



Doctors Against Violence

Standing up. Speaking out. Working for change.

SUBMISSION | JULY 2026

Submission to the Consultation on the

Second Action Plan

National Plan to End Violence against Women and Children 2022–2032.

A submission from the clinical and health-system perspective.

27

RECOMMENDATIONS

Mapped to the five priority areas

5

PRIORITY AREAS

A clinical response to each

800+

DOCTORS

A national clinical network

Prepared by Doctors Against Violence Ltd (also known as Doctors Against Violence Towards Women)

Contact: info@davtw.org · Consultation open 22 May – 31 July 2026 · engage.dss.gov.au/second-action-plan

Acknowledgement of Country

Doctors Against Violence acknowledges Aboriginal and Torres Strait Islander peoples as the First Peoples and Traditional Custodians of the lands and waters on which we live and work, and pays respect to Elders past and present. We acknowledge that First Nations women and children experience family violence at disproportionate rates, and that safety, healing and justice must be led by First Nations people and communities.

Acknowledgement of lived experience

We acknowledge every victim-survivor of domestic, family and sexual violence, and the strength it takes to live with, and to speak about, these experiences. People with lived experience hold the clearest knowledge of what the system does well and where it fails, and that expertise must shape its response. We remember those whose lives have been taken.

If you need support

This submission discusses domestic, family and sexual violence, including homicide and suicide. If reading it brings up anything for you, support is available, and you do not have to face it alone.

Lifeline (24 hours): 13 11 14

1800RESPECT, national sexual assault, domestic and family violence service (24 hours): 1800 737 732

DVConnect (24 hours): 1800 811 811

Full Stop Australia (24 hours): 1800 424 017

13YARN, for Aboriginal and Torres Strait Islander people (24 hours): 13 92 76

Rainbow Sexual, Domestic and Family Violence Helpline, for LGBTIQ+ people (24 hours): 1800 497 212

MensLine Australia (24 hours): 1300 789 978

In an emergency, call 000.

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About Doctors Against Violence

Doctors Against Violence is a network of over 800 doctors working to transform how the Australian healthcare system recognises and responds to domestic, family and sexual violence (DFSV). Our members are medical practitioners who see the health consequences of this violence in their consulting rooms every week, often long before it is named anywhere else.

Doctors Against Violence is the operating name of Doctors Against Violence Ltd (also known as Doctors Against Violence Towards Women).

We make this submission from a perspective the specialist domestic, family and sexual violence sector cannot provide on its own: that of the clinician who is frequently the first, and sometimes the only, professional a victim-survivor discloses to. We do not seek to duplicate the expertise of specialist services. We seek to strengthen the part of the response that runs through the health system, because that is where a large share of victim-survivors are already presenting, and where too much violence still goes unseen.

OUR POSITION IN ONE LINE

The Second Action Plan will shape five years of national policy. It should be built on the most complete and current evidence available, and it should treat the health system as core safety infrastructure, not as a peripheral referral point.

Executive summary

This submission makes one foundational point about the evidence base, and then a series of clinical recommendations mapped to the five priority areas proposed in the consultation paper.

First, we raise a concern about the evidence. The consultation's framing of progress, that most forms of violence have declined at the population level, rests substantially on the ABS Personal Safety Survey 2021-22, the only wave in the survey's history collected during the COVID-19 pandemic, when two thirds of women experiencing partner violence reported it had started or escalated, and many were unable to seek help safely. A more recent wave has since been collected, but the Australian Bureau of Statistics does not expect its results until mid-2027, after the Plan is due to be finalised. The Plan's own Monitoring and Reporting Framework confirms that 68 per cent of its performance measures currently lack data. Five years of national policy should not be built on a framing that does not reflect the weight of the evidence.

Second, this is a submission from a national network of more than 800 doctors. Our members are general practitioners, psychiatrists, emergency physicians and other clinicians who see the health consequences of domestic, family and sexual violence in their consulting rooms every week, often long before it is named anywhere else. The health system is not a peripheral referral point in the response to violence. It is where most victim-survivors present, it is where most violence goes undetected, and it is where the Plan has its greatest unrealised opportunity. We ask that the Second Action Plan treat the health system as core safety infrastructure.

Third, the violence has not paused for this consultation. Since it opened on 22 May 2026, at least seven women and two girls have been killed in circumstances police have identified as domestic and family violence. At the time of lodgement, that equates to roughly one woman or girl killed for every week this consultation has been open. The Plan's own Outcomes Framework sets a national target of a 25 per cent reduction per year in female victims of intimate partner homicide. In its most recent report, the Commission recorded a 35 per cent increase, in 2023-24.

Summary of recommendations

This is a thematic summary of our recommendations, grouped by area. The complete set of 27 numbered recommendations is listed in full under Consolidated recommendations at the end of this submission.

Evidence and data

- 1 Do not finalise the Second Action Plan on the ABS Personal Safety Survey 2021-22 alone. Commit in the Plan to a mandatory review of the evidence base once the next survey results are available, which the ABS expects from mid-2027. Holding finalisation until their release and independent assessment by ANROWS is preferable where possible.
- 2 Commit to nationally consistent, cross-system data collection across health, police, child protection and court settings, so that the true scale of violence can be measured rather than estimated.
- 3 Commission an independent national inquiry into criminal justice outcomes for domestic, family and sexual violence across the full pathway, from reporting to recidivism, to establish where and why cases exit the system and whether it is fit for purpose.

Clinical and health system

- 4 Treat the health system as frontline safety infrastructure. Embed a genuine “no wrong door” principle that includes general practice, emergency departments, mental health and alcohol and other drug (AOD) services and antenatal care.
- 5 Sustain and expand DFSV training for primary care, fund the longer consultations that trauma-informed care requires, and introduce a dedicated DFSV consultation item coded so a Medicare record cannot expose a disclosure.
- 6 Mandate DFSV education as a core annual continuing professional development (CPD) requirement for all Ahpra-registered health professionals, so that the system does not rely on a small number of informed clinicians carrying this work to burnout.
- 7 Establish a national DFSV credentialling approach so that completed training becomes a visible credential and a woman can find a doctor she can safely disclose to.
- 8 Act on non-fatal strangulation as a lethality marker, on the misidentification of victim-survivors as perpetrators, and on subpoenaed clinical records, through clinical guidance and documentation standards. Protect mental health and counselling records by default in family law proceedings.
- 9 Require named clinical competencies for priority populations, including neurodivergent victim-survivors. Embed 13YARN in health-setting responses.

Family court and child protection

- 10 Name the family law system as a site of systems abuse and post-separation coercive control. Secure ongoing Lighthouse funding, use the mandated 2027 statutory review of the Family Law Amendment Act 2023 to assess whether reforms have translated into safer outcomes, and finalise the regulations on family report writer competency.
- 11 Require specialist DFSV training for child protection caseworkers, and recognise that removing a child from a safe, protective parent causes measurable harm to the child.

Suicide and ICD-11

- 12 Recognise domestic, family and sexual violence as a driver of suicide. Implement the International Classification of Diseases, 11th Revision (ICD-11) with a committed date, and require structured DFSV screening in coronial and police suicide investigations so that these deaths are investigated, not just recorded.

Recovery and prevention

- 13** Fund and nationally scale evidence-based recovery care, including accessible community-based delivery models. Remove session caps and program time limits, and address the systemic barriers that force victim-survivors to choose between accessing evidence-based trauma treatment, including EMDR, and pursuing justice.
- 14** Make respectful relationships education universal, mandatory and sustained across all Australian schools, including teaching children to recognise the signs of trauma in themselves and in others.

Clinical contraindication

- 15** Do not endorse or fund couples counselling or mediation where coercive control is present. It is clinically contraindicated.

PART 1

The evidence the Plan is being built on



The claim

The consultation summary paper tells community members, under the heading of where progress has been made, that most forms of violence have declined at the population level, and that rates of deaths from intimate partner violence have been declining over time. The detailed consultation paper prepared by ANROWS carries the same assessment, drawn primarily from the ABS Personal Safety Survey (PSS) across its waves.

