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

An ANROWS submission to the Standing Committee on Social Policy and Legal Affairs

January 2026

ANROWS

AUSTRALIA'S NATIONAL RESEARCH ORGANISATION FOR WOMEN'S SAFETY
to Reduce Violence against Women & their Children

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ANROWS welcomes the Standing Committee on Social Policy and Legal Affairs Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide. Evidence shows a clear link between DFSV and suicide. However, systems do not routinely count DFSV-related suicides alongside DFSV-related homicides. There are strong opportunities to apply existing evidence to improve how agencies report, investigate, respond to and prevent DFSV-related suicides.

ANROWS welcomes the opportunity to support this work by sharing and translating evidence to inform best practice.

Recommendations

1. Explicitly recognising the serious risk of death by suicide associated with DFSV will strengthen knowledge on opportunities to intervene early and drive prevention, especially in community and health settings.
2. The Inquiry should prioritise strengthening the identification, recording and response to DFSV within suicide prevention, case review and data systems, to reduce misidentification, address underreporting, and ensure earlier and effective intervention for women and children at risk.
3. The Inquiry should recognise IPV as a major contributor to women's burden of disease through suicide and self-harm and ensure suicide prevention policy, funding and services are integrated with IPV prevention and response, particularly for women at highest risk.
4. The Inquiry should address key gaps in the evidence base by supporting more consistent, robust research to better understand the relationship between DFSV and suicide and strengthen prevention efforts.
5. Suicide prevention policy and services should explicitly integrate children and young people's experiences of DFSV into risk assessment, early intervention and trauma-informed responses, to reduce suicide and self-harm.
6. Further research should be prioritised to better understand the relationship between sexual violence and suicide, including sexual violence within and outside the context of DFV.
7. The Inquiry should recommend nationally consistent data standards, and guidelines to ensure DFV-related suicides are systematically identified in coronial data, investigated in depth, and used to inform prevention, learning and system reform across jurisdictions.
8. Emergency department data systems should be strengthened to more accurately identify and record both suicidality and domestic and family violence at the point of care, improved coding practices, using supplementary human-intent injury indicators and text-based analysis.
9. The Inquiry should explore opportunities to extend existing population-based surveys to capture the co-prevalence of DFSV victimisation and suicidal thoughts, behaviours and self-harm.
10. Response to DFSV-related suicide should strengthen early identification and risk assessment across health, justice and housing systems, address both clinical risk and structural drivers, and apply evidence-based approaches that are rigorously tested and grounded in existing best-practice frameworks.
11. Evidence-based screening and risk assessment tools exist for identification of both DFSV and suicidality. The Inquiry should recommend national adoption of, and staff training on appropriate and sensitive implementation within all health services, DFSV specialist and non-DFSV specialist services.
12. The Inquiry needs to focus on understanding of suicide threats and behaviours as potential tactics of coercive control, to support accurate risk identification, avoid practitioner collusion and improve early intervention responses.
13. Suicide prevention policy and services should strengthen early, coordinated access to mental health, social and DFSV supports across the life course, including targeted prevention of child sexual abuse and flexible responses that reflect changing risk over time.

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

There is a clear link between DFSV victimisation and suicide risk (see, for example, Alimoradi et al. 2025; Na et al., 2025; Fastenau et al., 2024; White et al., 2024; Grose et al., 2019; Bacchus et al., 2018; Pill et al., 2017; Devries et al., 2013; Dillon et al., 2013; McLaughlin et al., 2012; Golding, 1999). The link between DFSV victimisation and suicidal thoughts and behaviours are evident across community (e.g. population-based, women's shelters, specialised services) and clinical settings (e.g., general practice, psychiatric, emergency department, antenatal and human immunodeficiency virus (HIV) clinics).

Research conducted by the World Health Organization (WHO) identified DFSV victimisation as a consistent risk factor for lifetime suicidal thoughts and attempts in 20,967 women from nine countries of low- to upper-income levels (Devries et al., 2011). An almost fourfold increased odd of suicidal ideation was reported for lifetime DFSV victimisation[1] in the past year (White et al., 2024). Additionally, a recent review identified Intimate Partner Violence (IPV) victimisation as one of the strongest risk factors for suicidal ideation (Na et al., 2025).

Differential effects have been observed for the severity, type (e.g. multiple, physical, sexual, psychological and/or financial) and timing of DFSV (e.g., lifetime, past year, acute) on women's risk of suicide (Rasmussen et al., 2025; Jiwatram-Negrón et al., 2022; Gibbs et al., 2018). For example, compared with women who experienced non-sexual IPV, sexual violence victimisation was associated with increased severity of post-traumatic stress disorder (PTSD) symptoms, greater likelihood of psychological distress and depression, and higher rates of suicide attempts and threats (Cox 2015; ANROWS, 2019). Despite the growing research base, several knowledge gaps remain, such as understanding how risk accumulates over time and how coercive control, strangulation and fear of homicide can intensify that risk. (Vasil et al., 2025)

The risk of suicide among victim-survivors of DFSV is heightened for women experiencing homelessness, financial problems, PTSD, substance use disorder, HIV, pregnancy and among those with a history of child abuse (Turnbull et al., 2025; Renner & Markward, 2009; Campbell et al., 2021). Childhood sexual- and physical abuse are prevalent among women with a history of DFSV (Hegarty et al., 2013) and increase affected women's risk of suicidal ideation (Renner & Markward, 2009). Experiencing gender-based violence in childhood also increases the risk of experiencing other types of gender-based violence and poly-victimisation, across social contexts (Townsend et al., 2022).

