

# Submission to the Second Action Plan

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

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## Executive summary

**Family, domestic and sexual violence (FDSV) is both a safety issue and a public mental health issue.** While practical supports such as safe housing, legal advocacy and financial assistance are essential, long-term recovery also depends on timely access to evidence-based psychological treatment and fair legal proceedings. The EMDR Association of Australia (EMDRAA) supports the Second Action Plan placing greater emphasis on healing and recovery for victim-survivors, children, young people and families affected by FDSV.

**As a professional association representing EMDR therapists in Australia, EMDRAA recommends large-scale investment in workforce development, postgraduate training, community education, and implementation support for evidence-based trauma-focused treatments.** This should be delivered across public, private and non-government organisations, within family, domestic, and sexual violence services, child protection, health, mental health and community-based multidisciplinary teams. Further, governments should routinely evaluate whether funded services are delivering evidence-based care and whether victim-survivors experience meaningful improvements in psychological, social, and emotional wellbeing, functioning and quality of life.

## Priority Area 1: Victim-survivors

**Victim-survivors need improved access to timely effective trauma-focused treatment.** Incidences of family, domestic and sexual violence (FDSV) can result in needs for support that extends beyond practical assistance such as safe housing, financial assistance, legal advocacy, and ongoing case coordination. Many individuals also require timely access to effective psychological interventions to support long-term healing and recovery. Improving access to appropriate support requires action across multiple levels, including increasing the number of clinicians trained in evidence-based trauma treatments, improving public access to appropriately qualified clinicians, raising community awareness of available services, and ensuring that services are responsive to the needs of diverse populations. This includes providing culturally safe and developmentally appropriate care for Aboriginal and Torres Strait Islander peoples, children and young people, and individuals from culturally and linguistically diverse (CALD) and LGBTQIA+ communities.

**Upskilling the workforce in evidence-based trauma interventions should be a national priority.** There is now substantial evidence demonstrating the effectiveness of trauma-focused psychological interventions, including EMDR therapy (Australian Psychological Society, 2024; Forbes, Bisson, Monson, & Berliner, 2020; Phoenix Australia Centre for Posttraumatic Mental Health, 2020). Despite this, many frontline clinicians do not receive adequate training in empirically sound trauma treatments, limiting the availability of effective care for victim-survivors. A coordinated, system-wide workforce strategy is needed to build and sustain a skilled trauma workforce through investment in:

- University education with a stronger emphasis on understanding trauma, its impact, and treatment in terms of evidence-based, trauma-focused assessment and intervention.
- Affordable tertiary level education, and accessible high-quality training and ongoing professional development to support clinicians throughout their careers. This can include linking in with national trauma-focused organisations such as the EMDR Association of Australia (EMDRAA).
- Specialist training to meet the needs of populations with increased vulnerability, including Aboriginal and Torres Strait Islander peoples, children and young people, and other priority groups.
- Workforce development for organisations to support the implementation of skills and knowledge learnt in training and competent, safe and ethical delivery of effective trauma interventions across multidisciplinary teams.
- Education for paraprofessionals and other frontline workers to improve understanding of trauma, facilitate appropriate referral pathways, and support, but not replace, the delivery of appropriate psychological interventions by appropriately trained clinicians.

**The Second Action Plan should ensure that all victim-survivors have access to evidence-based interventions.** Psychological harm is not only born from witnessing or experiencing physical or sexual harm. It can also be the result of verbal abuse and emotional or physical neglect (Kawata et al., 2025; Khan et al., 2015). Experiences of FDSV leads to clinical presentations beyond that of PTSD, to clinical presentations that are complex and comorbid in nature (i.e. PTSD with anxiety, depression, panic, suicidal ideation). In addition to being effective for individuals with posttraumatic stress disorder, there is evidence that trauma-focused interventions, like EMDR therapy, can also be helpful for individuals with a range of presenting issues such as complex PTSD, depression, specific phobia, and substance use difficulties (Australian Psychological Society, 2024)

**Improving public awareness of family and domestic violence services is essential to increasing early access to support.** One of the key barriers to help-seeking is limited public awareness of the services that are available and how they can be accessed. Increasing awareness and accessibility would enable victim-survivors and their families to identify and seek appropriate assistance earlier. Accessibility must be considered, including the geographical distribution of services, hours of operation, affordability, and the impact of social stigma on help-seeking. In addition, broader community education is needed to increase awareness of the range of supports available and to help individuals recognise when and how to access them for themselves or others.

