Submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs

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

Submission on behalf of the Bayside Peninsula Integrated Family Violence Partnership

30th January 2026

BAYSIDE PENINSULA
Integrated Family Violence Partnership

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Our Acknowledgements

Acknowledgement of Country: We acknowledge the people of the Boonwurrung, Bunurong and Wurundjeri tribes of the Kulin Nation who are the traditional owners and custodians of the Aboriginal land of our region. We recognise their continued connection to the land and waters and acknowledge that sovereignty was never ceded. It always was and always will be Aboriginal land.

We embrace diversity in all its forms, and respect everyone's strengths and contributions irrespective of gender, ethnicity, culture, religious beliefs, sexual orientation and political views.

Recognition of Victim Survivors: We recognise the strength and resilience of victim/survivors of family violence, their voices, bravery and experiences continue to inform the work we do. We also honour those who are prevented from coming forward and those whose voices can no longer be heard.

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Executive Summary

The Bayside Peninsula Integrated Family Violence Partnership (BPIFVP) appreciates the opportunity to provide a submission in response to the Standing Committee on Social Policy and Legal Affairs inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide. This submission draws on the collective expertise of specialist family violence services, mental health and AOD practitioners, and lived experience advocates from the BPIFVP to examine the relationship between DFSV and suicide.

Across practice and lived experience, there is a strong and consistent relationship between DFSV victimisation and increased suicide risk and incidence. Suicidality in this context is not best understood as an isolated mental health issue, but as a situational, trauma-driven response to chronic coercive control, entrapment, and cumulative harm.

Suicide risk is observed to escalate at predictable points, including during separation, escalation of violence, housing loss, child protection involvement, and following failed or punitive system responses. Coercive control, including threats of suicide by perpetrators, plays a significant role in both elevating risk and constraining victim-survivors' ability to seek safety.

"In my view, suicide prevention … is most effective when systems focus less on individual pathology and more on restoring safety, agency, and continuity of support, while addressing the violence and coercive dynamics driving the risk." *BPIFVP member*

Current data collection practices significantly under-represent the true scale and nature of DFSV-related suicide. Fragmented reporting systems, coronial thresholds that struggle to capture coercion, and reliance on service engagement status obscure both prevalence and patterns.

Importantly, practice evidence demonstrates that suicide risk frequently reduces when victim-survivors are believed, supported, and provided with practical assistance that restores safety and agency. This indicates that DFSV-related suicidality is largely preventable, and that improved policy, data integration, and cross-sector responses have the potential to save lives.

This submission recommends that governments and service systems:

1. **Formally recognise domestic, family and sexual violence as a core driver of suicide risk**

   National suicide prevention policy and practice should explicitly recognise DFSV, particularly coercive control, entrapment, cumulative and historical trauma, as a primary and preventable contributor to suicide risk and suicide incidence across the life course.
2. **Identify suicide threats and coerced self-harm as tactics of coercive control**

   Suicide threats, encouragement to self-harm, and coerced overdose should be consistently recognised across policy, risk frameworks, and frontline practice as forms of family violence and coercive control, requiring both immediate safety responses and perpetrator accountability, rather than being misidentified as isolated mental health crises.
3. **Improve data, coronial processes, and national consistency**

   Data collection, reporting, and coronial investigations should better capture DFSV-related suicide, including coercion, cumulative harm, and historical violence exposure, supported by nationally consistent, cross-jurisdictional data systems that enable information sharing across relevant service sectors.
4. **Strengthen system responses at known escalation points**

   Suicide prevention and DFSV responses should be strengthened during predictable high-risk periods, including separation, housing loss, court and child protection involvement, and service transitions, with targeted, culturally safe responses for groups experiencing intersecting disadvantage, including children and young people.
5. **Embed violence-informed, cross-sector approaches**

   Suicide prevention efforts should embed specialist family violence expertise, adopt trauma-informed and harm-reduction approaches, and improve coordination across family violence, mental health, alcohol and other drug, housing, education, child protection, and justice systems, including early identification, sustained support, and tailored responses for children and young people impacted by DFSV.