Despite the growing evidence base, DFSV-related suicides are not typically counted alongside DFSV homicide rates in national estimates and as such, overall DFSV mortality remains unknown (Vasil et al., 2025; Domestic, Family and Sexual Violence Commission, 2025).

Recommendation 1) Explicitly recognising the serious risk of death by suicide associated with DFSV will strengthen knowledge on opportunities to intervene early and drive prevention, especially in community and health settings.

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[1] This was found for DFSV victimisation (multiple types: e.g. physical, sexual, psychological and/ or financial) and for physical DFSV.

Understanding prevalence: Completed suicides

On average in Australia, 15 women suicide each week (Australian Bureau of Statistics (ABS), 2024). Case analysis of completed suicides suggests that DFV may be a contributing factor in 25-56% of these deaths (Coroners Court of Victoria, 2024; Ombudsman WA, 2022; Domestic Violence Death Review Team (DVDRT), 2017).

The New South Wales (NSW) DVDRT examined suicides by women in NSW over a 6-month period through a review of police, health and coronial records (n=85) (DVDRT, 2017). Evidence of DFV history, relationship conflict or breakdown was identified in 49% of these suicides reviewed (DVDRT, 2017). Similarly, a Western Australia (WA) study (n=124) found that 56% of women and children who died by suicide in 2017 had been identified as victims of DFV by governments and authorities prior to their death (Ombudsman WA, 2022). More recently, an analysis of women's suicides in Victoria between 2009–2016 (n=1,197) found evidence of DFV histories in 28% of deaths (Coroners Court of Victoria, 2024). Across studies, between 39–55% of women and children had contact with policing and/or emergency services for DFV-related reasons prior to their death. These findings point to missed opportunities to offer timely and appropriate support to women and children with imminent risk of death. Case reviews of suicide in DFV contexts revealed that women were most often identified as the primary victim of DFV, however, identification of women as perpetrators reached 16% (Coroners Court of Victoria, 2024). Misidentification of women as the primary perpetrators of DFV in police and justice records is a well-documented and ongoing concern undermining women's safety and access to justice (Nancarrow et al., 2020; Boxall et al., 2020; Mackay et al., 2018).

Efforts to establish DFV circumstances in cases of completed suicides is limited by the significant underreporting of violence in the community (Ombudsman WA, 2022). As such, analysis based on administrative data is likely to underestimate the true rates of DFV, as many incidents are never reported to police and specialist services (DVDRT, 2017). Further challenges include gaps and changes in existing data and the time costs associated with retrospective examinations of suicide cases (Ombudsman WA, 2022). These case reviews suggest that more in-depth qualitative reviews, including examination of narrative records and interviews with family and friends, can improve identification of DFV histories.

Australian estimates suggest DFV is a factor in 28-56% of completed female suicides (DVDRT, 2017; Ombudsman WA, 2022; Coroners Court Victoria, 2024). Comparatively, DFV was identified as a precipitating circumstance for suicide in 6–23% of completed suicides in the US (female- and mixed gender samples) (Kafka et al., 2022; Kafka et al., 2021; Brown & Seals, 2019; Jack et al., 2018). The National Violent Death Reporting System identified DFSV as a contributing factor for suicide in 23% of female suicides (Jack et al., 2018 in Forray & Yonkers, 2021). Variation in identification of DFV is likely driven by data and methodological factors rather than true variation in risk. Contributing factors include limited information on abuse history, inconsistent recording practices, differences in the depth of inquiry, whether homicide–suicide cases are included, and variation in case definitions and data sources. Differences in how DFSV is defined and measured, such as relationship type and recency, further affect prevalence estimates and limit comparability across studies.

Recommendation 2) The Inquiry should prioritise strengthening the identification, recording and response to DFSV within suicide prevention, case review and data systems, to reduce misidentification, address underreporting, and ensure earlier and effective intervention for women and children at risk.

Burden of disease

Burden of disease data shows that IPV is among the top five risk factors for disease burden in Australian women aged 15-54 years (AIHW, 2024). The total burden due to IPV was highest for women aged 35–44 years (AIHW, 2024). Across all age groups, IPV contributed to 19% of suicide and self-inflicted injuries

burden (AIHW, 2024). Estimates are more than double in adult Indigenous women, contributing 48% to suicide and self-inflicted injuries burden (Ayre et al., 2016, cited in Webster 2016).

In 2022, suicide and self-inflicted injuries were the ninth leading cause of fatal burden among women in Australia (down from eigth in 2018) (AIHW 2022b). Consistent over all study years, the second greatest contributor to the years of healthy life lost due to 'suicide and self-inflicted injuries' in women was IPV. It contributed 25% of the years of healthy life lost due to suicide and self-inflicted injuries in women. Women aged 35–44 experienced the highest number of healthy years of life lost due to suicide and self-inflicted injuries linked to IPV. (AIHW 2022b).

Burden of disease study findings are supported by a recent Australian study involving emergency department service users (n=1,715) that reported high rates of lifetime- (59%) and recent IPV victimisation (35%) among women seeking support for suicide (Rasmussen et al., 2025). Among this cohort, psychological abuse was the most common form of IPV experienced both recently (n=565, 93% of 608) and historically (n=966, 95% of 1,012). Recent and lifetime physical (n=307-692, 51-68%) and sexual IPV (n=261-626, 26-62%) were also prevalent among women with a history of victimisation (Rasmussen et al., 2025).

