AFFILIATION OF AUSTRALIAN WOMEN'S ADVOCACY ALLIANCES

AAWAA

Towards Tasmania's Next Mental Health Strategy
Rethink and Beyond
Submission
8 May 2026

PART I: AAWAA'S STANDING IN THIS MATTER

About AAWAA

The Affiliation of Australian Women's Advocacy Alliances (AAWAA) is a national peak body representing women's advocacy organisations with member groups in all states and territories of Australia. We advocate for the protection advancement, and human rights of women and girls, particularly where we are vulnerable on the basis of our sex. AAWAA's member organisations include

- Women's Advocacy Alliance Tasmania (WAAT), which has made a separate submission to this consultation and which represents our Tasmanian members directly. This AAWAA submission is complementary to WAAT's submission and draws on the same national and international body of work, while offering greater depth of evidence and analysis at the national and international level.
- Queensland Women's Advocacy Alliance (QWAA), NSW Women's Advocacy Alliance (NSWWAA), Women's Advocacy Alliance Western Australia (WAWAA), all of whom are also making submissions to this review.

Our membership includes teachers, academics, health professionals, lawyers, and social workers, as well as others with direct experience of the conditions that drive women's and girls' mental distress. AAWAA has Tasmanian members and their interests are represented through both this submission and through WAAT's separate submission to this consultation.

Our standing

AAWAA's engagement with mental health policy at the national and international levels establishes our standing to contribute to this consultation. In October 2024, AAWAA provided input to the UN OHCHR's comprehensive report on mental health and human rights, addressing the conditions that drive women's and girls' mental distress and the policy failures that compound them. AAWAA has also contributed to the NSW Government's mental health and wellbeing strategy consultation in 2025, drawing on the same analytical framework presented here.[1]

[1] Specific mental health needs of women and girls must be addressed in next OHCHR comprehensive report, AAWAA submission, October 2024; Restoring rights and realities: Reforming mental health policy for women and girls in NSW, NSWWAA, August 2025.

The conditions that drive women's and girls' mental distress are not state-specific. They are structural and consistent across Australian jurisdictions. The policy choices Tasmania makes in this strategy will both reflect and shape national directions, and AAWAA has a direct and legitimate interest in contributing to this consultation.

Our body of work is directly relevant to the strategy's proposed stakeholder roundtables and other structured engagements. AAWAA respectfully requests that the Tasmanian Government include sex-based women's organisations — including WAAT and AAWAA — in advisory, roundtable, implementation and review processes established under the final strategy. See the annex for our selected recent engagements.

Note on format
This submission is provided in document form rather than via the online feedback form because it is intended to function as a reference text for the strategy, bringing together international human rights standards, national evidence and the intersecting analysis from AAWAA's member organisations. The structure, length and level of citation required for that role cannot be accommodated within the form's fields. AAWAA therefore respectfully requests that the Department receive this document as our formal submission and as the national framework within which the member organisations' form-based responses should be read.

PART II: FRAMEWORK: WHY SEX MUST BE CENTRAL TO THIS STRATEGY

The 'Rethink and Beyond' discussion paper reflects genuine effort to improve Tasmania's mental health system; however, it approaches mental health primarily as a system design and service access problem, with limited recognition of the sex-based structural conditions that drive the most serious patterns of women's mental distress. A strategy designed without these conditions at its centre will produce incremental service improvements that leave the underlying causes of women's distress unaddressed.

Mental health policy cannot be framed as sex-neutral design if it is to respond properly to the conditions affecting women and girls. Women and girls are not a generic sub-population within a broader service system. Our mental health is shaped by specific, identifiable structural conditions: male violence, economic dependence and insecurity, reproductive and perinatal vulnerability, unpaid caregiving burdens, institutional harms, and the erosion of female-only services and sex-based protections. These are not incidental features of individual women's lives. They are structural patterns that policy has both the obligation and the capacity to address.

AAWAA's submission to the UN OHCHR in 2024 noted that the WHO and OHCHR have themselves recognised that human rights violations, including forms of violence and discrimination, are significant contributors to adverse mental health outcomes, and that this link underscores the urgent need for policies that address these critical issues, especially for women and girls. Tasmania's next mental health strategy should be grounded in this understanding.

