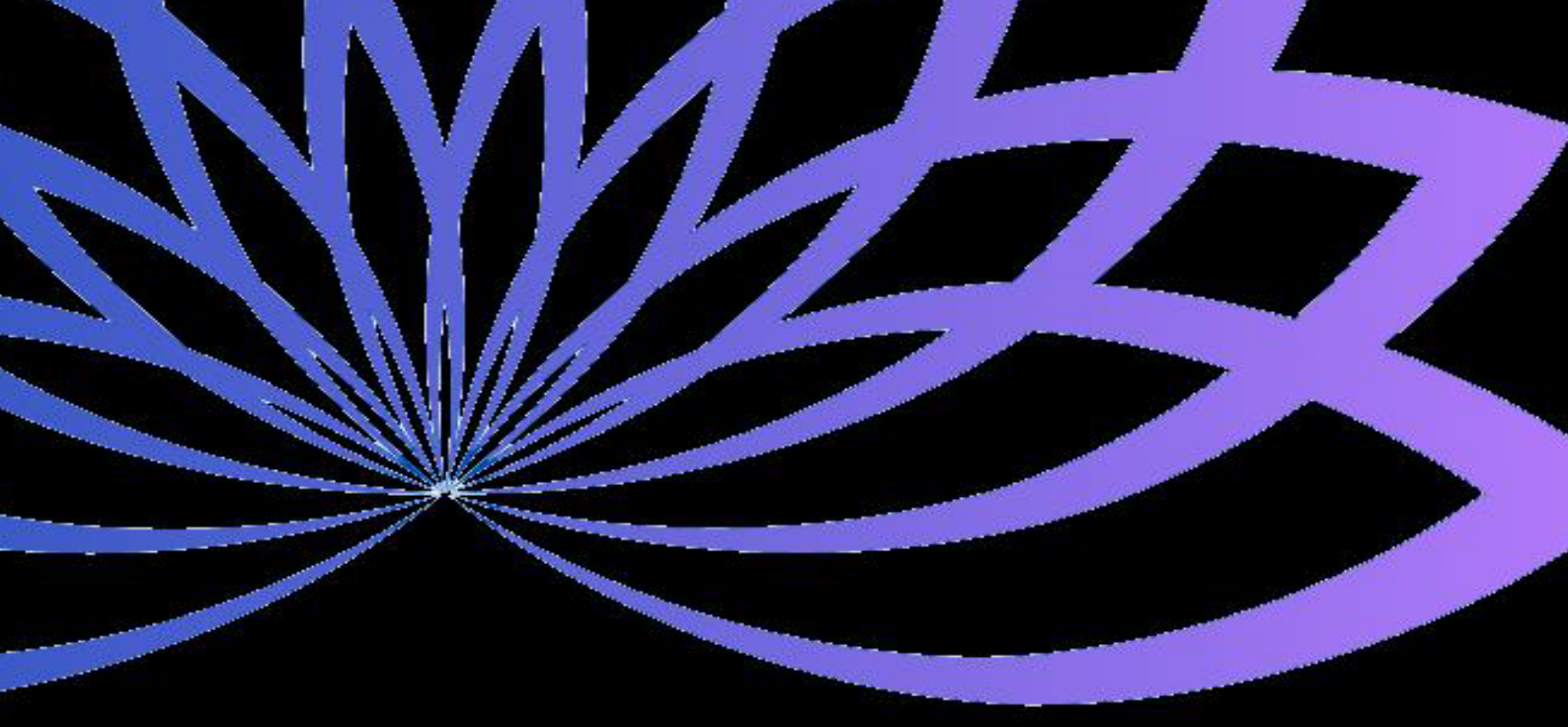




Response to the Second Action Plan under National Plan to End Violence Against Women and Children 2022-2032

**Transforming health systems to restore wellbeing and
enhance access to healing after sexual violence**

RESTORE Centre
July 2026

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RESTORE Submission to the Consultation on the Second Action Plan: Key Recommendations

Background

In Australia, sexual violence is perpetrated against 1 in 5 women and 1 in 16 men [since the age of 15](#). Despite increased national awareness, particularly over the last decade, rates of sexual violence continue to increase.