"Within my own experiences, and within my experience as a specialised Family Violence Practice Lead, what I have seen in practice is a simple "giving up" on even trying to engage support for suicidal ideation due to the length (often years) of systems navigation and financial burden of continually hitting dead ends. I have seen countless survivors in my practice, depleted of energy to continue attempting to engage in support for suicidal ideation, or even basic mental health support prior to suicidal ideation commencing, as a preventative option." *Lived experience advocate*

For questions or for further information regarding this submission please contact:

Louise Sheehan

Principal Strategic Advisor Bayside Peninsula Integrated Family Violence Partnership

e: louise.sheehan@vt.uniting.org

BAYSIDE PENINSULA Integrated Family Violence Partnership

About the BPIFVP

Established in 2006, the Bayside Peninsula Integrated Family Violence Partnership (BPIFVP) is one of 13 Family Violence Regional Integration Committees (FVRICs) in Victoria. Formed initially to improve the coordination of family violence services, FVRICs are now key in the rollout of the Victorian Government's Family Violence reforms. Since its inception, the BPIFVP has evolved into a platform for collaborative action. The BPIFVP provides leadership, advocacy, and specialist expertise to strengthen, integrate and improve the family violence system, including supporting workforces and building family violence literacy across different service sectors.

The FVRICs are funded by the Victorian Department of Families, Fairness and Housing (DFFH) to support their operation, the role of the Principal Strategic Advisor (PSA) who leads the FVRIC, and area-based projects. The PSA provides leadership in the development, implementation, and monitoring of the integrated approach to family violence in their specific DFFH Area. The PSA works closely with the FVRIC Chair and partnership members.

Further information about the BPIFVP is available on our website, SouthSafe: https://southsafe.org.au/about-2/about/

Membership

The BPIFVP membership cross multiple sectors and Bayside Peninsula Area (BPA) based organisations. The BPIFVP represents government and non-government agencies, family violence services, children and family services, Victoria Police, justice and legal services, housing, community, and health services.

A full list of BPIFVP members can be found in the Appendix.

Strategic Focus

Safety and inclusivity are at the core of everything the BPIFVP does, with the Partnership prioritising the physical, emotional, cultural, and psychological safety of all people with lived and living experience, persons using violence, children and young people, communities, and practitioners. Our approach recognises that sustainable change is only

possible when those impacted by family violence can contribute and lead through their lived realities and when it is grounded in the belief that a truly inclusive, just, and safe system must recognise and respond to the diverse communities we serve.

Our current Strategic Plan, available here, focuses on five pillars:

1. Partnership for systems impact
2. Lived/Living Experience leadership
3. Strengthening our workforce
4. Prevention/early intervention
5. Evidence-informed strategy

Local Government Areas

The BPIFVP encompasses the Victorian LGAs of Bayside City Council, Frankston City Council, Glen Eira City Council, Kingston City Council, Mornington Peninsula Shire Council, Port Phillip City Council, and Stonnington City Council.

Domestic, family, and sexual violence (DFSV) and suicide

The relationship between DFSV victimisation and suicide

There is a strong, consistent, and well-observed relationship between DFSV victimisation and increased suicide risk. Across specialist family violence services, lived experience expertise, and frontline practice, suicidality is not understood as an isolated mental health issue, but as a situational and trauma-driven response to chronic, interpersonal, and power-based harm.

DFSV is rarely a single incident. It is more often cumulative and ongoing, characterised by coercive control, fear, isolation, and loss of autonomy. This form of trauma is particularly damaging to mental health and sense of self.

