Australian Government | DFSV COMMISSION

Committee Secretary
House of Representatives Standing Committee on Social Policy and Legal Affairs
PO Box 6021
Parliament House
Canberra ACT 2600

6 February 2026

Inquiry into the relationship between domestic, family and sexual violence and suicide

Dear Standing Committee on Social Policy and Legal Affairs

The Domestic, Family and Sexual Violence Commission (Commission) welcomes the opportunity to provide a submission to the Standing Committee on Social Policy and Legal Affairs (Standing Committee) Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide.

Critical to addressing the harm caused by DFSV is building a clearer understanding of how it intersects with mental health, wellbeing, and suicidality. The Commission's Y*early Report to Parliament 2025* (Yearly Report) highlighted the efforts of lived experience advocates and services to raise awareness of this issue.

The enclosed submission outlines current evidence on the relationship between DFSV and suicide, highlighting potential opportunities to enhance data collection, strengthen system responses, and integrate prevention and early intervention efforts across justice, health, and specialist DFSV services. Preventing and responding to DFSV and suicide requires collaboration between a range of sectors and portfolios, such as housing and social security.

The Commission reiterates its commitment to assist the Standing Committee in seeking insights from people with lived and living experience. We look forward to working with the Standing Committee to facilitate this process.

Through this Inquiry, the Standing Committee will make a significant contribution to informing the resources, interventions, and healing supports required to end gender-based violence.

Yours sincerely,

[redacted]

Micaela Cronin

Commissioner

Domestic, Family, and Sexual Violence Commission

Australian Government | DFSV COMMISSION

Inquiry into the relationship between domestic, family and sexual violence and suicide

Submission to the Standing Committee on Social Policy and Legal Affairs

Executive Summary

The Domestic, Family and Sexual Violence Commission (Commission) welcomes the Standing Committee on Social Policy and Legal Affairs (Standing Committee) Inquiry into the relationship between domestic, family, and sexual violence (DFSV) and suicide (Inquiry).

The Commission was established to promote and support the achievement of the *National Plan to End Violence against Women and Children 2022-2032* (National Plan).[1] The Commission recognises the critical importance of building a clearer understanding of the intersection between DFSV and suicidality.[2]

This submission provides responses to each of the Inquiry Terms of Reference, with key themes summarised below.

1. **Relationship between DFSV and suicide:** While the evidence makes clear that there is a connection between DFSV and suicide, gaps in data consistency, reporting practices, and cross-sector coordination limit our understanding of its nature and scale. In addition to strong alignment between policy frameworks, exposure to violence and abuse is a common experience for people also disproportionately represented in suicide and self-harm data. This reinforces the need to build workforce and system capability to respond to both issues.
2. **Opportunities for improved reporting:** There is no nationally consistent data on domestic and family violence (DFV) deaths by suicide. Data quality could be strengthened by coordination, linkage, and increased visibility of the experiences of priority populations. Both coronial investigations and the Australian DFV Death Review program present potential pathways to deepen our understanding of the link between DFSV and suicide.
3. **Responding to suicide in the context of DFSV:** There is a need to improve capability to recognise and respond to DFSV and suicidal distress across specialist services, the health system, and in legal and justice settings. This can be achieved through improved cross-sectoral collaboration, aligned risk assessment tools and safety plans, and increased investment in trauma-informed, culturally safe, and accessible services that support long-term recovery. Shared responsibility for risk identification is essential given the size of these workforces and the likelihood of receiving disclosures.
4. **Suicide as a tactic of coercive control:** Responses must take suicide risk seriously while at the same time maintaining focus on safety for those impacted by coercive control and violence and accountability for use of violence. Clear practitioner guidance and training can assist safe, consistent responses.
5. **Prevention and early intervention:** Preventing suicide in the context of DFSV requires coordinated prevention and early intervention efforts that operate across both the DFSV and mental health systems. Early identification of violence, safe disclosure environments, and accessible supports are critical to prevention.

The submission reinforces a need for coordinated, evidence-based action to strengthen data sources and build capability to prevent and respond to DFSV and suicide risk across sectors. Action must be

meaningfully guided by people with lived and living experience, reflecting diverse backgrounds and intersecting identities.

Introduction

The Commission is an Executive Agency established under the *Public Service Act 1999* (Cth) to support implementation and monitoring of the National Plan. Its functions include monitoring progress, providing strategic advice, supporting coordination across governments and sectors, and amplifying lived and living experience in policy and system design.

This submission draws on research, stakeholder perspectives, and lived experience insights. It provides a national systems perspective to assist the Standing Committee in identifying areas of focus for the Inquiry.

The Commission acknowledges that suicide is a complex issue influenced by multiple factors. DFSV is one of these factors. Strengthening how systems recognise and respond to this intersection is a step toward improved safety and wellbeing outcomes.

