PHN	x	x		
Northern QLD PHN			x	
North Western Melbourne PHN	x			
Perth South PHN (WA Primary Health Alliance)	x			
South Western Sydney PHN		x		
Southern Eastern NSW PHN (COORDINARE)			x	
Tasmania PHN (Primary Health Tasmania)	x			
Western QLD PHN			x	
Western Victoria PHN	x			

Appendix B: Pilot Program Evidence

This appendix provides the evidence base for the four Australian Government funded pilots referenced throughout this submission, including program data, stories of impact and actionable solutions for each.

Pilot One: Supporting the Primary Care Response to DFSV

Activating the primary healthcare sector as part of a whole-of-society response to DFSV

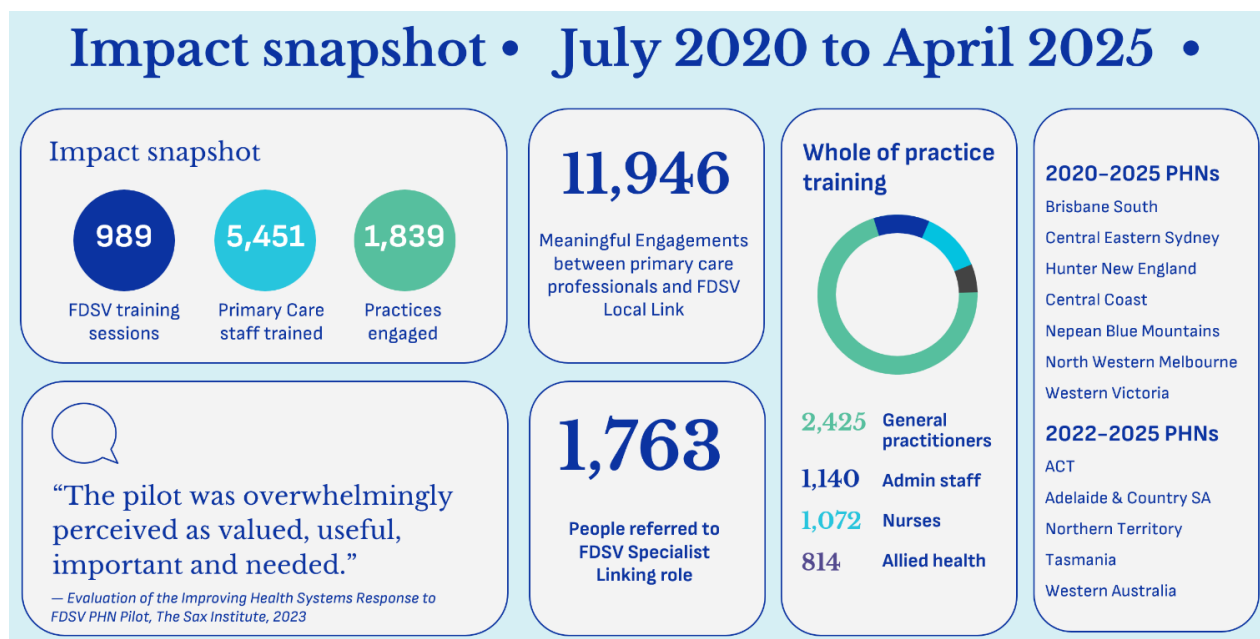
For many people, primary health care is the first place they seek help, whether for their own health, a child's behaviour or development, or a concern they cannot yet name. GPs and other primary health care professionals build trusting, long term relationships with patients, making primary health care settings a critical entry point for identifying and responding to DFSV across prevention, early intervention, response and recovery.

Originally developed by Brisbane South PHN in 2018, the pilot has been expanded through Australian Government funding to 11 additional PHNs across Australia. The model embeds dedicated Local Link roles providing a specialist DFSV referral pathway, alongside workforce capability building and whole of practice supports.

Through dedicated training and system integration measures such as specialist DFSV Local Link workers, general practices build confidence in recognising DFSV in their patients, including coercive control, technology facilitated abuse and the impacts of violence on children that may otherwise go unrecognised in a general health consultation.

A whole of practice approach has fostered cultural change and increased confidence among both clinical and non-clinical staff to identify and respond to people experiencing violence, demonstrating that primary care can become a safe entry point to specialist support when equipped with the right capability, partnerships and referral pathways.

Sax Institute evaluation, July 2020 to April 2025 (Sax Institute, 2023; Sax Institute, 2025)



STORY OF IMPACT – Brisbane South PHN

A victim survivor was referred to the regional DFSV service by a Social Worker at a local hospital after high-risk DFV concerns were identified during her hospital admission. The DFSV service could not safely contact her due to the person using violence's (PUV) ongoing surveillance and control.

