Australian Women's Health Alliance

Submission to the Second Action Plan Consultation

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

Australian Women's Health Alliance

August 2026

1. Introduction

The Australian Women's Health Alliance (AWHA) welcomes the opportunity to contribute to the consultation on the Second Action Plan under the National Plan to End Violence against Women and Children 2022–2032. AWHA is the peak organisation for women's health in Australia, bringing together state and territory women's health services and national organisations that share a commitment to women's safety, equity and wellbeing across the life course.

As a health-focused alliance, AWHA views family, domestic and sexual violence (FDSV) primarily as a health and social determinants issue as well as a criminal justice and social welfare issue. Women who experience DFV attend general practice, emergency departments, maternity and mental health services more often than women who do not, frequently without disclosing what is happening at home.[1]

Under the First action plan of the of the National Plan to End Violence against Women and Children 2022-27 the initial scope of the ten activities areas for action, and responsibility with respect to outcomes, outlining how we make our vision a reality was set out.

The National Plan recognises that gender-based violence, including sexual harassment, can include specific forms of violence that may disproportionately impact:

- Aboriginal and Torres Strait Islander women and children
- Women and children with disability
- Women and children from culturally diverse, migrant and refugee backgrounds
- Children and young people
- LGBTIQA+ people, including Sistergirls and Brotherboys
- Older women
- Women and children in rural, regional and remote locations.

Drawing on AWHA's emerging Position Statement on the Empowerment of Women and Girls in the Australian Health System, this submission is informed by a health equity approach that

[1] Australian Medical Council, Ahpra and National Boards, and Accreditation Authorities, Joint statement: Building the capability of the health workforce to recognise and respond to family, domestic and sexual violence (2026), noting around one in five Australian women who experience violence from a current or former partner turn to a GP or other health professional for advice or support.

recognises violence is not only an individual experience, but also a consequence of social, structural and institutional conditions.

AWHA considers that lasting prevention requires more than responding to violence after it occurs but requires creating the conditions in which women, girls and children are safe, able to exercise agency, participate in decisions that affect them, and access equitable, culturally safe and gender-responsive systems throughout their lives. This framework underpins AWHA's recommendations across each of the five priority areas.[2]

2. Priority Areas

The Australian Women's Health Alliance welcomes the 5 priority areas for the next phrase of the National Plan to End Violence against women and children 2022-2032.

2.1 Victims-survivors of domestic, family and sexual violence

Everyone has the right to feel safe. The National plan needs to continue to build the capacity of services and systems that support victim-survivors to provide trauma-informed, connected and coordinated responses that support long-term health and well-being.

Ensuring the capability of workforces deliver quality services, which are trauma-informed, culturally safe and are tailored to respond to intersectionality and the unique experiences of victim-survivors and accessible to everyone.

Culturally appropriate services provide flexible care that meets the unique social, religious and cultural needs of diverse women. The key elements to these services are to employ more women with disability, Indigenous, migrant and LGBTIQA+ people to bring a range of perspective to organisations, build community trust by ensuring culturally safety and address unique barriers that diverse women face in relation to FDSV.

FDSV can involve single and/or repeated traumatic experiences which impact victim-survivors health and wellbeing.[3] The health outcomes can be serious and long-lasting, affecting physical and/or mental health, which in turn can affect a person's employment and education, relationships and financial and housing stability.[4]

AWHA recognises that recovery extends beyond protection from violence. Restoring agency, bodily integrity and autonomy are essential components of long-term healing and health equity. Women experiencing violence require health, justice and community systems that support informed decision-making, dignity and meaningful participation in decisions affecting their lives.

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[2] Australian Women's Health Alliance. (2026). AWHA Position Statement: Empowerment of Women and Girls in the Australian Health System (Draft), pp. 6–8. 'Embedding empowerment in practice, policy and research.'

[3] Australian Institute of Health and Welfare - Health outcomes - Australian Institute of Health and Welfare.

[4] Ibid.

This reflects AWHA's broader view that strengthening agency is fundamental to women's health and wellbeing.

2.1.1 Police

The role of the police is to protect the public from crime and harm. They keep peace, prevent and investigate crime, protect property and enforce the law. Police are equipped with many powers to help them enforce the law and protect the public. Police powers are set out under legislations.