About the Commission

The Commission is an independent, accountable, and transparent agency that maintains a national focus on ending gender-based violence. The Commission is focused on practical and meaningful ways to measure progress towards the objectives outlined in the National Plan.[3]

This submission is informed by the Commission's main objectives:

(1) Promoting National Plan objectives to end gender-based violence and monitoring impact.
(2) Amplifying voices of people with lived and living experience for meaningful engagement in shaping policy design and service delivery.
(3) Fostering collaboration and coordination across government and communities to enhance connection and reduce fragmentation to improve outcomes.
(4) Providing strategic advice to inform strengthened policy and practice, and improved outcomes.[4]

1. Relationship between DFSV and suicide

> **Term of Reference 1:** The relationship between domestic, family and sexual violence (DFSV) victimisation, and suicide, and the extent to which DFSV victimisation contributes to suicide risk and incidence in Australia, including prevalence, patterns, and any identifiable at-risk groups, in order to improve understanding of the role of DFSV in suicides nationally.

There is already sufficient evidence to establish that DFSV is a significant and under-recognised contributor to suicidal distress and suicide in Australia. The key challenge is the limited visibility of this relationship in national data, policy design, and service system responses.

This section outlines the Commission's assessment of the relationship between DFSV and suicide, drawing on available evidence, lived and living experience engagement, and the Commission's role in monitoring the implementation of the National Plan. It highlights the implications of this relationship for policy coherence, service system design, and prevention efforts.

The Commission is concerned that suicide linked to DFSV is often framed as an individual mental health outcome rather than as a foreseeable consequence of prolonged exposure to violence, coercive control,

and trauma. This approach risks obscuring systemic responsibility and limits opportunities for prevention across government.

This submission identifies areas of strategic alignment between the National Plan and the *National Suicide Prevention Strategy 2025-2035* (National Suicide Prevention Strategy),[5] and notes that priority populations under the National Plan are also overrepresented in their experiences of suicide.

1.1. Framing the issue

National Cabinet has identified addressing gender-based violence as a national priority, including a specific focus on the recommendations made by the Rapid Review of Prevention Approaches.[6]

From the Commission's perspective, the relationship between DFSV and suicide must be understood within a broader social context. Population-level data illustrates the prevalence of DFSV across the Australian community.

According to the Australian Bureau of Statistics (ABS) Personal Safety Survey (PSS) 2021-2022:

- One in four women (27%) and one in eight men (12%) have experienced violence by an intimate partner or family member since the age of 15.[7]
- One in five women (22%) and one in 16 men (6.1%) have experienced sexual violence since the age of 15.[8]
- One in six women (18%) and one in nine men (11%) have experienced childhood abuse before the age of 15.[9]
- Fourteen percent of people aged 18 years and over experienced physical and/or sexual abuse by an adult before the age of 15.[10]

While anyone can be impacted by violence, research by Australia's National Research Organisation for Women's Safety (ANROWS) shows that women are around three times more likely than men to experience sexual violence and intimate partner violence.[11] Most violence is perpetrated by men.[12]

DFSV can have serious and long-term impacts, including on mental health.[13] The Commission recognises that mental ill-health and DFSV are, in many cases, deeply interconnected. However, treating mental ill-health as a primary explanation for suicide risk without addressing ongoing or past experiences of violence risks overlooking the full context in which suicidal distress emerges, and therefore misses opportunities for intervention.

1.1.1. Evidence of the relationship

Lived and living experience advocates and services have repeatedly highlighted a strong connection between experiences of DFSV and suicidal distress. This aligns with the Commission's engagement with people who have experienced violence and their families, who frequently describe suicidality as emerging after prolonged exposure to violence, systems abuse, or failures to receive protection and support.

A growing body of evidence supports this connection, including findings that:

- Relationship conflict, separation and intimate partner violence are commonly identified psychosocial risk factors in deaths by suicide;[14]
- Intimate partner violence and childhood abuse contribute substantially to years of life lost due to suicide and self-inflicted injury, particularly for women;[15] and
- Violence and abuse are often present in the histories of people who die by suicide, including children and young people.[16]

While the Commission acknowledges limitations in existing datasets, the consistency of findings across studies, jurisdictions, and population groups is striking. From a system-level perspective, this convergence of evidence points to an opportunity to better integrate DFSV prevention and response into suicide prevention efforts.

Importantly, suicide data rarely captures the full context or history of violence experienced by an individual. As a result, DFSV is likely to be under-represented as a contributing factor in suicide statistics, reinforcing its invisibility in policy and funding decisions.

The Commission recognises the complexity of suicide, including the interaction of individual, relational, and structural factors. However, this complexity should not prevent action in response to preventable drivers of harm.

National data shows distinct gendered patterns: men are more likely to die by suicide, while women are more likely to experience hospitalisation for self-harm.[17] The Commission notes that these patterns intersect with gendered experiences of violence, help-seeking, and systems response.

Victorian and Western Australian research has identified the presence of family violence in a significant proportion of suicides.[18] For the Commission, these findings reinforce concerns that DFSV is often not identified as a contributing factor in suicide, including after death, and is not consistently integrated into service responses.