PART III: THE EVIDENCE BASE: WHAT DRIVES WOMEN'S AND GIRLS' MENTAL DISTRESS IN TASMANIA

Male violence against women and girls

Male violence against women is a primary structural driver of women's mental distress in Tasmania and across Australia. In Tasmania, an estimated 95,600 women — 43% of the female population — have experienced violence since the age of 15, and 28.1% have experienced intimate partner violence since age 15. Although some short-term prevalence rates fell between 2016 and 2021–22, Our Watch concludes that overall levels of violence against women in Tasmania remain "unacceptably high".[2]

Nationally, on average, one woman a week is killed by a current or former intimate partner. In Tasmania, family and domestic violence has risen markedly over recent years, with police and government reporting sustained growth in family violence incidents and FDV-related assault victims, while sexual assault reports remain well above historical averages. These figures understate the real scale of harm, as family and sexual violence are widely recognised as substantially under-reported to police.[3]

Male violence towards women and children causes trauma, depression, anxiety, suicidality, substance use, housing instability and repeated crisis contact with health, housing and justice systems. In Tasmania, between 2012 and 2016, 70% of suicides in which a partner-related stressor was identified involved partner conflict, and 62% of those involved a history of conflict or violence involving a partner. A mental health strategy that does not treat male violence as a primary determinant — rather than a social issue adjacent to mental health — will remain structurally incomplete.[4]

AAWAA also notes a specific concern about data integrity in Tasmania. In 2025–26, Tasmania Police data showed that more than a quarter of police family violence orders were directed at women, a pattern that does not align with the broader evidence that family violence is predominantly perpetrated by men against women. This may reflect not only data distortion but systems abuse, including misidentification of victim-survivors through counter-allegations and incident-based policing practices, with some male perpetrators becoming more adept at using these tactics to have victim-survivors recorded as aggressors. This has direct mental health consequences for women who are disbelieved, excluded from support, separated from children or re-traumatised by the very systems meant to protect us.[5]

Perinatal mental health

Perinatal mental health is a critical and under-resourced area of women's mental health in Tasmania. Nationally, perinatal anxiety and depression affect up to one in five women during

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[2] Latest data snapshot shows Tasmania's progress in preventing violence against women and children, Our Watch, November 2025.
[3] Tasmanian 2025-26 Budget Submission, December 2024; Family and domestic violence in Australia 2025, Bankwest Curtin Economics Centre, April 2025.
[4] Family & domestic violence in Tasmania: a summary of what health datasets tell us, Primary Health Tasmania, 2021; Recorded crime - victims, 2024, ABS.
[5] Quarter of Tasmanian police family violence orders issued against women, with fears victims are being misidentified, ABC News, March 2026.

pregnancy and in the year after birth, making perinatal mental illness one of the most common complications of childbirth. Suicide is one of the leading causes of maternal death in Australia; when late maternal deaths are included it is the leading cause, and mental illness is now recognised as a major contributor to maternal mortality. Recent research from Queensland shows that the prevalence of suicidality in pregnant women and new mothers is almost twice as high as previously estimated, underscoring the scale of unmet need. Yet continuity of care between maternity services, primary care and mental health services remains weak nationally and in Tasmania, with clinicians calling for more systematic screening and follow-up.[6]

There is currently no dedicated public mother and baby unit (MBU) in Tasmania, despite national clinical guidance recommending that, where it is safe, mothers and babies should be treated together in specialist perinatal mental health settings. Tasmania is the only state without a public residential mother–baby mental health service following the closure of the St Helen's private MBU, and general practitioners have called explicitly for standalone MBUs in Hobart and Launceston. Evidence from Queensland and other jurisdictions indicates that access to specialist perinatal mental health services, including MBUs, can be life-saving, and that the absence of such services has been identified in coronial and clinical reviews as a contributing factor in maternal deaths. Tasmania cannot credibly claim to address women's mental health while the perinatal period — a period of heightened acute risk for many women — remains inadequately served.[7]

The mental health consequences of mother–child separation also require explicit strategic recognition. Whether arising from child protection proceedings, custody arrangements or incarceration, separation from their children is a profound driver of maternal distress and has been linked to elevated risks of self-harm and suicide among affected women. International human rights standards under the Convention on the Rights of the Child emphasise that mothers and children should not be separated except in rare and extreme circumstances, and call for provision for children to remain with their mothers where they are detained, where this is consistent with the child's best interests. A perinatal mental health strategy that ignores the harms of unnecessary mother–child separation will fail to protect the women and babies at greatest risk.