Police officers are to ensure, where appropriate while conducting an investigation, they are conversant with the safeguards and powers contained within the *Police Powers and Responsibilities Act*, which contain the Police Responsibilities Code, and any other applicable legislation as well as the contents of the manual.[5]

Rates of reporting family and domestic violence have historically been negatively impacted by a range of factors including: fear of repercussions; misconceptions about what constitutes a crime; mistrust of police; concerns relating to the misidentification of the perpetrator; concerns relating to being believed and having to relive the experience; past native experiences with police/ institutional violence at the hands of police for some populations groups; and barriers to accessing police, such as knowledge and understanding, geographical location and specific population group characteristics.[6]

Case example: Sarah* New South Wales: After her husband became violent one evening, she called the police. When the police officers arrived, they treated her as the aggressor, they arrested Sarah, a woman in her sixties, and held her in a police cell for hours.

Sarah was doing exactly what victims of family violence are urged to do: pick up the phone and ask for protection from the police. When the police attended the scene, they spoke with her husband and formed the view that Sarah as the perpetrator of violence leading to her arrest.

In New South Wales, police powers of arrest are governed by the Law Enforcement (*Powers and Responsibilities Act 2002*).[7] An arrest generally requires the officer to hold a reasonable suspicion that the person has committed an offence, and to be satisfied the arrest is reasonably necessary.[8]

When a victim finds the courage to call the police after years of abuse, the response should be protection, not prosecution.[9] *Accountability matters, but for every victim who hesitates to seek help because they fear they won't be believed*.[10]

[5] OPM-ch.2-Investigative-Process.pdf (police.qld.gov.au).
[6] (ABS 2017; Douglas 2019; DSS 2022; Voce and Boxall 2018).
[7] False Imprisonment: DV Victim Wrongly Arrested by NSW Police.
[8] Ibid.
[9] Ibid.
[10] Ibid.

2.1.2 Protection Orders

Under the National Domestic Violence Order Scheme, protection orders made in any Australian jurisdiction on or after 25 November 2017 are automatically recognised and enforceable nationally.[11]

A protection order is a legal order made by the court to keep the victims safe from violence, threats, intimidation and harassment, conditions are imposed to restrict the behaviours.

Protection orders are expected to be enforced by police, if the conditions of the protection are breached the perpetrator can be charged with a criminal offence of breaching the order. The Magistrate must be satisfied beyond reasonable doubt the conditions on the bail have been breached.

There needs to be better enforcement with breaches of protection orders. Victim-survivors need better support to obtain protection orders through accessible information, trauma-informed practices and greater connections between the different systems.[12] The presence of a protection order does not guarantee safety for victim-survivors. In 40% of cases where a woman was killed by a current or former partner, she had a protection order.[13]

There are numerous barriers to the effective enforcement of protection orders in cases of domestic violence, including:

- limited reporting of breaches by victims[14]
- insufficient evidence to support successful prosecution [15]which is particularly the case for non-violent breaches, which often lack tangible evidence such as victim injury or property damage[16]
- police perceptions that weak sentences are imposed by the courts for breach offences [17] and that the criminal justice system has a limited capacity for processing them[18]
- complexities associated with co-parenting arrangements and contacts that compromise the integrity of the order[19]
- the number and volume of protection orders active within a jurisdiction.

2.1.3 Bail Acts

How many more deaths must there be to invoke reforms to the Bail Act and make these amendments that repeatedly traumatise victims under a flawed justice system? Bail should be an option in circumstance of heinous crime where the perpetrator is protected, and the

[11] National Domestic and Family Violence Bench Book – last update: August 2025 Article | AIJA
[12] Family violence protection orders can be a lifeline, but the system needs reforming : Find an Expert : The University of Melbourne.
[13] Ibid.
[14] (Logan, Shannon & Walker 2005);
[15] (CMC 2005; Taylor et al. 2015; Trimboli & Bonney 1997; NSW Ombudsman 2006; State of Victoria 2016),
[16] (Phillips & Varano 2008).
[17] (CMC 2005).
[18] (Logan, Shannon & Walker 2005).
[19] (Douglas & Stark 2010).

victim suffers till a court date is given to a perpetrator. Current Bail Acts do not protect victims of families where there should be paramount, rather it has confirmed community protection has come at a cost and protects the perpetrator.