**Aboriginal and Torres Strait Islander communities have increased vulnerabilities and increased risk of FDSV, however, also often have limited access to support.** For many, access to effective trauma-focused mental health treatment remains limited, particularly in regional and remote areas. Services are often geographically inaccessible, difficult to sustain, or not delivered in culturally safe ways that align with Indigenous worldviews, community priorities and healing practices.

**Healing from FDSV happens through relationships, culture, Country and community.** People engage when they experience genuine, consistent and culturally safe relationships with workers they know and trust. Conversations and genuine partnerships between Aboriginal and Torres Strait Islander communities, Indigenous clinicians, Elders and trauma practitioners are needed to explore how trauma-focused therapies can complement existing cultural healing practices and indigenous

models of emotional and social wellbeing. Cultural healing and Western psychological interventions should not be viewed as competing approaches, but rather as complementary when they are community-led, culturally governed, and responsive to local community needs. An EMDRRA member, who is a Wiradjuri woman and Clinical Counsellor working alongside Aboriginal communities for more than two decades, reflected: *"Healing grows within relationships, culture, Country and Community, not external to them. Our role is not to bring healing into communities, but to walk alongside communities, recognising and strengthening the resilience and wisdom that have always been there."*

**The Second Action Plan should recognise and build on the strengths that already exist within Aboriginal and Torres Strait Islander communities.** We are not bringing healing or resilience to people; rather, we are helping create the conditions for individuals, families and communities to reconnect with stories of resilience, the strengths, identity, culture and wisdom that already exist. Every community is different, and there is no one-size-fits-all model. Services need to spend time understanding each person's story and each community's unique strengths rather than making assumptions about culture or community needs.

**Communities should be genuine partners in designing policies, programs and services.**

Governments should invest in meaningful consultation with local Elders, Aboriginal Community Controlled Organisations, respected community leaders and experienced frontline practitioners from the beginning of policy development. Relationships should come before assessment. Extensive data collection and repeated requests for people to retell their stories before trust has been established can unintentionally become another barrier to engagement.

**Long-term investment is essential to building trust and supporting recovery.** Short-term funding cycles and workforce turnover undermine the trusted relationships that are fundamental to healing from trauma and family violence. Rather than continually introducing externally designed programs, policy should build on what already exists. There is enormous knowledge, leadership and effective practice within Aboriginal and Torres Strait Islander communities, and these existing community-led responses should be strengthened and supported.

**Indigenous leadership should guide the cultural adaptation and implementation of evidence-based trauma therapies.** Collaborative research and implementation should explore how trauma-focused therapies, including EMDR therapy, can be culturally adapted and integrated within existing healing practices, cultural spaces and community-led ceremonies where appropriate. Indigenous clinicians and Indigenous research centres, such as the Wollotuka Institute, are uniquely positioned to lead this work through their clinical expertise, cultural knowledge and trusted relationships with communities. Their leadership is essential to ensuring that trauma-focused interventions uphold cultural identity, connection to Country, kinship, spirituality and collective wellbeing while maintaining fidelity to current evidence.

**Investment in Indigenous-led models of care, workforce development and research is critical to improving long-term outcomes.** Investment is needed to support Indigenous-led models of care, workforce development and research evaluating culturally adapted evidence-based trauma-focused interventions. Such approaches have the potential to improve access to effective family, domestic and sexual violence trauma treatment while strengthening self-determination, cultural continuity and community healing for Aboriginal and Torres Strait Islander children, families and communities.

## Priority Area 2: Prevention and early intervention

**Early intervention is critical in minimising the distress caused by FDSV.** Mental health concerns are now the biggest driver of disability worldwide (Santomauro et al., 2026), resulting in substantial personal, social and economic costs. There is growing evidence that early trauma-focused psychological interventions, including EMDR therapy, can reduce mental health symptoms, improve quality of life, and support longer-term recovery.

**Untreated trauma and mental health symptoms can contribute to an ongoing cycle of violence and disadvantage.** The relationship between mental health difficulties and FDSV is well established. In addition, victim-survivors experiencing significant psychological distress are often less likely to seek or engage with essential supports, including police, legal, medical and psychological services. Providing timely, effective intervention can therefore improve both recovery and engagement with broader support systems.

**Early intervention services should consistently deliver evidence-based trauma treatment.** While many frontline services provide invaluable practical and emotional support, access to established trauma-focused psychological interventions remains inconsistent, particularly for children and families. Even where psychological support is available, care is not always aligned with current clinical practice guidelines. Ensuring that early intervention service providers have access to appropriate training, supervision and referral pathways would substantially improve the quality and consistency of care provided to victim-survivors.