Girls, young women, and the harms of online culture

Girls and young women are experiencing a significant deterioration in mental health that is directly linked to identifiable social and cultural pressures. Nationally, more than one in four females (27.9%) aged 16–24 years have self-harmed in their lifetime, and 8.7% had self-harmed in the previous 12 months. In the same age group, girls experience substantially higher rates of mental disorders and self-harm than boys, with 24.6% of young women experiencing a mental disorder in the previous 12 months compared with 18.3% of young men. Eating disorders carry among the highest mortality rates of all mental health conditions,

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[6] Suicide prevention in expectant and new mothers, Life In Mind, March 2024; Public Submission into Reproductive, Maternal and Paediatric health services in Tasmania, Centre of Perinatal Excellence (COPE), January 2024; Study shows high rates of suicide crisis in pregnant women and new mothers, Queensland Centre for Mental Health Research, June 2022.

[7] Suicide prevention in expectant and new mothers, Life In Mind, March 2024.

and suicide accounts for approximately two-thirds of all non-natural deaths in individuals with anorexia nervosa and all non-natural deaths in individuals with bulimia nervosa and binge eating disorder.[8]

AAWAA's submission to the UN OHCHR identified social media algorithms and pornography as significant contributors to girls' mental distress, normalising unhealthy body image standards and contributing to eating disorders, suicidal ideation and gender distress. Women with eating disorders are approximately seven times more likely to attempt suicide than women without eating disorders, underscoring the severity of this distress. These harms are structural and socially produced; they require policy responses that address root causes rather than focusing only on endpoint symptoms.[9]

Gender distress among girls and young women also requires careful, evidence-based attention. Referrals to youth gender clinics, in Australia and comparable countries, have shifted over the past decade from being predominantly male to being female-dominated. AAWAA is concerned that some policy settings — including the misapplication of conversion therapy bans to exploratory psychological services — create pressure to move rapidly towards particular pathways, when the emerging international evidence strongly supports careful, individualised psychological assessment. A growing number of national health authorities, including in Finland, Sweden, Norway and the United Kingdom, now recommend cautious, exploratory psychosocial interventions and regard medical interventions for minors as experimental or restricted to tightly controlled circumstances, following systematic evidence reviews. Girls and young women presenting with gender distress frequently have co-occurring conditions including autism, depression, anxiety, trauma and internalised homophobia, and deserve access to a full range of therapeutic options, including respectful, exploratory psychotherapy.[10]

Women in prisons and closed settings

The mental health needs of women in Tasmanian prisons and custodial settings are poorly served and have received insufficient strategic attention. Nationally, more than half of people entering prison (51%) report a previous diagnosis of a mental health disorder, and around one in five report a history of self-harm, with many more likely to be undiagnosed. People in prison are two to three times as likely as those in the general community to have a mental illness and up to 10–15 times more likely to have a psychotic disorder. Women in prison carry disproportionately high rates of mental health conditions relative to the general population, and most have histories of male violence and trauma that drive their distress.[11]

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[8] Self-harm and disordered eating among adolescents, Black Dog Institute; National Study of Mental Health and Wellbeing, 2020-2022, ABS summary statistics, October 2023; Eating disorders and negative body image: Suicide and suicide prevention, Butterfly Foundation, May 2021.

[9] Eating disorders and negative body image: Suicide and suicide prevention, Butterfly Foundation, May 2021.

[10] See Time trends in referrals to child and adolescent gender identity services: A study in four Nordic countries and in the UK, *Nordic Journal of Psychiatry*, 2019; Swedish transgender treatment guidelines for youth, SEGM, 2022; Finland looks reasonable on gender transition for minors, Family Research Council, 2021; Mental health of youth with autism spectrum disorder and gender dysphoria, *Pediatrics*, 2023.

[11] Inquiry into Tasmanian adult imprisonment and youth detention matter, Tasmanian Health Service, March 2023; Just Support Project Report, Women's Health Tasmania, March 2023.