The tension between the presumption of innocence and the protection of women and children who are a victim of FDSV and their families. The concept of 'risk' when determining bail decisions and pending a court date jeopardises innocent victims to often the perpetrator in the cases of:

- Sophie Quinn (January 2026) – shot and killed while pregnant by her ex-partner Julian Ingram who was on bail for domestic violence.
- Molly Ticehurst (2024) killed by her estranged husband, David Bradford, who had been bailed shortly before despite police objections.

These are two examples of perpetrators who were free to walk around, and the result was death. Their future prospects were stripped of all possibilities and dreams, and the families are left grieving for a life not lived.

Australia's traditional bail framework operates on a fundamental principle: a person is innocent until proven guilty.[20] Under the existing common law, most accused persons are entitled to be released on bail unless the prosecution demonstrates 'show cause', that is reasons why detention is warranted.[21]

In 2024-25, there were 344,620 offenders proceeded against by police across Australia.[22] The number of family and domestic violence offenders increased by 8% to 97,800 offenders, over a quarter (28%) of all offenders recorded nationally had a least one FDV offence, the highest rate recorded since 2019-2020. Seventy-eight percent were male, the rest female. The median age of FDV offenders was 35 years in 2024-25. [23]

Across the states and territories, the number of offenders proceeded against for at least one breach of an FDV related violence or non-violence order was:

- 15,841 in Queensland
- 13,046 in New South Wales
- 10,448 in Victoria
- 5,571 in Western Australia
- 2,137 in the Northern Territory
- 1,997 in South Australia
- 725 in Tasmania
- 182 in the Australian Capital Territory.[24]

[20] https://obriensolicitors.com.au/nsws-toughest-domestic-violence-laws-yet-bail-reversed-stalking-criminalised-monitoring-expanded.
[21] Ibid.
[22] Australian Bureau of statistics - Recorded Crime - Offenders, 2024-25 financial year | Australian Bureau of Statistics.
[23] Ibid.
[24] Ibid.

This is the highest FDV offender rate recorded since the start of the national time series in 2019–20.[25]

A domestic violence order is not a criminal conviction it is a civil offence, when a domestic violence is breached it then becomes a criminal offence.

3. Prevention and early intervention

Prevention and early intervention is a critical mechanism of reducing and addressing violence against women and children and the current Plan's own evidence shows the most persistent gaps are in this area. FDSV is a major contributor to poor physical and mental health among women, and its health impacts compound the longer violence continues unaddressed. The Consultation Paper's own evidence shows that most people who use violence never engage with a formal behaviour change program, and that shame, normalisation and lack of trusted entry points keep them outside the system until crisis point.[26]

From a health perspective, this means the health system is frequently the last point of contact before harm becomes severe, rather than an early one. Strengthening prevention and early intervention capability within general practice, maternal and child health, emergency departments and mental health services would allow risk to be identified and addressed well before it escalates to the level requiring police, court or refuge involvement.

The evidence is clear that childhood exposure to violence is one of the strongest predictors of future harm, and equally clear that this pathway is not inevitable. The Consultation Paper cites cohort research showing men who grew up with positive, affectionate father figures were substantially less likely to become perpetrators of family violence in adulthood,[27] and that most children exposed to violence do not go on to use violence themselves.[28]

This tells us that protective factors can be built deliberately, through parenting support, early childhood services and school-based programs, rather than left to chance. A Second Action Plan that invests early, before harmful attitudes and behaviours become entrenched, has a genuine opportunity to break cycles of violence across generations rather than manage their consequences.

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[25] Ibid.

[26] ANROWS (2026). Evidence to action: informing direction for the Second Action Plan, p. 31. "Where we are falling behind", Priority Area 2: Prevention and early intervention.

[27] ANROWS (2026). Evidence to action: informing direction for the Second Action Plan, p. 31. Citing Australian Institute of Family Studies, Ten to Men: The Australian Longitudinal Study on Male Health — men who grew up with positive father figures expressing affection were 48% less likely to become perpetrators of family violence in adulthood.

[28] ANROWS (2026). Evidence to action: informing direction for the Second Action Plan. "Where we are falling behind".

Prevention addresses the conditions that drive violence, not only its symptoms. FDSV is driven by rigid gender norms and unequal power between men and women and is worsened by contextual factors such as harmful alcohol and substance use, gambling, financial stress and adverse childhood experiences.

