23 July 2026

Re: Submission in response to the Consultation Paper in support of the National Plan to End Violence against Women and Children 2022-2032.

Women's Health NSW (WHNSW) is the peak body for 21 non-government community-based women's health centres (WHCs) in New South Wales (NSW). We are proactive on priority issues relevant to women's health, advocating for improved health outcomes so that women and girls can reach their potential within a gender and culturally safe and healthy environment.

We are funded by a Ministerial Approved Grant called the Women's Health Program. Women's Health Centres deliver violence prevention and service provision as an essential part of the NSW primary integrated health care system. While there are some members who have received specific funding for targeted domestic, family and sexual violence (DFSV) programs, this is the exception and not ongoing.

Assisting women who experience violence and supporting them through the health impacts has always been core work of the Women's Health Network. The work of WHCs includes safety planning, medical services, specialist trauma counselling and therapeutic resilience work, legal and financial information, case management, court support, grief and loss counselling and parenting skills to name just a few. In 2024-2025 18% of women presenting at Women's Health Centres presented with violence and abuse issues.

We have reviewed the consultation paper and are pleased to see the framing and new areas identified for attention being recognition of children and young people as survivors in their own right, the use of technology, the influence of the 'manosphere' and addressing mistrust, misunderstanding of the data and survivors. We also support that while there has been some progress, more work needs to be done across the board including strengthening national data systems, improving responses to sexual violence, stalking and technology-based abuse, and enhancing workforce capability.
We acknowledge the need to address systemic inequalities that result in disproportionately higher impacts and targeted prevention and support for Aboriginal and Torres Strait Islanders, migrant and refugee women or unique needs such as LGBTIQA+ people.

We provide specific feedback on needs and opportunities identified within the consultation plan below, drawing on our relevant experience and role within the domestic and family violence and sexual violence sectors.

Regarding the Second Action Plan consultation plan we wish to highlight the following points as relevant to our experience and role.

Priority Area 1: Violence against women and other forms of gender-based violence

- Recognition of the importance of trauma-informed, culturally safe, person-centred approaches and service options, particularly the first time someone seeks help and in crisis response. We believe this is an important role WHCs play in the service system as trusted community organisations with all-female workforce and bilingual workers. Two thirds of referrals to WHCs

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report that 75% or more of their clients would be unable to access the services they require if the WHCs were not available.

Priority Area 2: Prevention and early intervention

- Strengthening and simplifying legal processes to reduce adversarial practices that can result in victim-blaming, re-traumatisation, and disengagement from the justice system. We have concerns about the impact of subpoenas for client notes and non-disclosure agreements in silencing and intimidating women from pursuing legal avenues and so welcome addressing legal systems and protections.
- We support targeted efforts to address persistent attitudes, including persistent beliefs that domestic and family violence is committed equally by men, and persistent mistrust of women's reports of sexual violence. We are concerned by the impact of media coverage that minimises the experiences of survivors and conveys impunity for perpetrators, perpetuating negative societal beliefs and deterring survivors from reporting and pursuing justice in the legal system.
- Improve understanding of the range of prevention and early intervention programs and approaches nationally and support long-term evaluation to understand impact and outcomes. Too often we see time-limited projects of less than two years tendered. This does not encourage success, instil confidence in communities nor allow for substantive behaviour changes to occur and be evaluated. We therefore advocate for more sustained investment that enables evidence-based approaches, embedding of outcomes and robust evaluation.
- Engage young people in prevention efforts, including education on consent and healthy relationships, before harmful attitudes become entrenched. We recognise the importance of education that reinforces knowledge and skills for young people to engage in healthy relationships and to identify issues and seek timely help.

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

- Recognition of children and young people as survivors of violence in their own right and a systematic response that includes meaningful engagement to inform policies and programs that support them, and work across families, communities and educational settings to respond early to prevent harm. Two WHCs have had specialist funding for working therapeutically with children and young people as survivors of violence including sexual. They report being in high demand filling a service gap in their communities that otherwise is not available.

Priority Area 4: People who use violence

- Identify opportunities to encourage or compel people who use violence to seek support early, helping families, communities and workplaces to identify and link to help. Where WHCs have undertaken targeted community initiatives, including a region-specific project to work with men, to raise awareness and increase the capacity of the community to address gender-based violence we have seen strong engagement and partnership across sectors. Unfortunately, such initiatives tend to be time-limited and therefore limit the embedding of behavioural and cultural change.