The Tasmanian Custodial Inspector's 2023 Adult Health Care Inspection Report found that mental health input to the Mary Hutchinson Women's Prison "may require review" and recommended an audit of need, noting staff concerns that the Crisis Support Unit has "insufficient cells for the current mental health needs" of the prison and needs to be made more therapeutic. Subsequent commentary from the Custodial Inspector, the Mental Health Council of Tasmania and AMA Tasmania has highlighted chronic under-resourcing, with prison mental health services operating at less than a quarter of recommended staffing levels and many inspection recommendations still not implemented. Independent experts have warned that Tasmania's prison mental health services lag behind best practice in other Australian jurisdictions and fall short of international standards such as the Nelson Mandela Rules.[12]

AAWAA submits that the mental health strategy must address women in custody as a distinct priority population, including through clear commitment to female-only therapeutic environments where clinically indicated, substantial improvements in the resourcing and governance of prison mental health services, and minimisation of unnecessary mother–child separation in custodial settings.

Older women

Older women are largely absent from mental health policy frameworks in Tasmania and nationally, despite facing compounded and intersecting vulnerabilities. The 2021 National Elder Abuse Prevalence Study found that one in six older Australians (15%) living in the community experienced elder abuse in the preceding year. Women retire with significantly less superannuation than men and face markedly higher rates of poverty in old age; women over 55 are the fastest-growing group of homeless people in Australia, and between 2016 and 2021 the rate of homelessness for females increased while the rate for males decreased.[13]

AAWAA's April 2026 submission to the UN Special Rapporteur on Violence Against Women and Girls documented that older women's mental distress is produced by structural conditions — poverty, financial abuse, institutional neglect, administrative failures, and the continuation of long-term intimate partner violence in old age — that policy systematically fails to name or address. For many older women, abuse and neglect in aged-care and home-care settings are direct contributors to psychological harm, yet key systems such as aged care and pension administration still do not systematically collect and report sex-disaggregated data on service quality, safety or outcomes, making these harms effectively invisible in official monitoring.[14]

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[12] Adult Health Care Inspection Report 2023, Office of the Custodial Inspector, Tasmania, 2023; Inquiry into Tasmanian adult imprisonment and youth detention matter, Tasmanian Health Service, March 2023; Just Support Project Report, Women's Health Tasmania, March 2023.

[13] National Report Card 2024, National Mental Health Commission; Older women: the forgotten cohort in Australia's male violence response, AAWAA, April 2026.

[14] Older women: the forgotten cohort in Australia's male violence response, AAWAA, April 2026.

The erosion of female-only services

Female-only services are not a historical arrangement to be rationalised away. They are a clinical and ethical necessity for a significant population of women whose capacity to engage with mental health care depends on the safety and privacy of female-only environments. Research and survivor testimony demonstrate that trauma-informed, female-only services are essential to effective recovery for many women who have experienced male sexual violence, offering a safe environment free from further distress and allowing women to lower their vigilance and engage in treatment.

In Australia, AAWAA has documented a pattern in which female-only medical and legal services have become increasingly difficult to access and sustain, as policies prioritising gender identity over biological sex have led services to repurpose themselves as general rather than female-only services to avoid perceived legal and funding risks. This shift is likely to have disproportionately harmed economically vulnerable and migrant women, who are most reliant on low-cost, accessible women-only services. Tasmania's strategy should affirm that female-only services are lawful, clinically justified and necessary, and should protect and fund them accordingly.

Law reform work in Tasmania has already highlighted the importance of a 'gender safety principle', acknowledging that people receiving mental health services "may have specific safety needs or concerns based on their gender" and that services must be safe and responsive to family violence and trauma. The mental health strategy should build on this recognition by embedding gender-safety principles in policy and practice, not undermining them.[15]

PART IV: SYSTEM FAILURES: WHAT THE STRATEGY MUST CORRECT

The absence of sex-disaggregated data

The absence of robust, publicly reported sex-disaggregated mental health data is one of the most serious structural failures in Australian mental health policy, and it is directly relevant to Tasmania. Without sex-disaggregated data, policymakers cannot identify which women are being harmed, by whom, and in what settings; cannot assess whether services are reaching women equitably; and cannot hold the system to account.

AAWAA has raised this concern at the UN level. In our submission to the OHCHR, we noted that allowing sex self-declaration in crime and service data produces measurable distortion of statistics, with ABS data showing an increase in recorded 'female' offenders for sexual assault and related offences following the introduction of sex self-identification laws in some jurisdictions. Since women commit a very small proportion of violent and sexual offences, even small changes in recording can have statistically significant effects, a problem that UN experts have already identified in other countries.[16] The evidentiary foundation for policy on male violence against women is being corrupted at the point of collection.

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[15] Law Reform Institute, Tasmania, September 2023.