We want to be careful and fair here. The consultation paper is not naive about this data. It states plainly that a national decline in prevalence does not fully show how the Plan is working for all groups, especially those at highest risk, that the survey does not adequately capture some population groups, that sexual violence has increased since 2012, and that stalking has not declined since 2005. It also notes, in its own footnotes, that caution is warranted because of the COVID conditions under which the 2021-22 data were collected, and that the 2025 survey wave has been collected but not yet released.

Our concern is not that these caveats are missing from the technical paper. It is that they do not survive translation into the public-facing summary and, potentially, into the framing of the Plan itself. “Most forms of violence have declined” is the sentence that shapes public understanding and political appetite. It deserves scrutiny.

“Most forms of violence have declined” is the sentence that shapes public understanding and political appetite. It deserves scrutiny.

The Commission’s own Monitoring and Reporting Framework, released in May 2026, reports that of the 131 measures in the National Plan’s Performance Measurement Plan, 89, or 68 per cent, currently lack data, and that among the measures with data available, more than half rely on four-year national surveys of the kind discussed above. The Commission also reports that the existing public reporting process is not linked to the Plan’s ten-year outcomes or national-level targets. A Plan whose own monitoring framework cannot yet measure most of what it promises should be especially careful about the single survey its public framing leans on most, and about locking that framing in for five more years.

131

measures in the National Plan’s
Performance Measurement Plan

68%

of measures currently lack data

>50%

of measures with data rely on four-
year national surveys

The data problem extends beyond the survey. Australia does not have a national, cross-system picture of how much domestic and family violence is actually occurring. Police data captures only what is reported, and the ABS confirms that 79 per cent of women experiencing violence from a current partner never report to police. Health system presentations are not routinely coded for DFSV across jurisdictions. The AIHW’s own reporting on family, domestic and sexual violence and health services acknowledges that general practice, the most common point of contact for victim-survivors, is largely missing from the data. Data is collected state by state, system by system, with no mechanism to link police presentations, hospital admissions, GP consultations, child protection notifications and family court filings into a single picture. The burden of illness from domestic and

family violence is therefore not just underestimated; it is structurally invisible. Police presentations need to be documented even where the woman does not want to report or press charges. The effectiveness of apprehended violence orders is not being measured in any meaningful way. The Second Action Plan should commit to nationally consistent, cross-system data collection that captures DFSV presentations across health, police, child protection and court settings, so that the scale of what is happening can finally be measured rather than estimated.

The data gap is not limited to the health system. Australia has no comprehensive national picture of what happens to a domestic or sexual violence case once it enters the criminal justice system. Existing research examines one stage or one jurisdiction at a time. A 2025 attrition study by the NSW Bureau of Crime Statistics and Research (BOCSAR) tracked domestic assaults through the NSW system and found that of 33,811 incidents recorded by police, only 14 per cent of cases that reached a proven charge resulted in a custodial sentence. BOCSAR's separate study of sexual assault attrition found that only 15 per cent of incidents reported to NSW police resulted in charges being laid, and only 7 per cent ended in a guilty verdict. These are the figures for one state, for the cases that were reported, which is itself the minority. There is no national equivalent. The South Australian Royal Commission (2025), the Australian Law Reform Commission's inquiry into justice responses to sexual violence (2025), and the Victorian Royal Commission into Family Violence (2016) all made significant contributions, but none systematically examined criminal justice outcomes across the entire pathway from reporting to final disposition. The result is that policymakers do not know, at a national level, where DFSV cases are most likely to exit the criminal justice system, why attrition occurs at each stage, or what factors are associated with successful prosecution and sentencing. When we know the rates of violence are so high, we should be asking why the conviction rates are so low. That question cannot be answered without the evidence, and the evidence does not yet exist. The Second Action Plan should commit to establishing an independent national inquiry to produce it.

Why the 2021–22 survey warrants caution

It is the only COVID-era wave in the survey's history

The Personal Safety Survey has run at intervals since 2005. The 2021-22 wave is a set of data collected during the COVID-19 pandemic period, between March 2021 and May 2022. The ABS attaches caution to comparisons with this wave and other data reporting periods. It confirms that, due to the pandemic, the survey was postponed from its original proposed 2020 timing and the approached sample was reduced in size and redesigned. The ABS notes that this had some impact on the range of data that was able to be produced.

The conditions of collection matter for a further reason. In May 2020 the Australian Institute of Criminology surveyed 15,000 women and found that, among those who experienced physical or sexual violence from a current or former cohabiting partner, almost two thirds reported that the violence had started or escalated since the pandemic began, and many reported that safety concerns stopped them from seeking help. A survey enumerated in these conditions was measuring violence at precisely the moment when disclosing it, and escaping it, was hardest. The question is not whether the 2021-22 wave was honestly conducted. It is whether a wave collected in those circumstances can carry the claim that violence declined.

Australian research from that period, including a separate, later AIC survey of more than 10,000 women who had been in a relationship in the previous year, found that the pandemic coincided with first-time and escalating intimate partner violence for some women, though as a cross-sectional study it could not establish a causal relationship. A prevalence figure collected in these conditions cannot be read as a clean measure of a downward trend.

Some measures have no baseline at all

Economic abuse was measured for the first time in the 2021-22 survey. The ABS confirms it was introduced as a distinct concept and topic in that wave, with no comparable estimates of economic abuse prevalence prior to 2021-22, so it cannot contribute to any statement about violence declining over time. This matters because economic and systems abuse are precisely the forms of harm that the sector, and the Domestic, Family and Sexual Violence Commission, now identify as growing and under-recognised. Even in that single wave, around one in six women reported having experienced economic abuse by a partner.

The survey that should inform the Plan already exists

A further wave of the Personal Safety Survey has since been collected, outside the pandemic conditions that affected the previous wave. The consultation paper itself confirms this, noting that the 2025 survey wave data have been collected but not yet released. On the current timetable, the Australian Bureau of Statistics expects the results of the next Personal Safety Survey to be available from mid-2027, after the Second Action Plan is due to be finalised.

This is the heart of our first recommendation. It is not defensible to lock in five years of national policy direction on the only pandemic-affected wave of the survey when a post-COVID wave has already been collected and its results are expected within the first year of the Plan's operation. At a minimum, the Plan must commit to revisiting its evidence base the moment those results are available.

RECOMMENDATION 1

The Government should commit in the Plan to a mandatory review and revision of the evidence base as soon as the next Personal Safety Survey results are available, which the Australian Bureau of Statistics expects from mid-2027, within the Plan's first year of operation. Where finalisation can be held until those results are released and independently assessed by ANROWS, that is preferable.

The clinical evidence points the other way on demand

While a population survey suggests decline, the signals clinicians and services actually see point to sustained or rising demand. Contacts to 1800RESPECT rose by around 11 per cent in a single year, to over 342,000 contacts in 2024-25 (Women's Budget Statement 2026-27). Police-recorded family and domestic violence-related sexual assaults doubled between 2014 and 2024, a figure the consultation paper itself cites. And the Government's own Domestic, Family and Sexual Violence Commission reported that 2023-24 brought a 35 per cent rise in the number of women killed by an intimate partner, from 34 to 46 victims, after the number had already risen from 26 to 34 the year before, the largest single-year increase in over a decade, even as the long-run homicide rate has declined. The most recent year, 2024-25, recorded a decrease from that peak, and we note it, because the point is not that every year worsens. The point is that volatility of this scale is not a settled decline, and on the most recent AIHW figures a woman was still killed by an intimate partner roughly every eleven days. The National Plan's own Outcomes Framework sets a national target of a 25 per cent reduction per year in female victims of intimate partner homicide. In its most recent report, the Commission recorded a 35 per cent increase, in 2023-24.

11%

rise in 1800RESPECT contacts in a single year (to over 342,000)

35%

rise in women killed by an intimate partner in 2023-24 (34 to 46)

~11 days

one woman is still killed by an intimate partner, on the most recent AIHW figures

That long-run decline in the intimate partner homicide rate is real, and we do not dispute it. But the killing has not stopped, and it did not pause for this consultation. In the weeks since it opened on 22 May 2026, at least seven women and two girls have been killed in circumstances police have identified as domestic and family violence. They ranged in age from a six-year-old girl to a woman in her late fifties. These are confirmed domestic and family violence cases, not a broader count of all violent deaths.