Response services, by design, address the consequences of these drivers after violence has occurred. Prevention and early intervention are the only levers capable of shifting the underlying attitudes, norms and structural conditions that give rise to violence in the first place, including in workplaces, schools, health settings and online environments where harmful norms are increasingly reinforced through the manosphere.

AWHA considers the following to be the highest-impact actions:

- Embedding routine enquiry and safe disclosure pathways within universal health settings (general practice, maternal and child health, antenatal care, emergency departments), supported by trauma-informed training and clear referral pathways into specialist services.
- Long-term, sustained respectful relationships education starting in primary school and continuing through adolescence, rather than one-off or poorly contextualised programs, which the evidence shows can produce backlash effects.
- Addressing the substantive risk factors that compound gendered drivers of violence, harmful alcohol and substance use, gambling, financial stress and adverse childhood experiences through coordinated policy across health, social services and regulation.
- Building accessible, low-stigma entry points for people using violence to seek help early, recognising that shame and fear of judgement currently prevent most from engaging with formal behaviour change programs.

AWHA considers that preventing violence is fundamentally about creating the conditions in which violence is less likely to occur. Prevention extends beyond changing individual behaviours and includes addressing structural barriers, embedding gender-responsive systems, strengthening institutional responses and creating enabling environments that support women and girls to exercise agency throughout the life course. This approach complements the evidence presented throughout this section and reflects AWHA's commitment to health equity through systems reform.

4. Children and young people in their own right

AWHA focuses on children and young people because gendered health differences and inequalities begin at birth.

Children and young people are particularly at risk of experiencing FDSV and its impacts. For children and young people who experience or exposed to FDSV, the harm caused can be

serious and long-lasting, affecting their health, wellbeing, education, and social emotional development.[29]

Witnessing domestic violence can involve a range of incidents, ranging from the child 'only hearing the violence, to the child being forces to participate in the violence or being used as part of a violent incident. This exposure on children can have a serious impact on children, this includes psychological and behavioural impacts, health and socioeconomic impacts and it can be linked to intergenerational transmission of violence and re-victimisation.

There are a number of difficulties associated with assessing the extent of children's exposure to domestic violence including the fact that this type of data is rarely collected by police. This may partly be because children are not usually considered 'ideal' witnesses in a court proceeding, for a variety of reasons and because the focus has traditionally been on the primary victim of violence.[30]

Consistent with AWHA's policy framework, agency begins in childhood. AWHA recognises children and young people as rights holders whose voices, participation and equitable access to information, services and decision-making are fundamental determinants of lifelong health and wellbeing. Building agency early strengthens protective factors, supports recovery from violence and contributes to breaking cycles of intergenerational trauma. This framing provides the policy context for the evidence presented in this section.

Children and young people experience FDSV both directly and indirectly, with significant implications for their health, safety, development and lifelong wellbeing. The Kids Helpline Impact Report 2025 demonstrates that child abuse, family violence, technology-facilitated abuse and escalating mental health crises continue to drive demand for specialist support services. The evidence highlights the importance of recognising children and young people as victim-survivors and strengthening prevention, early intervention and integrated responses across health, education, child protection and justice systems.[31]

Child abuse and family violence remain significant drivers of help-seeking. In 2025, child abuse or family violence was identified as a concern in 1 in 8 counselling contacts involving children aged 5–9 years (12%; n = 212), 1 in 10 contacts involving children aged 10–14 years (10%; n = 2,649), and 1 in 14 contacts involving young people aged 15–18 years (7%; n = 1,987). The burden is disproportionately experienced by First Nations children and young people (1 in 13 contacts), children and young people from culturally and linguistically diverse backgrounds (1 in 11 contacts), and those living in outer regional and remote Australia (1 in 13 contacts), reinforcing the need for culturally safe, equitable and place-based responses.[32]

[29] Australian Institute of Health and Welfare, Family, domestic and sexual violence Children and young people - Australian Institute of Health and Welfare.
[30] Australian Institute of Criminology – Children's exposure to domestic violence in Australia – Richard Kelly, ISSN: 1836-2011.
[31] Yourtown. (2025). Kids Helpline Impact Report 2025, pp. 3, 7–10. At a glance; When safety is at risk.
[32] Yourtown. (2025). Kids Helpline Impact Report 2025, p. 15. 2025 data snapshot: Counselling contacts concerned child abuse or family violence (including physical and emotional abuse).