[16] 97 per cent of sexual assault offenders are male, ABS, 2022; A/HRC/59/47: Sex-based violence against women and girls: new frontiers and emerging issues, OHCHR, June 2025.

Tasmania should require mandatory sex-disaggregated data collection, analysis and public reporting across all major mental health domains, including: service access; compulsory treatment and seclusion and restraint; suicide and self-harm; eating disorders; perinatal mental health; forensic pathways; and violence-related presentations. Sex recorded at birth should remain the core planning and safeguarding category, with gender identity recorded, where needed, as a separate variable rather than a replacement for sex.

The 'lived experience' governance problem

The discussion paper places significant emphasis on lived experience as a framework for strategy development and governance. AAWAA supports meaningful participation by women who use mental health services; however, 'lived experience' frameworks, when used as the primary or dominant governance mechanism, can function to elevate individual testimony at the expense of objective, material, structural analysis.

When strategies lean too heavily on curated lived experience, governance can slide into a contest of personal testimonies, with accounts that challenge prevailing policy frameworks more likely to be sidelined. Tasmania should ground its mental health strategy in objective, material analysis of the structural conditions that drive women's and girls' distress — including the sex-based patterning of male violence, economic insecurity and institutional harm — and then use women's experiences to test and refine, rather than replace, that structural analysis.

In particular, AAWAA is concerned that some policy environments selectively include in consultation and governance processes only those organisations whose positions align with prevailing frameworks, while excluding women's organisations that advocate for sex-based protections and rights. Tasmania must not reproduce this pattern. Advisory, implementation and review processes should explicitly include sex-based women's organisations and permit rights-based disagreement to be examined openly and respectfully.

Policy settings that weaken female-only services

AAWAA is concerned by national and state policy trends in which female-only services are diluted, administratively discouraged, or redefined under generic frameworks. Tasmania's *Births, Deaths and Marriages Registration Act 1999*, as amended to allow sex self-identification, creates legal ambiguity about the basis on which services described as "women's services" may be constituted. WAAT has previously written to the Tasmanian Attorney-General urging the government to review the real-world impacts of sex self-identification laws on women and girls in the state.[17]

PART V: INTERNATIONAL HUMAN RIGHTS FRAMEWORK

Tasmania's mental health strategy sits within Australia's obligations under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the International Covenant on Economic, Social and Cultural Rights (ICESCR). CEDAW requires Australia to eliminate discrimination against

[17] Tasmanian women call for review of sex self-ID laws, WAAT, July 2025.

women in the field of health care and to ensure access to health care services on a basis of equality. CEDAW General Recommendation No. 24 makes clear that this obligation extends to mental health and to the structural conditions that cause women's mental distress, including male violence, poverty and institutional neglect.

CEDAW General Recommendation No. 27 recognises that discrimination experienced across a woman's lifetime has a severe and compounded impact in old age, establishing a specific obligation to protect older women from abuse, neglect and the mental health consequences of structural disadvantage.

The WHO's own framework acknowledges that human rights violations, including violence and discrimination, are significant contributors to adverse mental health outcomes. A strategy that does not address these conditions is not merely inadequate, it falls short of Australia's human rights obligations.

AAWAA urges Tasmania to use 'Rethink and Beyond' to demonstrate that a state government can build a mental health strategy grounded in material reality, honest data, and genuine commitment to the safety and wellbeing of women and girls. The submissions provided by AAWAA's member organisations — WAAT, QWAA, NSWWAA and WAWAA — each contribute dimensions of this analysis. This AAWAA submission offers the synthesising national and international framework within which those contributions should be understood.

PART VI: RECOMMENDATIONS

AAWAA recommends that Tasmania's next mental health strategy include the following commitments.

Priority 1: Name women and girls as a priority population

The strategy should explicitly identify women and girls as a priority population and include a dedicated women's and girls' mental health action area, supported by measurable targets, implementation timelines and public reporting obligations. Without this structural commitment, women's needs will continue to be subsumed within generic, sex-neutral frameworks that obscure sex-specific patterns of harm.