Priority Area 5: System integration and workforce

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- Service feasibility relies on specialised staffing and adequate resourcing including gender-matched practitioners, and the availability of bilingual and interpreter support where culturally required. A fundamental strength of women's health centres is the expertise of workers including a workforce that reflects the cultural diversity of the communities we serve. We recognise that several factors can threaten this including time-limited funding that does not support the retention of staff nor the organisational knowledge and stakeholder relationships.
- We support improving national coordination of workforce capability, role definition and conditions, including support for greater consistency in standards, training and practice across jurisdictions. The highly specialised workforce across the Women's Health Network is a great strength, however there is always more that can be done to recognise and sustain retention, recognising the strong propensity to burn out and experience vicarious trauma.
- Strengthening workforce capability to respond to the full spectrum of violence including coercive control, sexual violence and technology-facilitated abuse. We support building collaborations and coordination between workforces including specialist and non-specialist, and domestic and family violence and sexual violence which we agree continues to remain siloed. We understand this is the result of system mechanisms, such as separate policies which may be necessary. From our experience, when given the opportunity there is a strong desire to collaborate and come together for professional development opportunities. The feedback is that the positive impacts are immense to cross-pollinate expertise and network.

We also wish to provide as a case study 'The Pathways Project' funded by the Australian Government and NSW Government under the Sexual Violence Project Fund as an example of what can be achieved with investment in innovative multisector DFSV initiatives. We hope this may also provide information on the issue of non-fatal strangulation and sexual choking for your consideration of incorporating into the objectives of the Second Action Plan.

Regards,

Denele Crozier AM
Chief Executive Officer
Women's Health NSW

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CASE STUDY: The Pathways Project (non-fatal strangulation and sexual choking)

Evidence of prevalence and need

The most recent cross-sectional study on non-fatal strangulation in the context of sexual violence in Australia is a decade old. This study examined data collected from the forensic examination of women (aged 13 and over) referred to the Western Sexual Assault Resource Centre between January 2009 and March 2015 after alleged sexual assault. Of the 1,064 women included in the study, 79 (7.4%) alleged strangulation, with prevalence highest in the cohort of women aged 30 to 39 years (15.1%) compared with all other age cohorts (all less than 8.2%)[i]. The first Australian prevalence data on sexual choking found more than half (57%) of a nationally representative sample of Australians aged 18 to 35 reported having ever been choked during sex[ii].

Overview

The Pathways Project came about when Women's Health NSW (WHNSW) identified a need to support and strengthen professional understanding and local capacity to respond to sexual assault-related non-fatal strangulation and acquired brain injury. Funded under the Sexual Violence Project Fund[iii] administered by the NSW Department of Communities and Justice, our two-person project team expanded this remit into creating sustainable practice change to address strangulation in the context of domestic, family and sexual violence, and in consensual sexual choking. Our work on sexual choking took a harm reduction approach, aiming to reduce the prevalence of sexual choking via giving practitioners the tools they needed to work with women engaging in this sexual practice. Drawing from evidence, expert knowledge and partnerships, the project included the development and dissemination of evidence-based health promotion that was acceptable and accessible to priority populations.

The project was delivered in partnership with 15 women's health centres (WHCs) who received funding for their work. However, up to three rounds of face-to-face training and support to develop bespoke screening, assessment and referral pathways was delivered to all 21 members. Additionally, 20 of the 21 WHCs implemented screening and referral pathways by working in partnership with existing local networks of domestic, family and sexual violence (DFSV) support services, Police, general practitioners (GPs), Primary Health Networks (PHNs), Local Health Districts (LHDs) and legal services, and building new relationships with brain injury and other services women might need.

The project developed a suite of resources including a bespoke, open-access website, *It Left No Marks*, 15 WHNSW resources and eight co-branded resources. These included guidelines, videos, templates and brochures with a total distribution of 130,544 as at 30 June 2025.
Importantly, we contributed to a growing evidence base on the prevalence and impact of non-fatal strangulation and sexual choking, including with an often-cited evidence brief[iv].