Through collaboration with health partners, it was identified that the victim survivor regularly attended a local GP clinic. The DFSV service sought support from the internal PHN-funded Local Link service to establish whether the GP clinic was a safe avenue for engagement. Through an established relationship with the clinic and consent obtained via the hospital partnership, the Local Link team was able to complete a face-to-face engagement with the patient at the clinic, undertake further risk assessment and sought her consent for an integrated service response.

As risk escalated, Local Link referred the client to the DFSV High-Risk Team (HRT) and coordinated with the GP clinic and HRT to develop a safe engagement plan. Through advocacy and partnership with the clinic, Local Link arranged for HRT and QLD Police Service representatives to meet with the victim survivor during a scheduled appointment, enabling confidential engagement with specialist services without the PUV's knowledge.

By working collaboratively, agencies were able to prioritise the victim survivor's safety, reduce barriers to support, and ensure her voice, choices and priorities remained at the centre of decision-making.

This example demonstrates the value of strong partnerships between the health and DFSV sectors in creating safe and effective pathways to support for victim survivors experiencing high-risk domestic and family violence.

STORY OF IMPACT – Western Australia Primary Health Alliance

Following a General Practice DFSV education session delivered by the GP Local Link worker, a GP used the DFSV screening tool provided through the program with a patient attending the practice. During the consultation, the patient disclosed for the first time that she and her children were experiencing high risk physical violence in the home.

Working alongside the GP, the Local Link provided immediate specialist support, including risk assessment, safety planning, referral to child protection services and coordination with external agencies. The worker identified that the patient had previously disengaged from a specialist DFSV service and arranged for that service to meet the patient at the GP clinic, which the patient identified as one of the only places she was permitted to attend alone.

Through the trusted relationship established with the Local Link, the patient re engaged with specialist support and completed thorough safety planning for herself and her children.

This example demonstrates how embedding DFSV expertise within general practice can transform a routine consultation into an opportunity for identification, protection and connection to specialist support for women and children experiencing violence.

Pilot Two: Supporting Outreach Healthcare

Bringing primary care directly to women and children in crisis

When a family is fleeing violence, they often arrive at a refuge with no Medicare card, no medications, and children who require medical care, yet accessing mainstream general practice or specialist services can be difficult due to cost, transport, safety concerns and competing crisis priorities.

Originally developed by HNECC PHN and first trialled on the Central Coast in NSW, the Supporting Outreach Healthcare model removes these barriers by bringing violence informed health care directly into refuges through a multidisciplinary team of GPs, nurses, allied health practitioners, health linkers/navigators and specialist paediatricians, delivered through a twice weekly GP, Nurse and Speech Pathology Clinic and a monthly Paediatric Clinic (Triandafilidis et al., 2025).

The monthly Paediatric Clinic brings together paediatricians, GPs, nurses, occupational therapists, speech pathologists and DFSV specialist workers to assess and, if required, diagnose children in refuge accommodation, an option otherwise inaccessible given public paediatric waiting lists of up to three years.

Recognising the model's potential, DHDA expanded the pilot to five further PHNs, Central and Eastern Sydney, COORDINARE, Northern Queensland, Western Queensland and Gippsland, spanning metropolitan, regional, rural and remote communities.

Central Coast pilot: three-month data snapshot

150 clients supported across two refuge sites in three months	96 children served, 64% of total caseload	92% of children aged 0 to 12	47% identified as Aboriginal and Torres Strait Islander
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National Modelling:

A consistent rollout across all 31 PHNs could reach approximately 18,600 victim survivors annually, including around 11,900 children, more than half aged under 12 (illustrative modelling based on HNECC PHN's current two site delivery rate).

STORY OF IMPACT – Northern Queensland PHN

A woman fleeing domestic and family violence in a remote community arrived in a regional city with her two young children, needing a safe, trusted pathway into care. The Supporting Outreach Healthcare team provided GP led primary healthcare through the women's shelter, seeing the family every one to three weeks and coordinating trauma informed, culturally safe support across mental health, women's health and chronic disease care.

The children received health checks, immunisations and referrals, including early intervention support for one child's congenital hearing loss. The family moved from crisis toward stability, continuing to engage with the Supporting Outreach Healthcare team after leaving temporary accommodation.

STORY OF IMPACT – COORDINARE – South Eastern NSW PHN

A 25-year-old woman residing in refuge accommodation was living with multiple complex health issues, including cerebral palsy, mental health challenges, asthma, an untreated foot infection and poor nutrition, alongside alcohol and other drug use. The Supporting Outreach Healthcare team coordinated specialist referrals, wound care, asthma management, dietetic support and connections to local mental health and AOD services, with ongoing education and regular follow up.