Sexual violence causes [enormous harm to health and wellbeing](#). Victim/survivors are 2.6 times more likely to experience anxiety, 3.4 times more likely to have symptoms of depression and 7.6 times more likely to experience post-traumatic-stress-disorder [compared to those who are not victimised](#). Sexual violence is [strongly linked](#) to a range of debilitating and life-limiting health conditions, including but not limited to eating disorders, substance misuse, self-harm and suicidal ideation. The impacts of sexual violence are often long-lasting, extending far beyond the crisis stage. It is likely that [experiences of sexual violence](#) underpin a significant proportion of the burden of chronic-ill health and disability, particularly for [women](#) and [LGBTQ+ individuals](#).

The possible health consequences of sexual violence must be addressed [effectively and early to avoid](#) worsening symptoms, lost productivity, and reduced participation in public life. [As identified by the World Health Organisation](#), the health system should constitute a central piece of the sexual violence service landscape. Specifically, the role of the health system must extend beyond emergency and forensic care and include a spectrum of services across early engagement and longer-term healing and recovery. Yet, research consistently suggests that the health system is under-prepared and under-resourced to be able to do this work.

Through world-leading research and collaboration with practitioners and lived experience experts, the [RESTORE Centre](#) will tackle these pressing issues over the next 5 years to ensure that the health system delivers care that is trauma-and-violence-informed and tailored to individual needs. Led by Professor [REDACTED] at The University of Melbourne, in collaboration with world-leading experts from University of Newcastle, UNSW, Monash University, Johns Hopkins University and Coventry University, our Centre has a priority focus on sexual violence against women and LGBTQ+ individuals.

Recommendations

The RESTORE Centre recommends the following actions for strengthening responses to sexual violence:

1. Sexual violence as a priority focus

Sexual violence should be identified as a key priority and area of focus in the Second Action Plan. Compared to domestic and family violence, sexual violence has received less attention, funding, and policy action over the last decade, yet rates of sexual violence continue to increase.

Attention should be paid to the diverse contexts of sexual violence and the tailored responses that are needed for each (e.g. intimate partner sexual violence; stranger sexual violence; sexual violence experienced in childhood vs adulthood). The voices of victim/survivors and robust research evidence should be central to understanding these dynamics.

The RESTORE Centre recommends that the Second Action Plan address sexual violence as a standalone issue that requires tailored prevention, early engagement and response.

2. Strengthening data collection on sexual violence

Measuring the prevalence and incidence of sexual violence is fraught with methodological challenges, largely stemming from a lack of consistency in how sexual violence is defined, operationalised, and measured across studies, surveys, and jurisdictions. Definitions of sexual violence vary considerably — from narrow legal definitions focused solely on rape or penetrative assault, to broader conceptualisations encompassing coercion, harassment, and non-physical behaviours — meaning that prevalence estimates are rarely directly comparable. Some studies rely on official crime statistics, which are known to substantially underestimate the true scale of sexual violence due to widespread under-reporting, whilst others use self-report surveys that may vary in question wording, recall periods, and the degree of anonymity afforded to respondents.

An example of these diverse prevalence estimates is recent data from the Australian Longitudinal Study on Women's Health (ALSWH), which reported far [higher prevalence rates for sexual violence](#) compared to the Australian Bureau of Statistics' (ABS) [Personal Safety Survey](#) (PSS). ALSWH estimates that 51% of women in their twenties, 34% of women in their forties, and 26% of women aged 68-73 have ever experienced sexual violence in their lifetime, while the PSS estimates that 22% of women have experienced sexual violence since the age of 15. ALSWH uses broad questions about unwanted sexual experiences in adulthood and childhood, whereas the PSS relies more heavily on respondents identifying and reporting specific experiences within predefined categories of sexual assault and sexual threat. This disparity highlights how differences in question design and definitions of sexual violence impact disclosure and prevalence estimates.

These inconsistencies exist across the sector, presenting a challenge for future monitoring of activities under the Second Action Plan. Addressing these measurement challenges is essential if researchers, policymakers, and practitioners are to develop a coherent and evidence-based understanding of the true burden of sexual violence and make progress towards prevention.