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Example of targeted messaging: GP, client, health practitioner and service providers

What we found

Most of the two-year grant term was used to develop and embed referral pathways at WHCs. In the first tranche of data representing less than six months of screening by WHCs in 2024–25 we found:

Strangulation

- Women were screened for strangulation 452 times (or 41 times per centre) at 11 WHCs.
- Women were assessed after a positive screen 275 times (or 25 times per centre) at 11 WHCs. However, not all WHCs documented assessments.
- Positive screening for strangulation sits between 7% and 81% in complete reports. For example, 7% (n=8 of 122) at Wagga Women's Health Centre; 42% (n=31 of 73) at Benevolent Society's Centre for Women; and 81% (n=17 of 21) at Women's Health Northern Rivers.
- Women received 316 occasions of service for needs following strangulation at the 72% (n=13 of 18) of WHCs who recorded them.
- The number of follow-up appointments to address women's needs following a disclosure of strangulation varied greatly between centres. For example, the Women's Centre for Health and Wellbeing Albury–Wodonga provided on average 1.75 (n=49 from 28) occasions of service per client who disclosed strangulation.

Sexual choking

- Women were screened for sexual choking 283 times (or 31 times per centre) at 9 WHCs.
- Women were assessed after a positive screen 30 times (or 3 times per centre) at 7 WHCs.
- Positive screening for sexual choking sits at 11 per cent (n=30 of 283) in the 7 WHCs who recorded assessments.
- Women received 57 occasions of service for needs following a positive screen for sexual choking at the 28 per cent (n=5 of 18) of WHCs who recorded them. However, the number of follow-up appointments following a disclosure of sexual choking varied greatly between centres. For example, Central Coast Community Women's Health Centre provided on average 2 (n=8 from 4) occasions of service per client who disclosed sexual choking.

Project outcomes

Short-term outcomes

- The number and breadth of external training requests, including from interstate DFSV peak bodies, demonstrates changemakers and gatekeepers are aware of, and supportive of workforce development related to strangulation, sexual choking, and acquired brain injury.
- WHC staff are screening for strangulation, sexual choking and brain injury. All 20 protocols and referral pathways included directions to staff about when to screen for strangulation, sexual

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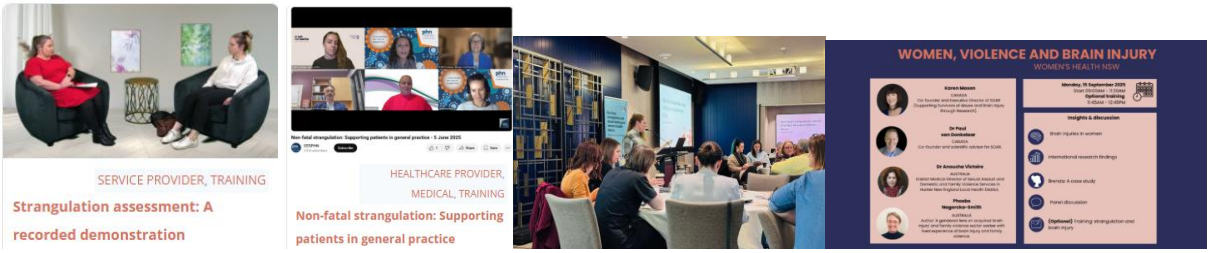
choking and brain injury. Almost all centres, 83% (n=15 of 18 survey participants) said staff are using the referral pathways and protocols.

- With improved tools, procedures, staff training, and database systems, WHCs now deliver more consistent, coordinated, and trauma-informed care to women impacted by violence, which is evidenced in the improved quality of case notes across the service.
- Pre- and post-training survey data shows WHC staff indicated confidence had improved after every round of training. Project workers observed increased confidence delivering health promotion and psychoeducation in round three of training.



Examples of multimedia training: videos, webinars, conferences, workshops and podcasts

Medium-term outcomes

- Every external training and presentation built awareness in the DFSV workforce about the need to make a multidisciplinary response to strangulation and sexual choking. For DFSV service providers this related to making a health response alongside a safety response. As one training participant noted: "After your training, a client disclosed strangulation and I felt comfortable discussing the health impacts with her. We went through the signs and symptoms on your website together."

