

SUBMISSION No. 1: Response to Second Action Plan under National Plan to End Violence against Women and Children 2022–2032

Strengthening Health System Responses to Domestic, Family and Sexual Violence: A Whole-of-System Approach to Prevention, Early Intervention, Response, Recovery and Healing

About Safer Families Centre at the University of Melbourne:

We transform the health sector response to DFSV to promote safety, wellbeing and healing of families. Through working alongside people with lived expertise, collaborative research, training and evaluation, we equip services with tools and skills to support early recognition and response to DFSV so those affected can receive the care they need, when they need it.

[Safer Families Centre](#) () collaborates extensively with local, national and international partners. The Centre's work is strengthened by key partners- [WEAVERS](#) lived expertise group, [Melbourne Research Alliance to End Violence Against Women and their Children](#), [Centre for Family Violence Prevention](#) at the Royal Women's Hospital and [RESTORE Centre](#) on sexual violence and healing.

At Safer Families Centre,
we address the problem of inadequate identification and response to DFSV in health services.
Our solution is through survivor-led, evidence-based programs and partnering to:
uplift workforce capacity to identify and respond, support the workforce, change health systems and
improve service integration by building relationships between sectors.

Note: We have hyperlinked evidence and provided project examples and quotes to support our recommendations.

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Executive summary

Health services are the [single most common point of contact](#) for people experiencing domestic, family and sexual violence (DfSV) after informal disclosure to family and friends, and are [frequently engaged by victim survivors](#), children, young people and [people who use violence](#) before they reach formal support systems. This makes the [health system](#) one of the most powerful, and most under-used, levers available to the National Plan. This submission sets out how a [whole-of-system health response](#) can prevent DfSV, engage early, provide a safe first-line response, and support recovery and healing across the life course.

Despite this reach, the system is not yet equipped to respond. Health professionals receive [on average just 3 hours of DfSV training](#) before registration, Medicare does not recognise DfSV as a distinct health issue, workforce capability programs are inconsistent, and short-term pilot funding prevents sustained reform. Lived expertise is under-harnessed, [trauma-and-violence-informed care](#) is not embedded across services, and children, young people and people who use violence often fall outside current responses.

Safer Families Centre understands the [personal](#) and [structural](#) barriers and what makes health professionals [ready](#) to do this complex work.

This transformation is achievable. Safer Families Centre, in collaboration with people with lived expertise, practitioners, health services, Primary Health Networks and DfSV services, has already demonstrated what works in practice - from co-designed early-intervention tools to comprehensive training programs and workforce wellbeing models.

We recommend the National Plan drive health system reform across six areas:

- embedding lived expertise in health reform;
- uplifting workforce capability through national standards, mandatory training and a national healthcare safety and quality framework;
- sustainably funding health system infrastructure, including a Medicare item for family safety planning, clinical champions and secondary consultations;
- strengthening prevention and early intervention, including antenatal screening and structured responses to people who use violence;
- protecting children and young people's independent access to care, including lowering the age for mandatory reporting by health practitioners to under 14; and
- driving system-wide integration, implementation and evaluation.

“Health care needs to be better supported to listen carefully to survivors’ needs and assist them to navigate our complex support system.”

Lily, WEAVER member

“Changed my own feelings of readiness to bring up the topic of DfSV...I am now more confident to support a patient who is being abused.”

GP, Pathways to Safety

Ten priority recommendations are set out in full below. While written through a health system lens, these recommendations speak to all six consultation questions - prevention, services and support, children and young people, people who use violence, recovery and healing, and access to support - as set out in the alignment table at the end of this submission.

Current specific challenges that need to be urgently addressed

- [Lived expertise](#) is not being harnessed to generate better solutions in the system
- [Survivor fatigue with retelling of stories and unmet need](#) in the system
- Indigenous knowledge and [healing models](#) are not being supported in the health system
- [Medicare funding does not recognise DFSV](#) as its own separate health issue and there is insufficient support for secondary consultations and referrals
- No consistent accessible workforce capability programs for allied health staff and staff in [mental health settings](#)
- [Current Supporting Primary Care Pilots](#) are not reaching 17 Primary Health Network catchment areas
- Mandatory reporting of child abuse for 14- to 18-year-olds is holding back disclosures by young people and [response by health practitioners](#)
- Mandatory reporting requirements in the Northern Territory for adult victim survivors discourage disclosure and override victim survivor choice and control
- Health professionals are not equipped to [engage people who use DFSV](#)

Key recommendations:

1. Embed and fund lived expertise leadership and co-design in health system reform.
2. Establish nationally consistent DFSV capability standards across the health workforce.
3. Establish a national healthcare safety and quality framework for DFSV.
4. Embed mandatory DFSV and safeguarding capability requirements across education, registration and employment.
5. Sustainably fund health system infrastructure (Medicare item number Family Safety Plan, clinical champions, secondary consultations) to support identification, response and referral.
6. Establish linking of health, specialist DFSV and community responses.
7. Strengthen workforce wellbeing, supervision and sustainability.
8. Lower age of mandatory reporting by health practitioners to under 14 years.
9. Deliver structured programs for health practitioners to engage people who use violence.
10. Invest in sustained implementation and ongoing evaluation of health system programs.

Health System Reform

We provide detailed recommendations in six areas: Lived expertise, Victim survivors, Prevention and early intervention, Children and Young people, People who use DFSV, and System change.

1. Overarching Principle: Engage Lived Expertise in health system reform

We recommend that the Australian government:

- **Fund engagement of [victim survivor groups](#) in health sector and other reform** to ensure changes meet the needs of service users.

Victim survivors deeply know what can be done to provide better trauma-and-violence-informed care but may not be heard or given choice and control over their journey through the health system. Ending violence against women requires more than addressing individual acts of violence - it also requires recognising and preventing systems abuse.