Addressing the harm caused by DFSV requires a clearer understanding of how it intersects with mental health, wellbeing, and suicidality. The Commission identified significant gaps in our understanding of the full impact of DFSV on mortality in its *Yearly Report to Parliament 2025* (Yearly Report).[19] It highlighted the need for a stronger evidence base regarding the role played by DFSV in suicides in Australia.[20]

1.2. National policy frameworks

A range of national policy frameworks are relevant to the government and sector responses to DFSV and suicide. Understanding these frameworks and points of intersection is critical to identifying opportunities to strengthen prevention, early intervention, service responses, data systems, and recovery supports.

This section briefly summarises two policy frameworks – the National Plan and the National Suicide Prevention Strategy – to identify key areas of alignment between them. It is not intended to provide a detailed overview of all relevant policy frameworks.

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

The National Plan is Australia's primary policy framework for preventing and responding to DFSV. It is a ten-year coordinated strategy developed collaboratively by the federal, state, and territory governments.[21] The National Plan is structured around four integrally connected domains:

- **Prevention:** Stopping violence before it starts;
- **Early intervention:** Stopping violence escalating and preventing it from reoccurring;
- **Response:** Efforts and programs to address existing violence; and
- **Recovery and healing:** Helping to break the cycle of violence and reduce the risk of re-traumatisation.[22]

While its focus is DFSV, the National Plan explicitly acknowledges the broader, long-term impact of violence on health, mental wellbeing, and relationships, as well as the need for trauma-informed support across health, mental health, and community services.[23]

There are additional policy frameworks relevant to the Standing Committee's consideration of this Inquiry. The *National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence* ("*Our Ways – Strong Ways – Our Voices*") will soon be launched.[24] The National Agreement on Closing the Gap commits to reducing all forms of family violence and abuse against Aboriginal and Torres Strait Islander women and children by at least 50%, as progress towards zero, by 2031.[25]

1.2.2. National Suicide Prevention Strategy 2025-2035

The National Suicide Prevention Strategy, released in 2025, provides a unified framework for long-term, coordinated action to reduce suicide across Australia.[26] It aims to prevent people from reaching the point of suicidal distress, strengthen support systems for those impacted, and drive collective efforts from governments, sectors beyond health, service providers, and communities.[27]

It identifies two core priorities for suicide prevention:[28]

- **Preventing suicidal distress** by strengthening community wellbeing and supporting those struggling with factors that can lead to such distress; and
- **Supporting people experiencing suicidal thoughts and behaviours** and those who care for them.[29]

1.2.3. Areas of strategic alignment

The Commission considers there is strong alignment between the National Plan and the National Suicide Prevention Strategy, including a shared emphasis on prevention, trauma-informed practice, lived experience leadership, cross-sector collaboration, and evidence-informed decision-making. There is also significant intersection between the issues and people's lives that these policies are designed to serve. However, alignment at a strategic level does not always translate into integration in practice due to differing governance, funding, and service boundaries.

1.2.4. Priority populations

Exposure to violence and abuse is a common experience among people also disproportionately represented in suicide and self-harm data. This includes Aboriginal and Torres Strait Islander peoples, children and young people, people with disability, LGBTIQA+SB communities, and people in rural and remote areas.

Intersectionality matters. Compounding vulnerabilities can increase risk and create barriers to support, including stigma, discrimination, accessibility barriers, and mistrust of systems. Culturally safe and community-led responses are essential.

Populations identified as priorities within the National Plan [30]	**Experiences of DFSV**	**At-risk populations in the National Suicide Prevention Strategy**
Aboriginal and Torres Strait Islander women and children	In 2023–2024, the rate of family violence hospitalisations for First Nations females was 27 times as high as for non-Indigenous females.[31] There is limited longitudinal data on the impacts and outcomes of family	Aboriginal and Torres Strait Islander peoples are more than twice as likely to die by suicide.[35] Children and young people in out-of-home care are more likely to be

	violence on Aboriginal and Torres Strait Islander communities, especially children.[32] In 2023–2024, 20% of all female victims of intimate partner homicide were Aboriginal and/or Torres Strait Islander females.[33] As of 30 June 2024, around two in five children on care and protection orders or in out-of-home care were First Nations people.[34]	exposed to risk factors for suicidal thoughts and behaviours.[36]
Women and children living with disability	In 2016, 30% of women with disability and 11% of men with disability had experienced partner violence since the age of 15.[37]	People with disability are three times more likely to die by suicide than people without disability.[38]
Women and children from culturally diverse, migrant, and refugee backgrounds	Despite limited disaggregated data for specific groups, such as refugees, cultural groups, and specific migration visa holders, certain forms of violence are more likely to be influenced by these factors, such as visa and dowry abuse.[39]	People who enter Australia as humanitarian entrants have nearly twice the rate of suicide as other permanent migrants.[40]
Children and young people	In 2021-2022, 13% of adults had witnessed partner violence against a parent before the age of 15.[41] In 2021-2022, 14% of people aged 18 years and over have experienced physical and/or sexual abuse by an adult before the age of 15.[42]	In 2023, nearly one-third of deaths among Australians aged 15-24 years were due to suicide.[43]
LGBTIQA+SB people	In a 2024 national survey, 52% of LGBTIQA+SB participants reported experiencing sexual violence in both childhood and adulthood.[44]	LGBTIQ+ communities experience higher levels of suicidal thoughts and self-harm.[45]
Older women	The Australian Institute of Family Studies (AIFS) National Elder Abuse Prevalence Study found that 15.9% of older women living in community have experienced elder abuse in the previous year.[46]	Some of the highest rates of suicides in a single age group occur among Australian men aged 85 and older.[47]
Women and children living in rural, regional, and remote communities	In 2023-2024, rates of hospitalisation for DFV generally increased with remoteness.[48]	People living in lower socio-economic areas consistently experience higher rates of suicide.[49] Indicators of lower