Recommendation 3) The Inquiry should recognise IPV as a major contributor to women's burden of disease through suicide and self-harm and ensure suicide prevention policy, funding and services are integrated with IPV prevention and response, particularly for women at highest risk.

Limitations of the DFSV-suicide evidence base

Key limitations in the DFSV–suicide evidence base relate to variation in study design, measurement and research settings, which are often poorly explained (Ayre et al., 2016). For example, across studies there is significant variation in DFSV definitions, measurement, and categorisation of suicidal outcome (Rasmussen et al., 2025). Additional limitations include reliance on cross-sectional data, snapshot analysis and the under-representation of data including vulnerable populations and under-resourced or low-income countries (White et al., 2024). These limitations may explain variation in prevalence estimates and affect the identification of subpopulations at increased risk of suicide (Leiner et al., 2008).

Importantly, analyses have rarely examined key mediators in the relationship between DFSV and suicide, such as PTSD (Rasmussen et al., 2025; Gibbs et al., 2018; Jiwatram-Negrón et al., 2022). PTSD is strongly associated with suicide and has been described as one of the most clinically significant mental health problems reported by DFSV survivors, with international prevalence rates ranging between 31–84% among DFSV-populations (Dutton, 2009; Spencer et al., 2019).

Despite the extent of DFSV-suicide literature, consensus has not been reached on the strength of the association between victimisation and suicidality, nor has causality been established (Ayre et al., 2016; WHO, 2013).

Recommendation 4) The Inquiry should address key gaps in the evidence base by supporting more consistent, robust research to better understand the relationship between DFSV and suicide and strengthen prevention efforts.

DFSV victimisation and suicide risk in children and young people

Suicide is the leading cause of death among young Australians (AIHW, 2022a). Research consistently shows that child abuse and neglect contribute to years of healthy life lost from suicide and self-inflicted injuries in both women and men. (AIHW 2022b). Childhood maltreatment has been identified as a contributing factor to suicide attempts in 41% of cases (Grummit et al., 2024), and child sexual abuse linked to higher rates of suicide (Haslam et al., 2023). Children who experience DFV victimisation also

face a 59% higher risk of intentional self-harm compared with children who are not affected. (Orr et al., 2022). DFV victimisation was also found to be a risk factor for Aboriginal and Torres Strait Islander children (Orr et al., 2022). A recent US population-based study of adverse childhood experiences and mental health outcomes found that women who experienced child abuse had greater odds of attempted suicide than men with childhood abuse histories (Cavanaugh et al., 2025).

There is a need to better understand how children and young people's experiences of DFSV and suicide risk intersect (Vasil et al., 2025). As set out in the Australian National Research Agenda, children and young people are a priority research investment (Lloyd et al., 2023). Despite substantial evidence of the relationships between DFSV and suicidality in adult populations, the intersection between victimisation and suicide risk in children and young people remains understudied.

Contributing factors to youth suicide are often grouped under broad terms like adverse childhood experiences or childhood abuse, without examining how different types of abuse and neglect affect risk in distinct ways. In suicide risk assessment, acute risk factors often overshadow childhood experiences such as mental health problems and harmful substance use. (Meyer et al., 2023). Additionally, there is limited research examining the mortality risk associated with childhood experiences of DFSV (Meyer et al., 2023). Consequently, existing research may mask the significant impact of childhood trauma on youth suicide. There are opportunities to incorporate interpersonal violence as risk factors (e.g., child/lifetime abuse) or acute stressors (e.g., recent victimisation) in suicide risk assessment tools. This has proven successful in longitudinal research predicting repeat suicide attempts (Haglund et al., 2016; Jokinen et al., 2010). One study linked degree of reported interpersonal violence with elevated risk of repeat attempt within six months of prior attempt (Haglund et al., 2016), while another demonstrated that exposure to violence as a child was strongly associated with suicide (Jokinen et al., 2010).

We need a trauma-informed service system that recognises when children and young people experience multiple forms of violence, and the cumulative effects of adverse childhood experiences on wellbeing across the life course (Meyer et al., 2023). To support early identification and timely referral, routine screening for potential DFV across universal services (statutory and non-statutory) should be adopted to strengthen data quality and enable child- and young person-centred pathways (Meyer et al., 2023).

Recommendation 5) Suicide prevention policy and services should explicitly integrate children and young people's experiences of DFSV into risk assessment, early intervention and trauma-informed responses, to reduce suicide and self-harm.

Sexual violence

Experiences of sexual violence are linked to higher risk of self-harm and suicidal behaviours (Agenda Alliance, 2023). Women who experience intimate partner sexual violence have higher rates of suicide attempts and threats than women who experience non-sexual IPV alone (Cox, 2015). As cited above, a recent Australian study (Rasmussen et al., 2025) examining emergency department service users (n=1,715) found sexual IPV victimisation in many cases where women were seeking support for suicide (n=261-626, 26-62%). In that study, psychological abuse was the more common form of IPV, and physical violence was also prevalent among women seeking support for suicide (Rasmussen et al., 2025). Sexual violence has been linked to long-term mental health harms, including depression and hopelessness, and to self-harm and suicidal behaviour among trans women of colour from culturally and linguistically diverse backgrounds (Ussher et al., 2020). Further, intersecting social inequalities and marginalising contexts amplify the risk of suicidality. For example, factors that commonly co-occur with sexual violence for trans women of colour, including homelessness, substance use, social isolation, stigma, discrimination, and lack of culturally safe services, increase their vulnerability to self-harm and suicide behaviour (Ussher et al., 2020). Child sexual abuse is also linked to higher rates of suicide (Haslam et al., 2023), with Australians who experience sexual abuse being 2.7 times more likely to have self-harmed in the prior 12 months and 2.3 times more likely to have attempted suicide in the prior 12