When seeking healthcare for themselves or their children, victim survivors frequently encounter disbelief, minimisation, or institutional reluctance to intervene. These responses can inadvertently enable ongoing abuse and undermine opportunities for early identification and support. This institutional betrayal has profound and lasting impacts on victim survivors' safety, mental health, and trust in essential services. Mandatory reporting requirements in the Northern Territory (NT) for adult victim survivors compound this loss of choice and control, overriding their autonomy and discouraging disclosure altogether.

The National Plan should explicitly address how healthcare policies, practices and cultures can be manipulated by people who use DFSV or inadvertently cause harm; it should remove mandatory reporting requirements in NT and replace them with models that support voluntary, victim-survivor-led engagement with health and specialist services and it should drive reforms that ensure healthcare professionals and systems consistently respond in ways that prioritise safety, accountability and trauma-and-violence-informed care.

Examples of successful lived expertise hospital projects.

Redesign of family violence online learning packages for staff- (2025-Alfred Hospital, Victoria)
[This project](#) involved engagement of victim-survivors from the Safer Families WEAVERS lived expertise group to review and update online learning materials for frontline and managerial staff at the Alfred hospital. Victim-survivors were involved in development of resources and in the launch. Feedback from the hospital was very positive about how the engagement of lived expertise enhanced the packages for staff.

Co-design Lived Experience Project (2024-7-Royal Women's Hospital, Victoria funded by Equity Trustees)
[This project](#) recruited and worked with 17 women who have experienced DFSV who are also previous consumers of The Royal Women's Hospital. The lived expertise survivors co-designed and will implement a pilot program at the Women's supporting the hospital's model of trauma-and-violence informed care. The first step was to work with victim-survivors to adapt and synthesise an Experts by Experience Framework that will guide the Women's trauma-and-violence-informed care model in the health services setting.

2. Victim survivors: strengthening prevention, early intervention, response, recovery and healing

We recommend that the Australian government:

- **Establish national DFSV capability standards** across all health professions through universities and [Colleges](#) (pre-registration, CPD, workplace training).
- **Mandate whole-of-workforce DFSV [child/adult safeguarding training](#)** programs in health settings, through Australian Health Practitioner Regulation Agency and other regulatory bodies with regular refresher training and [survivor-led, evidence-based content](#).
- **Ensure [through national audits](#)** that all health services deliver [trauma- and violence-informed](#), [culturally safe](#) and [survivor co-designed care](#), including tailored responses for priority populations.
- **Embed routine [identification and response tools](#) for victim survivors** into practice systems (screening prompts, response scripts, decision aids, safety assessments and plans, documentation templates and referral pathways).
- **Establish national standards for screening and response** in antenatal care.

Health professionals need [a health system](#) that assists them to undertake [this complex work](#). There is an urgent need for uplifting health workforce capability and enhancing workforce support for undertaking the challenging work of addressing DFSV with victim survivors. Every health interaction should provide an opportunity for recognition, support, safety planning and connection to specialist services.

“It has helped give me some tools & ways to start a dialogue with patients while keeping environment a safe & judgement-free zone.”

Primary care nurse,
Safer Families e-learning modules

Uplift health workforce capability

Health professionals need standards and comprehensive programs to upskill them. Safer Families Centre has contributed to the [World Health Organization guidelines](#) (Kelsey Hegarty chairing the guidelines group for the current update in 2026), [clinical handbook](#) and [global curriculum](#). Practitioners need resources and [tools](#) to assist them in their work.

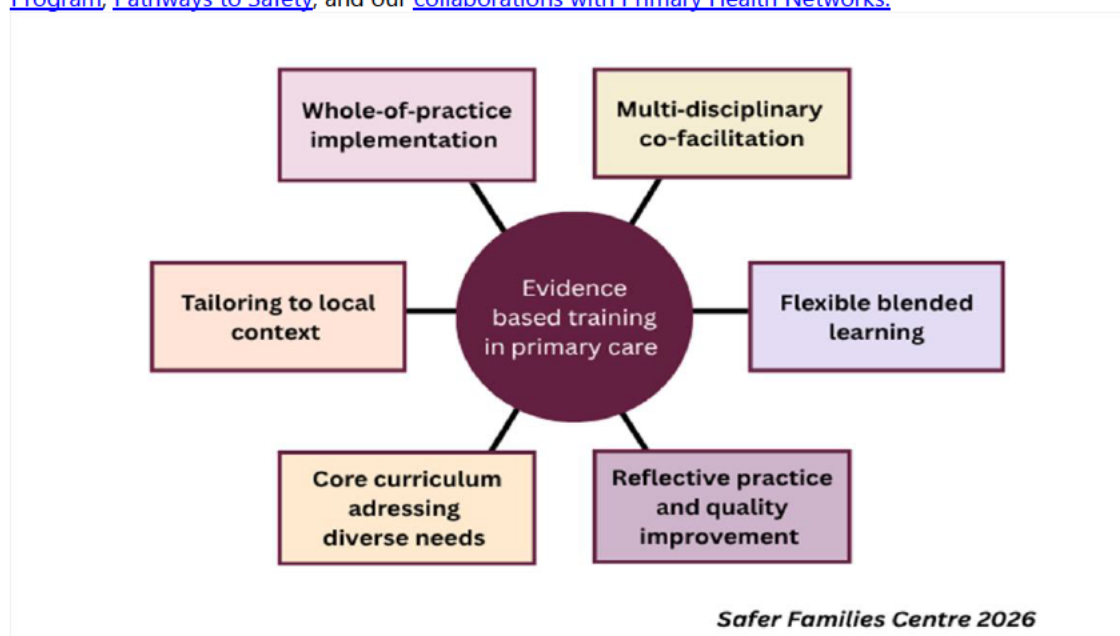
In Canada, a standard health curriculum has been achieved through a [national project](#) consulting with medical colleges and other key stakeholders. The United Kingdom have established [child and adult safeguarding procedures](#) across the country, with clinicians with extra child and adult safeguarding knowledge in each regional area to support other staff. Safer Families Centre has worked with the Royal Australian College of General Practitioners on [The White Book guide](#).