The report also identifies technology-facilitated abuse as an emerging and rapidly growing form of violence affecting children and young people. In 2025, Kids Helpline recorded 818 counselling contacts relating to sextortion and image-based abuse, representing a 67% increase since 2020.

These contacts more than doubled as a proportion of all counselling contacts over the same period. Importantly, the pattern of victimisation has shifted, with boys and young men accounting for 63% of counselling contacts where gender was known in 2025, compared with girls and young women who were previously the majority. These findings demonstrate the rapidly evolving nature of online abuse and the need for prevention strategies that respond to emerging forms of technology-facilitated violence.[33]

The sustained growth in emergency Duty of Care interventions further demonstrates that many children and young people are reaching crisis before receiving support. In 2025, 36% of emergency interventions involved suicide attempts, 34% involved child abuse, 8% related to acute mental health escalation, 7% involved self-injury and 5% involved sexual assault. Kids Helpline notes that these interventions increasingly require emergency services and child protection involvement, reflecting a sustained increase in high-risk presentations rather than a short-term fluctuation.[34]

Collectively, this evidence supports greater investment in child-centred primary prevention, early intervention and trauma-informed responses that recognise children and young people as rights holders and victim-survivors. It also reinforces the need for coordinated, gender-responsive and culturally safe systems that address the changing nature of violence experienced by children and young people, particularly in digital environments.[35]

Policy relevance for the National Plan

- Recognise children and young people as victim-survivors and rights holders.
- Prioritise early identification and intervention before concerns escalate to crisis.
- Fund culturally safe, inclusive and place-responsive services, with particular attention to First Nations, culturally diverse, trans and gender-diverse, and rural and remote young people.
- Strengthen prevention and response to technology-facilitated abuse and ensure accessible after-hours and digital pathways.
- Improve integration across health, mental health, schools, child protection, police and specialist violence services.

[33] Yourtown. (2025). Kids Helpline Impact Report 2025, pp. 17–18. A growing threat: Sextortion and image-based abuse; A shifting pattern: From girls to boys.

[34] Yourtown. (2025). Kids Helpline Impact Report 2025, p. 10. Types of interventions; Sustained demand for emergency intervention.

[35] Yourtown. (2025). Kids Helpline Impact Report 2025, pp. 7–18. Evidence relating to crisis intervention, child abuse, technology-facilitated abuse and children and young people experiencing violence.

Children and young people need to be part of the funding because most funded programs under domestic, family and sexual violence is catered to adults' cohorts, primarily women or target perpetrators without the consideration of the therapeutic and support needs of children and young people who are also subject victims to domestic, family and sexual violence. Targeting young people also provide opportunities for earlier healing and intervention to continue to break cycles of violence rather than neglect children and allow them to continue on a path of intergenerational violence. They also need to be included in policy changes, decision making and family safety plans because they have lived experience.

Australian Women's Health Alliance support the Domestic Family and Sexual Violence Commissioners Children and Young Peoples Roundtable Summary Report. "To break the cycle of violence and support long-term safety and wellbeing, governments should invest in sustainable, long-term, individualised and culturally appropriate recovery and healing support for children and young people affected by DFSV."

5. People who use violence

Domestic, family and sexual violence is a serious, persistent issue across Australia. Despite legislative changes, limited funding, research, violence remains one of the main areas of concerns for men.
Holding the person using violence to account, risk assessment and safety planning should normally be addressed in collaboration with other agencies and systems.

Perpatrators who have breached their domestic violence order in Queensland and are serving over 12 months in custody, will receive an assessment and a plan that could include requirements to complete one or more programs.[36] Some specialised programs are only delivered in certain locations, perpetrators may need to transfer to another centre to access a program.[37]

If perpetrators are serving less than 12 months in custody, they can still ask staff to participate in programs. Programs include:
- culturally specific programs
- general offending
- substance abuse
- violence
- sexual offending.

Many abusers deny responsibility of their behaviour. Mandatory programs should be put in place for all perpetrators who are incarcerated for breaching their domestic violence orders. There needs to be a review of all programs in prisons for any offence of violence, no matter what their serving time is.