At the time of lodgement, that equates to roughly one woman or girl killed for every week this consultation has been open. Every one occurred while the Government's assessment that most forms of violence have declined was open for comment.

Policy should hold both the long-run trend and the present reality in view, rather than resolve the tension by choosing the more comfortable measure.

PART 2

A clinical response to the five priority areas



The consultation proposes five priority areas. Each intersects with the health system. Below we set out, for each, what the clinical evidence shows and what the Plan should do.

PRIORITY AREA 1

Victim-survivors

The health system is already where a large share of victim-survivors present, whether or not violence is ever named in the encounter. The 2021-22 Personal Safety Survey found that around one in five women who experienced violence from a current partner sought advice or support from a general practitioner or other health professional. The general practitioner is, for many women, the most accessible and least stigmatising point of contact in the entire system, and often the only professional they see regularly.

Yet detection remains low. Up to 70 per cent of domestic and family violence goes undetected by hospital staff (Creedy et al., BMC Health Services Research, 2021). And most women never involve the police at all. According to the ABS Personal Safety Survey 2021-22, about 79 per cent of women who experienced violence by a current partner, and about 68 per cent of those who experienced violence by a previous partner, have never reported it to police. For the majority, the justice system is not the first door, and may never be a door at all. A response that treats police and courts as the primary pathway will miss most victim-survivors at the point where they are most reachable.

1 in 5

women abused by a current partner sought help from a GP or health professional

up to 70%

of domestic and family violence goes undetected by hospital staff

79%

of women abused by a current partner never report it to police



What the Plan should do

- Embed a genuine “no wrong door” principle that explicitly names general practice, emergency departments, mental health, AOD and antenatal services as recognised points of identification, safety planning and warm referral, resourced to respond rather than only refer on to other services
- Recognise reproductive coercion, non-fatal strangulation and technology-facilitated abuse as clinical presentations, not only as legal categories.

PRIORITY AREA 2

Prevention and early intervention

Prevention is not only community education. In a health setting, early intervention means routine, skilled enquiry at the points where risk is known to concentrate, and the training and time to act on what is disclosed. Pregnancy, for instance, is a recognised period for the initiation and escalation of violence, and antenatal care is a near-universal point of contact. These are opportunities the system currently underuses.

The infrastructure to intervene earlier through primary care substantially exists. Since 2019 the Australian Government has invested more than \$48.7 million in training GPs and primary care staff to recognise and respond to family, domestic and sexual violence, and in February 2026 committed a further \$22.7 million to extend that training. Independent evaluations have found the training changes clinical behaviour. The weaknesses are in reach and continuity, not in concept: the program runs through a limited set of Primary Health Network catchments, and the funding is repeatedly short-term.

\$48.7M

invested since 2019 training GPs and primary care staff

\$22.7M

committed in February 2026 to extend that training

\$77.6M

committed to Consent and Respectful Relationships Education

AT A GLANCE

-  Antenatal care is a near-universal contact point, and a recognised period for the initiation and escalation of violence.
-  Primary care DFSV training changes clinical behaviour, but funding is short-term and reaches only limited PHN catchments.
-  Respectful relationships education should be universal, mandatory and sustained across all Australian schools.
-  Rapid Review Recommendation 11 and the 2 June 2026 Ahpra joint statement already call for this.

This is not a direction we are introducing to the consultation. It is one the consultation paper itself identifies. In its assessment of prevention and early intervention, the paper calls for investing in early intervention pathways outside the justice system, including consistent capability across health, naming GPs specifically. Our recommendation is to resource that call rather than restate it.

Prevention must also reach the generation forming its first understanding of relationships. The Australian Government has committed \$77.6 million to the Consent and Respectful Relationships Education measure, and a National Respectful Relationships Education Framework was released in March 2026. DAV supports this work and recommends it be universal, mandatory and sustained across all Australian schools. Children and young people should also be taught to recognise the signs of trauma in themselves and in others, so that a child living with violence at home has language for what is happening to her and does not blame herself for the symptoms she is experiencing.

None of this asks the Government to break new ground. Its own Rapid Review of prevention approaches, *Unlocking the Prevention Potential* (August 2024), recommended in Recommendation 11 that the Commonwealth and the states and territories activate the health system and workforce as a key prevention lever. That recommendation includes equipping and resourcing GPs, perinatal, mental health and AOD services; creating a specific Medicare item number for GPs to spend appropriate time with people affected by DFSV; and mandating DFSV training for general practice and psychology, developed in collaboration with the RACGP. The Review heard that this training should be considered a necessary, life-saving requirement, on par with the mandatory requirement for training in CPR. The Second Action Plan is the vehicle to fund and deliver what the Government's own review has already recommended.

The regulators have moved too. On 2 June 2026, Ahpra, the National Boards and the Accreditation Authorities issued a joint statement committing to build the health workforce's capability to recognise and respond to family, domestic and sexual violence through professional capabilities, codes of conduct and continuing

professional development guidelines. The commitment now exists across the professions. The Second Action Plan is where it becomes funded, mandated and measurable.



What the Plan should do

- Move primary care DFSV training from time-limited, catchment-limited pilots to sustained national coverage.
- To adequately remunerate the longer consultations that trauma-informed enquiry and response require. A disclosure cannot be safely handled in a standard appointment, and clinicians should not have to absorb that time as an unfunded cost.
- Make respectful relationships education universal, mandatory and sustained across all Australian schools, including teaching children to recognise the signs of trauma.

PRIORITY AREA 3

Children and young people in their own right

Children are patients in their own right, not appendages to a parent's file. Clinicians see the health consequences of children's exposure to violence directly, and too often those consequences are read as something else. Children's trauma responses are often pathologised as a behavioural or developmental disorder, which both mislabels the child and obscures the violence driving the presentation. This is the paediatric parallel to the misdiagnosis pattern our members see in adults.

⚠ CLINICAL FLAG

Children's trauma responses are often pathologised as a behavioural or developmental disorder. This both mislabels the child and obscures the violence driving the presentation.

Post-separation abuse is a particular blind spot. Contact arrangements for children, repeated court-initiated litigation and handovers, become weaponised vehicles of control where children are drawn through systems that were not designed to recognise these harmful dynamics. A health system that only sees the child at the point of a behavioural referral is seeing the symptom and missing the cause.

Child protection systems and the failure to see the protective parent

The consultation paper names children and young people as a priority, but it does not examine whether child protection systems are themselves operating safely in DFSV contexts. Multiple independent reviews, including the Family is Culture report in New South Wales (Davis, 2019), the Yoorrook Justice Commission in Victoria (2023), and the NSW Auditor-General's 2024 performance audit, have found child protection systems failing to recognise DFSV dynamics, blaming mothers for the violence perpetrated against them, and removing children from safe parents without adequate understanding of the harm that separation itself causes.

Child protection caseworkers, in some jurisdictions with qualifications as limited as a Certificate IV, are removing children from protective parents on the basis that the mother failed to protect her children from violence she was herself experiencing. The premise is inverted: the mother is treated as the risk, rather than the perpetrator who created the risk. A system that threatens women with the removal of their children for not leaving a violent partner is using the same coercive leverage as the perpetrator. The Second Action Plan should

require specialist DFSV training for child protection caseworkers and recognise that separating a child from a safe, protective parent causes measurable harm to the child.

CLINICAL FLAG

Removing a child from a safe, protective parent causes measurable harm to the child. Treating the mother as the risk, rather than the perpetrator who created it, replicates the perpetrator's coercive leverage.

What the Plan should do

- Support health, early childhood and school settings to recognise children's trauma responses as potential markers of exposure to violence rather than defaulting to behavioural diagnoses.
- Ensure services respond to children as victim-survivors with their own needs, including after separation.
- Recognise that removing a child from a safe, protective parent causes measurable harm to the child. Require specialist DFSV training for child protection caseworkers.

PRIORITY AREA 4

People who use violence

People who use violence also pass through health services, often well before violence is formally identified, which creates genuine early-intervention contact points. We support accountability pathways that keep victim-survivor safety at the centre. From a clinical standpoint two cautions are essential, because getting them wrong causes direct harm.