We have the knowledge and skills to do this in Australia.

Model of key elements that need to be in training programs to make them effective.

Safer Families Training Implementation model

This model was developed by Safer Families Centre from synthesis of findings from training models and programs aiming to build the capacity of primary care to address DFSV and build greater cohesion across primary and social care services. [Sustainable Primary Care FV model](#), [CATCH model](#), [REAL model](#), [The Readiness Program](#), [Pathways to Safety](#), and our [collaborations with Primary Health Networks](#).



Examples of programs for uplifting capability of the health care workforce.

The Readiness Program (2021–2026, funded by Australian government):

Reached 6,000 primary care staff nationwide through webinars, workshops, e-learning modules and *Pathways to Safety* whole-of-practice intensive training. The program strengthened workforce capability to recognise and respond to DFSV using evidence-based, trauma-and-violence-informed approaches, while embedding lived expertise and fostering stronger partnerships between primary care and DFSV services. Evaluation demonstrated increased practitioner confidence, readiness, skills, with sustained demand highlighting need for continued investment in equitable access to training across Australia.

“One of the best programs I have attended! It is vital information and I now feel immediately ready to implement into practice”.

General Practitioner,
Pathways to Safety

Strengthening Hospital Response to Family Violence (2014–2026, funded by Victorian government):

In 2014, the Strengthening Hospital Responses to Family Violence (SHRFV) model was developed to provide a system-wide approach which is now being applied by hospitals across Victoria. The SHRFV program supports staff both professionally and personally and introduces practices in hospitals that assist patients affected by DFSV. Since 2021, the SHRFV initiative has sought to support hospitals and health services to meet their legislative obligations under relevant legislations. The Women's, along with Bendigo Health, continue to provide statewide leadership for the SHRFV program.

Workforce support

We recommend that the Australian government:

- **Support and protect the workforce**, including supervision, communities of practice, dedicated wellbeing and trauma-focused support to sustain all staff (particularly victim survivor staff) to continue their work with survivor patients.

Health professionals are often first line responders to patients who present for healthcare after DFSV. Yet, health professionals themselves experience [high rates of DFSV](#), with 22% having experienced intimate partner violence in the last 12-months, 42% DFSV across their [adult lifetime](#). While health professionals who have experienced DFSV appear to provide [enhanced care](#) to survivor patients, they are also three times more likely to experience [worse health](#) than their colleagues, particularly posttraumatic stress, depression and anxiety. DFSV adds to the cumulative trauma faced by all health professionals whose job exposes them every day to sickness, stress and sadness and [abuse and aggression from patients](#). A concerning proportion of the Australian health workforce are considering [leaving the sector](#) and burnout may affect up to [half](#) and is [associated with poorer](#) quality healthcare and reduced patient safety.

“I feel that my personal life experiences with domestic violence have made me a better nurse who can connect with people.”

Victim Survivor, Nurse, working in private hospital

Examples of well-being programs developed across hospitals and general practice.

The THRIVE Project (2026, Royal Women’s Hospital, funded by Victorian government)

This 12-month project will implement and evaluate a sustainable Workplace Trauma and Violence informed staff toolkit and program at seven hospitals/health services in Parkville Local Health Services Network to support the wellbeing of healthcare workers.

Deliverables: *Workforce TVI Wellbeing Toolkit*: Digital and printed guide, to complement 2024 training package. *Staff TVI Wellbeing sessions*: Structured programs, including yoga, mindfulness, [Eye Movement Desensitisation](#) and Reprocessing group sessions evaluated by University of Melbourne.

GP survivor’s experiences Project (2024-, funded by APA scholarship, Libby and Ross Hindmarsh Fund):

This PhD study is exploring Australian general practitioners’ [survivor experiences](#). It is common for survivors of DFSV to attend their GP, with a fulltime GP seeing on average 5 current survivor patients per week. Interviews explored how managing [victim survivor patients affect GPs](#) who have been survivors of DFSV themselves. Interviews also explored how DFSV affects their own well-being and the professional effect it has on the way GPs manage their survivor patients. We will also explore what kind of supportive interventions survivor GPs would value to assist with their wellbeing.

Clinical Champions and Contact Officers

We recommend that the Australian government:

- **Establish a local system of clinical champions** for primary care and hospitals in a region.
- **Appoint DFSV clinical champions/leads in every health service** to drive implementation, mentoring and quality improvement.
- **Fund a community of practice resource centre** (like the [national sexual and reproductive health resource](#))

‘Clinical Champions’ support other staff responding to DFSV in healthcare settings fostering evidence-based practice and promoting and sustaining first line responses to DFSV victim survivors. ‘Contact Officers’ on the other hand, provide support to staff who are victim survivors of DFSV. This evidence-based model functions through several key components:

- **Secondary Consultation:** Champions are equipped with high-level knowledge of DFSV responses to support and mentor general clinical staff.
- **Behavioural Change:** Rather than just providing educational materials, these champions promote change through direct skill-building, peer mentorship, and behavioural modelling.
- **Systemic Culture Shift:** Because a high percentage of DFSV victim survivors utilise health settings before seeking specialised services, clinical champions are utilised to implement safe, trauma-informed identification, screening and response protocols and referral pathways.
- **Overcoming Resistance:** Champions actively build coalitions to counter institutional resistance, survive leadership turnover, and facilitate best-practice adoption during leadership changes.

Example of a successful program of supporting the workforce through clinical champions.