[36] Queensland Corrective Centre – Prisoners information booklet - Microsoft Word - Prisoner Information Booklet (2).
[37] Ibid.

AWHA recognises that achieving gender equity requires the active participation of men and boys as allies. Challenging restrictive gender norms, promoting respectful relationships and supporting healthy expressions of masculinity are important components of primary prevention alongside accountability for the use of violence. AWHA considers sustainable prevention requires both individual responsibility and institutional change.

6. System integration and workforce

People experiencing violence frequently need to navigate multiple systems at once, including health, housing, policing, justice, education, child protection and specialist DFSV services, often while in crisis, and often without any single service coordinating their journey between them.[38]

System integration and workforce capability are not a fifth, separate priority sitting alongside prevention, children's safety and accountability for people who use violence, they are the mechanism through which progress in each of those areas is delivered or lost. A well-designed prevention program, a well-trained specialist workforce, or a well-intentioned early intervention pathway will each underperform if the system around them remains fragmented and the non-specialist workforce surrounding them remains under-resourced and under-trained.

The Second Action Plan needs to build capability to deliver culturally safe, trauma- and violence-informed services for Aboriginal and Torres Strait Islander people, migrant and refugee communities, LGBTIQA+ people and people living with disability, and to address systemic bias and inequities in policing and justice responses.[39]

AWHA supports this as a foundational design principle rather than an add-on. A system integration agenda that is built first for a default population and adapted afterward for diverse communities will systematically under-serve the people who already face the greatest barriers to help-seeking. Cultural safety, disability access, and LGBTIQA+ inclusion need to be built into workforce standards and referral pathways from the outset, not layered on as a secondary phase of reform.

AWHA recommends embedding empowerment across health and community systems by strengthening trauma-informed, culturally safe and gender-responsive services; increasing women's leadership in system design; integrating lived experience into policy development; and ensuring research, funding and evaluation frameworks promote health equity. AWHA considers these principles should be embedded across systems rather than delivered through isolated programs.

[38]ANROWS (2026). Evidence to action: informing direction for the Second Action Plan, p. 50. Priority Area 5: System Integration and Workforce.

[39]ANROWS (2026). Evidence to action: informing direction for the Second Action Plan, p. 51.

7. Other Issues

7.1 Older women and DFSV

AWHA is concerned that older people, and older women in particular, are largely absent from the Consultation Paper. Elder abuse is not named as a distinct issue within any of the five proposed priority areas, despite the National Plan's stated commitment to a whole-of-life-course approach.

AWHA recommends the Second Action Plan explicitly recognise elder abuse as a form of domestic, family and sexual violence requiring dedicated prevention, early intervention and workforce attention.

Elder abuse is family violence occurring in a relationship where there is an expectation of trust, most commonly involving a spouse, partner, adult child or other family member, and can include physical, sexual, psychological and financial abuse as well as neglect.[40]

The 2020 Survey of Older People, conducted for the National Elder Abuse Prevalence Study, found that 15% of people aged 65 and over living in the community had experienced at least one form of elder abuse in the preceding 12 months, and that 24% of those affected experienced more than one type. Psychological and financial abuse were the most commonly reported forms.[41]

These figures are widely considered an underestimate. Older people may be reluctant to disclose abuse by a family member on whom they depend for care, and older people with dementia or other cognitive impairment may be unable to report abuse at all — meaning current data, drawn only from community-dwelling respondents able to participate in a survey, is likely to significantly understate the true scale of the problem.[42]

Elder abuse follows similar gendered patterns to other forms of family and domestic violence, with older women more likely to be victims than older men, and most identified perpetrators of physical and sexual elder abuse are male.[43]

For a significant number of older women, abuse in later life is not a new phenomenon but the continuation of a lifelong pattern of intimate partner violence, sometimes described in

[40] Australian Institute of Health and Welfare, Older people (family, domestic and sexual violence topic summary), citing Kaspiew, R., Carson, R., & Rhoades, H. (2019). Elder abuse: Understanding issues, frameworks and responses. AIFS.

[41] Australian Institute of Family Studies (2021). National Elder Abuse Prevalence Study: Final Report, prepared for the Attorney-General's Department under the National Plan to Respond to the Abuse of Older Australians (Council of Attorneys-General, 2019).