months (Haslam et al., 2023). More research into sexual violence and suicide, including sexual violence that intersects with DFV, and non-DFV contexts would be valuable. For example, collecting data on the mode of violence (e.g. sexual violence, physical violence, etc.) in coronial investigations has been identified as something that would be highly beneficial (Coroner's Court of Victoria 2024). Similarly, sexual violence occurring outside the context of DFV is not in the remit of existing Australian DFV death review mechanisms. DFV death reviews do examine instances of sexual violence that occur in the context of DFV-related homicides and suicides (including intimate partner homicide-suicide).

Recommendation 6) Further research should be prioritised to better understand the relationship between sexual violence and suicide, including sexual violence within and outside the context of DFV.

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

The accuracy of data on the links between DFSV victimisation and suicidal outcomes can be enhanced by modifying or expanding data collection processes within existing national administrative data sets and strengthening data linkage projects and their funding (e.g., National Non-admitted Patient Emergency Department Care Database, National Ambulance Surveillance System, National Hospital Morbidity Database, National Mortality Database, Specialist Homelessness Services Collection, Recorded Crime – Victims Collection). Nationally representative surveys on violence victimisation and mental health can also improve DFSV–suicide data by expanding their scope to measure the co-occurrence of DFSV victimisation and suicidal outcomes. (e.g. Personal Safety Survey, National Study of Mental Health and Wellbeing).

Coronial data

There are substantial opportunities to expand reporting on and investigation of DFV-related deaths. DFV death reviews across jurisdictions need to be better resourced to investigate DFV-related suicides. Due to the complexity and nuance of DFV-related suicides, resourcing needs to allow for in-depth examination and qualitative case reviews. Existing data collection practices (including resourcing and processes) related to DFV and suicide vary significantly across each state and territory. The processes for identifying and investigating DFV-related suicides, and the level of data (if any) held in relation to DFV and suicide can also vary, as does the staffing and resourcing across states and territories. As a result, not all DFV death reviews are able to consistently examine suicides with current resourcing.

Existing data is typically limited to reference material gathered as part of the coronial investigation. There is significant variation in the depth of data collected, including for example, number of and quality of witness statements, medical records, police records, service records (e.g. from housing, health, child protection, DFSV services, etc.). Consequently, there may be cases of suicide (and homicide) where evidence of DFV exists but is not collected or is incomplete. Underreporting of DFV victimisation is also a key challenge impacting accuracy of data on DFV-related suicides (Vasil et al., 2025).

In addition to cross-jurisdiction variation, the availability and depth of data can differ across cases within a jurisdiction. For example, data from the Victorian Coroners Court includes a core data set and enhanced dataset, with the enhanced dataset containing more information from which to base an assessment of DFV. The core dataset includes suicide method, latitude and longitude of usual residence and fatal incident locations, deceased intent, and the type of location where the fatal incident

occurred. The enhanced dataset contains extensive binary, categorical and free-text information across nine main areas including socio-demographics, physical health, mental health, evidence of intent, interpersonal stress, and contacts with police or other service providers, among others.

While the core dataset is available for all suicide deaths reported to the Victorian Coroners Court, enhanced datasets are not available in all cases. The enhanced data set is resource-intensive to maintain and requires trained and experienced coders. As a result, coding in Victoria, as of June 2024, is only complete for 2009-2016 (Coroner's Court of Victoria 2024). Other jurisdictions use separate, more limited measures. This makes comparison between jurisdictions extremely challenging. Most jurisdictions now have suicide registers to record information provided to coroners when a suspected suicide is referred (AIWH, 2025). Three jurisdictions (NSW, Victoria and Queensland) have published reports on their suicide data, and only Victoria's refers to family violence (AIWH, 2025). Other than Victoria, it is unclear if there is a mechanism to record relevant DFV information within these registers. There may be an opportunity to incorporate this into the registers, resourcing would need to include training in assessing for DFV in cases or resourcing death review teams to incorporate this into their work.

Additional points of data that could be beneficial to routinely collect include:

- The mode of violence (e.g. sexual violence, physical violence, etc.) (Coroner's Court of Victoria 2024).
- The proximity of violence to the suicide (Coroner's Court of Victoria 2024).[2]
- People with whom the deceased had discussed the violence prior to suicide (Coroner's Court of Victoria 2024).
- The dynamics and history of DFV (e.g. predominant abuser, predominant victim).
- Whether separation was a characteristic in the case (e.g. when the separation occurred, if there were any current or historical family law proceedings).
- Whether there had been any current or historical protection orders in place (either naming the person as a defendant or person in need of protection) and if there had been breaches of orders.

ANROWS anticipates a future national project on suicide in the context of DFSV, to be delivered in partnership with the Death Review Network. This project will examine DFSV-related suicides using death review data from across states and territories, the first of its kind in Australia. The project will provide insight into the current death review data collection approaches in each jurisdiction and make recommendations for resourcing required to routinely undertake this work.[3]

There are also opportunities to learn from international death review processes. In 2024, the UK government announced changes to the Domestic Homicide Review (DHR) process. Changes include expanding the scope of DHRs so that a DHR is considered for all deaths that have or appear to have been the result of domestic abuse and renaming DHRs to domestic abuse related death reviews (Home Office 2024). UK DHR now capture suicide and homicide and involve family, friends and other networks (such as employers) in the review process, which is not typical practice in Australia (Domestic Abuse Commissioner, 2025). Involving friends and family in Australian death reviews provides an opportunity for more accurate identification of DFSV in both homicides and suicides but is resource intensive.