Evaluation of Clinical Champions and Contact Officers (2025-6, funded by Vic/Australian government):

A Royal Women’s Hospital [implementation model](#) was evaluated that put trained "Clinical Champions" and "Contact Officers" into healthcare environments. Family Violence Clinical and Non-Clinical Champions is an evidence-informed, sustainable workforce development and organisational model that strengthens health service responses to family violence through a network of trained champions across clinical and non-clinical roles. Champions build workforce capability, support colleagues, promote best practice, strengthen referral pathways, and drive policy and systems improvement. By embedding family violence knowledge and leadership across an organisation, the model strengthens early identification and response to family violence and promotes trauma and violence informed care for victim survivors.

3. Prevention and early intervention

Prevent abuse and violence before it progresses

We recommend that the Australian government:

- **Provide universal education about healthy relationships** for young people who are dating.
- **Provide universal education about healthy relationships** in multiple languages for pregnant women and their partners.
- **Support sustainable screening and response in antenatal care**, including for diverse populations.
- **Engage fathers through antenatal care** to promote healthy, respectful relationships (see People who use DFSV section).

Strategies to change gender attitudes are essential but will be less impactful if children are going home to households where fathers are role modelling abuse and violence. [In Australia, this is four in ten households](#). Interrupting this cycle is essential if we are to provide pathways to safety and healing for children. Links between early childhood abuse experiences and later victimisation and perpetration is clear. Responding to the [prevalent childhood trauma in Australia](#) through our antenatal, primary care and mental health services will prevent DFSV.

Screening and response to DFSV in antenatal care

We recommend that the Australian government:

- **Implement multilingual digital screening platforms integrated into the Electronic Medical Record** alongside a **focused implementation package** that ensures disclosures lead to safe, timely support.
- **Support trauma-informed and culturally safe training** for all antenatal clinicians.
- **Optimise Electronic Medical Record integration** with clear prompts for clinicians and standardised follow-up pathways.
- **Strengthen privacy safeguards or concerns** (device safety checks, secure messaging), provide professional interpreters, where needed, and explore low-technology alternatives for those with limited digital access or literacy.
- **Monitor uptake and outcomes by language and migrant status and co-design** ongoing refinements with culturally diverse consumers and community partners.

Pregnancy can be a risk factor for onset and escalation of DFSV. Routine screening provides a crucial opportunity for early engagement to improve safety and well-being. It is an opportune time to access new parents to discuss and promote healthy respectful relationships (see section on People who use DFSV). Effective screening for DFSV in diverse populations requires [culturally and linguistically adapted approaches](#) that prioritise privacy, safety and accessibility.

Examples of how to sustain screening and response in antenatal care

Screening in antenatal care for diverse populations (2023-6) funded by National Partnerships Australian and Victorian governments

This study implemented a patient self-administered digital screening platform, (accessible on patients' mobile device, where safe) offering validated DFV questions in 25 languages integrated in the Electronic Medical Record (EMR) at public hospitals in Victoria. Patient responses were automatically immediately visible to clinicians within the EMR, enabling prompt response. Before the digital tool integration, DFV screening was clinician-administered paper-based.

Evaluation comparing a 10-month period before and after implementation showed screening rates rose from 7.7% to 57.8%. Screening for patients born outside Australia rose from 7.5% before implementation to 59.8% after. Qualitative findings emphasised that the multilingual digital screening was widely acceptable to patients and staff, providing valued privacy advantages and greater accessibility. Participants framed training needs, workflow and technical integration issues as opportunities to strengthen implementation and underlined the importance of culturally sensitive question phrasing and clear follow-up pathways.

"Having it available in lots of languages was excellent ... patients seemed to really find it very easy and love to complete the survey."
Midwife

Sustainability of identification and response to domestic violence in antenatal care (the [SUSTAIN Study](#)) 2018-20 funded by ANROWS

This study provides an evidence base for ways to improve practices to address DFSV. Drawing on experiences of women and practitioners in six antenatal hospital clinics across Victoria and New South Wales, their responses emphasise importance of building relationships and engagement with women during the screening process.

The report puts forward a framework for implementing effective screening, called the [REAL Transformation Model](#). This model can be used in all Australian health settings to better implement sustainable family violence practices into their antenatal services.

"It was very easy to answer things on your [phone] quickly, no-one has to see what you're doing."
Antenatal patient

Screening in antenatal care for South Asian populations (2023-7, funded by Melbourne Social Equity Institute, The University of Melbourne)

This PhD study involved two [systematic reviews](#) of [global evidence](#) on how health professionals and [women victim survivors](#) experience screening in antenatal care when the patient is from a South Asian population. Cultural factors and social obstacles may prevent South Asian women from seeking and using appropriate support services. Additional barriers may include healthcare providers' reluctance to address DFSV with South Asian women because of a lack of cultural knowledge and/or appropriate methods to address DFSV. South Asian women participants reflected that they want healthcare providers to understand them, acknowledge their discomfort, and provide culturally appropriate strategies and solutions. Further data will be available from in depth interviews in late 2026.

You don't want her to feel like you're just there asking questions - you want her to feel like she's being cared for and nurtured so that she can disclose information to you,"
Midwife

Health as a prevention setting - addressing the underlying factors

We recommend that the Australian government:

- **Adopt the [World Health Organization Prevention RESPECT Framework](#)** to guide all prevention of violence against women activities.
- **Deliver economic intervention programs in combination with case management** for victim survivors.
- **Expand public health interventions to reduce alcohol use** as a prevention strategy for DFSV.
- **Integrate all policy and practice with DFSV in the areas of mental health, alcohol and drug, and suicide** to prevent DFSV.

The World Health Organization has a public health and human rights approach to scaling up an [evidence-based framework](#) for preventing violence against women; ‘RESPECT’.