First, couples counselling and family mediation are contraindicated where coercive control is present. Bringing a victim-survivor and a person using violence into a shared therapeutic space can escalate risk. A shared therapeutic space also implies shared responsibility of the victim-survivor and reinforces the leverage that a person using violence may wield. Choosing to use violence in relationships should not be softened, and it should not be funded or recommended as a response in these circumstances.

CLINICAL FLAG

Couples counselling and family mediation are contraindicated where coercive control is present. A shared therapeutic space can escalate risk, implies shared responsibility, and reinforces the perpetrator's leverage.

Second, misidentification is a real and measurable clinical and legal risk. Police family violence data indicate that a meaningful proportion of people recorded as respondents are in fact victim-survivors misidentified as perpetrators. In Victoria this has been estimated by Victoria Police at around 12 per cent of family violence reports where a woman is named as the respondent, and Women's Legal Service Victoria puts it at around 10 per cent of its clients. First Nations women are disproportionately affected. Misidentification follows a woman through health, legal and child protection records. Careful clinical identification and documentation requires training to reduce this risk.

⚠ CLINICAL FLAG

Misidentification of victim-survivors as perpetrators is a measurable clinical and legal risk, estimated at around 12 per cent of Victorian family violence reports where a woman is named as respondent, and it follows her through health, legal and child protection records.

✓ What the Plan should do

- Exclude couples counselling and mediation as a funded or recommended response where coercive control is present. It is clinically contraindicated.
- Invest in clinical and cross-system training to reduce the misidentification of victim-survivors as perpetrators, and in documentation standards that support accurate identification.

PRIORITY AREA 5

System integration and workforce

This is where the clinical voice has the most to add, and where the current system has its clearest gap. Australia has invested heavily in training the primary care workforce. It has not built any way to signal that training to the public, or to measure whether it improves what victim-survivors actually experience.

A woman cannot search for a GP she can safely disclose to. A GP who completes training receives no visible credential. A practice with a strong trauma-informed culture is indistinguishable, from the outside, from one with no training at all.

The system trains but does not signal. The corrective is a national DFSV credentialling approach: completed training that becomes a visible credential, so that victim-survivors can identify clinicians equipped to receive a disclosure safely, and so that the system itself can see where capability exists and where it does not.

Credentialling could align with the existing model of credentialling for mental health care plan item numbers, and with any future dedicated DFSV consultation item. If such an item is introduced, it should be coded in a cloaked form, recorded for example as a social wellbeing consultation. The purpose is not to obscure the clinical record, which, documented accurately and without pathologising labels, can support a victim-survivor in legal proceedings. It is to prevent a perpetrator with access to a shared Medicare card, a linked myGov account, My Health Record or a family claims history from discovering that a disclosure has been made. This is what a trauma-informed system looks like in practice: one that anticipates how perpetrators use systems to surveil and control, and is designed so that the act of seeking help can never become a new source of harm. The Government's own Rapid Review of prevention approaches recommended exactly this in August 2024: a specific Medicare item number for GPs to spend appropriate time with people affected by DFSV, noting that any such step would need to be accompanied by privacy measures. The cloaked coding described here is that privacy measure.

Workforce sustainability belongs here too. The clinicians doing this work carry vicarious trauma, and the specialist services they refer to are operating far above funded capacity, with the result that the highest-need victim-survivors are sometimes screened out by every system at once. Integration is not only about data-

sharing protocols. It is about whether a warm referral actually lands somewhere with the capacity to hold it. Funding models compound this.

Services funded on throughput targets rather than outcomes are pushed toward premature discharge and workforce burnout, and the clinicians and workers most skilled in this care are the ones most likely to be lost to it.

This is not abstract. AIHW data indicate that around one in four people fleeing violence who need a safe bed have that need go unmet, and Homelessness Australia's Call Unanswered report (2024) found that specialist homelessness services are forced to turn away families with children on roughly one in five days. When a clinician makes a warm referral into a system operating beyond capacity, the referral fails at the point a woman most needs it to hold.

1 in 4

people fleeing violence who need a safe bed have that need go unmet

1 in 5 days

specialist homelessness services turn away families with children

Here too, the consultation paper makes our case. Its own assessment finds that practitioners outside the specialist sector need more support to identify financial and sexual abuse, and that they nominate cross-sector collaboration and information sharing as the single most important thing that would increase their confidence.

That confidence gap is compounded by the fact that information sharing schemes remain state and territory dependent, with some schemes still at draft stage and legislation that permits release of information only in limited circumstances involving risk to children. A visible credential, shared frameworks and clear information-sharing guidance answer that stated need directly.



What the Plan should do

- Establish national DFSV credentialling for clinicians.
- Resource the workforce that carries this work, including vicarious-trauma support, and fund specialist services to a level where warm referrals do not fail for want of capacity.
- Adopt shared risk-assessment and case-coordination frameworks across health, mental health and specialist services so that complex victim-survivors are not left in the gap between systems.

PART 3

Issues the Plan must address



Clinical recognition and documentation

Non-fatal strangulation as a lethality marker

Non-fatal strangulation is one of the strongest known predictors of later homicide in intimate partner violence. A victim-survivor who has been subjected to non-fatal strangulation is markedly more likely to be killed by that partner. It is frequently missed clinically because external injuries can be minimal while internal and neurological injury is serious. The Plan should support recognition of non-fatal strangulation as a distinct, high-risk clinical presentation warranting specific assessment, documentation and safety response.

CLINICAL FLAG

Non-fatal strangulation is one of the strongest predictors of later homicide in intimate partner violence, and is frequently missed because external injuries can be minimal while internal and neurological injury is serious.

When trauma is pathologised: diagnostic labels as a weapon

Our members, particularly in general practice, report a consistent pattern: the trauma responses of victim-survivors are misread as psychiatric pathology and recorded as diagnostic labels that describe how a patient presents rather than what has happened to her. The harm is twofold. Clinically, treatment is directed at the label rather than at the violence driving the presentation, and victim-survivors are deferred into a separate, waitlisted mental health system when the underlying issue is safety. Legally, the label becomes evidence. A psychiatric diagnosis on a victim-survivor's record can be used in family law proceedings to portray a protective parent as unstable, and can contribute to children being placed with the parent who uses violence. This mirrors the pathologisation of children's trauma responses described in Priority Area 3, and it is one of the most consistent themes victim-survivors raise with us directly.

CLINICAL FLAG

A psychiatric diagnosis applied to a trauma response can become evidence, used in family law proceedings to portray a protective parent as unstable and to place children with the parent who uses violence.

Clinical records, confidentiality and the courts

Clinicians should not reassure patients that what they disclose will remain confidential in the way patients often assume. Clinical records, including counselling and crisis-service records, can be subpoenaed in family law and other proceedings. This is a matter of accurate, trauma-informed documentation and of honest communication with patients about what records are and how they may be used, so that a woman is not led to disclose on a false premise. The Plan should support clinical guidance and documentation standards that reflect this reality rather than obscure it.

⚠ CLINICAL FLAG

Clinical records, including counselling and crisis-service records, can be subpoenaed in family law and other proceedings. Confidentiality cannot be promised, and a patient should not be led to disclose on a false premise.

The Family Law Amendment Act 2024 introduced protected confidences provisions from 10 June 2025. But the protection is not automatic: a victim-survivor must apply for an order, and the court retains discretion to admit the records. The first systematic study of subpoenaed clinical notes in Australian family law (Psychiatry, Psychology and Law, 2025) found practitioners reported their notes being weaponised and used to form a case against a parent. The Royal Australian and New Zealand College of Psychiatrists has advocated for law reform to protect client-psychiatrist confidentiality. DAV supports mental health and counselling records being protected by default in family law proceedings, with disclosure only where the court is satisfied a specific safety concern cannot be addressed by other evidence.

✓ What the Plan should do

- Support clinical recognition of non-fatal strangulation as a distinct, high-risk clinical presentation.
- Fund clinician training grounded in trauma-informed frameworks rather than diagnostic labels.
- Support clinical guidance and documentation standards reflecting that clinical records can be subpoenaed.
- Protect mental health and counselling records by default in family law proceedings.