[42] Australian Institute of Health and Welfare, Older people (family, domestic and sexual violence topic summary), citing Qu, L., Kaspiew, R., Carson, R., Roopani, D., De Maio, J., Harvey, J., & Horsfall, B. (2021). National Elder Abuse Prevalence Study.

[43] Australian Institute of Health and Welfare, Older people (family, domestic and sexual violence topic summary), citing Ho, C. S. H., Wong, S. Y., Chiu, M. M., & Ho, R. C. M. (2017), a systematic review finding a greater likelihood of abuse among women (17%) than men (11%).

the literature as ‘spouse abuse grown old’, meaning some women who could not or did not leave an abusive relationship earlier in life continue to experience violence from an ageing partner well into their seventies, eighties and beyond.[44]

Most identified elder abuse is intergenerational rather than spousal, most commonly involving abuse of a parent by an adult child, with sons identified as perpetrators more often than daughters.[45]

Aboriginal and Torres Strait Islander people aged 50 and over are significantly overrepresented in hospitalisations for assault-related injury, as victims of family and domestic violence–related assault, and as homicide victims, relative to their share of the older population.[46]

Elder abuse is currently addressed principally through a separate National Plan to Respond to the Abuse of Older Australians, overseen by the Council of Attorneys-General, rather than through the National Plan to End Violence against Women and Children. AWHA is concerned that this separation contributes to older women's abuse being seen as a distinct policy problem rather than as part of the same continuum of gendered violence addressed elsewhere in this Plan.

AWHA recommends the Second Action Plan formally establish points of alignment and shared accountability between the two National Plans, particularly for older women whose experience of abuse is gendered, intimate-partner-related, or a continuation of lifelong family violence, so that older victim-survivors are not excluded from the protections, funding and workforce development this Plan seeks to deliver.

7.2 Women experiencing incarceration

The Action Plan presents an opportunity to recognise incarceration as both a consequence of gendered violence and a critical point for intervention.

Almost all women entering prison have experienced repeated traumas throughout their lives, including intimate partner violence, childhood abuse, poor mental health, homelessness, poverty and substance abuse. These experiences of abuse and trauma can create a pathway to prison; upon leaving custody women frequently encounter significant barriers to building safe and healthy lives.

For Aboriginal and Torres Strait Islander women, these experiences are compounded by the ongoing impacts of colonisation, systemic racism and the overrepresentation of First Nations women within the criminal justice system.

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[44] Australian Institute of Family Studies, Elder abuse: Understanding issues, frameworks and responses, citing Cramer, E. P., & Brady, S. R. (2013) and Mann, R., Horsley, P., Barrett, C., & Tinney, J. (2014).
[45] Australian Institute of Family Studies, Elder abuse: Understanding issues, frameworks and responses (Family Matters No. 98).
[46] Australian Institute of Family Studies, National Elder Abuse Prevalence Study: Final Report, citing Australian Institute of Health and Welfare (2019a).

Correctional settings, community corrections and transition services provide crucial opportunities to identify victim-survivors of DFV, identify and respond to trauma therapeutically, strengthen safety planning, and connect women with culturally safe health, housing, legal and social supports before, during and after release.

Limited access to stable housing, healthcare, employment, financial security and trauma-informed support increases vulnerability to further violence and can contribute to reoffending. Without coordinated, gender-responsive services, many women return to unsafe relationships simply to meet basic needs.

The Australian Women's Health Alliance recommends that the Second Action Plan:

- Recognise incarcerated and formerly incarcerated women as a priority cohort within responses to family, domestic and sexual violence.
- Invest in trauma-informed, culturally safe, gender-responsive health and support services across custodial settings and during transition back into the community.
- Strengthen collaboration between correctional services, health services, housing, specialist family violence services and Aboriginal Community Controlled Organisations to ensure continuity of care.
- Support early intervention and diversion initiatives that address the underlying drivers of women's offending, including violence, trauma, poverty and housing insecurity.

Responses that prioritise healing, recovery and long-term wellbeing alongside accountability will improve health outcomes, reduce reoffending and contribute to breaking intergenerational cycles of violence.

About us

The Australian Women's Health Alliance provides a national voice on women's health. We highlight how gender shapes experiences of health and health care, recognising that women's health is determined by social, cultural, environmental, and political factors.

Contact us

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