[R – elationship skills strengthened](#)

[E – mpowerment of women](#)

[S – ervices ensured](#)

[P – overtly reduced](#)

[E – nvironments made safe](#)

[C – hild and adolescent abuse prevented](#)

[T – ransformed attitudes, beliefs, and norms](#)

Acknowledging the need for the Our Watch Framework addressing changing gender attitudes, Safer Families Centre focuses on ensuring services engage early with victim survivors and people who use DFSV in the health system (see separate sections).

Additional to these prevention and early interventions, poverty reduction has been an underdeveloped area of prevention of DFSV. [Economic interventions in conjunction with other communication and community-based programs](#) have been shown to be effective in reducing DFSV. It is urgent we trial unconditional cash interventions in Australia, particularly for women who have separated from but [who often return to a partner for financial reasons](#) and because [economic abuse is very prevalent](#) in Australia.

[Reducing alcohol and drug use](#) through a health approach is also very likely to reduce DFSV. At a public health level, reduction of alcohol outlets, decreased messaging about alcohol in the community during sporting events, brief motivational interviewing delivered by general practitioners all have been shown to be effective.

We also need to recognise violence and abuse as core mental health and suicide prevention issues, and align health, mental health and violence prevention services and policy.

4. Children and young people in their own right

We recommend that the Australian government:

- **Develop nationally consistent clinical guidelines** on consent, confidentiality and healthcare decision-making for children and young people affected by DFSV, including where family law orders or shared parental responsibility arrangements are in place. The guidelines should address:
 - assessment of a child's decision-making capacity, including [Gillick competence](#);
 - circumstances in which it is unnecessary, unsafe or inappropriate to seek or rely on the consent of a parent using violence; and
 - documentation of management of disputes about treatment.
- **Reduce age of mandatory reporting by health practitioners to under 14 years** to increase the degree of agency so that adolescents aged 12/13 yr+ with maturity to make decisions can have a say about what actions are taken when risk is not immediate, life threatening or severe.

Systems designed around parental authority fail to recognise rights of children and young people as victim survivors. This can allow people who use DFSV to obstruct access to support, including mental health, causing further harm. Children and young people forced into contact with a parent using DFSV can experience ongoing psychological harm, including anxiety, depression, trauma-related symptoms. Early access to appropriate mental health care is therefore critical. However, the [VOICES study](#) showed that where there are family law orders or shared parental responsibility arrangements, health professionals may be reluctant to provide care if one parent objects, even where there is documented DFSV and the child is seeking help. This can persist even where an older child has the maturity and capacity to participate in decisions about their own healthcare. Faced with uncertainty about consent requirements, possible legal consequences or involvement in family law proceedings, [clinicians](#) may conclude that they cannot get involved. This is not simply an issue of individual clinical practice, rather a systemic gap across Australia's health system. Health professionals lack clear, nationally consistent guidance on how to respond where children's evolving capacity, parental responsibility, DFSV risk and court orders intersect. This has been characterised as operating in the 'grey zone'. Without clear legal and professional protections, [risk-averse practice](#) can unintentionally prioritise parental dispute and institutional liability over children's safety, wellbeing and access to healthcare.

'The system failed my children'

A major theme for victim survivors in the VOICES study was that no one supported or protected their children from harm due to the fathers' abuse. Comments from victim survivor study participants:

"Services need to put children's voices at the forefront and put in place mechanisms that stop their voices from being drowned-out by the noise of an entitled, controlling, abusive male parent."

"I see a counsellor who supports me to support my children, but they are unable to receive any direct support themselves because their father blocks access to it."

"Not much has helped my children. My son won't speak to anyone because his psychologist told his dad what they'd discussed and people didn't believe him."

Children and Young People in their own right (continued)

We recommend that the Australian government:

- **Strengthen legislation, professional standards and regulatory guidance** to make clear that children's safety, rights and best interests must guide healthcare decision-making in context of DFSV. Clinicians who act in good faith and in accordance with evidence-based guidance should be protected from adverse professional or legal consequences.
- **Improve access to confidential, trauma- and violence-informed mental health care** through Medicare items and other funding models that enable children and young people to access treatment safely, including where the involvement of a parent using violence creates risk or obstructs care.
- **Upskill general practitioners to deliver developmentally appropriate responses** to DFSV using existing Medicare item numbers such as the three-year-old health check.
- **Provide mandatory child/adolescent safeguarding** capability across the workforce and training for all health professionals (including psychologists) on coercive control, systems abuse, children's rights, trauma- and violence-informed practice, decision-making capacity and the interaction between healthcare and family law.

We recommend that the Australian government:

- **Fully incorporate the Convention on Rights of the Child into Australian domestic law.**
- **Require Commonwealth, state and territory legislation that substantially affects children and young people to give effect to the rights and principles contained in the Convention.** This should include legislation relating to family law, domestic and family violence, child protection, healthcare and mental health, education, disability, policing and youth justice.
- **Require legislative and administrative decision-makers to:**
 - treat the best interests of the child as a primary consideration;
 - recognise children and young people as individual rights-holders;
 - provide children with a genuine opportunity to express their views and give those views due weight according to their age and maturity;
 - recognise children's evolving capacities and increasing autonomy;
 - protect children from physical and psychological violence, including coercive control and systems abuse; and
 - protect children's right to timely and appropriate healthcare, including mental health care.
- **Introduce mandatory Child Rights Impact Assessments** for proposed legislation and significant policy reforms affecting children and young people.

5. Strengthening responses to people who use violence

We recommend that the Australian government:

- **Foster safe engagement with [people who use DFSV in general practice, mental health, alcohol and drug services](#)** for people to seek further help and to challenge violence supportive thinking.
- **Deliver safe engagement approaches** that challenge violence-supportive beliefs, reduce practical and attitudinal barriers through national campaigns to destigmatise help seeking and counter the normalisation of violence, and by improving navigation through culturally tailored information and online resources.
- **Establish culturally safe, community-led pathways for priority populations**, particularly, Aboriginal and Torres Strait Islander-led services and community-controlled organisations, and culturally and racially marginalized communities, including bilingual workers and interpreter access. Faith and community leaders should receive appropriate safeguarding training.