The family law system**The family court as a site of ongoing violence**

The consultation paper names systems abuse as a gap and calls for simplified legal processes that reduce re-traumatisation. But it folds the family law system into a single undifferentiated reference to courts and justice responses, with no dedicated analysis and no specific commitments to family law reform. This is a significant omission. In 2024–25, in 86 per cent of matters before the Federal Circuit and Family Court of Australia where parenting orders were sought, at least one party alleged they had experienced family violence, and in 77 per cent at least one party alleged a child had been abused or was at risk (Productivity Commission, Report on Government Services 2026; Federal Circuit and Family Court of Australia (FCFCOA) 2024–25 Annual Report). In 73 per cent of those matters, four or more risk factors were alleged. A national plan that claims to deliver a whole-of-system response to ending violence against women and children cannot credibly omit the system that the majority of separating families affected by violence are compelled to enter.

86%

of parenting-order matters (2024-25)
had at least one party alleging family
violence

77%

at least one party alleged a child had
been abused or was at risk

73%

of those matters had four or more risk
factors alleged

The clinical evidence is now robust. A 2023 scoping review by Griffith University and Melbourne Law School (Wilde, Sheeran and Douglas, Psychiatry, Psychology and Law, 2023) examined what happens to mothers who have experienced domestic and family violence when they enter the family court system, and identified four

consistent themes: perpetrators using the system itself as a mode of coercive control; secondary victimisation as a result of interacting with the system; being required to relive their abuse; and long-term psychological harm including post-traumatic stress, anxiety and depression. The review found that court processes facilitated ongoing abuse by perpetrators, that fathers deliberately prolonged cases to financially drain mothers, and that poor understanding of coercive control among legal professionals was a key contributing factor.

A 2024 peer-reviewed study of 540 Australian separated parents (Cook, Byrt, Edwards and Burgin, *Violence Against Women*, 2024) found that perpetrators used the child support system and the intersections between the family court, taxation and benefit payment systems to threaten and control mothers after separation. The Commonwealth Ombudsman's June 2025 report, *Weaponising Child Support: when the system fails families*, corroborated this, finding that at the end of 2023 over 150,000 parents collectively owed \$1.9 billion in unpaid child support, with women comprising 84 per cent of recipients, and that Services Australia was not proactively identifying financial abuse or using its enforcement powers.

For children, the harm is direct and measurable. A 2026 peer-reviewed United States study of 497 family court-involved mothers (Spearman, Perrin, Bethell, Alexander, Hardesty and Campbell, *Journal of Advanced Nursing*, 2026) found that children whose mothers experienced high levels of post-separation abuse were twice as likely to report gastrointestinal problems, 2.3 times more likely to report chronic pain including headaches, 2.1 times more likely to have been diagnosed with anxiety, and 2.7 times more likely to have unmet mental health needs than children in low-exposure families. These are the children our members see in their consulting rooms. The symptoms are real. The question is whether the system that produces them is visible in the Plan.

The family court is also where the pathologisation described in the preceding section does its most consequential damage. Peer-reviewed Australian research (Reeves, Fitz-Gibbon, Meyer and Walklate, *Violence Against Women*, 2025) documents how victim-survivors' credibility is systematically undermined through legal systems abuse, and how the concept of parental alienation, despite being widely discredited clinically, continues to be deployed predominantly against mothers. The UN Special Rapporteur on Violence Against Women (Alsalem, 2023) concluded that parental alienation is an unfounded and unscientific pseudo-concept, highly gendered, used by perpetrators to continue abuse and to discredit allegations of domestic violence. Australia's recent family law reforms did not adopt the Rapporteur's recommendation to restrict its use in family law proceedings.

DEFINITION · PARENTAL ALIENATION

The UN Special Rapporteur on Violence Against Women (Alsalem, 2023) concluded that parental alienation is an unfounded and unscientific pseudo-concept, highly gendered, and used by perpetrators to continue abuse and to discredit allegations of domestic violence.

Family report writers and the absence of accountability

Family report writers play a decisive role in family court parenting matters, yet their accountability and competence remain inadequately regulated. The Attorney-General's Department consulted in December 2021 on improving their competency and committed to establishing regulations. The Family Law Amendment Act 2023 introduced a power to regulate them, but the regulations have not yet been made.

Family report writers are self-identified experts who may lack specialist training to assess coercive control. They use concepts such as parental alienation despite it being widely discredited clinically. Their recommendations are not subject to independent review, yet they carry decisive weight with the court. Recommendations are made on the basis of assertion rather than evidence. Courts make orders that ban distressed children from

seeing a psychologist, prevent mothers from seeing their treating clinician, and direct police to remove children and return them to a parent they are afraid of. A child in distress should never be denied access to mental health care by a court order made on the basis of an unsubstantiated opinion. It should not cost a mother hundreds of thousands of dollars to protect her child.

DAV's members report a consistent clinical pattern: women presenting with anxiety, exhaustion, financial stress and deteriorating mental health who, when asked, disclose that they are in the middle of family law proceedings. The pattern of harm is identifiable. Repeated litigation, each application requiring a response, each adjournment costing money she does not have. False allegations of alienation when she raises safety concerns. Children's disclosures disbelieved. Clinical records subpoenaed and stripped of context. Diagnostic labels applied to trauma responses and then used against the protective parent in court. Protective parents losing custody to the parent who uses violence. These are not isolated cases. They are what over 800 doctors in our national network see, and they represent the implementation gap between policy intent and lived outcome that a national plan must name if it is to be credible.

The Government has made significant reforms in this space. The Family Law Amendment Act 2023 repealed the presumption of equal shared parental responsibility and streamlined the best-interests framework. The Family Law Amendment Act 2024 brought economic abuse into property settlements and introduced protected-confidences provisions to safeguard therapy records. The Lighthouse triage program has screened 24,193 parties (28 November 2022 to 30 June 2025), with 64 per cent identifying that they had experienced family violence. DAV acknowledges this work. But reforms on the statute book are not reforms in the courtroom. A statutory review of the Family Law Amendment Act 2023 is due to start in 2027 and to report within twelve months, within the Second Action Plan's five-year window. The Plan should commit to using that review, and the evidence it produces, to assess whether the reforms have translated into safer outcomes for women and children, not just safer legislation.

The Lighthouse program received \$33.8 million in the 2025-26 MYEFO, extending its funding to 2027-28. That funding should be made ongoing, and the program expanded to regional and remote registries, so that the Plan's own family violence screening program is not left to lapse within the life of the Plan.



What the Plan should do

- Name the family law system as a site of systems abuse and post-separation coercive control.
- Secure ongoing funding for the Lighthouse family violence screening program.
- Commit to using the mandated 2027 statutory review of the Family Law Amendment Act 2023 to assess whether reforms have translated into safer outcomes.
- Finalise the regulations on family report writer competency and accountability.

Counting the deaths the system misses

Domestic, family and sexual violence and suicide

Suicidality is a frequently invisible outcome of domestic, family and sexual violence, particularly where coercive control, post-separation abuse and systems abuse intersect. Suicidal distress presenting in a health setting should be able to trigger enquiry into violence, entrapment and perpetrator tactics, and perpetrator threats of

suicide should be recognised as a tactic of control and a marker of heightened lethality risk. We support the direction of specialist submissions, including that of DVNSW, calling for coordinated pathways across health, mental health and specialist services, and for consistent definition and counting of DFSV-related suicide.

Identifying and counting DFSV-related suicide

Domestic, family and sexual violence is a driver of suicide, and these deaths are largely absent from the national picture. Analysis of the AIHW's linked data has found that people with a recorded history of family and domestic violence are markedly more likely to die by suicide; for women the association is around 3.4 times. Yet routine national mortality data identifies a DFSV history in only about 19.4 per cent of women's suicide deaths, while specialist state reviews that look specifically for it, including the Victorian Suicide Register, the WA Ombudsman and the NSW Domestic Violence Death Review Team, have found DFSV present far more often: in about 25 per cent of all recorded suicides in Victorian data, 49 per cent of female suicides in a New South Wales death review pilot, and 56 per cent of women who died by suicide in Western Australia in 2017. The gap between those figures is the measure of what routine data is missing.