Her foot infection has since resolved, her asthma has improved, and she has ceased alcohol and drug use. She is now actively engaging with healthcare providers and peer support and is considering further study and independent living options.

Pilot Three: Supporting Recovery DFSV Pilot

Sustained, whole of family healing after violence

Immediate safety is not the end of the story for people who have experienced DFSV. It is the beginning of a recovery journey that, without coordinated support, many children and families find difficult to navigate alone.

The Supporting Recovery model was developed through an Australian Government appointed Expert Review Panel to address the absence of dedicated, long-term recovery and healing services for individuals and families following violence. The Department of Health, Disability and Ageing commissioned the pilot across six PHNs: Hunter New England and Central Coast, Brisbane South, Western Sydney, Northern Territory, Western Australia and Gippsland.

The pilot delivers up to two years of sustained, trauma informed mental health support and care coordination. This entails violence informed modalities such as EMDR and other evidence-based specialist trauma modalities. The program works at the level of the child through play-based therapy, the family through attachment repair, and the system through flexible brokerage that removes practical and financial barriers to specialist care such as psychiatrists or paediatricians.

Program reach: HNECC PHN, seven quarters of data (Cowlshaw et al., 2025)

1,023 Total Clients provided care coordination and mental health support	11,913 service contacts delivered	77% Of clients identify as female	36% of new clients identifying as Aboriginal and Torres Strait Islander
253 children and young people reached across seven quarters		7,456 hours of trauma-informed care	

Of particular strategic significance is the program's reach into boys during the developmental period when emotional regulation, relationship skills and attitudes towards gender and violence are still forming. Work with boys is not secondary to a DFSV response, it is central to preventing the next generation of harm. Clinical presentations among boys include post traumatic stress disorder (14%), anxiety (8%) and ADHD (8%).

126 total boys aged 0 to 17 supported	90 boys aged 0 to 11, reached during primary school before patterns become entrenched	36 boys aged 12 to 17, reached during adolescence when attitudes are actively forming
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National Modelling:

A consistent rollout across all 31 PHNs could deliver approximately **28,290 sessions** of trauma informed care annually to around **3,862 children and young people, including more than 1,800 boys** (illustrative modelling based on HNECC PHN's current single site delivery rate).

STORY OF IMPACT – Hunter New England and Central Coast PHN

Kylie (pseudonym), a mother of two children, Hugo (10) and Lily (2), was referred to the Supporting Recovery program following domestic and family violence perpetrated by her former partner. While the relationship had ended, the impacts of the violence continued to affect the wellbeing of Kylie and both children.

Kylie presented with significant trauma symptoms, including anxiety, hypervigilance, guilt and concerns about the long-term impact of violence on her children. Through trauma informed therapy, she has developed strategies to manage emotional distress, strengthened her confidence and self-worth, and begun rebuilding hope for the future.

Hugo initially struggled to identify and express his emotions. Through art therapy, he has gained confidence, improved his ability to communicate feelings and developed greater emotional resilience. Lily is currently undergoing assessment for developmental concerns, with the program supporting the family to navigate services and access appropriate care.

A key feature of the program has been the ability to support the family together. Kylie and Hugo attend therapy sessions concurrently, creating regular opportunities to strengthen their relationship and establish positive routines.

This family's experience highlights the importance of sustained, trauma informed recovery support that addresses the needs of both children and parents.

Pilot Four: Hope in Healing

A dedicated primary care response to mTBI and non-fatal strangulation in DFSV

Non-fatal strangulation and repeated head trauma are common and commonly overlooked consequences of DFSV. While Australia has established pathways for concussions sustained through sport, workplace injury or road trauma, few accessible pathways exist for victim survivors who sustain concussions through violence.

Hope in Healing is an MRFF-funded research project developed through collaboration between the Hunter DFSV sector, the University of Newcastle, Hunter New England Local Health District, General Practitioners and HNECC PHN.

Through a Delphi study, the project has established expert consensus on best practice care for DFSV related mild traumatic brain injury (mTBI) and non-fatal strangulation, with co design to commence in August 2026 and clinics to be trialled from 2027.

From 2027, HNECC PHN will commission a two-stage model: frontline DFSV practitioners trained to screen and refer, connected to a dedicated community-based concussion clinic where a GP, allied health practitioner and specialist DFSV social worker provide integrated assessment, treatment and care navigation.