		socio-economic status increase with remoteness.[50]

The Commission recommends that steps be taken to address evidence gaps in relation to:

- Children and young people – despite data indicating DFSV is a significant contributor to youth suicide we lack necessary evidence to inform policy and service design.[51] Consideration should also be given to their experiences of DFSV between adults, such as parents or carers, in the home.[52]
- Male victim-survivors of child sexual abuse.[53]
- Impacts of DFSV on the mental health of Aboriginal and Torres Strait Islander peoples.[54]
- Experiences of LGBTIQA+SB people and people with a disability in the context of suicide prevention.[55]

Some communities face additional barriers in seeking support across the service system, which both limits access to assistance and reduces the availability of data about their experiences. Barriers arise when services are not accessible or responsive to diverse needs, including limited communication supports, services that do not address migration-related concerns, a lack of age, gender or culturally appropriate options, inadequate confidentiality safeguards in remote and regional areas, and responses that reinforce stigma or mistrust shaped by discrimination.[56] Addressing barriers to disclosure is essential to encourage service-seeking and improve data on the intersection between DFSV and suicide.

2. Opportunities for improved reporting and investigation

Term of Reference 2: Opportunities for improved reporting and investigation methodologies to accurately capture and report on deaths as a result of DFSV, including the adequacy of existing data collection practices related to DFSV and suicide, and the availability, quality, and consistency of data across jurisdictions.

Recent reports highlight a lack of nationally consistent data on DFV-related deaths by suicide.[57] This Inquiry provides an opportunity to strengthen the availability, consistency, and quality of data across jurisdictions.

Overarching considerations relevant to this Term of Reference include:

- The importance of consulting with people with lived experience to identify barriers to disclosure and strategies to encourage service seeking.[58]
- The availability of specific data about the experiences of priority populations, discussed above.
- Opportunities to strengthen timely sharing of data trends and insights across sectors.[59]
- Cultural appropriateness of information gathering processes and potential concerns among priority populations about the use of data.[60]

There may also be an opportunity to consider a structured analysis of National Coronial Information System (NCIS), de-identified administrative data, and de-identified case information held across sectors to map key points at which people impacted by and using violence interact with services to identify when suicidal distress emerges or escalates and determine where earlier interventions may have reduced risk.

The Commission understands there needs to be consideration of the specific guardrails and requirements that apply to data sets such these.

2.1. National data on suicide

National suicide data is primarily derived from death registrations and coronial certification processes.[61] These systems provide valuable information but were not designed to capture DFSV context. Challenges include lack of consistency in practices across jurisdictions, distinct legislative requirements, and the time taken to complete coronial investigations.[62]

Incremental improvements may include greater consistency in recording relevant contextual information, practitioner training, and structured analysis of de-identified data where appropriate, while maintaining privacy and cultural safety.

AIHW notes that it is not possible to determine the extent or involvement of DFSV in a death by suicide using this data.[63] However, information on psychosocial risk factors – mentioned in NCIS reports and coded by the ABS – may provide some insight.[64] In 2023, "Problems in relationship with spouse or partner" was one of the most common risk factors among all age groups, present in 13.7% of deaths by suicide for males and 12.6% of suicides for females.[65] "Problems relating to legal circumstances" – including domestic violence orders and child support proceedings – accounted for 11.6% of deaths by suicide for males and 6.2% of suicides for females.[66]

There is data available at a state and territory level on DFV-related suicides. However, AIHW notes lack of consistency in the information collected and recorded on NCIS across jurisdictions, limiting its comparability.[67]

Avenues to explore with data owners include:

- Developing a shared understanding of the definition of DFSV-related suicide;
- Improving alignment between the coding practices and access arrangements applicable at a state and territory level; and
- Establishing clear governance arrangements to assign responsibility for maintaining an integrated dataset on DFSV-related suicide.

2.2. Relationship between DFSV and suicide

The Commission considers that improving visibility of DFSV in suicide reporting requires careful attention to definitions, governance, and the practical realities of information collection. Strengthening interfaces between relevant datasets and administrative systems may support earlier identification of risk patterns and improve policy targeting. This section discusses two data sources with potential to deepen understanding of the relationship between DFSV and suicide.