The RESTORE Centre recommends that the Australian Government consult with experts to standardise the definition and measurement of sexual violence across national datasets and services.

3. Improving health services and supports for victim/survivors of sexual violence

The principles of trauma-informed care have been considered a key component of best practice in the Australian mental health system [for decades](#). Trauma-informed services can identify the individual needs of clients with a history of trauma and utilise practices that promote healing and recovery while avoiding re-traumatisation. Building on this framework, trauma-and-violence informed care (TVIC) promotes understanding of violence and its impacts, advocates for emotionally and physically safe spaces, facilitates choice and collaboration; and a strengths-based approach to support resilience. TVIC operates from the assumption that any patient may have a history of abuse and violence, regardless of whether they disclose, or if it is the reason for their current presentation.

"My psychiatrist told me ... 'You haven't got PTSD - you haven't been in a war.'" (Victim/Survivor)

Unfortunately, research consistently demonstrates that within health services, including mental health services, TVIC is delivered [inconsistently](#) or not at all. Despite there being a [wealth of information](#) about what survivors want from health systems, real change has been elusive.

I felt like the people in mental health, they would never understand anything to do with my histories of being repeatedly sexually assaulted...They will just write everything off as being psychosis, whereas for me, it's a lot more complicated than that. (Victim/Survivor).

A lack of consistent, mandatory staff training and knowledge about sexual violence and trauma across the healthcare landscape is one part of the problem. [Research with Australian mental health workers](#) found the majority had not received sufficient training in responding to sexual violence. Similar findings were found in a study with staff in [psychiatric inpatient units](#). It is therefore unsurprising that [research with victim/survivors](#) in mental health settings found that they felt staff had a poor understanding of the complexity and long-term impacts of sexual violence, with a lack of awareness about the significant contribution of trauma to mental illness. Victim/survivors described being quickly diagnosed and medicated while experiences of trauma were neglected, as well as feeling unheard and victim blamed.

Other health professional cohorts, such as [allied health professionals](#), also report poor understanding of how to respond to gender-based violence (including sexual violence), despite being well-placed to respond.

Preliminary research from the RESTORE Centre, drawing on data from the ALSWH, suggests that a substantial proportion of female victim/survivors of sexual violence **have high psychological distress but have not recently accessed publicly available mental health treatment services**. This indicates that there is an unmet need for victim/survivors of sexual violence that the health system is currently not addressing.

I don't have much experience with being able to respond ...I would love to get a bit more training on, for example, if I did have a client that raised this to me, I want to know how to help them the best way that I can. ([Exercise physiologist](#)).

The RESTORE Centre makes recommendations across the following areas:

3.1 Build workforce capability across diverse health services

A health workforce that is well-equipped and ready to do the work of identifying and responding to sexual violence is critical. Preliminary research findings from the RESTORE Centre, drawing on data from the ALSWH, suggest that:

*Compared to women aged in their twenties in 2019-20 who had not experienced sexual violence, those who had experienced sexual violence¹ were more likely to have used **general practitioner mental health items, allied health provider mental health items, psychiatry services, anxiety and depression medications** in the last 12 months.*

This gives an early indication of which services could be most critical to target with initiatives to build workforce capacity and strengthen responses (although ideally, all health services should be resourced to deliver effective, trauma-and-violence informed care).

The RESTORE Centre recommends

Mandate and fund competency-based training for **general practitioners, allied health professionals, and mental health professionals** in responding to sexual violence, with nationally agreed competencies, regular refresher training, and evaluation of workforce capability. Training should incorporate:

- The unique dynamics of sexual violence,
- including within the context of an intimate relationship;
- Trauma and healing-informed practice;
- LGBTQ+ inclusion;
- Whole-of-practice approaches to TVIC;
- Victim/survivor lived expertise.

The RESTORE Centre has co-developed training (in collaboration with the Safer Families Centre) on identifying and responding to [intimate partner sexual violence in primary care](#), currently rolled out in Tasmania. This training could be expanded nationally to complement the existing program developed by Monash University.