Health and community services are ideal settings for early identification of people who use DFSV if health and other professionals are appropriately trained and supported, and referral pathways are available. Mental health and alcohol/drug services are key sites for early intervention opportunities. People using violence currently do not appear to have other avenues for being encouraged to seek help early before reaching the justice system.

Example of help-seeking behaviours of people who use DFSV

[VOICES study](#) (2023-5, funded by ANROWS)

From a survey of 500 people who used DFSV most people sought help, most commonly from informal contacts (friends, partners and family, 59%), and health services (33%), more than specialist family violence services (11%). There were distinct patterns in help seeking. Aboriginal and Torres Strait Islander participants tended to rely more on family, friends and specialist or other community services. People with lower educational status and those on limited incomes more frequently used health services. By contrast, migrants were less likely than others to access any support services. Older participants and those experiencing financial difficulty showed particularly high use of health services.

Overall, service users generally rated the support they received as helpful, with psychologists and counsellors most positively regarded and police least. The principal barriers to seeking professional help included shame; the normalisation of violent behaviour; practical obstacles such as cost, transport and limited availability; concerns about confidentiality; and a lack of awareness of services.

Primary Care and online early intervention responses

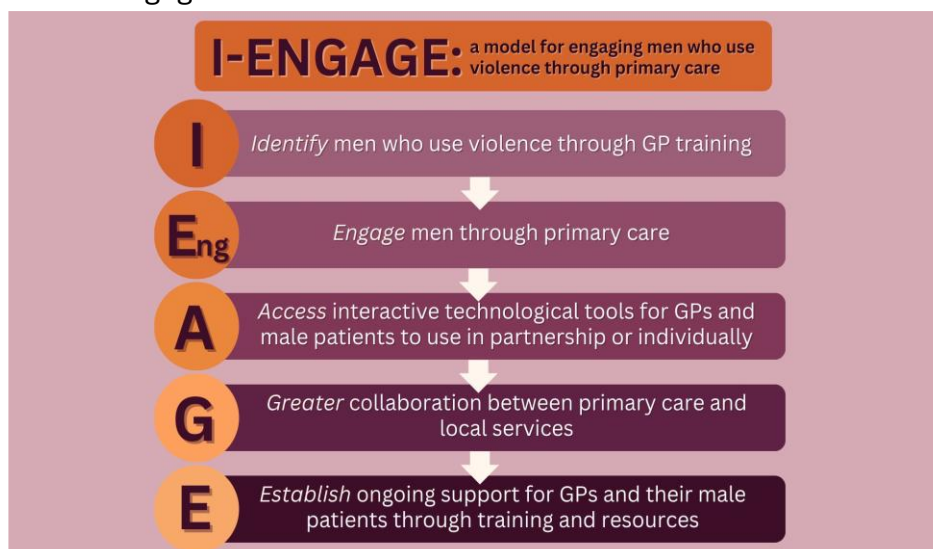
We recommend that the Australian government:

- **Fund capacity building programs for general practice, mental health and counselling services** to engage with people who use DFSV to seek further help and to challenge violence-supportive thinking and attitudes.
- **Expand referral pathways through evidence-based programs** including through the use of flexible delivery modes such as online interventions/tools (e.g. [Better Man](#)), telehealth, outreach and after-hours appointments. and increase equitable access through funding low-cost and no-cost entry points.

We need to engage men who use violence earlier to seek help from services. Engagement needs to change from justice to health settings, to enable earlier delivery of interventions, targeting men with internal motivations for change. However, [a systematic review](#) shows a paucity of evidence from health care settings (confined to a few clinical settings; alcohol dependant men, veterans).

What innovation is likely to work for men in health services?

An intervention model called I-ENGAGE (see figure below) for working with men through primary care is based on best evidence, consumer and practitioner input and theories of changing behaviour. The I-ENGAGE model is based on pilot training in 2018 with 67 GPs, interviews with 12 GPs and 3 focus groups with 23 men who used DFSV. Pilot evaluation showed increased GP confidence with men who use DFSV. Interviews with 12 GPs found that men who use DFSV are hidden patients, with majority of GPs believing they have a role to play. GPs were positive about using technology as a strategy to engage their patients. Focus groups with men who use DFSV revealed they have varying perceptions of their relationships with their GPs: some do go to their GPs to seek help, with issues around disclosing to GPs centring on the GP-patient relationship - men want GPs to have time to engage and listen.



“The training greatly helped in conversations. During discussions [the patient] admitted there were some drug and alcohol abuse and relationship problems. After probing a little, he admitted there were some behaviours that were not great and was open to discussing some behaviour change and accepted the card. I don’t think I would have continued to probe about behaviours if I had not completed the training. I felt much more confident dealing with the perpetrator during these consultations.” GP

I-ENGAGE includes use of an evidence-based, interactive healthy relationship website called [Better Man](#), developed and tested by Safer Families Centre with a group of diverse men from the community.

Example of an online healthy relationship tool

Better Man offers tailored early online intervention for voluntary men using DFSV and provides an avenue for people seeking help who are not in contact with mainstream services.

Motivational Interviewing techniques encourage awareness and self-reflection, reduce stigma and shame through digital stories.