Priority 2: Recognise male violence as a central mental health determinant

The strategy should explicitly name male domestic abuse, sexual violence, coercive control, childhood abuse and institutional abuse as central drivers of women's mental distress. Practical commitments should include:

- Routine, safe screening for violence exposure across mental health settings
- Formal, funded referral pathways between mental health services and specialist domestic and sexual violence services
- Workforce capability requirements on trauma and the sex-based patterning of male violence
- Service planning that acknowledges mixed-sex settings as potential barriers to care for women with histories of male violence

Priority 3: Protect and fund female-only service options
The strategy should affirm that female-only inpatient, crisis, residential, community, forensic and custodial services are lawful, clinically justified and necessary for a significant proportion of women who have survived male violence. It should commit to:

- Funding female-only pathways across community mental health, crisis support, step-up/step-down and sub-acute care
- Ensuring access to female-only accommodation, programs or streams where clinically indicated in inpatient and custodial settings
- Requiring transparency in the constitution of services described as 'women's services'

Priority 4: Mandate sex-disaggregated data
The strategy should require sex-disaggregated data collection, analysis and public reporting across all major mental health domains. Sex recorded at birth should be preserved as the core planning and safeguarding category, with any gender-identity information collected, where relevant, as a separate variable. The strategy should also commit to a regular, publicly available monitoring report on outcomes specifically for women and girls.

Priority 5: Develop a specific agenda for girls and young women
The strategy should include a targeted agenda for girls and young women that addresses:

- Eating disorders, self-harm, suicidality and body-image distress, including the role of social media and pornography
- Online harms and sexual exploitation
- Gender distress, with explicit commitment to evidence-based psychological assessment and exploratory therapy, and exclusion of professional psychological services from any conversion-therapy provisions that would restrict such care

Priority 6: Strengthen perinatal and maternal mental health
The strategy should include explicit commitments to:

- Routine universal screening for all expectant and new mothers at multiple time points, consistent with national COPE guidelines
- Continuity of care between maternity services, primary care and community mental health
- Commitment to publicly funded mother and baby units, including through advocacy to the Commonwealth
- Recognition of the mental health impact of mother–child separation in child-protection and custodial settings

Priority 7: Establish older women as a distinct priority group
The strategy should explicitly include older women as a priority population, addressing:

- Financial abuse, institutional abuse and neglect in aged care as mental-health drivers
- The intersection of housing insecurity, poverty and mental distress in older women
- The absence of sex-disaggregated data in aged care and pension administration

Priority 8: Reform prison mental health services for women
The strategy should address the mental-health needs of women in Tasmanian prisons as a specific, under-resourced priority, including:

- Dedicated review of mental-health resourcing at the Mary Hutchinson Women's Prison
- Female-only therapeutic environments and programs in custodial settings
- Minimisation of unnecessary mother–child separation, consistent with the Convention on the Rights of the Child and best practice in custodial health care

Priority 9: Ensure sex-based women's organisations are included in governance
The strategy should establish advisory, implementation and review structures that explicitly include sex-based women's organisations advocating for sex-based protections and rights. AAWAA and its member organisations, including WAAT, are available to contribute to structured engagements including stakeholder roundtables, expert consultations and review processes.

CONCLUDING REMARKS
Tasmania's next mental health strategy will only succeed for women and girls if it is informed by organisations with deep, women's sex-based expertise in the structural drivers of distress. AAWAA and WAAT together bring both national and Tasmanian experience in mental health, violence against women and girls, and human rights engagement at UN and domestic levels. We therefore urge the Tasmanian Government to ensure that both AAWAA and WAAT are invited to participate in any stakeholder roundtables, expert workshops and ongoing governance forums established for 'Rethink and Beyond', so that Tasmanian policy can draw on both local and national analysis of what is needed to keep women and girls safe and well.

ANNEX. Selected recent engagements, AAWAA

AAWAA member organisations have contributed constructively to complex law and policy reform processes at state, national and international level. Relevant recent engagements include:

- UN OHCHR call for contributions: comprehensive report on mental health and human rights, October 2024
- NSW Mental Health and Wellbeing Strategy consultation, August 2025
- Australian Law Reform Commission review of surrogacy laws, roundtable, December 2025
- Australian Human Rights Commission, Sydney meeting in relation to its statutory obligations in protecting women's rights, February 2026
- UN Special Rapporteur on Violence Against Women and Girls: submission on violence against older women, April 2026
- NSW Department of Communities and Justice roundtable on the statutory review of sexual-consent reforms, April 2026
- NSW Legislative Council Select Committee on fertility and assisted reproductive technology, hearing evidence, April 2026
- Senator David Pocock, consultation on the Federal Government's Combatting Antisemitism, Hate and Extremism Bill 2026, roundtable, January 2026

See womensadvocacy.net for a fuller record of our advocacy work.