**Individuals need education to ensure they are aware of the supports available to them in a timely manner.** For specialist services, such as substance use programs, it is essential that the workers are also trained in appropriate trauma-focused interventions such as EMDR to improve prognoses and outcomes for their clients.

**Victim-survivors and the broader community need clear, accessible information about when and how to seek support.** Public education initiatives should increase awareness of the early signs of trauma, the benefits of timely intervention, and the range of evidence-based treatments and services available. Improving mental health literacy, knowledge and understanding of available services and supports will enable individuals, families, children, and communities to recognise when professional help may be needed and access appropriate services before difficulties become more clinically severe and pervasive in terms of the impact upon the individual.

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

**Children and young people affected by family, domestic and family violence (FDSV) should be recognised as victim-survivors in their own right and given timely access to effective trauma treatment.** A child and young person's mental health and developmental recovery should be prioritised alongside their immediate physical safety. While ensuring safety is essential, protection alone is not sufficient. Children cannot recover simply because the violence has stopped. They require timely therapeutic intervention to reduce and recover from the long-term impacts of trauma on all areas of social, relational, emotional, cognitive (educational), and physical development.

**Australia's child protection system should evolve from a predominantly statutory risk management model to one that equally prioritises healing and recovery.** Child protection services are often the first government agencies to identify the impacts of family violence. However, the

current system is primarily designed to assess and manage risk rather than facilitate recovery from trauma. Increasing demand, workforce shortages, resource constraints and fragmented service delivery have placed significant pressure on the sector. As a result, many children and families experience repeated assessments, multiple service transitions and lengthy delays before receiving appropriate therapeutic support. These experiences can unintentionally compound trauma, reduce trust in services, erode hope and limit opportunities for recovery.

**The Second Action Plan should prioritise timely access to evidence-based trauma treatment for children and young people.** Many children currently move through multiple services without receiving interventions that directly address the psychological impacts of trauma. Best practice trauma-focused therapies should be available early and integrated into child and family services so that recovery begins alongside efforts to ensure safety and stability.

**Children's recovery requires coordinated, multidisciplinary and family-centred care.** Effective interventions should not occur in isolation but involve collaboration across child protection, health, education and community services. Trauma treatment should support children to process traumatic experiences, strengthen secure relationships, restore emotional regulation and promote healthy development across emotional, physical, social, educational and relational domains. Where appropriate, interventions should also include parents, caregivers and educational settings to strengthen recovery within the child's everyday environment.

**Building a healing-focused child protection system requires sustained investment in workforce capability and evidence-based care.** This includes increasing workforce capacity, providing specialised training in child development, attachment, developmental trauma, family and domestic violence, and ensuring clinicians have access to high-quality training in effective trauma-focused interventions. Embedding culturally safe, family-centred and evidence-based trauma treatment within child protection and related services will strengthen Australia's capacity to interrupt intergenerational cycles of trauma, family violence and community violence, while improving long-term outcomes for children and families.

## **Priority Area 4: People who use violence**

**Responses to people who use violence must maintain a clear focus on accountability and the safety of victim-survivors.** Trauma history, mental health difficulties and substance use may be important considerations during assessment and intervention, but they should never be used to excuse violent behaviour or diminish personal responsibility. Interventions should reinforce accountability while addressing factors that may contribute to the risk of future violence.

**The workforce should be equipped to recognise and respond to the full range of abusive behaviours.** This includes identifying patterns of coercive control, psychological abuse, technology-facilitated abuse and escalating risk, while maintaining a strong focus on the ongoing safety of victim-survivors and children.

**The Second Action Plan should support evidence-informed interventions that integrate accountability, behaviour change and appropriate mental health care.** Responses for people using violence should combine accountability, behavioural change and risk management with access to evidence-based assessment and treatment for co-occurring mental health conditions, trauma and substance use disorders where clinically indicated. Emerging evidence suggests that psychological trauma treatments, including EMDR therapy, may have a role in addressing trauma-related

symptoms in some people who use violence (Sousa et al., 2025). However, further research is needed to better understand the relationship between mental health difficulties, trauma and violent behaviour, and whether effective treatment of these conditions contributes to reduced recidivism and improved long-term outcomes.