3.2 Improve integration and coordination between specialist sexual violence and health services

[Service integration remains a problem](#) across the health and specialist sexual violence sectors in Australia. Despite a [strong and established relationship](#) between mental illness and sexual violence, services continue to be fragmented. Mental health services [often do not identify or discuss](#) sexual violence, and disclosure [does not always result in referrals](#) to violence services. On the other hand, women with mental or physical health problems may be [inadequately assisted](#) by sexual violence service providers who are under-resourced and unable to provide clinical care.

I got sick of going to the doctors and saying how I felt ... It just felt like, why, why do I keep going there and saying [the same things]? ... I feel like a record going around in circles and I just don't think that it's fair ... I feel like they wasted my life. I feel like I've been on an island shipwrecked. (Victim/survivor)

¹ Other forms of violence were controlled for in this preliminary analysis
RESTORE Centre, University of Melbourne, July 2026

These services will be able to provide better care for victim/survivors if they work together. Victim/survivors of sexual violence who are also experiencing health problems should have a streamlined and coordinated pathway to safety and care no matter which service they approach first.

[Research commissioned by ANROWS](#) (the WITH Study) found that organisational barriers such as a lack of communication and cross-referrals between mental health and sexual violence services negatively impacted survivors' experiences of seeking care. Victim/survivors perceived the integration of sexual violence and mental health services (as well as other key services such as AOD, sexual health, and family violence) as critical and had strong views about how this could be done. Victim/survivors wanted to be made aware of easily accessible and trauma-informed services by practitioners, and to be provided with warm referrals. Victim/survivors also highlighted that information sharing about past trauma (with consent) between services would prevent them from having to re-share their experiences, and co-locating practitioners within each other's services would provide more holistic care.

Victim/survivors want to feel part of a supportive network of services along their pathway to healing and recovery, reflecting the best-practice approach of multi-disciplinary care.

The RESTORE Centre recommends:

- Improving collaboration and information sharing between specialist sexual violence services and the health sector (particularly mental health). Survivors should have the option to share information between services if they wish, to avoid having to re-tell their stories multiple times. Formal referral pathways and shared care protocols between specialist sexual violence services and health services would facilitate this.
- Increasing capacity for 'warm referrals' and supported pathways to care.
- Co-locate specialist sexual assault counsellor/advocates within mental health services, and mental health practitioners within specialist sexual assault services.
- Increase capacity for FDV services to address sexual violence – this is often left out of the conversation.

3.3 Deliver services that meet diverse community needs

Research consistently shows that healthcare responses should be tailored to the needs of diverse communities. Cohorts who have been traditionally overlooked in policies, research and practice include:

Women international students:

There are unique intersecting inequalities that put women international students at high risk of experiencing sexual violence in Australia. [A survey](#) of 1,491 women international students undertaken by RESTORE Centre investigators found over half (54%) reported experiencing sexual violence since arriving in Australia, with over 11% reporting sexual assault or attempted sexual assault. Those experiencing housing or financial insecurity or having low levels of social support in Australia were at greater risk. Many reported

'He knew that I was isolated, I was alone ... I was the perfect target. Somebody who's new to the area and doesn't have anybody to support them' (International student from Singapore)

being sexually objectified by men because of their culture or race, or perpetrators using their temporary visa status, limited social networks or understanding of local laws and services to [trap and manipulate them](#). Yet when they sought help, they faced [major barriers](#) in accessing services and often felt ‘abandoned’ by the Australian service system.

It would be my dream to have sexual assault workers in mental health facilities who are accessible when women need them. (Victim/survivor)

Our INVEST study has identified [actions needed to strengthen responses](#), including:

- Address structural issues that increase risk, including through increasing students’ financial security; providing affordable healthcare and greater regulation of accommodation and access to safe, affordable housing options
- Develop an online hub of information for international students about navigating relationships, dating and sex and understanding legal rights and DFSV supports (eg. by expanding the *Study Australia* website)
- Fund institutions to deliver tailored support to international students, including through training student counselling and support staff and providing information in languages other than English

The RESTORE Centre recommends expanding the supports available to international students who experience sexual violence and/or intimate partner violence as per the actions recommended in the [INVEST good practice guide](#).