While not specific to suicide, The Montana Model for domestic violence fatality reviews involves intensive data-gathering. The entire review team travels to the location of the homicide highlighting the value of place-based approaches to ensuring appropriate depth of data and insights collected. This

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[2] Proximity of violence refers to the time elapsed between most recent reported exposure to IPV and death from suicide (MacIsaac et al., 2018).
[3] See the Filicide report recommended directions for future research (Australian Domestic and Family Violence Death Review Network, & Australia's National Research Organisation for Women's Safety, 2024).

allows more accurate identification of DFSV because it increases the opportunity to capture complexity and nuance often absent in suicide death review data. There may be lessons from the approach for death review processes in Australia, including in cases of DFV-related suicides.[4] Victorian research (Vasil et al., 2025) also points to the need to enhance evidence-gathering practices in coronial investigations, including through improved police training, multi-agency information sharing, and involving evidence from friends and family to ensure investigations draw on a wide arrange of sources. Looking to the UK reforms and the Montana Model provide examples for some of the ways in which this can be done.

Another critical area is to consider recommendations from past coronial investigations which highlight the importance of consistent National data and accountability for acting on coronial recommendations. There are various approaches to implementing recommendations from coronial inquests and death reviews. Queensland for example reports publicly on implementation; NSW provides evidence on how many recommendations have been implemented or not implemented; and some jurisdictions are not required to have public responses to inquest recommendations. Prior research (Buxton-Namisnyk & Gibson, 2024) highlights substantial implementation gaps relating to action on recommendations made by Australian death review bodies in Qld and NSW. Their analysis shows that of the 197 recommendations made since establishment (NSW in 2010 and Qld in 2016), only 16% have been fully implemented, 59.1% partially implemented[5], and 24.9% not implemented in any way (Buxton-Namisnyk & Gibson, 2024). Notably, implementation gaps were particularly evident in relation to recommendations to Commonwealth entities (Buxton-Namisnyk & Gibson, 2024). Enhancing processes and accountability of the Commonwealth to implement death review recommendations should be considered.

Recommendation 7) The Inquiry should recommend nationally consistent data standards, and guidelines to ensure DFV-related suicides are systematically identified in coronial data, investigated in depth, and used to inform prevention, learning and system reform across jurisdictions.

Emergency department data

The primary national method to collect data on suicidal thoughts and behaviours in emergency departments uses ICD-10-AM codes[6] for intentional self-harm categorised by method and suicidal ideation. This is problematic because intentional self-harm without suicidal intent and suicide attempt overlap but differ in important ways, including frequency, prevalence, lethality of methods and risk factors (Mars et al., 2015; Muehlenkamp & Kerr, 2010). The literature treats these behaviours either as separate phenomena or as part of a continuum (Mars et al., 2015).

Expanding target codes can enhance the accuracy of National Non-admitted Patient Emergency Department Care Database information on the co-prevalence of DFSV victimisation and suicidality (suicidal thoughts/ideation, behaviours and attempts) in emergency department users. Specifically, coding could distinguish between intentional self-harm with suicidal intent (suicide attempt) from intentional self-harm without suicidal intent (e.g. cutting resulting in minor tissue damage). Additional

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[4] For more information on the Montana Model see https://vimeo.com/15147441

[5] Other implementation statuses include: implemented in a different way than anticipated by the recommendation, implementation ongoing, partially implemented, partially implemented in a different way than anticipated by the recommendation, government adjudicates that implementation is complete but there is insufficient detail to assess implementation, and no implementation (recommendation missed) (Buxton-Namisnyk & Gibson, 2024).

[6] The International Classification of Diseases, 10th Revision, Australian Modification (ICD-10-AM) are the national standard in Australia (Independent Health and Aged Care Pricing Authority, 2025). ICD-10 codes are a standardised, international classification system for diagnoses and external causes of injury used for billing, epidemiology, and health reporting.

barriers to data coding of suicide in Emergency Departments include data entry limitations such as form design, data entry by clinicians rather than trained Health Information Managers, incomplete assessment at the time of data entry with final assessment entered later in free text fields, high clinician workload and/or complex patient presentations involving a mix of self-injury, mental health and/or substance use conditions. Therefore, supplementing ICD-10-AM codes with text-based codes may help to overcome recording challenges. For example, analysis of free-text data fields describing patients' presenting problems can identify keywords indicative of suicidal thoughts and behaviours that might not be otherwise captured by ICD-10-AM codes (Sara & Wu, 2023).

Some Australian states and territories have employed a "human intent" flag within information systems to identify intended injuries either self-inflicted or inflicted by another person (Sara & Wu, 2023). "Human Intent" may be used to identify suicide and for coding identified DFV injuries. National adoption of "human intent" flagging, alongside consistent coding of DFV, self-harm, and suicidal behaviours at presentation stand to improve the accuracy of both DFV and suicidality data. Flagging can quickly and accurately identify cases of intentional harm and suicidal behaviours in real-time within an emergency department information system, often at triage, for immediate clinical and administrative response (Sara & Wu, 2023).