## **Priority Area 5: System Integration and Workforce**

**The Second Action Plan should prioritise the development of a sustainable, well-trained and adequately resourced trauma-focused workforce that delivers care consistent with current evidence and best practice.** Investment should focus on increasing the number of clinicians trained in frontline evidence-based trauma treatments, including EMDR therapy, while ensuring ongoing supervision and professional development. Additional investment is also needed to support the appropriate application of these interventions for vulnerable populations, including children, families, Aboriginal and Torres Strait Islander peoples, and individuals presenting with complex clinical presentations, comorbid mental health conditions, ongoing risk and limited safety. Workforce capability is not solely determined by workforce numbers but also by the quality of the team and the support they are given, and their access and capacity to implement gold standard interventions.

**Workforce development should extend beyond specialist mental health services.** Clinicians working within frontline services, including child protection, family and domestic violence, health and community sectors, should receive training that enables them to recognise the impacts of trauma, respond appropriately within their scope of practice, and facilitate timely referral to evidence-based trauma treatment where required. Broader education for community and support workers would also strengthen understanding of current best practice, improve referral pathways, and increase access to appropriate care.

**Governments must also invest in the wellbeing and sustainability of the frontline workforce.** Chronic exposure to trauma, high workloads, workforce shortages and increasing service demand place staff at significant risk of burnout, compassion fatigue, vicarious trauma and workforce attrition, ultimately affecting service quality and continuity of care. Investment in workforce wellbeing, reflective supervision, manageable caseloads and trauma-informed organisational cultures is essential to maintaining a skilled workforce capable of delivering safe, effective and compassionate care. Supporting those who support others is fundamental to creating systems that promote healing, strengthen trust in services and improve outcomes for vulnerable children, families and victim-survivors.

## **Other areas of action**

The Second Action Plan should recognise that recovery depends not only on increasing access to services, but also on ensuring that the services provided are evidence-based, culturally safe, developmentally appropriate and capable of delivering meaningful long-term healing. One additional area that requires immediate attention is the intersection between access to justice and evidence-based psychological support for victim-survivors.

## **Background**

**Victim-survivors of sexual violence are being discouraged from evidence-based psychological intervention or excluded from justice after receiving it.** This is because the intervention is wrongly believed to compromise their evidence. The effect is felt well beyond the cases that make the news. Faced with a choice between their recovery and their day in court, some victim-survivors will step away from a prosecution altogether; others will stay in, but proceed through a process that is demanding, adversarial and drawn out, and is not itself therapeutic, without the treatment that would have helped them cope with it. Reported instances in several jurisdictions, documented by the ABC in 2026, are illustrative rather than exhaustive: other victim-survivors have since come forward to the media and to EMDRAA with their own experiences, and more may choose to speak.

### **Where this has been reported**

- ABC News, 9 March 2026 — *EMDR mental health therapy helped Katie heal, but her court case was discontinued*<https://www.abc.net.au/news/2026-03-09/mental-health-emdr-therapy-may-have-cost-katie-justice/106425114>
- ABC News, 1 July 2026 — *Calls for legal system to change approach to EMDR and witnesses*<https://www.abc.net.au/news/2026-07-01/calls-for-legal-system-to-change-approach-to-emdr-and-witnesses/106856868>
- ABC Radio National, *Law Report* — *Healing and Justice: does EMDR therapy taint witness recollection?*<https://www.abc.net.au/listen/programs/lawreport/does-emdr-therapy-taint-witness-recollection/106595274>
- *Pursuit* (University of Melbourne) — *Why do Australian courts still distrust a proven trauma therapy?*<https://pursuit.unimelb.edu.au/articles/why-do-australian-courts-still-distrust-a-proven-trauma-therapy>
- *The Citizen* — *Australian prosecutors revise EMDR therapy guidance amid backlash*<https://www.thecitizen.org.au/articles/australian-prosecutors-revise-emdr-guidance>

### **Recommendations**

Although this legal issue has so far centred on EMDR, the concern is broader. EMDRAA's members practise across the full range of evidence-based trauma therapies, and EMDR is only one of several that could be treated in the way these cases describe. The recommendations below are therefore framed at the level of trauma-focused treatment generally, so that they resolve the present problem and guard against the same misunderstanding attaching to another therapy in future.

**Recommendation 1** That the Second Action Plan recognise the deferral of trauma-focused treatment, and the exclusion from justice of those who have undertaken it, as a barrier to recovery and to justice that requires national action.

**Recommendation 2** That governments adopt and state publicly the position that victim-survivors should not be discouraged from accessing evidence-based trauma-focused treatment and should never have to choose between their recovery and their pursuit of justice. A clear public position of this kind reassures victim-survivors that seeking treatment will not count against them, gives clinicians a settled footing on which to treat, and signals to police and prosecutors that a complainant's access to therapy is not a matter that weighs against a case.