Older women

Although sexual violence is typically thought of as something that happens to younger people, many older Australians – most of them women – experience [sexual violence every year](#). For example, the *Royal Commission into Aged Care Quality and Safety* estimated there are almost [50 incidents each week](#) in institutional settings. Many more incidents occur outside of institutions, within older women’s homes and communities. Perpetrators often exploit older women’s dependency and isolation, and older women’s disclosures are often disbelieved or dismissed. The impacts of sexual violence for older women [are significant](#), and some studies report that older women suffer additional consequences such as genital trauma, fear of leaving the home, cognitive decline and even premature death. However often the ‘intersectionality’ frameworks that guide our policy and practice responses fail to recognise how ageism and sexism create unique risks and impacts for older women.

The RESTORE Centre is working with Celebrate Ageing, Older Women’s Network NSW, and Older People’s Advocacy Network on ARC-funded research into older women’s experiences of sexual violence (findings expected 2027-2028).

The RESTORE Centre recommends:

- Expanding access to support for older women via outreach-based service provision (South East CASA’s outreach model is an example)
- Ensuring older women are included in community campaigns to address sexual violence.
- Implementing existing training programs for responding to sexual violence in aged care and support resources such as those developed by OPAN and Older Women’s Network to guide practitioners.
- Capturing more data on older women’s experiences of sexual violence, separate from broader experiences of elder abuse.

Women with disabilities

People with disabilities, particularly women and girls, are more than [twice as likely](#) to have experiences sexual violence compared to other community members. Survivors and disability practitioners in the [REACH project](#), led by RESTORE Centre members, highlighted how disrespect and discrimination, limited decision-making autonomy, and inaccessible service responses put women with a disability at risk of being targeted by perpetrators and mean they do not receive the support they need. Findings identified major barriers to safety and recovery, including inadequate policies and practices to prevent and address sexual violence within disability services, group homes and inpatient psychiatric care; and a lack of access to sexual rights and consent education, legal protection and therapeutic support from specialist sexual assault and other organisations. Despite being consistently recognised as a cohort that faces increased risk of sexual violence, their support and recovery needs remain under-researched.

The RESTORE Centre recommends:

- Co-designing and developing disability-accessible sexual rights education programs to promote recognition of sexual violence (an example is Gippsland CASA's peer-based relationships and sexual rights education program for people with cognitive disability)
- Delivering peer-based support programs to promote healing, solidarity and counter social exclusion
- Establish a rights-based access strategy for specialist sexual assault services, focusing on survivors with disability.

LGBTQ+ Individuals

The RESTORE Centre is undertaking specific research into the impacts of sexual violence on the mental health of LGBTQ+ individuals and the factors that might support better mental health amongst LGBTQ+ victim/survivors. This work draws on national datasets including the ALSWH and the LGBTQ+ sexual violence survey. Findings of this work are expected 2027-2028.

The RESTORE Centre has also been a part of ANROWS-funded research led by the Australian Centre for Sex, Health & Society at La Trobe University. This research highlighted the contextual nuances of LGBTQ+ individuals' experiences of sexual violence and their help-seeking needs. The findings from this work are expected later in 2026.

4. Supporting healing and recovery

It is essential that the health consequences of sexual violence are addressed [effectively to avoid](#) worsening symptoms, lost productivity, and reduced participation in public life. However, current healthcare services for victim/survivors are heavily front-loaded on crisis and forensic responses to sexual violence, creating a void of long-term healthcare support services for victim/survivors to heal and recover. Ongoing supports within the health system are inadequately funded and not widely accessible.

The impacts of sexual violence [often persist for years](#) after the trauma has occurred, and it is well-known that [many victim/survivors have also experienced](#) childhood sexual abuse or other co-occurring forms of violence. Research confirms that poor mental health related to sexual violence can be more

severe and long-lasting than other types of traumas (road accidents, climate disasters or physical assaults). Victim/survivors have [described](#) sexual violence as uniquely dehumanising and degrading. The impacts of such profound and complex trauma often require long-term healthcare and support to address.