The modules each take 30 minutes:

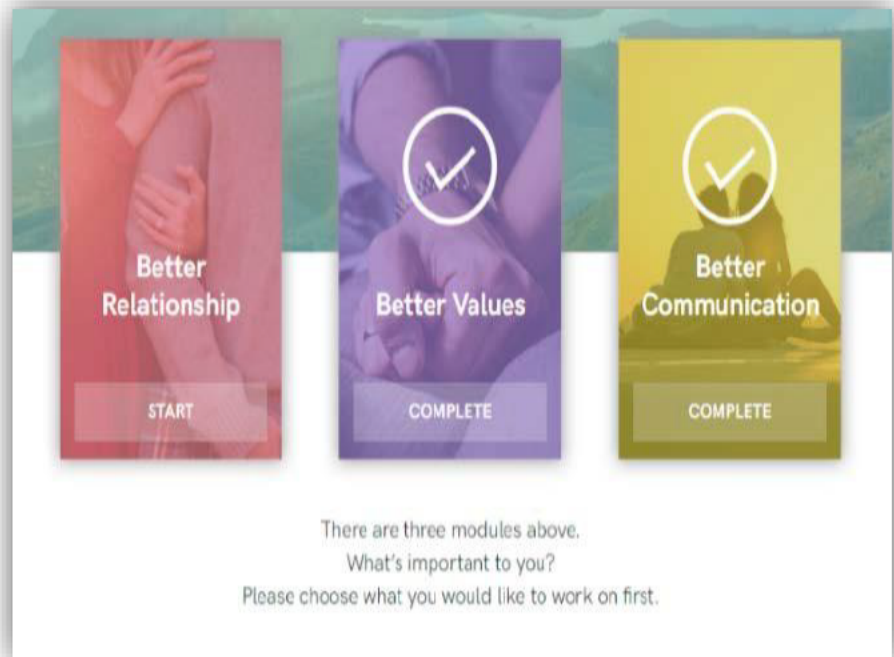
BETTER RELATIONSHIPS encourages a man to reflect on his behaviours (physical, emotional, sexual abuse) and weigh up pros/cons of his relationship.

BETTER VALUES explores how men's behaviour aligns with his values.

BETTER COMMUNICATION looks at how a man's communication style may differ with a partner compared to others and promotes a grounding breathing exercise when recognising signals of potentially abusive behaviour.

A final **TAKE BETTER ACTION** reinforces help seeking, provides resources for parenting, alcohol/ drug use, mental health).

Better Man is currently being evaluated in a [randomised controlled trial](#) and piloted in [general practice settings](#) using the I-ENGAGE model.



Better Man
users

"The best thing about Better Man is..."



“The best thing about Better Man is it made me feel less alone and more aware of the options out there where I can get help”

“It made me take a 360 view of myself and my actions”

“It helped me realise things that I didn't want to think about but needed to. And I could do it online”

Hegarty K, et al. A Brief Online Motivational Tool to Promote Early Help-Seeking in Men Using Abuse and Violence in Relationships: A Feasibility Trial. *Violence Vict.* 2024 Aug 6;39(3):243-262.

6. System change, integration and implementation

Health System Organisational Change

We recommend that the Australian government:

- **Establish a national healthcare safety and quality framework for DFSV** including specific requirements relating to children and young people, consent, confidentiality, DFSV risk and obstruction of care.
- **Implement national monitoring, audit and evaluation** to measure capability, practice change, referral outcomes and continuous quality improvement for accountability.
- **Embed DFSV into health service accreditation, governance and clinical standards**, including organisational readiness measures, identification, response and referral rates as key performance indicators.

The World Health Organization has clearly outlined a [health system model](#) for enabling the health sector to address DFSV. Health system changes occurring in isolation (e.g. training of staff or introduction of policies alone) are unlikely to improve patient outcomes, based on existing systematic review evidence. Improving patient outcomes in the context of DFSV will require patient centred care, but also a ‘whole of system’ health service response and systems change.

At a health provider level, changes could include;

- promoting a culture of gender equity;
- adopting trauma-and-violence-and healing- informed principles and approaches;
- allowing sufficient consultation time and
- promoting awareness of DFSV protocols and referrals.

At a systems level, change might involve:

- national standards, committed leadership;
- provision of workforce training, support and mentoring;
- appointment of clinical champions (see workforce support section);
- allocation of finances to family violence services; and
- information systems for evaluation.

Health services should be required to demonstrate that they have appropriate policies, referral pathways, governance arrangements and workforce capability in place.

We recommend that the Australian government:

- **Support continuity of care models and sufficient consultation time in primary and antenatal care** to promote trust of victim survivors.
- **Introduce Medicare funding for family safety planning and expand access to telehealth and longer consultations** for people affected by trauma.
- **Support standardised family safety and risk e-clinical decision tools.**

The health system needs to address health system cost and time barriers that inhibit disclosure and continuity of care.

Survivors have told us they would like to talk to health professionals about their relationship issues. [A 2022 survey](#) of 1102 survivors' help seeking needs showed that half the survivors sought help from health practitioners. Responses showed 1 in 5 women did not seek any help. Barriers identified included shame (63%), lack of awareness of services (62%), perception that practitioners were too busy (49%), limited availability (55%) and cost (49%). A Medicare Benefits Scheme (MBS) rebate for family safety would give health practitioners more time to provide a caring, empathetic and validating first-line response. WHO and RACGP recommend a first line response which includes safety/needs assessment followed by ongoing care and a "warm" referral to DFSV, psychological, housing, financial services, legal, police, or crisis support. This has previously been called for by the RACGP and Victorian Royal Commission into Family Violence.

Clinical Decision Support Systems (CDSS) are needed to aid early risk recognition and tailored support.

There are standard risk assessment frameworks in most States and Territories in Australia, however these are not always embedded in electronic medical record systems. The use of CDSS tools could facilitate access to screening tools and overcome the burden of documentation for health practitioners.

Service integration and relationship building across sectors

We recommend that the Australian government:

- **Fund peer support workers and care navigators** to improve survivor engagement, continuity of care and service coordination.
- **Strengthen partnerships and relationships between health, mental health (public and private) and specialist DFSV services**, with coordinated local referral pathways and multidisciplinary care.
- **Invest in sustainable long-term multidisciplinary trauma- and violence-informed healing services**, in each State and Territory, drawing on Aboriginal and Torres Strait Islander healing models.