3.4x

more likely: women with a recorded DFSV history dying by suicide

19.4%

of women's suicide deaths have a DFSV history recorded in routine data

25–56%

range found by specialist state reviews that look for it

The problem is not that these deaths can never be counted. State reviews prove they can. It is that there is no nationally consistent definition, no agreed coding framework, and no routine mechanism to identify a suicide as DFSV-related at the point of death registration or coronial finding, which the AIHW itself names as a gap. A death the routine system does not count is a death the Plan cannot be held accountable for.

A death the routine system does not count is a death the Plan cannot be held accountable for.

Part of the fix already exists and has already been endorsed. Australia has committed to the World Health Organization's ICD-11 classification, adopted internationally in 2019, which improves the capacity to record a history of partner or family violence alongside a cause of death. Australia has not yet implemented it for the routine identification of DFSV-related suicide. We support that implementation, alongside a nationally consistent definition, structured DFSV screening within coronial and police suicide investigations, and privacy-safe data linkage across coronial, health, justice and specialist datasets. We acknowledge the work already under way: the Australian Institute of Health and Welfare leads the Australian ICD-11 Task Force, and demonstration projects, including one examining how ICD-11 can support reporting on deaths resulting from family, domestic and sexual violence, are informing a business case on the scope and timing of implementation. That work deserves support, but a task force is not a timeline, and a business case does not count a death. The Second Action Plan should commit to an implementation date, so that the five years it covers are not another five years in which these deaths go unseen in the national data. The Rapid Review likewise recommended that governments establish and uplift death review panels across all jurisdictions, because deaths hold lessons about where prevention failed. Counting DFSV-related suicide through ICD-11 is part of the same principle: deaths that are not counted cannot teach. The Commission's Monitoring and Reporting Framework asks, as guiding questions, whether the Plan has the right measures and how data gaps are being identified and addressed. Implementing ICD-11 for DFSV-related deaths is a direct answer to both.

Counting is the first step, not the last. Once these deaths are visible, research funding must follow to understand them, including what the escalation points are, what intervention prevents them, and why some women survive years of this and others do not. A code on a death record tells us a death happened. It does not yet tell us how to prevent the next one. A live public count of the kind maintained for femicide is not clinically possible for suicide, because attribution often cannot be settled until a coronial process concludes. The right ambition is the fastest and most consistent identification and counting that classification allows, not a premature public figure.



What the Plan should do

- Recognise domestic, family and sexual violence as a driver of suicide.
- Implement ICD-11 with a committed implementation date for routine identification of DFSV-related suicide.
- Require structured DFSV screening in coronial and police suicide investigations.

Recovery, treatment and access

Sexual violence as a distinct clinical domain

The consultation paper is emphatic that sexual violence must be treated as distinct from domestic and family violence, with its own drivers and responses, and it notes that sexual violence has risen since 2012 while the specialist sexual violence response remains siloed from the domestic violence system. We agree, and from a clinical standpoint the health system sits at the centre of that distinct response. Acute sexual assault care combines medical treatment, forensic examination, sexually transmitted infection and pregnancy management, and trauma-informed follow-up, and it is time-critical, because forensic evidence degrades within days.

The problem is a workforce and access gap. There is a documented national shortage of doctors and nurses trained as sexual assault medical and forensic examiners, in capital cities as well as rural areas, and outside metropolitan centres victim-survivors often face limited or non-existent access to a forensic examination at all. A victim-survivor who cannot reach an examiner within the forensic window loses both clinical care and evidence, in a form of violence where reporting and prosecution are already low. The Plan should treat medical and forensic sexual assault care as core health infrastructure, and should invest in training and sustaining that examiner workforce, including the greater use of appropriately trained nurse examiners, so that access does not depend on postcode.

Recovery and healing as a health responsibility

Recovery is one of the four domains of the National Plan and a dedicated consultation question, yet it is the domain the health system is least configured to deliver. The health consequences of violence are long-term and often lifelong, spanning mental health, chronic pain, and the sequelae of non-fatal strangulation, but care is overwhelmingly funded and organised around crisis rather than the years of recovery that follow. Victim-survivors with complex trauma frequently encounter mental health services with long waitlists and poor continuity, and the system has never been resourced for recovery as a sustained undertaking.

Australian evidence supports what holistic recovery looks like in practice. A peer-reviewed evaluation of the Beyond DV Recovery Pillars framework (Satyen, Sharda and Robinson, BMC Public Health, 2025) found that a

model addressing social, health, financial, housing and legal needs simultaneously, with long-term consistent support, produced sustained recovery benefits for victim-survivors.

Recovery from trauma may take decades, or a lifetime. The funding models that shape care assume otherwise. Session caps and time-limited program funding require discharge and re-referral at intervals the trauma evidence base does not support, so that victim-survivors are referred on after a set number of sessions or months regardless of clinical need, at exactly the point where continuity of the therapeutic relationship matters most. Victim-survivors and frontline workers consistently describe this to us as a cycle of referral without resolution. The health system also needs the capacity, within Medicare and general medical care, to recognise and respond to the effects of abuse and violence in relationships without every response deferring to a separate, waitlisted mental health pathway.

Even where evidence-based trauma treatment exists, the system creates barriers to accessing it. EMDR, eye movement desensitisation and reprocessing, is recommended by the World Health Organization and Australia's National Health and Medical Research Council as a treatment for PTSD.

The Australian Government funds it for veterans through the Department of Veterans' Affairs as a recommended, evidence-based treatment, fully funded and without question. Yet for victim-survivors of domestic and family violence, EMDR is largely self-funded, and accessing it can carry a direct legal cost. NSW prosecution guidelines, tracing to a single 1995 case, bracket EMDR with hypnosis and treat prior treatment as grounds to exclude or discontinue a victim-survivor's evidence. Women in family court proceedings are routinely advised by their own lawyers not to seek trauma therapy at all, because their clinical records can be subpoenaed and used against them. The result is a forced choice between recovery and legal recourse. A woman who heals may lose her criminal case. A woman who seeks safety through the family court is told therapy could be turned against her. A veteran with the same diagnosis, treated with the same therapy, faces no such choice. There is no clinical basis for this distinction. The Second Action Plan should address the systemic barriers that force victim-survivors to choose between accessing evidence-based trauma treatment and pursuing justice.

CLINICAL FLAG

NSW prosecution guidelines, tracing to a single 1995 case, bracket EMDR with hypnosis and treat prior treatment as grounds to exclude or discontinue a victim-survivor's evidence, forcing a choice between recovery and legal recourse.

There are proven, evidence-based Australian models for holistic, trauma-informed recovery care developed specifically for victim-survivors of domestic violence. The Plan should support the sustained funding and national scaling of such models, including the recently piloted long-term trauma-informed recovery programs, rather than leaving recovery to short-term pilots and waitlisted mainstream services. How that care is delivered matters too. Beyond DV's HOPE Hubs in Queensland place free, trauma-informed recovery support in shopping centres where women already go, from counselling to housing, legal and financial help, removing much of the stigma and difficulty of seeking it. The Carindale hub has recorded more than 6,000 interactions since it opened in 2022, and the Queensland Government has committed \$7.8 million to open three more across the state. The Plan should support the evaluation and national expansion of accessible community recovery models like these, so that recovery does not depend on which state a woman lives in. Recovery should be treated as essential health care, not an optional extension of crisis response.

Rural and remote access

The consultation paper repeatedly identifies that people in rural and remote areas find it harder to get help. This is where the health system's gaps and DAV's proposals meet most sharply. In many rural communities the GP is not one option among several but the only accessible health professional, sexual assault forensic services and specialist trauma care may be hundreds of kilometres away, and confidentiality is harder to protect where the clinician, the patient and sometimes the perpetrator are known to one another. Nationally credentialled DFSV-trained clinicians who are visible to the women who need them, and properly funded telehealth are not marginal conveniences in this context; they are often the difference between some care and none. The Plan should ensure that every element of the health response, from trained GPs to forensic examination to recovery care, has a deliverable rural and remote pathway rather than a metropolitan model assumed to reach everywhere.