2.2.1. Australian Domestic and Family Violence Death Reviews

Domestic and family violence death review mechanisms provide an important pathway for learning from deaths and improving systems. The Commission considers there may be value in exploring how death review processes can support improved understanding of DFSV-related suicide, noting their current focus and remit vary across jurisdictions.

The Australian Domestic and Family Violence Death Review Network (ADFVDRN) has indicated an intention to broaden its reporting to include DFV-related suicide deaths in future.[68] This is consistent with the recommendation made by the Rapid Review of Prevention Approaches to develop a consistent approach to death review processes and build knowledge on the relationship between suicide and DFSV.[69] A key finding of the Commission's *Yearly Report to Parliament 2024* was the opportunity for the Standing Council of Attorneys-General to work on making death reviews faster, more consistent, and better-funded across the country.[70]

2.2.2. Coronial investigations

Coronial investigations can identify contextual factors associated with deaths by suicide but approaches to information gathering differ across services and jurisdictions. The Commission notes the importance of trauma-informed processes, careful management of family engagement, and culturally safe practice, particularly where DFSV may be present but not previously disclosed.

Recent research identifies coronial investigation processes as a valuable avenue to explore the relationship between DFV victimisation and suicide.[71] The research involved a background review of published Victorian coronial findings between 2014 and 2024 involving women's death by suicide where DFV victimisation was identified or suspected.[72]

The study highlighted challenges associated with identifying DFV experienced by women through coronial investigations in the Victorian context, including:

- Limited data quality, particularly in the information collected by police.[73]
- A multitude of presenting factors, reducing the visibility of the impact of DFV.[74]
- A reliance on secondary sources, potentially compounded with a reluctance among family members to put themselves in view of state systems.[75]
- A requirement to consider circumstances that are causally related or sufficiently proximate to the death, often excluding the relevance of life histories of violence.[76]
- Reliance on next of kin evidence in circumstances where they may be a perpetrator of violence.[77]

Other enabling factors identified in the Victorian study included information sharing practices between sectors; adequate resourcing; and improvements to data quality, including through police training.[78] There may also be an opportunity to strengthen the implementation and tracking of any recommendations made in coronial investigations.[79]

3. Responding to suicide in the context of DFSV

> **Term of Reference 3:** How legal and justice systems, DFSV specialist services, health, mental health and other services recognise and respond to suicide in the context of DFSV.

Identifying and responding to DFSV disclosures is a shared responsibility across the range of sectors that engage with people who have experiences of DFSV. Disclosures can happen in a variety of contexts and at different stages of help-seeking. Similarly, the impacts of DFSV, including on mental health, can be long-term, with ongoing support required. A guiding principle should be that there is no wrong door through which to seek support for DFSV and suicidal distress.[80]