**Recommendation 3** That every jurisdiction stop treating a complainant's receipt of evidence-based trauma-focused treatment as a reason to decline or discontinue a prosecution. No jurisdiction need wait for the others to act.

**Recommendation 4** That jurisdictions remove from their prosecution guidelines any characterisation of trauma-focused treatment, and of EMDR in particular, as a risk to the integrity of a witness's evidence.

**Recommendation 5** That the principle replacing the EMDR provisions be one of general application: a victim-survivor's receipt of any evidence-based trauma-focused treatment is not, without more, a basis for doubting their account or declining their case. Removing EMDR alone would preserve the reasoning that produced the problem and leave every other trauma-focused therapy exposed to it.

**Recommendation 6** That governments fund the correction of this misconception wherever it now operates: in police practice, in prosecutorial decision-making, in victim support services, and in the clinical professions. Repealing a guideline does not correct a belief that has already propagated beyond it.

**Recommendation 7** That governments support judicial education and jury directions correcting misconceptions about trauma-focused psychological treatment, drafted at the level of trauma-focused treatment generally and naming no modality, so that prosecutors assessing the prospects of conviction can proceed on the footing that those misconceptions will be corrected at trial.

A direction of this kind would be protective and neutral. It would prohibit an unsupported inference (that treatment renders an account unreliable, or that composure after treatment indicates fabrication) without inviting the jury to conclude that treatment makes an account more reliable, which it does not. It should name no therapy. The misconceptions it corrects arise from treatment as such, not from any one modality, and a direction that singled one out would reproduce the very error this submission identifies. Existing directions on counterintuitive victim behaviour provide the model, and the drafting is a matter for the individual jurisdictions and the relevant law reform bodies.

## **The evidence of harm**

The following is drawn from ABC investigative reporting published on 9 March 2026 and 1 July 2026. EMDRAA has not sought to identify or contact the individuals concerned and cites their accounts as published.

### **A discontinued Commonwealth prosecution**

A junior doctor reported alleged childhood sexual abuse to police in 2021. She was able to report it because of EMDR treatment. In 2023 the Commonwealth Director of Public Prosecutions discontinued the matter, the correspondence stating that the circumstance of a critical crown witness having undergone EMDR therapy can have a significant effect on the admissibility of that witness's evidence. She sought review, without success.

No Commonwealth prosecution guideline names EMDR. The decision was made under the Prosecution Policy of the Commonwealth, which does not mention the therapy. The premise operated without any document containing it.

### **A Queensland investigation closed before charge**

A Sunshine Coast woman reported alleged childhood physical and sexual abuse to Queensland Police and gave a detailed statement. In early 2024 she was told the investigation would not proceed because she had received EMDR. The investigating officer wrote to her:

*"As police we understand the process and purpose of EMDR therapy however it is still viewed by the courts as a form of hypnosis therefore it is governed by the same laws and rules of evidence as hypnosis ... any evidence now obtained is inadmissible as it was obtained after the EMDR therapy was conducted."*

A police officer decided the admissibility of evidence and terminated a criminal investigation on that basis: before charge, apparently before the a prosecutor from Queensland ODPP had considered the file (as per the Office's comment they did not consider the matter), and without any court being asked to rule. The police officer, on the face of the correspondence, was applying what they understood the Queensland Director's guidelines to require.

### **A Tasmanian complainant waiting since 2023**

A Tasmanian woman has waited since 2023 to give evidence against a man she alleges sexually abused her in childhood. Her psychologist was told by staff of the Tasmanian Director of Public Prosecutions that EMDR was discouraged before she gave evidence. She asked to pre-record her evidence so that she could then be treated and has waited more than a year for an answer. She has had cognitive behavioural therapy and dialectical behaviour therapy; in her psychologist's account, they are at a loss of what to do. She told the ABC she has begun to reconsider whether the prosecution is worth continuing.

These examples are but a subset of the experiences of those willing to share their story publicly. It highlights the pervasiveness of the issue across jurisdictions and sectors of the justice system and the urgent need for reform and education. Many other stories of similar experiences have been shared in the comments section of various media articles. Ultimately, it provides an urgent case for more than the simple removal of a guideline, but rather an explicit affirmative position on psychological therapy for complainants and victim survivors to the numerable parties involved in the provision of and execution of justice in the legal system.

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