The cost of failing to do so is documented. Domestic Violence NSW reported in December 2025 that delivering DFSV services in regional, rural and remote communities costs up to 8.94 times more than in cities, in communities where domestic violence incident rates run up to 7.45 times higher than in major cities. Funding models that assume metropolitan conditions are not neutral in these places; they are a decision about who gets care.

up to 8.94x

more to deliver DFSV services in regional, rural and remote communities than in cities

up to 7.45x

higher domestic violence incident rates than major cities



What the Plan should do

- Treat medical and forensic sexual assault care as core health infrastructure.
- Fund evidence-based recovery care and remove session caps that force discharge regardless of clinical need.
- Address systemic barriers that force victim-survivors to choose between trauma treatment, including EMDR, and justice.
- Ensure every element of the health response has a deliverable rural and remote pathway.

System-wide gaps

Information sharing: when a clinician can share to prevent harm

Clinicians frequently hold information that could prevent serious harm, and are frequently unsure whether they are permitted to share it. Several jurisdictions now allow prescribed bodies to share information about serious domestic and family violence threats without consent for the purpose of preventing harm, but the thresholds, obligations and protections are inconsistent across the country and poorly understood in general practice. A GP who suspects escalating risk should know, with confidence, when they can and cannot share, to whom, and with what legal protection. The Plan should support clear national guidance and clinician training on lawful information sharing in the DFSV context, so that uncertainty does not become a barrier to safety.

Economic and systems abuse as a clinical and social determinant

Economic and systems abuse, including the weaponising of child support, tax and social security systems, is increasingly recognised, most recently by the Domestic, Family and Sexual Violence Commission, as a persistent and under-addressed form of harm. Its health consequences are real, sustained and often presented to clinicians as stress, mental-ill-health or somatic symptoms without the underlying cause being visible. Clinicians should be equipped to recognise it, and the government-systems reforms already underway should be sustained.

Priority populations require named competencies, not general goodwill

Several groups experience violence at higher rates, face compounding barriers to disclosure, and require clinical competencies that generic trauma-informed care does not supply. A credentialling or training standard should name them explicitly.

Population	Clinical challenge in the health setting
LGBTIQA+ people	High lifetime intimate partner violence rates; screening tools assume a heterosexual dynamic; risk of being outed; perpetrator may attend. Rainbow DV Helpline (1800 497 212) belongs in every referral toolkit.
People with disability	The carer may be the perpetrator; symptoms can mask violence and vice versa; standard screening may not be accessible.
Neurodivergent people	Abuse may be described literally rather than contextually; DFSV presentations can be misread as autistic traits. We are not aware of any RACGP-accredited training in this area. This gap should be funded.
Culturally and linguistically diverse communities	Interpreter-protocol violations; visa-status fear; culturally specific definitions of harm.
Older people	Abuse dynamics distinct from partner violence; symptoms masked by ageing or dementia; carer often the perpetrator.
Pregnant women	Pregnancy is a risk period for initiation and escalation; partner often present at antenatal care.

First Nations women

First Nations women experience violence at grievously disproportionate rates. They are about 3 per cent of the adult female population but, on average, 16 per cent of adult female homicide victims each year since 1989-90 (AIC Statistical Bulletin 46, 2024). The consultation paper itself records that Aboriginal and Torres Strait Islander women are hospitalised for assault-related injuries at a rate 32 times higher than for non-Indigenous women (ADFVDRN and ANROWS, 2024). We name this because it is central to any honest account of the evidence.

We also recognise that the appropriate response is led by Aboriginal and Torres Strait Islander people. We defer to and support the direction set by communities and the dedicated standalone plan, Our Ways – Strong Ways – Our Voices: National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence 2026–2036, rather than speaking over it. Culturally safe healthcare is a clinical obligation. 13YARN (13 92 76), the 24-hour national crisis support line run by Aboriginal and Torres Strait Islander people, already exists; what is missing is any systematic requirement that health settings use it. It should be embedded in health-setting

responses as a routine, culturally safe referral option offered at the point of care and in discharge safety planning.

3%

of the adult female population

16%

of adult female homicide victims each year, on average, since 1989-90

32x

higher rate of hospitalisation for assault-related injuries than non-Indigenous women

Police disclosure (right-to-ask) scheme

A right-to-ask, right-to-know disclosure scheme allows a person to ask police whether a partner or former partner has a history of violence. South Australia has operated the only Australian scheme since October 2018, and its design is distinctive. Unlike disclosure schemes elsewhere, the South Australian model is delivered as a coordinated partnership between South Australia Police and specialist Domestic and Family Violence Services, so that disclosure is always wrapped in risk assessment, safety planning and ongoing support from a specialist worker. Information is never handed over without support around it.

An independent review by the University of Essex (2025) found the scheme has been accessed over 2,500 times, with applications more than doubling since introduction. Ninety-eight per cent of applicants found the disclosure meeting helpful in making decisions about their personal safety, over 95 per cent found it helpful in making decisions about the safety of their children and pets, and 99 per cent were satisfied with the service. The reviewers concluded that other jurisdictions looking to implement disclosure schemes or review existing ones should use the South Australian initiative as their model.

2,500+

times the South Australian scheme has been accessed

98%

found the disclosure meeting helpful for their personal safety

99%

were satisfied with the service

The evidence from Beyond DV in Queensland reinforces why. In a survey of over 100 of their clients in early 2026, more than 82 per cent reported that their perpetrator was a repeat offender, only 2.4 per cent knew this when they entered the relationship, 20 per cent reported that their perpetrator had at least five other victims, and 87 per cent said they would have accessed a disclosure scheme had one been available. The pattern is clear: the information exists in the system, the women do not have it, and by the time they do, the violence has already begun.

Doctors Against Violence supports the national expansion of a disclosure scheme modelled on the South Australian partnership approach, which remains the only such scheme operating in Australia. In Queensland, Beyond DV has been advocating for a disclosure scheme since 2020, drawing on the experiences of the women it supports. How and where a scheme is delivered matters as much as whether it exists. Because police hold the relevant information, a disclosure scheme must be police-led. But the disclosure itself is a face-to-face meeting, and it does not have to happen in a police station, which can be a barrier or a source of distress for some women. Existing schemes already allow the disclosure to be made at an agreed safe place. In partnership with police, that place could be a trusted community setting such as Beyond DV's HOPE Hubs, the accessible support spaces it runs in Queensland shopping centres, where women already feel safe enough to walk through the door. Meeting women where they already are, rather than requiring them to approach a police station, would reach those who would otherwise never come forward. DAV recommends that any national scheme be designed and evaluated with victim-survivors, that disclosure always be accompanied by specialist support and safety planning, and that safety, not merely the provision of information, remain the test of whether it works.



What the Plan should do

- Provide clear national guidance on lawful information sharing in the DFSV context.
- Sustain reforms addressing economic and systems abuse.
- Require named clinical competencies for priority populations and fund training where none exists.
- Embed 13YARN (13 92 76) in health-setting responses as a routine referral option.
- Support national expansion of a domestic violence disclosure scheme modelled on the South Australian approach.