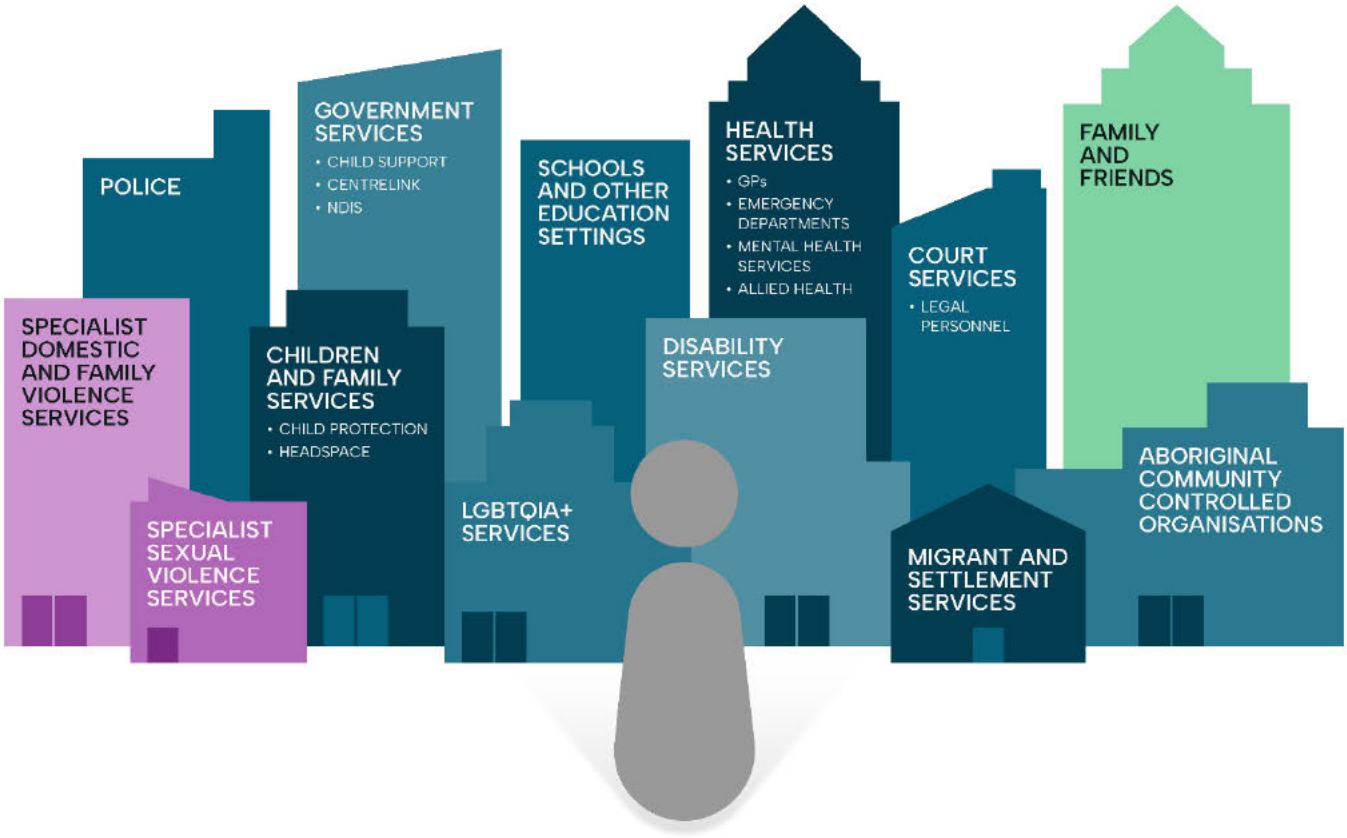

Figure 1: This infographic is intended to demonstrate the range of services accessed. Services depicted are not shown to workforce scale and do not represent relative size or capacity.

There are more than 169,500 Allied health workers and over 81,848 police workers, compared to fewer than 9,000 specialist DFSV workers.[81] This disparity makes clear that the specialist DFSV sector cannot meet demand alone.

The ABS PSS 2021-2022 estimated that one in five women who experienced violence from a current partner sought advice or support from a GP or other health professional.[82] Elevated risk can arise in health settings and during legal system interactions.[83] The size of these workforces and likelihood of receiving disclosures reinforce the importance of shared responsibility for DFSV risk assessment.

Service co-location is an established approach to improving coordinated responses. Such approaches are consistent with the *First Action Plan 2023-2027* (First Action Plan) priority to build service and system capacity to provide trauma-informed, connected, and coordinated responses to DFSV that support long-term recovery, health, and wellbeing.[84]

Examples of co-location models include:

- In South Australia (SA), the Southern Domestic Violence Prevention and Recovery Hub, which includes co-located services from Cedar Health and Yarrow Place, a sexual assault service, provides wraparound support including counselling, risk assessment and safety planning, medical care, legal advice, and tailored recovery programs.[85]
- The WA Family and Domestic Violence Response Team (FDVRT) model is a partnership between the Department of Communities, WA Police Force and DFV sector, which aims to take a

collaborative approach focused on timely and early intervention following a police call out to a DFV incident.[86] In most regions, the team is co-located.[87]

- The Victorian Orange Door network brings together multiple services, including risk and needs assessments, safety planning, and crisis support.[88] The network can also connect people to other forms of ongoing safety and wellbeing support.[89]
- In Tasmania, the Safe at Home initiative provides integrated criminal justice responses to DFV through a partnership between six government departments.[90]

Developing an effective service response requires meaningful consultation with people with lived and living experience from diverse backgrounds, including Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, LGBTQIA+SB people, children and young people, and people with disability.

3.1. DFSV specialist services

Specialist DFSV services provide critical crisis and recovery support. The Commission considers that recognising and responding to suicidal distress within DFSV practice is critically important, including through clear guidance on roles, referral pathways, and safety planning.

DFSV specialist services provide a range of supports including:

- DFV crisis support, including perpetrator services;
- Sexual violence services;
- Helplines and online services; and
- DFV legal services.[91]

Telephone helplines also provide an important entry point into the DFSV service system.[92] 1800RESPECT is Australia's national counselling, information, and support service for people affected by or at risk of DFSV, their family and friends, and frontline workers.[93] In 2023-2024, there were more than 294,000 contacts (over telephone, web chat, SMS, and video) answered by 1800RESPECT.[94]

3.1.1. Strengthening capability

Workforce capability can be strengthened through training, practice guidance, and tools that support practitioners to recognise intersecting risk, respond safely, and connect people to appropriate supports.[95] This includes capability in mainstream services where disclosures are common.

Guidance on recognising and responding to suicide risk can be embedded into existing DFV risk and wellbeing assessment processes. For example, in 2026, the Victorian Government will release practice guidance and tools including specific content on identifying and responding to children and young people's suicide risk.[96] Recent Victorian research emphasised a need to consider the cumulative impact of coercive control, intersecting vulnerabilities, and trauma on suicide risk.[97]

Where people who are using violence disclose suicidal thoughts, we know that there is an increased likelihood of serious harm in the context of intimate partner violence by men against women.[98] Work is underway to develop new national best practice risk assessment principles and a model risk assessment framework (see also Section 4).[99]

3.1.2. Strengthening the service system

System strengthening requires adequate resourcing, trauma-informed and culturally safe service models, and accessible pathways for priority populations. Integrated and co-located models may improve coordination but require ongoing evaluation to ensure they deliver safe outcomes.