Peer Support Workers should be introduced into the DFSV system.

Victim survivors should not need to navigate multiple disconnected systems to receive safe and effective care. Peer Support Workers have been adopted in mental health and primary care, yet their use with survivors of DFSV has not been implemented. Peer Support Workers are uniquely positioned to be an “ally”, support shared decision making, goal setting, and provide continuity of care in a complex system of health and social care services. Peer Support Workers can use a strengths based approach to empower survivors on their recovery journey. They can aid early access to care and overcome barriers, including cultural stigma, particularly if the survivors are from a similar cultural group.

“Peer support is often the best support. Victim-survivors have a different way of ‘knowing’ and understanding what their peers are navigating.”

Lily, survivor

“With fellow peer supports, frustrations and feelings can be heard without judgement but can also help guide us through the system.”

Kelly, survivor

Example of a health system model intervention

WEB Project (2025-8, funded by MRFF)

The WEB Project is a Randomised Controlled Trial that aims to improve the capability of primary care to respond to survivors of DFSV and coordinate referrals for women and non-binary people. This 3-year study is recruiting participants who have attended a general practice and report experiencing fear due to a partner or family member’s behaviour. Participants will be offered:

- **A fully funded GP appointment** of 30 minutes for a confidential discussion to understand and assess risk to safety and prepare a plan for safety using a **Clinical Decision Support System**
- **Referrals** to domestic violence service and a Peer Support Worker
- **Peer Support Workers** will offer personalised, empathetic support and practical guidance to help women understand and access available health and social services.

The trial will provide evidence for the effectiveness of a **comprehensive primary care system** intervention that increases help-seeking and improves safety for women and non-binary people affected by DFSV. This intervention has the potential to create lasting positive change and support for victim survivors and their children.

Evaluation and data measurement

We recommend that the Australian government:

- **Invest in sustained implementation and ongoing evaluation** of health system programs
- Promote the adoption and use of [validated tools](#) to measure DFSV.

Many DFSV programs are not evaluated so we are unable to improve through feedback the way that health system change is implemented. Audit with feedback is one of the ways that programs are likely to improve to enable outcomes that matter to people affected by DFSV. National audit systems have worked to improve hospital responses in [New Zealand](#) and in Victoria, Australia (see example below).

Example of an audit of hospital system interventions project

[SAFE Audit Project](#) (2019-25, funded by Collier Foundation and National Partnership Funding)

The System Audit Family violence Evaluation (SAFE) Project implemented a robust research initiative using a purpose designed System Audit Tool (SAFE Tool) at 18 health service sites to evaluate the impact of the Strengthening Health Services Response (SHRFV) Initiative (from 2019 -21). The SAFE Project built an evidence base for how health services can effectively implement system change to address DFSV. It tracked innovation and improvements (or lack thereof) in the identification and response to patients and staff who experience DFSV. The SAFE Tool measured ten domains covering one patient, two staff and seven organizational domains. Further work was undertaken 2023-5 and involved recruitment of new hospitals to participate. All sites who participated in the original SAFE Project were invited to undertake a second audit through an expression of interest process. This project involved implementation of a System Audit Tool (SAFE Tool and SAFE Lite Tool) across 21 health services.

The ultimate outcome of system change must be a measurable reduction in DFSV in Australia. Yet we currently do not measure women's experiences of abuse and violence holistically. The Personal Safety Survey measures types of abuse - physical, sexual, emotional, financial, technology-facilitated - separately. This fragmented approach reflects neither individual experience nor public health reality: the majority of women experience multiple forms of abuse concurrently from the same partner or ex-partner. These *patterns* matter, because different combinations (e.g. sexual and psychological, or physical and sexual) carry different risk factors, trajectories and health impacts. Patterns also differ by gender, with women more likely to experience coercive control - a pattern defined by entrapment and fear.

At Safer Families Centre, we have developed methods for [measuring these patterns](#) that capture a person's whole experience of abuse and violence, rather than isolated incident types. Technology-facilitated abuse, for example, should no longer be measured in isolation: the majority of cases co-occur with face-to-face abuse.

The field will not progress while measurement continues to treat abuse types as separate and unrelated. National measurement frameworks must shift to a pattern-based approach.

Alignment with the National Plan consultation questions

Government consultation question	Relevant submission sections	Corresponding recommendations
Prevention <i>What actions can governments, workplaces, industries, schools, families and individuals take to stop violence before it starts?</i>	Prevention and early intervention (Prevent abuse and violence before it progresses; Screening and response to DFSV in antenatal care; Health as a prevention setting)	Recs 2, 4, 9
Services and support <i>How can services and supports work better for people who have experienced, or are at risk of experiencing, DFSV – including specialist DFSV services and general services like health, education and housing?</i>	Victim survivors: strengthening prevention, early intervention, response, recovery and healing (Uplift health workforce capability; Workforce support); System change, integration and implementation	Recs 1, 2, 3, 5, 6, 7, 10
Supporting children and young people <i>How can communities and services best support children and young people to stay safe from violence?</i>	Children and young people in their own right	Recs 4, 8
People who use violence <i>What more can be done across the community to promote healthy, safe relationships and strengthen accountability for people who use violence?</i>	Strengthening responses to people who use violence (Primary Care and online early intervention responses)	Recs 5, 6, 9
Recovery and healing <i>What would make the biggest difference in helping people and families to recover and heal after being affected by DFSV?</i>	Overarching Principle: Engage Lived Expertise in health system reform; Victim survivors: strengthening prevention, early intervention, response, recovery and healing (Workforce support)	Recs 1, 6, 7, 10
Access to support <i>What makes it easier for people to access support or services related to DFSV?</i>	System change, integration and implementation (Health System Organisational Change; Service integration and relationship building across sectors); Uplift health workforce capability	Recs 3, 5, 6, 10

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