Key evidence — why this matters

75% of victim survivors had sustained at least one TBI (Valera and Berenbaum, 2003)	85 victim survivors screened, Raymond Terrace, NSW, over 3 months	82.4% had not sought medical care following head, face or neck injuries	68% reported non-fatal strangulation alongside head, face or neck assaults
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None of the children or young people in the Raymond Terrace screening trial had received medical care despite experiencing serious physical violence, demonstrating that the gap extends beyond women to the children living in these households.

Alignment to Evidence

Dr Eve Valera, one of the world's leading researchers on traumatic brain injury among victim survivors, found that 75% of women who had experienced DFSV had sustained at least one traumatic brain injury caused by a partner, and 50% had sustained multiple injuries (Valera and Berenbaum, 2003). Australian evidence similarly highlights gaps in practitioner awareness, referral pathways and access to rehabilitation (Women's Health NSW, 2024a; 2024b).

Hope in Healing ensures these injuries are treated with the same clinical seriousness as sports related or workplace concussions.

STORY OF IMPACT – Raymond Terrace Screening Trial

The Hope in Healing project was informed by a screening trial led by Port Stephens Family and Neighbourhood Services. The trial screened 85 victim survivors accessing a local DFSV service and identified a substantial burden of previously unrecognised head, face and neck injuries. Of those screened, 42.4% identified as Aboriginal and Torres Strait Islander and 82.4% had not sought medical assistance following their injuries.

Among the women screened, 68% reported experiencing non-fatal strangulation in addition to assaults involving the head, face or neck. None of the children or young people screened had received medical care despite experiencing serious physical violence.

This project demonstrates that injury caused by violence should be treated with the same clinical seriousness as injury sustained in any other context.

Appendix C: The Key Role of Primary Health Networks in a DFSV Systems Response

Primary Health Networks (PHNs) are independent organisations, funded by the Department of Health, Disability and Ageing to assess local population needs and commission health and social care services to improve access, integration and health outcomes.

Australia has 31 PHN regions which closely align with the state and territory local hospital networks across metropolitan, regional, rural and remote Australia.

PHNs have a unique and essential role in creating a more coordinated and connected system response for people affected by DFSV and people using violence. PHNs provide localised supports to a key segment of the non DFSV specialist workforce, the primary health sector.

To understand the unique and important role that PHNs play in implementing DFSV health reforms, they must be contextualised within the broader Australian healthcare system.

The Australian healthcare system is diverse and complex, and, as such, there is not a one size fits all answer to getting the Australian healthcare sector to take up a role in a national systems response to DFSV.

The Australian healthcare system sits across three main tiers (AIHW, 2026).

Primary health care: Frequently accessed services including general practice, ACCHOs, allied health, pharmacies and community health. Generally, a person's first contact with the health system and holds a coordinating role for their care over time.
Secondary health care: Specialist health services and facilities. This can be offered as outpatient hospital care or in private or community clinics. Patients are referred to these services by the primary health care services when they require more specialised health care than is available in the primary health care.
Tertiary health care: Highly specialised, complex health service provision that generally occurs within hospital settings, both public and private

Funding and oversight for services across these tiers sit across federal and state or territory governments and the private sector. These areas also provide the system levers that Federal and State governments can utilise to implement DFSV reforms within the health system. This is outlined in the table below.

Table 1: Overview of the Australian Healthcare System (Australian Institute of Health, 2026)

STATE / TERRITORIES	FEDERAL
• Manage public hospitals • Regulate and license private hospitals • Provide oversight of Local Hospital Networks • Responsible for public community based and primary health services (e.g. child and maternal health, mental health, dental health, alcohol and drug services) • Deliver preventive services such as cancer screening and immunisation programs • Responsible for ambulance services, regulating, inspecting, licensing and monitoring health premises	• Development of national health policy, including health workforce policy • Managing the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme • Contributes funds to States and Territories to support public hospital services • Regulating and supporting private health insurance • Supporting and monitoring primary healthcare services • Providing oversight of PHNs • Funding community controlled Aboriginal and Torres Strait Islander primary health care • Funding and organising health services for veterans • Funding health and medical research, collecting and publishing health and welfare data and statistics • Regulates medicines, devices and blood
SHARED • Regulation of health workforce, pharmaceuticals and pharmacies • Education and training of health professionals • Support improvements in safety and quality of health care • Funding of public health programs and services, e.g. Aboriginal and Torres Strait Islander health services and palliative care • National mental health reform	
PRIVATE • Operating certain health services such as private hospitals, general practices, pharmacies, allied health, mental health and specialist medical services • Providing funding via private health insurance	

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