Opportunities include:

- Investing in trauma-informed, culturally safe, and accessible services that support long-term recovery and provide wraparound support for people impacted by DFSV who are at risk of suicide.[100]
- Empowering Aboriginal Community-Controlled Organisations (ACCOs) to develop culturally appropriate responses by providing long-term, flexible investment.[101]
- Addressing gaps in system responses, particularly in relation to children and young people who have experienced DFSV and are at risk of suicide.[102]

Rigorous evaluation of service models and interventions, and sharing learnings from these evaluations, is also essential.[103] The Commission is working with ANROWS to develop a set of best practice evaluation principles to guide the evaluation of DFSV programs. This resource will be released in 2026.[104]

3.2. Other sectors

Many disclosures of DFSV and suicidality occur in mainstream settings, including health services, policing, education, and social support systems. A 'no wrong door' approach has repeatedly been identified as important, so people do not need to navigate separate systems for safety and mental health.

3.2.1. Health and mental health sector

Health services are a common point of disclosure for people who experience violence and are also key settings for early identification of suicidal distress.[105] In 2015-2016, the health system costs associated with treating the impacts of violence against women were estimated to be at least $1.4 billion.[106] Strengthening screening, referral pathways, and integrated care models can support safer, earlier intervention.

Strategies to strengthen the health response to DFSV include:

- Training to assist practitioners in recognising the signs of DFSV and considering the associated suicide risk;[107] and
- Integrated support pathways to ensure holistic wraparound support for people impacted by DFSV and experiencing suicidal distress.[108]

3.2.2. Legal and justice system

Engagement with legal and justice processes can coincide with elevated risk periods (including separation and court proceedings). Trauma-informed practice, safe information sharing, and appropriate supports during these interactions can reduce harm and improve outcomes.

The legal and justice system can contribute to accountability for people who use violence.[109] However, the system can also contribute to distress. The Commission often hears from people with lived and living experience of DFSV about the impact of legal and justice systems. The Australian Law Reform Commission (ALRC) report on justice responses to sexual violence noted stakeholder feedback that negative experiences of reporting may lead to re-traumatisation, mental health issues, self-harm, and suicide.[110] It

also observed the detrimental impact of delays in justice responses, given the stress associated with waiting for proceedings.[111]

Experiences of discrimination – both historical and ongoing – may also impact on how people engage with legal and justice systems.[112] Concerns with legal system responses to DFSV have prompted some Aboriginal and Torres Strait Islander groups to advocate for alternative approaches that centre family and community healing and holistic support, while also holding people who use violence accountable.[113]

Legal proceedings can also coincide with contexts of elevated risk. Both relationship separation and the release of perpetrators from prison may present contexts of heightened risk for suicidality among people impacted by DFSV.[114] Responses in legal and justice settings could consider ensuring that mental health support available at critical junctures and throughout engagement with the legal and justice system is cognisant of both DFSV and suicide risk.

DFV is the largest single demand on police services.[115] Police are primary responders to both DFSV and mental health crises and therefore play an important role in providing immediate support and determining appropriate referral pathways.[116] The Commission has also heard about the value of integrated police and mental health clinician responses to mental health crises to facilitate referral and assist in de-escalation.[117]

4. Suicide as a tactic of coercive control

Term of Reference 4: The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFSV.

Responses must take suicide risk seriously while at the same time maintaining focus on safety for those impacted by coercive control and violence and accountability for use of violence. Clear practitioner guidance and training can assist safe, consistent responses.

While approaches vary across jurisdictions, there is a clear trajectory toward legislative reform regarding coercive control that encompasses both criminal law amendments and enhanced civil protection measures:[118]

- New South Wales (NSW), Queensland, and SA have legislated coercive control as a standalone criminal offence.[119]
- The Australian Capital Territory (ACT) has indicated an intention to introduce legislation this year to commence the process of criminalising coercive control.[120]
- The Victorian Government has committed to introducing a standalone coercive control offence in 2026.[121]
- The WA Government has indicated it will take a "phased approach to criminalisation."[122]
- The Northern Territory (NT) includes a definition of coercive control under the *Domestic and Family Violence Act 2007* (NT) but has not created a standalone offence.[123]
- In Tasmania, elements of coercive control are included in relevant sections of the *Family Violence Act 2004* (Tas).[124]

A study drawing on NCIS data from 2010-2015 to explore situational contexts relevant to suicide and DFV perpetrated by men in rural Australia sheds further light on relevant dynamics.[125] The majority of the research cohort was aged between 25 and 44 (54%) and had perpetrated violence against past and present female partners (84%).[126] Violence was generally longer-term, with physical violence reported less frequently than other forms of controlling behaviour.[127]

Addressing suicide risk among people who use violence requires a nuanced approach. Researchers in this study observed that the use of violence and suicide by men in the research cohort "was almost always a deliberate and calculated response"[128] to contextual factors. It is important to respond seriously to all expressions of suicidal distress, while at the same time this is accompanied by an understanding of principles of accountability for violent behaviours.[129]

5. Prevention and early intervention

Term of Reference 5: Opportunities to enhance prevention and early intervention efforts to reduce suicide in the context of DFSV victimisation and perpetration.