- The first tranche of case studies from the WHCs speak to women's satisfaction with the response they have received. However, building referral pathways identified many gaps in services relating to brain injury. As case studies indicate, some WHCs have been particularly effective in filling those gaps to improve outcomes for women.
- In 2024–25 sector data collated by WHNSW, of the 20 WHCs that developed bespoke referral pathways, 90% (n=18 of 20) submitted data reports. Of these, 89% (n=16 of 18) submitted data on strangulation; 61% (n=11 of 18) submitted data on sexual choking; and 50% (n=9 of 18) submitted data on brain injury. Further embedding of these workplace tools is needed to achieve consistent recording of data.
- WHC staff report resources for women have been well-received. The Recovering from Brain Injury booklet was directly focus tested with women with experiences of violence in a WHC. Service providers identified further need for bespoke resources, like easy-read resources for women with disability.
- Women's self-advocacy was improved by the referral letter template, which was widely adopted by WHCs and external DFSV services, including in Victoria via Safe+Equal.

How we shared knowledge more widely

- A dedicated website (itleftnomarks.com.au) hosting resources for women, healthcare providers and service providers.

ABN 51 392 627 790
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- 2,164 participants external to the women's health sector received training on 34 different occasions as of 30 June 2025. Training continued in a more reduced form after the grant concluded. In 2025–26 we trained 227 people on seven different occasions. Confidence (fairly or extremely) recognising the signs and symptoms of strangulation grew from 19% to 68% after receiving this one-hour training package.
- Of those who identified a key takeaway from the training, 51% (n=25 of 49) identified the importance of language, asking follow-up questions and screening for strangulation.
- 1,368 people attended a presentation as of 30 June 2025. Presentations included elements of our training, and information about the project and its resources. Presentations took place at events including conferences, communities of practice, and interagency meetings. Presentations continued in a more reduced form after the grant concluded. In 2025–26 we presented to 527 participants at seven different occasions.
- Collectively, we presented work at University of NSW's Tackling Stigma Conference 2024, STOP DV Conference 2024, the Domestic Violence NSW Conference 2024, Ending Coercive Control and Family Violence 2025, Fifth World Conference on Women's Shelters 2025, ENIGMA IPV 3rd Annual Virtual Brain Injury Conference 2025, the University of Sydney 2025 Domestic, Family & Sexual Violence Conference and Red Rose Foundation's Breaking the Hold 2026 conference, alongside events hosted by interstate peak bodies in Victoria, South Australia and Western Australia.
- The project was mentioned in 13 media pieces across the project lifespan, in a broad range of publications. Most were Australian outlets, in articles focused on sexual choking.

Examples of resources: client-facing information, practitioners' guides and clinical guidelines

Our work has been recognised locally and internationally

These achievements contribute to Australia being world-leading in the field of non-fatal strangulation and sexual choking. Most notably this has included:

- Having the NSW women's health model of practice recognised by the Queensland Law Reform Commission as a model for addressing strangulation in that state[v].
- Getting an article for general practitioners on the harmful effects of sexual choking published in The BMJ, a globally recognised medical journal owned by the British Medical Association (BMA)[vi].
- Seeing our harm reduction work on sexual choking publicly recognised in an international journal by the key American researcher in this field, Professor Debby Herbenick, as one of only four examples worldwide, with a recommendation for further evaluation[vii].

Case Vignette: Brenda's Story

We provide this case vignette as an example of the direct impact this project had on victim-survivors.

ABN 51 392 627 790
Funded by NSW Health Department

Brenda was referred to the Benevolent Society's Centre for Women's, Children's and Family Health for their Staying Home Leaving Violence program by their local Women's Domestic Violence Court Advocacy Service at the beginning of 2025. This was before this team had completed Pathways Project training and implemented local protocols. They knew Brenda had been subjected to significant physical abuse, including non-fatal strangulation and many assaults to the head, some of which continued until Brenda lost consciousness. One assault directly preceded Brenda waking up in hospital being told she had been in a coma.
Brenda had shown incredible strength and relocated from interstate to leave Steve, who chose to perpetrate violence and control against Brenda throughout their four-and-a-half-year relationship. As Brenda was an existing client when this service implemented their strangulation protocols, she was not "screened" as such, as she had already disclosed the incidents. However, the very next appointment after this team completed their training and implemented their protocols, the case manager revisited those disclosures and asked Brenda for more information, including whether Brenda had noticed any changes to her physical health.