Alongside case-finding approaches to DFV identification, DFV-specific codes and data fields must be generated. For example, codes and data fields are required to capture key information on DFV including the external cause of injuries, perpetrator relationship and lifetime- and recent history of victimisation. Systemic issues and data field limitations will need to be addressed to capture a complete national picture of DFV presentations to emergency departments and their co-occurrence with suicidality.

Overall, approaches for improving DFV and suicidality data in emergency departments may differ across health systems based on variation in local information systems, data availability, resources and organisational factors.

Recommendation 8) Emergency department data systems should be strengthened to more accurately identify and record both suicidality and domestic and family violence at the point of care, improved coding practices, using supplementary human-intent injury indicators and text-based analysis.

Population-based survey data

Extending existing population-based surveys to capture the co-prevalence of DFSV victimisation and suicide risk may enhance the accuracy of data on their relationship. For example, the National Study of Mental Health and Wellbeing (NSMHW) could be extended to include items assessing antecedents of suicidal thoughts and behaviours including DFSV victimisation.

Another option is to extend the scope of the Personal Safety Survey (PSS) to assess the safety issue of self-directed violence (e.g., suicide attempt). Such extension of the survey stands to link self-reported suicidality and DFSV victimisation at the population-level.

Recommendation 9) The Inquiry should explore opportunities to extend existing population-based surveys to capture the co-prevalence of DFSV victimisation and suicidal thoughts, behaviours and self-harm.

How legal and justice systems, DFSV specialist services, health, mental health and other services recognise and respond to suicide in the context of DFSV

There is a clear need to improve identification, risk assessment and management practices across service systems to more effectively prevent DFSV-related suicides (Vasil et al., 2025). Effective responses require better cross-sector integration, with services equipped to address DFSV victimisation, mental health and suicidality as intersecting issues (Vasil et al., 2025). While coordinated, multi-agency interventions are appealing, evidence shows that police co-responder programs for IPV and mental health crises have not demonstrated consistent beneficial results (Lowder et al., 2024; Peterson et al., 2022). This underscores the need to test cross-agency models rigorously in DFSV-related suicide contexts.

In the Australia context, death review boards identify that IPH and IPH-suicide perpetrators often have diverse and repeated historical contact with service systems (Domestic and Family Violence Death Review and Advisory Board, 2021). There are opportunities to enhance identification and risk assessment and management through these service system contacts. For example, services can improve how they identify and assess the risk of DFSV perpetration among men who access support for other needs, including housing. This requires collaboration across DFSV and housing sectors such as training housing service staff to identify DFSV perpetration. Housing insecurity has also emerged as a critical context in women's DFSV-related suicides, highlighting the need for responses that address structural insecurity as well as clinical risk (Vasil et al., 2025). Improving the alignment between housing and DFSV policies and programs is already an action under the First Action Plan 2023–2027. Further support is needed to enable women and children to remain safely in their own homes when they choose to do so.

Addressing Australia's housing crisis is critically needed as part of broader efforts to prevent DFSV related suicides.

The accuracy of DFV data may be further improved by consistent implementation of a case-finding approach to DFV identification in emergency departments alongside information management and data coding reforms. Adopting a case-finding approach to DFV victimisation is endorsed by the WHO as part of a systems-based approach to violence against women prevention (WHO, 2014). Instead of routine DFV identification, clinicians are encouraged to ask women about DFV when they identify injuries or conditions associated with abuse (WHO, 2014). A recent Australian study of women presenting to emergency departments in suicidal crisis supports integrating DFV exposure profiles into suicide risk assessments (Rasmussen et al., 2025). The study found that compared with lifetime DFV victimisation, recent DFV (multiple types) was most strongly associated with suicidal ideation and attempt among women, demonstrating the acute aftermath of severe abuse (Rasmussen et al., 2025). In contrast, post-traumatic stress disorder (PTSD) diagnosis was evidenced to play a pivotal role in the development of suicidal ideation for women experiencing fewer types of DFV (Rasmussen et al., 2025). Taken together, these results can be used to inform the assessment and categorisation of suicide risk within targeted intervention strategies in women with recent multiple DFSV and lifetime DFV exposure resulting in PTSD.

DFSV victimisation should be assessed in emergency departments using validated measures, in private environments, compassionately and with appropriate response and referral options offered (Spangaro et al., 2011). Organisational support and health professional training on DFV dynamics, impacts, presentations, identification and recording are critical to the outcomes of this intervention (PD2023_009, NSW Health, 2023; Spangaro et al., 2020).

Risk assessment frameworks already provide practical guidance to embed suicide risk into DFSV practice. Victoria's Multi-Agency Risk Assessment and Management (MARAM) includes specific guidance on recognising increased suicide (and homicide-suicide) risk. The foundational knowledge guide for professionals working with people using violence highlights indicators of serious and escalating risk as linked to suicide and homicide-suicide and advises immediate action if the person using violence:

- expresses feelings of losing control of the relationship, particularly if there are obsessive, desperate behaviours and victim-stance narratives,

- lacks connection with known protective factors such as employment and/or other social supports,
- experiences a decline in mental wellbeing or expresses an inability to cope or feelings of hopelessness, or
- empathises with other men who have killed their partner or children (Family Safety Victoria, 2021, p.100).