Preventing suicide in the context of DFSV requires coordinated prevention and early intervention efforts that operate across both the DFSV and mental health systems. Such efforts must recognise violence as a key driver of suicidal distress and a risk factor for future harm. Opportunities exist to strengthen prevention and early intervention by aligning DFSV prevention initiatives with suicide prevention frameworks and embedding systematic consideration of DFSV risk within health-led early intervention.

5.1. Aligning prevention frameworks

The Commission considers there is opportunity for mutually reinforcing prevention efforts between DFSV and suicide prevention frameworks, including through shared learning, community-led initiatives, and clearer recognition of violence and trauma as risk contexts.

DFSV could be more explicitly integrated within community-based suicide prevention initiatives. For example, LifeSpan is an integrated suicide prevention framework that combines nine evidence-based strategies into a single community-led approach.[130] It incorporates health, education, frontline services, business, and the community.[131] The link between DFSV and suicide could be reinforced in this framework, for example through incorporating information about available referral pathways.

5.2. Strengthening identification and intervention across systems

Early identification of violence, safe disclosure environments, and accessible supports can reduce escalation. Health, education, housing, and social services are key early intervention points. Addressing social determinants and reducing stigma are also important to prevention.

Consistent with recommendations from the Rapid Review of Prevention Approaches, the Commission has called for governments to activate the health system and workforce as a key prevention lever in the context of DFSV.[132] In response to the Rapid Review, the Department of Prime Minister and Cabinet has identified several initiatives underway to achieve this goal, including:

- Supporting Primary Health Networks (PHN) to assist in the early identification and intervention of DFSV and coordinate referrals to support services;
- PHN-led trial of a new model of trauma-informed mental health recovery care for victim-survivors of DFSV; and
- Building the capacity for primary care providers to respond, refer, and record disclosures.[133]

Government systems such as Centrelink, child support services, housing, and other social support programs can also play a role in early intervention by identifying both DFSV and suicide risk. These services frequently interact with individuals in contexts of elevated risk, such as financial insecurity and

relationship separation.[134] Building workforce capability in these systems to recognise risk and make appropriate referrals would further strengthen early intervention.

Proposed areas of focus

The Commission has identified the following areas of focus as particularly relevant to the Standing Committee's consideration of this Inquiry. These areas are informed by the Commission's role in promoting and supporting the achievement of the National Plan, engagement across jurisdictions and sectors, and insights from people with lived and living experience. They represent practical areas where system strengthening could improve safety, reduce harm, and support recovery.

Some actions, including data development and research, will require sustained, long-term effort. Others present opportunities for more immediate progress. Given the scale and urgency of harms associated with DFSV and suicide, the Commission considers that advancing work across these areas should be treated as a priority.

1. **Lived experience engagement:** Ensure that efforts to strengthen prevention, responses, and research relating to DFSV and suicide are guided by meaningful engagement with people with lived and living experience, reflecting a diverse range of backgrounds and intersecting identities. Engagement should be safe and respectful, and provide appropriate support to participants.
2. **Ensure adequate resourcing:** Assess whether current resourcing across sectors responding to DFSV and suicide reflects both the scale of these issues and the likely volume and distribution of disclosures across the service system. This should take into account ongoing work to map the DFSV sector and any insights surfaced by the Inquiry regarding where disclosures occur.
3. **Build the evidence base:** Consider opportunities to strengthen research on the intersection between DFSV and suicide by addressing key evidence gaps, including for priority and under-researched populations. Determine the feasibility of leveraging national datasets, such as the NCIS, alongside de-identified administrative data and de-identified case information from DFSV, health, mental health, and justice systems to understand where intervention would be most effective for people impacted by and using violence.
4. **Data collection:** Consult with data owners to identify opportunities to uplift and link existing datasets to better understand the relationship between DFSV and suicide, with a focus on improving cross-jurisdictional consistency (including within NCIS); enabling safe data sharing and linkage across sectors; and strengthening data for communities disproportionately impacted.
5. **Alignment and integration:** Review policies, training, risk assessment tools, and safety plans across the DFSV, health, and justice sectors to identify opportunities to build the capability of workforces to identify both DFSV and suicide risk and respond effectively. Reduce silos between portfolios by ensuring social and specialist DFSV services participate in PHN needs assessment processes.

Conclusion

DFSV and suicide are both significant national concerns. Their intersection represents an area where improved recognition, alignment, and coordination could reduce harm within our communities. The Commission stands ready to support practical reform aligned with the National Plan.

The importance of strengthening service system responses by building workforce capacity across health, mental health, justice, and specialist DFSV services and ensuring services are adequately resourced to respond to intersecting risks cannot be overstated. In parallel, prevention and early intervention should be

advanced through closer alignment between DFSV and suicide prevention frameworks, expanded health-led early intervention, and initiatives to reduce barriers to help-seeking.

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