Brenda outlined more details about the multiple head injuries she sustained as a result of Steve's choice to use violence, and about instances of non-fatal strangulation. Brenda stated that after the last incident in July 2024, where Steve repeatedly hit her head into a wall, she had noticed a number of changes:

- *Memory loss*
- *Frequent headaches*
- *Difficulty concentrating*
- *Confusion*
- *Vision impairment*
- *Changes in her hearing*
- *Vomiting directly after the incident*

The caseworker provided Brenda with health promotion about the potential physical and mental health impacts of head injury and non-fatal strangulation. She discussed Brenda's options with her, and the importance of medical follow-up. This centre is located in the catchment for Campbelltown Hospital, which developed a strong referral pathway that would see women up to nine months after the strangulation at the Emergency Department. Brenda's latest assault was less than nine months ago, and she agreed to access the emergency department for medical assessment. The case manager followed the protocol and the local referral pathway for head injury and called the emergency department and made an appointment for the following day.

The next day Brenda attended emergency accompanied by the case manager, who advocated for Brenda to be placed in the short stay unit while she waited for assessment. Unfortunately, on that day, there were no beds, and after waiting for four hours, Brenda left. The case manager discussed the importance of medical follow-up, considering her symptoms and provided her with a copy of the referral pathway.

Three days later, Brenda attended the hospital independently and was admitted to the short stay unit. She reported being seen by a supportive nurse and doctor, and that CT scans were conducted. While scans were looking for potential injuries related to the violence Steve had perpetrated against Brenda, the medical staff detected that there was something else going on. The CT scan revealed an aneurysm (a weakening in a blood vessel wall that was bulging or ballooning) in Brenda's brain, and she was referred to a neurologist for evaluation and support. Before that appointment could take place, Brenda experienced a severe headache one evening, vomiting and collapsing. She was

ABN 51 392 627 790
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unresponsive, so her parents called for an ambulance, and were able to inform emergency services about her aneurysm diagnosis. The ambulance arrived quickly, Brenda was admitted to hospital and had surgery that night.

According to Brenda, the referral pathway played a critical role in the diagnosis of her brain aneurysm and was instrumental in saving her life. She expressed deep gratitude for the support provided and stated that without the hospital referral, the aneurysm may not have been detected in time.

Brenda's mother also conveyed her appreciation for the support given to her daughter and strongly believes that the early referral was vital. When Brenda collapsed, her family was able to inform 000 and the ambulance team about the diagnosed aneurysm, which helped emergency services respond quickly and appropriately, getting Brenda the urgent care she needed.

Brenda's journey is ongoing, and this women's health centre continues to work alongside her, helping her to enhance her safety, stabilise her life and recover. Brenda is still processing the implications of her injury, and is disappointed by the impact it may have on her career aspirations. However, she shared that receiving a formal diagnosis has given her a renewed sense of strength and clarity.

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[i] Zilkens, R., Phillips, M., Kelly, M., Aqif Mukhtar, S., Semmens, J., & Smith, D. (2016). Non-fatal strangulation in sexual assault: A study of clinical and assault characteristics highlighting the role of intimate partner violence. Journal of Forensic and Legal Medicine, 43(10), 1–7. https://doi.org/10.1016/j.jflm.2016.06.005

[ii] Sharman, L., Fitzgerald, R., and Douglas, H. (2024). Prevalence of Sexual Strangulation/Choking Among Australian 18–35 Year-Olds. *Archives of Sexual Behavior* 54 (2) 465–480. https://link.springer.com/article/10.1007/s10508-024-02937-y

[iii] NSW Department of Communities and Justice. (November 14, 2024). *NSW Sexual Violence Project Fund*. https://dcj.nsw.gov.au/service-providers/supporting-family-domestic-sexual-violence-services/dfv-programs-funding/nsw-sexual-violence-project-fund.html

[iv] Women's Health NSW. (2024). *Non-fatal strangulation and acquired brain injury in the context of sexual violence: An evidence brief*. WHNSW. https://www.itleftnomarks.com.au/an-evidence-brief/

[v] Queensland Law Reform Commission. (2026). *Education, accountability and support: Improving Queensland's response to non-fatal strangulation*. https://apo.org.au/node/333524

[vi] Victorie, A., de Boos, J., McMillan, J. & White, C. (2026). Harmful effects of sexual choking *BMJ* 392:s275 doi: https://doi.org/10.1136/bmj.s275

[vii] Herbenick, D., Fu, Tc., Simić Stanojević, I. et al. (2025). Exploring Educational Messages About Sexual Choking: Results of a Feasibility, Acceptability, and Efficacy Study Among College Students. *Sex Res Soc Policy*. https://doi.org/10.1007/s13178-025-01189-2.

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