The MARAM framework also outlines 'in common' risk factors for suicide and DFV, articulating the criticality of including suicide risk as part of DFV risk assessment and management. These 'in common' risk factors include planning to leave or recent separation, financial abuse/difficulties, access to weapons, previous threats or attempts to self-harm and suicide, history of family violence, drug and/or alcohol misuse, and mental illness such as depression. Additional factors warranting attention include history of childhood trauma, shame, feelings of hopelessness or despair and social isolation. See Appendix 6: Recognising suicide risk in the context of adult people using family violence of the MARAM framework for a detailed table of the 'in common' risk factors.

Recommendation 10) Response to DFSV-related suicide should strengthen early identification and risk assessment across health, justice and housing systems, address both clinical risk and structural drivers, and apply evidence-based approaches that are rigorously tested and grounded in existing best-practice frameworks.

Emergency department settings

Survivor experiences indicate that service responses, particularly those of emergency department and mental health staff, can inadvertently pathologise or dismiss women presenting with self-harm or suicidality (Salter et al., 2020). Women have described being sent home shortly after presenting with suicidal thoughts, being involuntarily hospitalised, or treated coercively or dismissively (Salter et al., 2020). Such negative experiences deter future help-seeking, compounding risk. For many women, complex trauma is often entwined with social inequalities such as poverty, unstable housing or homelessness, substance use, marginalisation, discrimination, stigma, racism and lack of social supports (Salter et al., 2020). These intersecting adversities create more complex and chronic vulnerability. As such, trauma-informed, holistic and wrap-around services are critically needed to recognise and respond to complex trauma as a multidimensional issue (Salter et al., 2020).

Recommendation 11) Evidence-based screening and risk assessment tools exist for identification of both DFSV and suicidality. The Inquiry should recommend national adoption of, and staff training on appropriate and sensitive implementation within all health services, DFSV specialist and non-DFSV specialist services.

The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFSV

In Australia, specific coercive control laws[7] have recently been adopted in New South Wales and Queensland (2024). Other jurisdictions including Victoria, Tasmania, Northern Territory and the Australian Capital Territory have elements of coercive control embedded in existing family violence legislation, while South Australia and Western Australia are in process of reviewing and adopting processes for criminalisation. The flow-on effect is that police, courts, specialist and non-specialist DFVS social services have increased awareness and recording of coercive control in case files. Being a relatively new data field, historical information will mostly be available in case notes. Suicides are

[7] https://www.australianfamilylawyers.com.au/information-centre/coercive-control-laws-australia-victoria-queensland-nsw

often included in the pathology or mental illness category and therefore may not be investigated for history of DFSV (Bourget & Bradford 1990, Kauppi et al. 2010), and less likely to have information about suicide, or threat of suicide, as a form of coercive control. Therefore, police, court and medical/psychiatric records are likely to underestimate any form of coercive control in the context of both DFSV and suicide until there is wide-spread common practice to record this information.

Specialist DFSV practitioners and researchers do recognise the use of suicide and threats of suicide as a tactic of coercive control that elevates risk of DFSV. This is captured, for example, in risk assessment practices such as the National Risk Assessment Principles where 'suicide threats and attempts' (Toivonen & Backhouse, 2018, p.15) are listed as a risk factor for DFSV. The MARAM risk assessment framework (Victoria) recognises that a perpetrator's suicide ideation represents a significant risk to (ex)partners, children and other affected family members.

There is little research on completed suicide used as a tactic of coercive control, primarily because the death makes it difficult to assess motivation and mental health status retrospectively at the time of the incident. However, seminal case study research by Kirkwood (2000, 2003 and 2012) has identified a cohort of people who have committed homicide-suicide, or filicide-suicide as an extreme form of coercive control in the context of separation and DFSV. 'Retaliatory filicide-suicide or retaliatory homicide-suicide', [8] are almost exclusively perpetrated by men seeking revenge towards their female partners (Liem and Koenraadt, 2008; Kauppi et al. 2010; Kirkwood, 2012).

There is recent analysis of suicide in the context of DFSV, for example, the Australian Domestic and Family Violence Death Review Network and ANROWS (2024) found that among men who killed their intimate partner or ex-partner, 18.3% (n=44) died by suicide after the homicide, with only one woman dying by suicide after killing her male partner. No male offenders who killed a male intimate partner died by suicide after the homicide. Further, a study of suicides in Victoria between 2009 and 2012 found that many (n=143, 35.5%) of the men with an identified history of perpetrating IPV had perpetrated IPV in the six weeks prior to suicide (MacIsaac et al., 2018). The connection between suicide and DFV, including IPH, highlights the need to take suicidal ideation and threats of suicide seriously. However, while there is a clear relationship between perpetrating DFV (including IPV and IPH) and suicide, there is limited data on the use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFV where this has not escalated to homicide and/or suicide completion.

Research by Seamer (2024), found that among participants in a men's behaviour change program (MBCP) (n=39), 48.9% reported experiencing suicidal ideation in the past and 36% admitted at intake to threatening to commit suicide to their (ex)partner. Similarly, a US study examining 294 men who were court-ordered to attend an MBCP, found that almost half of perpetrators had threatened suicide in the past, with 70% in the 6-months prior (Wolford-Clevenger et al., 2015). Seamer's research reported that statements of suicidal ideation were often accompanied by descriptions of attempts or suicide plans indicating real and genuine intent. There is complexity in balancing care and therapeutic response to genuine suicide risk with the identification of, and response to, threats of suicide as part of a partner pattern of exerting power and control over (ex)partners and other family members and potential for escalating harm (e.g. connection to homicide risk). Practitioners face significant challenges in providing support while avoiding collusion and accurately identifying risk, particularly in DFSV contexts where responses to suicide risk can more easily cross into collusion than in other settings. Further research on the use of suicide threats—both in cases involving homicide or suicide and in situations where threats are not accompanied by genuine intent—is essential to inform effective early intervention.