"Suicide risk increases not because victims "want to die," but because the violence can make life feel inescapable, unsafe, and unbearable." BPIFVP member

Several key pathways between DFSV and suicide risk are consistently identified in practice:

- **Complex trauma and PTSD**: Repeated exposure to abuse, particularly by someone trusted, commonly results in complex PTSD. Symptoms such as hypervigilance, emotional numbing, intrusive memories, dissociation, and persistent hopelessness are strongly associated with suicidal ideation.
- **Entrapment and loss of agency**: Victim-survivors frequently describe feeling trapped financially, emotionally, culturally, or through threats relating to children, immigration status, or safety. Suicide can emerge as a perceived escape when all other exits feel blocked.
- **Shame, self-blame, and identity erosion**: Coercive control tactics such as humiliation, gaslighting, and blame-shifting can lead victim-survivors to internalise responsibility for the violence. This erosion of identity and self-worth is a powerful driver of suicidal thinking.

- **Social isolation**: Many perpetrators deliberately isolate victim-survivors from friends, family, and community. This removes critical protective factors and is particularly evident in culturally and linguistically diverse communities.
- **Co-morbid mental health and substance use**: Depression, anxiety, dissociation, and substance use often develop as survival responses to violence. Each independently increases suicide risk and can compound harm when violence continues.
- **Exacerbation of pre-existing vulnerabilities**: Where victim-survivors or their children have pre-existing mental health conditions, neurodivergence, or learning differences, DFSV can significantly intensify distress and suicidal ideation, particularly where specialist, trauma-informed supports are scarce or inaccessible.

In practice, suicide risk is observed to escalate at specific points, including:

- when violence intensifies,
- during separation or after leaving a perpetrator,
- when child custody is threatened or contact with children is disrupted,
- following failed help-seeking attempts, such as not being believed, minimised responses, or exclusion from services,
- and when housing, financial security, or continuity of support is lost.

Victim-survivors often present to health or mental health services with depression, anxiety, self-harm, or suicidality, while the underlying DFSV remains undisclosed or unrecognised. Where service responses focus narrowly on mental health symptoms or physical safety without addressing coercive control, ongoing contact with the perpetrator, or systemic barriers, suicide risk can remain unmitigated.

"Where the family violence has been cumulative and persistent over time, victim-survivors often present with marked hopelessness and feelings of being trapped, at times expressing no other way out other than suicide" *BPIFVP member*

Lived experience advocates and practitioners highlight that system complexity, long wait times, lack of specialist expertise, and financial barriers frequently lead to people disengaging from help altogether. For some, suicidal ideation emerges or worsens after years of navigating systems that are fragmented, inaccessible, or not equipped to

respond to the intersection of DFSV, trauma, and suicidality, including for children and young people.

Importantly, practice experience consistently shows that suicidal ideation often reduces once safety, belief, practical assistance, and trauma-informed support are established. This reinforces that suicidality in the context of DFSV is largely contextual and preventable, rather than intrinsic to the individual.

How DFSV victimisation contributes to suicide risk and incidence

Practice experience, lived experience expertise, and frontline service responses consistently indicate that DFSV victimisation contributes directly to both increased suicide risk and suicide incidence. The relationship is not incidental; it is driven by identifiable mechanisms that accumulate over time and are often intensified by system responses.

Victim-survivors commonly describe profound powerlessness, hopelessness, and entrapment within a cycle of abuse they cannot safely escape. This sense of being unable to stay and unable to leave is a critical driver of suicidality. Suicide risk in this context is not typically impulsive but rather emerges as a perceived last option when all other pathways to safety and stability appear closed.

"In my work, suicidality most often appears in the context of prolonged fear, entrapment, and loss of agency, rather than as an isolated mental health issue." *BPIFVP member*

Key mechanisms through which DFSV contributes to suicide risk and incidence include:

- **Chronic psychological harm**: Prolonged exposure to violence produces sustained stress responses, hypervigilance, emotional dysregulation, anger, shame, and self-blame. These experiences are frequently accompanied by depression, anxiety, and trauma-related symptoms, all of which elevate suicide risk.
- **Coping through substance use**: Alcohol and other drug use often emerge as survival strategies to numb pain or manage trauma. Rather than reducing risk,

substance use can compound distress and, critically, lead to exclusion from housing, crisis accommodation, and specialist DFSV services, inadvertently escalating suicide risk.