Despite this, specialist sexual violence services continue to face chronic under-funding resulting in long wait lists and a lack of capacity to provide long-term counselling for victim/survivors. Additionally, mainstream healthcare services, including many mental health services, are not structured or equipped to provide specialised trauma-and-violence informed care that is tailored to an individual's needs.

There's a huge difference between surviving and thriving. Their [services'] job is to help you to survive but it's got nothing to do with how to thrive—how to actually get your life back. (Victim/survivor).

Victim/[survivors have emphasised](#) the importance of being able to access ongoing trauma-and-violence informed services that share information, provide referrals and help for complex issues beyond the crisis period. Victim/survivors want to move from surviving to thriving with holistic and practical help that reflects their stage of recovery.

4.1 Invest in long-term healing and recovery

Whilst crisis intervention remains a critical component of the health system's response to sexual violence, this alone is insufficient to support survivors' full recovery. Health systems need to provide trauma-and-violence informed, [long-term care pathways](#) for victim/survivors beyond the immediate aftermath of violence, addressing not only psychological recovery but also the broader social determinants — such as housing, economic security, and social connection — that shape whether genuine healing is possible. The [Supporting Recovery Pilots](#) being run across selected Primary Health Networks are good examples of this approach.

A national healing and recovery-focused service framework for sexual violence is needed to guide health systems responses. This framework should be underpinned by principles of survivor-centred practice, trauma-and-violence informed care, long-term support, intersectionality, and cultural safety.

A genuinely healing and recovery-focused framework must avoid measuring success only at the point of crisis resolution. True recovery is often slow, non-linear, and deeply personal — and the health system's role is to remain a **consistent, safe, and skilled presence** throughout that journey, however long it takes.

The RESTORE Centre recommends:

- Developing a national healing and recovery focused service framework, which recognises that healing and recovery are often long-term processes.
- Expanding the role of the health system beyond short-term crisis responses.
- Fund long-term, wrap-around supports for victim-survivors and their families.

4.2 Promote emerging and diverse therapeutic options

Across the service spectrum, therapeutic options for victim/survivors of sexual violence that promote healing and recovery are lacking. Talking-based psychological treatments such as cognitive behavioural therapies (CBT) delivered by specialist mental health practitioners are [largely considered to be the only effective way](#) to address sexual violence-related mental health issues. While these are [first-line therapies](#), they are [not suitable for all victim/survivors](#), [particularly](#) those with complex trauma or who are experiencing ongoing sexual violence in the context of an abusive relationship. There are also several other barriers to accessing CBT-like treatments including cost, stigma, a reluctance to re-visit the trauma, or a symptom load too high for challenging cognitive tasks.

*When you see a counsellor, you kind of get locked into a track of, oh we're going to do CBT now, or ACT therapy, or DBT or EMDR ... it's a very prescribed sort of thing and you feel like, if it's not working for you, it's your fault.
(Victim/survivor).*

It is critical that victim/survivors of sexual violence be able to access a range of therapeutic options beyond CPT or other talking-based modalities. Victim/survivors frequently mention the benefits of low-cost, non-pharmaceutical approaches such as physical activity, mindfulness and yoga, art therapy, music therapy, and peer support. Many of these approaches – for example physical activity – already have a good evidence base for broader mental health issues. Yet these are not offered as standard within the health system, and there is no funding model to support victim/survivors accessing these therapies. Online tools (such as [Beyond Silence](#) for survivors of intimate partner sexual violence) can also provide low-cost 24/7 support to identify and reflect on experiences and options, make decisions and connect with local services. However, there is a need for [more research and evaluation](#) with survivors from diverse backgrounds to design effective and accessible digital tools.

The RESTORE Centre recommends:

- Funding and expanding peer support programs that provide connection, hope, and lived-expertise guidance to victim/survivors of sexual violence.
- Dedicated funding for emerging therapies (e.g. art therapy, music therapy, yoga, physical activity, online tools) that can promote healing and recovery.
- Expanding the remit of the mental health care plan to encompass emerging therapies alongside traditional psychological therapies.

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