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[8] Retaliatory filicide is associated with a specific intention to kill and committed out of revenge towards an intimate partner (Bourget & Gagne 2005). This type of filicide is also described as 'spouse revenge' in which the children are used as tools to punish the partner.

In addition to the use of suicide and threats of suicide, we also draw attention to instigated suicide, or the manipulation of women's suicidality by people who use DFSV (see also, Vasil et al. 2025). The UN Statistical Framework recognises instigated suicide as a form of gender-related killing when another person incites a woman to end her life following gender-based violence. It encourages countries to disaggregate data on victims and perpetrators of instigated suicide to build a more accurate picture of DFSV-related deaths. It is critical that instigated suicide is considered as part of the broader efforts of the inquiry to bring perpetrator tactics of coercive control into frame.

Recommendation 12) The Inquiry needs to focus on understanding of suicide threats and behaviours as potential tactics of coercive control, to support accurate risk identification, avoid practitioner collusion and improve early intervention responses.

Opportunities to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV victimisation and perpetration

Increase access to services. Research from the Coroner's Court of Victoria (2024) highlights the ways in which DFSV intersects with other stressors. For example, among women's deaths by suicide where there was also an experience of DFSV, it frequently co-occurred with diagnosed mental illness (78.2% of cases), financial stressors (39.4% of cases), legal stressors (19.9% of cases), and substance misuse (62.7% of cases). DFV not only increases risk of suicidality but co-occurs with a range of social and psychological challenges that negatively impact help-seeking and recovery (Fitz-Gibbon & Vasil 2025). Notably, similar patterns of co-occurrence are evident among male perpetrators who suicided, with the co-occurrence of diagnosed mental illness (59.2% of cases), financial stressors (44.7% of cases), legal stressors (60.5% of cases), and substance misuse (74.2% of cases) common across cases (Coroner's Court of Victoria 2024). While this is not evidence of accessing services in relation to these stressors, it highlights opportunities for earlier intervention. Improving access to mental health, substance misuse, financial and legal support could create earlier pathways for help-seeking and intervention for both victim-survivors and people who use violence. That is, if supports for mental health, etc. were readily available, it is possible that help may be sought prior to reaching crisis (on the need for improved service access see also, Jiwatram-Negrón et al., 2023).

Improve continuity of care and service linkage. One of the barriers to disclosure is that assessments are based on the information presented at one point in time and with limited information. There may have been multiple attempts at past help-seeking to other services that are not visible and therefore establishing greater connection and continuity of care may improve identification and early intervention opportunities (Vasil et al., 2025). Relatedly, there is a need for improved service linkage across DFSV and mental health services (Jiwatram-Negrón et al., 2023).

Available support across the continuum of violence. There is a need to work across all the DFSV National Plan pillars – prevention, early intervention, response, and recover and healing - with flexibility. There are diverse contexts in which DFSV may contribute to suicide risk, this can include feelings of entrapment, fear of the perpetrator, lack of help-seeking options, and the cumulative effects of violence (Vasil et al., 2025). Risk and safety levels, including suicide risk, change over time with many victim-survivors moving in and out of crisis. Suicide risk is non-linear and there is a need to think about immediate risk as well as longer-term risk mitigation (Vasil et al., 2025). It is critical that we work flexibly across the service continuum to ensure appropriate support is available when needed in practice, rather than when it is assumed to be needed. This challenges linear funding and service pathways across prevention, early intervention, response, recovery and healing, and can affect service eligibility at different points.

Targeted prevention of child sexual abuse. Child sexual abuse is linked to higher rates of suicide (Haslam et al., 2023). Targeted prevention of child sexual abuse through, for example, prevention efforts in schools focused on healthy development, attitudes to gender equality, emotional literacy, sexual literacy, and consent and relationships education should be prioritised (Haslam et al., 2023).

Recommendation 13) Suicide prevention policy and services should strengthen early, coordinated access to mental health, social and DFSV supports across the life course, including targeted prevention of child sexual abuse and flexible responses that reflect changing risk over time.

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Australia’s National Research Organisation for Women’s Safety Limited (ANROWS) is the country’s independent, trusted voice for reliable and informed evidence on domestic, family and sexual violence.

ANROWS was established by the Commonwealth, state and territory governments under Australia’s first National Plan to Reduce Violence against Women and their Children (2010–2022). As an ongoing partner to the National Plan, ANROWS continues to build, strengthen and translate the evidence base that informs the current National Plan to End Violence against Women and Children 2022–2032.

Our work is underpinned by a commitment to producing high-quality, policy-relevant evidence to inform and influence practice, service delivery, and systems reform. Since our establishment, ANROWS has led, contributed to, or commissioned more than 150 research projects. We undertake targeted research both internally and in collaboration with academic institutions and sector partners.

Every aspect of our work is motivated by the right of women and children to live free from violence and in safe, equitable communities. We engage closely with victim-survivors, communities, service providers, governments and policymakers to ensure our work reflects the diversity of lived experiences and supports collective responses.

We are committed to reconciliation with Aboriginal and Torres Strait Islander peoples, and work to recognise and amplify the strength and knowledge that exists in First Nations communities.

ANROWS is a not-for-profit organisation jointly funded by the Commonwealth and all state and territory governments. We are also commissioned from time to time by individual jurisdictions, and competitively tender for research and evaluation work.

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