- **Entrapment and erosion of agency**: Victim-survivors often experience a progressive loss of control over decisions relating to safety, housing, finances, and parenting. As agency erodes, suicide can become framed as the only remaining decision within their control.
- **Weaponisation of distress by perpetrators**: Mental health struggles, substance use, and suicidal ideation are frequently exploited by perpetrators to discredit victim-survivors, threaten child removal, undermine credibility with services, or justify further control. This deepens despair and reinforces help-seeking avoidance.
- **System responses that compound harm**: Many victim-survivors describe disclosing violence in good faith, only to have their experiences minimised, not believed, or used against them within service systems. The disconnect between encouragement to "speak up" and punitive or dismissive responses can intensify trauma and suicidal ideation.
- **Intersecting forms of disadvantage**: Suicide risk is heightened where DFSV intersects with disability, homelessness, substance use, or poverty. For culturally and linguistically diverse victim-survivors, additional stressors such as racism, language barriers, visa insecurity, lack of social networks, and limited understanding of local systems further inhibit help-seeking and increase isolation and despair.

"Victim-survivors have expressed experiencing coming out of the abuse, a place where they have been gaslit, belittled and silenced, into a service system that on face value encourages them to speak their truth, but when they do, it is used against them, falls on deaf ears, or is twisted, discounted or not believed. The victimisation along with lack of supports co-contribute to increased suicidal ideation and suicide rates." *BPIFVP member*

Practitioners and lived experience advocates report seeing victim-survivors articulate suicide explicitly as a contingency plan when safety, housing, financial security, and child-related outcomes feel unattainable. In this sense, suicide risk in the context of DFSV is often predictable and preventable, arising from cumulative harm and systemic abandonment rather than from individual pathology.

Prevalence, patterns, and any identifiable at-risk groups observed in practice

Across family violence, mental health, alcohol and other drug (AOD), and community services, exposure to domestic, family and sexual violence (DFSV) is extremely common among people presenting with suicidality, even when it is not the initial reason for presentation. In many cases, a history of DFSV only becomes apparent after trust is established, meaning prevalence is likely under-identified in routine suicide risk assessments.

"In my work across AOD, mental health, and family violence contexts, exposure to DFSV is extremely common, particularly among people presenting with suicidality or repeated crisis episodes." BPIFVP member

Prevalence

- DFSV is frequently present among people experiencing suicidal ideation, recurrent self-harm, or repeated crisis presentations.
- Sexual violence is disproportionately prevalent among people with chronic or recurrent suicidal ideation, particularly women and gender-diverse people.
- Duration and pattern of abuse matter: chronic exposure to coercive control, emotional abuse, and repeated sexual violence is associated with significantly higher suicide risk than isolated incidents.

"We often observe that suicidal ideation escalates during periods where the victim-survivor is attempting, or has recently attempted to leave, the relationship. In these cases, the person using violence often intensifies their abuse as a way of punishing the victim-survivor and reinforcing/ re-establishing control. Victim-survivors can lose hope during these periods, coupled with an escalation in family violence risk." BPIFVP member

Patterns observed in practice

Clear and consistent patterns emerge regarding when and how suicide risk escalates:

- **Timing and escalation points**: Suicide risk commonly increases during periods of transition or system involvement, including:

    - attempting to leave or having recently left the perpetrator,
    - separation, family law proceedings, or child custody disputes,
    - escalation of controlling behaviours or threats by the person using violence,
    - housing loss or instability,
    - and child protection involvement.