Consolidated recommendations

These are the 27 recommendations in full. They are the same recommendations grouped thematically in the Summary of recommendations at the front of this submission. Doctors Against Violence recommends that the Second Action Plan:

- 1 Not be finalised on the ABS Personal Safety Survey 2021-22 alone. The Government should commit in the Plan to a mandatory review and revision of the evidence base as soon as the next Personal Safety Survey results are available, which the ABS expects from mid-2027. Where finalisation can be held until those results are released and independently assessed by ANROWS, that is preferable.
- 2 Embed a genuine “no wrong door” principle that explicitly includes general practice, emergency departments, mental health and AOD services, and antenatal care as recognised points of identification, safety planning and warm referral, resourced to act rather than only to refer.
- 3 Move primary care DFSV training from catchment-limited, time-limited pilots to sustained national coverage. This will require appropriate Medicare remuneration for longer consultations that trauma-informed care requires. This should include a dedicated DFSV consultation item, coded in a cloaked form so that a Medicare claims record cannot reveal a disclosure to a perpetrator.
- 4 Mandate DFSV education as a core annual CPD requirement for all Ahpra-registered health professionals, modelled on the Medical Board of Australia’s cultural safety education requirement, so that the system does not rely on a small number of informed clinicians carrying this work to burnout.
- 5 Establish a national DFSV credentialling approach so that completed training becomes a visible credential, with an internal, structured, trauma-informed feedback and quality-improvement loop, as durable national infrastructure.
- 6 Require named clinical competencies for priority populations, and fund the development of training where none currently exists, including for neurodivergent victim-survivors. Embed 13YARN (13 92 76) in health-setting responses as a routine, culturally safe referral option offered at the point of care and in discharge safety planning.
- 7 Support clinical recognition of non-fatal strangulation as a lethality marker warranting specific assessment, documentation and safety response.
- 8 Support clinical guidance and documentation standards reflecting that clinical records can be subpoenaed, so that patients are not reassured on a false premise.
- 9 Invest in training and documentation standards, including established models such as Safe and Together, to reduce the misidentification of victim-survivors as perpetrators.

- 10 Fund clinician training grounded in trauma-informed frameworks rather than diagnostic labels alone, so that trauma responses are not pathologised into psychiatric diagnoses that can later be used against protective parents in legal proceedings.
- 11 Recognise domestic, family and sexual violence as a driver of suicide, and build coordinated pathways so that suicidal distress can trigger enquiry into violence.
- 12 Implement Australia's ICD-11 commitment, with a committed implementation date, for the routine identification of DFSV-related suicide, alongside a nationally consistent definition, structured DFSV screening in coronial and police suicide investigations, privacy-safe data linkage, and research funding to understand these deaths and prevent them.
- 13 Provide clear national guidance and clinician training on when information can lawfully be shared to prevent serious DFSV-related harm, so that uncertainty does not become a barrier to safety.
- 14 Sustain reforms addressing economic and systems abuse, and equip clinicians to recognise it.
- 15 Exclude couples counselling and mediation as a funded or recommended response where coercive control is present.
- 16 Treat medical and forensic sexual assault care as core health infrastructure, and invest in training and sustaining the examiner workforce, including trained nurse examiners, so that access does not depend on location.
- 17 Fund and nationally scale evidence-based, trauma-informed long-term recovery care, including accessible community-based delivery models, treating recovery as essential health care rather than an extension of crisis response, and removing session caps and program time limits that force discharge regardless of clinical need, and ensuring that accessing evidence-based trauma treatment, including EMDR, cannot be used to undermine a victim-survivor's credibility in criminal or family law proceedings.
- 18 Ensure every element of the health response, from trained GPs to forensic examination to recovery care, has a deliverable rural and remote pathway, supported by nationally credentialled clinicians and properly funded telehealth.
- 19 Resource the workforce carrying this work, including vicarious-trauma support, and fund specialist services to a level where warm referrals do not fail for want of capacity, and fund services on outcomes rather than throughput targets.

- 20** Commit to nationally consistent, cross-system data collection that captures domestic and family violence presentations across health, police, child protection and court settings, including documentation of police presentations where the woman does not report or press charges.
- 21** Require that child protection staff working on cases involving domestic and family violence hold specialist DFSV training, and that child protection responses be guided by the principle that separating a child from a safe, protective parent causes measurable harm.
- 22** Finalise the regulations on family report writer competency and accountability that the Government committed to in 2021, require specialist accreditation including demonstrated competency in DFSV and coercive control, and ensure recommendations are evidence-based, referenced and subject to independent review.
- 23** Protect mental health and counselling records by default in family law proceedings, with disclosure permitted only on application by the party seeking access and only where the court is satisfied a specific safety concern cannot be addressed by other evidence.
- 24** Make respectful relationships education universal, mandatory and sustained across all Australian schools, including teaching children and young people to recognise the signs of trauma in themselves and in others.
- 25** Name the family law system explicitly in the Second Action Plan as a site of systems abuse and post-separation coercive control. Secure ongoing funding for the Lighthouse family violence screening program beyond its current 2027-28 funding, and expand it to regional and remote registries. Use the mandated 2027 statutory review of the Family Law Amendment Act 2023 to assess whether reforms have translated into safer outcomes for women and children, and commit to acting on its findings within the life of the Plan.
- 26** Support the national expansion of a domestic violence disclosure scheme modelled on the South Australian partnership approach, where disclosure is always accompanied by specialist risk assessment, safety planning and ongoing support, and where safety rather than information alone is the measure of effectiveness.
- 27** Commission an independent national inquiry into criminal justice outcomes for domestic, family and sexual violence across the full pathway, from reporting and investigation through charging, prosecution, conviction, sentencing, imprisonment, parole and recidivism, to identify where and why cases exit the system at each stage and to establish the evidence base needed to determine whether the current system is fit for purpose.

We would welcome the opportunity to contribute further, including through the clinical expertise of our members and founders, as the Second Action Plan is developed.

APPENDIX

Response to the six consultation questions



The public consultation poses six questions. This submission is organised around the clinical evidence rather than the questions themselves, so the table below maps each question to where in this document our response sits. Question wording is drawn from the consultation summary paper. Those questions use the ordering ‘family, domestic and sexual violence (FDSV)’; elsewhere this submission uses ‘domestic, family and sexual violence (DFSVM)’. The two describe the same thing.

Consultation question	Where this submission responds
1. Prevention. What actions can governments, workplaces, industries, schools, families and individuals take to stop violence before it starts?	Part 2, Priority Area 2 (health-setting early intervention, routine enquiry, antenatal contact points, sustained primary care training, mandated DFSV CPD for Ahpra-registered professionals). We note the paper’s own call to invest in early intervention through GPs, and Recommendation 11 of the Government’s own Rapid Review. Part 3, Police disclosure scheme (South Australian model, Beyond DV HOPE Hubs). Part 2 (respectful relationships education in schools). Part 1 (national cross-system data collection).
2. Services and support. How can services and supports work better for people who have experienced, or are at risk of experiencing, FDSV?	Part 2, Priority Area 1 (the health system as a recognised “no wrong door”, detection, warm referral); Part 3 (sexual violence care, recovery, rural access, trauma pathologisation, DFSV and suicide including ICD-11); the capacity evidence on refuges and unmet need; Part 3, The family court as a site of ongoing violence (post-separation coercive control, litigation abuse, clinical records subpoenaed, Lighthouse program). Part 3, Police disclosure scheme (South Australian model, Beyond DV HOPE Hubs). Part 2, Child protection (caseworker training, protective parent principle).
3. Children and young people. How can communities and services best support children and young people to stay safe from violence?	Part 2, Priority Area 3 (children as patients in their own right, trauma responses misread as behavioural disorders, post-separation contact as a vehicle for control); Part 3, The family court as a site of ongoing violence (children’s health outcomes, parental alienation, protective parents losing custody). Part 3, Family report writers (accountability, accreditation). Part 2, Child protection.
4. People who use violence. What more can be done to promote healthy, safe relationships and strengthen accountability for people who use violence?	Part 2, Priority Area 4 (health contact points before violence is identified; couples counselling contraindicated in coercive control; misidentification of victim-survivors as perpetrators).
5. Recovery and healing. What would make the biggest difference in helping people and families to recover and heal?	Part 3, Recovery and healing as a health responsibility (long-term trauma-informed care, evidence-based Australian recovery models, treating recovery as essential health care, removing session caps and program time limits); Part 3, When trauma is pathologised (trauma-informed frameworks rather than diagnostic labels); Part 3, The family court (long-term psychological harm to protective parents, secondary victimisation); Part 3, Recovery (EMDR and the forced choice between treatment and legal recourse, veterans comparison). Part 3, Protected confidences (therapy records by default).
6. Access to support. What makes it easier for people to access support or services related to DFSV?	Part 2, Priority Area 5 (national DFSV credentialling, a dedicated DFSV consultation item with cloaked coding, information sharing, service capacity); Part 3, Rural and remote access (credentialled clinicians and telehealth pathways).

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Every figure in this submission has been included on the basis of a primary source. Full citations for the sources drawn on are listed below.

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