



Submission

Consultation on the Second Action Plan (National Plan to End Violence against Women and Children 2022–2032)

This submission has been prepared by The Royal Women's Hospital 31st July 2026.

Located in Melbourne the Royal Women's Hospital is Australia's first and leading specialist hospital for women and newborns, offering expertise in women's health and care. The Women's vision of **'Creating healthier futures for women and babies'** reflects a commitment to a social model of health seeking to achieve health equity.

The Social Model of Health (SMOH) division was established in July 2021 and has responsibility for ensuring the hospital's clinical and social support services are coordinated, aligned and leveraged to provide wrap around care for the women who need it most. In particular, the division has a focus on ensuring a woman's social, economic, cultural, environmental, geographic, and other factors are taken into account in her care plan, with the overall aim of reducing health inequalities and addressing systemic inadequacies that affect health access and outcomes.

Informed by a strong evidence base, the SMOH works to ensure the Women's can offer a continuum of care approach depending on the complexity of each woman's clinical presentation and social circumstance. SMOH works very closely with the Centre for Family Violence Prevention (a research centre at the hospital led by the joint Chair of Family Violence Prevention, [REDACTED] from The University of Melbourne).

The division plays a key role in guiding and supporting a number of specialist services as well as providing state-wide leadership and advocacy on a number of issues in this space. We explore how to address health inequities caused by the social determinants of health. These determinants include: socioeconomic status, access to education and housing, freedom from violence, and more. SMOH brings together a number of established critical clinical and social services including:

- Women's Mental Health Service
- Social Work (including Abortion and Contraception Services)
- Badjurr-Bulok Wilam our Aboriginal Health Liaison Service
- FARREP Fertility and Reproductive Rights Education Program
- Spiritual Care
- Women's Alcohol and Drug Service (WADS)
- A range of highly specialised services focused on violence against women, including the Strengthening Hospital Response to Family Violence program, the Centre Against Sexual Assault service and the Sexual Assault Crisis Line
- The Cornelia Project, a multi-agency service focused on providing an accommodation for up to one year, with integrated care and support to homeless mothers and babies.

SMOH is responsible for leading the Department of Health funded Strengthening Hospital Responses to Family Violence (SHRFV) Program, Family Violence Workplace Support Program and associated projects. These initiatives aim to increase staff competence, develop and share resources and build hospital capacity across Victoria to respond to family violence and improve outcomes for patients and staff who experience family violence. The Women's provides leadership and support to Victorian hospitals and health services implementing SHRFV to embed and sustain a whole-of-hospital approach to family violence.

Introduction

The Royal Women's Hospital welcomes the opportunity to provide a submission to the consultation on the National Plan.

We recognise the detrimental impact of domestic, family and sexual violence (DFSV) on health and the vast number of deaths that are not identified or recognised as a direct result of DFSV. We additionally recognise the systemic failures that contribute to further traumatisation of service users and often collude with perpetrators of violence, further isolating victim survivors and placing them at greater risk of harm.

In this submission we outline some recommendations in the areas of:

- Whole of hospital models to address DFSV
- Screening and response to DFSV in antenatal care
- Workplace support programs for staff
- Clinical Champions and Contact support officers
- Engaging lived expertise in co-design for health system reform

Whole of hospital models to address DFSV: Strengthening Hospital Responses to Family Violence

As a leader and advocate in women's health, The Royal Women's Hospital (RWH) as a maternity hospital sees high rates of DFSV within its patient/client group. Given that evidence-based research has identified pregnancy, in particular physical assault during pregnancy as a serious risk factor under the Multi-Agency Risk Assessment and Management (MARAM) Framework, it is not surprising that patients of RWH would see increased levels of DFSV at serious risk levels. In addition, reproductive coercion and sexual assault are common forms of violence and coercive control seen at the hospital.

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. The program was evaluated over the last 5 years through the [SAFE Audit project](#).

Example of an evaluation framework designed to continue strengthening hospital responses to family violence:

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 organisational 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.

Recommendation:

Extend the System Audit Family violence Evaluation (SAFE) Project to ensure more hospitals continually improve their early identification and evidence-based response to family violence.

Screening and response to DFSV in antenatal care

DFSV is associated with extensive adverse physical, psychological, and obstetric outcomes and is known to escalate during pregnancy. In response to this elevated vulnerability, the World Health Organization recommends routine screening for family violence during pregnancy due to the increased frequency of interactions with health care providers. In 2023, a digital antenatal screening platform available in 25 languages was implemented at the Royal Women's Hospital with Commonwealth funding. This platform supports routine DFSV screening along with perinatal mental health assessment, in line with Australia's National Perinatal Mental Health Guidelines. The day before antenatal appointments, pregnant patients receive a text message containing a link to complete the mental health screening questionnaires on their mobile device. These include validated measures assessing depression, anxiety, psychosocial risk factors, and other mental health disorders. The DFSV screening is done on the woman's phone during the booking appointment in a patient only time. Summary results are automatically uploaded to the electronic medical record (EMR) for clinician review during appointments. Effective screening for DFSV in diverse populations requires culturally and linguistically adapted approaches that prioritise privacy, safety and accessibility.

Example of best practice screening and response to DFSV in antenatal care:

Screening in antenatal care for diverse populations (2023-6) funded by National Partnerships Australian and Victoria 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% and disclosure rates increased marginally from 10.0% to 11.6%. 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.

Recommendation:

Implement multilingual digital screening platforms integrated into the Electronic Medical Record alongside a focused implementation package that ensures disclosures lead to safe, timely support. Optimise electronic medical record integration with clear prompts for clinicians and standardised follow-up pathways.

Workforce support

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." Nurse

Example of a well-being program to support the workforce:

The THRIVE Project (2026, Royal Women's Hospital, funding 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.

Recommendation:

Protect and support the workforce, including dedicated wellbeing and trauma-focused support and supervision to sustain all staff (particularly victim survivor staff) to continue their work with survivor patients.

Clinical Champions and Contact Officers

‘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’ 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 utilize health settings before seeking specialized services, clinical champions are utilized 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 supporting the workforce through Clinical Champions:

Evaluation Clinical Champions and Contact Officers (2025-6, funded by Vic./Federal 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.

Recommendation:

Appoint DFSV clinical champions/leads and contact officers in every health service to drive implementation, mentoring and quality improvement.

Engage Lived Expertise in health system reform

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. 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. It demonstrates that ending violence against women requires more than addressing individual acts of violence - it also requires recognising and preventing systems abuse. The National Plan should drive reforms that ensure healthcare professionals and systems consistently respond in ways that prioritise safety, accountability and trauma-and-violence-informed care.

Example of lived experience-led health system reform:

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.

Recommendation:

The Australian government fund engagement of victim survivor groups in health sector reform to ensure changes meet the needs of service users.