  Risk may also spike after immediate physical safety improves, when trauma symptoms intensify, and practical supports reduce.
- **Hidden and misidentified presentations**: Many victim-survivors present with depression, anxiety, substance use, self-harm, or repeated crises without disclosing the full extent of violence. Psychological abuse and coercive control, which are strongly predictive of suicidality, are less visible and less likely to be recognised than physical injury.
- **System-related harm and re-traumatisation**: Suicidal ideation often intensifies following:
    - not being believed or having disclosures minimised,
    - advice to "just leave" without practical or financial support,
    - lengthy and adversarial court processes,
    - child protection responses that place responsibility on the victim-survivor or compel contact with the person using violence,
    - or service systems that mirror patterns of control, disbelief, or punishment experienced within the abusive relationship.

      These experiences reinforce entrapment, shame, fear, and hopelessness.
- **Reluctance to disclose due to fear of consequences**: Parents and caregivers often avoid disclosing suicidal ideation or deteriorating mental health due to fear of child protection intervention or loss of custody, further increasing unaddressed risk.

Identifiable at-risk groups

While DFSV-related suicidality cuts across all demographics, risk is heightened for particular groups, especially where multiple forms of disadvantage intersect:

- Women and gender-diverse people
- First Nations people
- Culturally and linguistically diverse victim-survivors, particularly those experiencing:

    - migration stress and visa dependency,
    - language barriers,
    - racism and discrimination,
    - fear of authorities or community repercussions,
    - and legal system misidentification or failure
- LGBTQIA+ victim-survivors experiencing rejection, isolation, or discrimination
- Pregnant and early-parenting people
- People experiencing housing insecurity or homelessness
- People who use substances
- People with disabilities or neurodivergence
- People navigating multiple systems simultaneously, particularly child protection, AOD, mental health, housing, and justice systems

Risk increases significantly where these factors overlap, particularly during periods of system transition, exclusion, or loss of agency.

Children and young people

Children and young people who experience DFSV represent a significant at-risk group for suicidal ideation and self-harm. DFSV can have profound and lasting impacts on children's emotional regulation, sense of safety, and self-worth. Practice experience indicates that suicidality in children and adolescents often emerges alongside feelings of fear, powerlessness and responsibility for the violence, particularly where exposure is prolonged or combined with system responses that prioritise contact with the person using violence over the child's expressed safety and wellbeing. Risk is further heightened for children involved in child protection and family law systems, where repeated assessments, forced contact arrangements, and lack of trauma-informed responses can compound distress and reinforce a sense of entrapment and hopelessness.

Key Issues Affecting Children and Young People

1. **Trauma and Developmental Impact**
   Children exposed to family and sexual violence often live in environments of chronic stress that disrupt healthy emotional, social and cognitive development.

This trauma can persist into adolescence and adulthood, contributing to increased risk of self-harm and suicidal behaviour.

2. **Under-Recognition of Risk**

   Current systems may inadequately identify and respond to the full spectrum of violence experienced by children and young people, including emotional abuse, coercive control and neglect. These forms of violence are less visible than physical injury but can be equally harmful and contribute to cumulative trauma that elevates suicide risk.

3. **Service Access and Fragmentation**

   Services for children and young people affected by family violence are often fragmented across child protection, mental health, education and community support systems. Lack of coordination can delay identification of risk and access to timely support, further exacerbating mental health outcomes.

4. **Data Gaps**

   There are significant limitations in the quality and consistency of data regarding how many children and young people exposed to family violence go on to experience suicide attempts or deaths. Better data is needed to understand prevalence and to tailor effective prevention and support strategies. The inquiry's terms of reference highlight improving data collection practices and consistency across jurisdictions as a priority.

Key areas of need

1. **Comprehensive Early Identification and Risk Assessment**
   - Develop and implement standardised, trauma-informed screening tools across healthcare, education and child protection settings to identify children at risk from DFSV and monitor suicide risk over time.
   - Integrate assessment of violence exposure and mental health risk into routine care for all children presenting in clinical, school or community contexts.
2. **Enhanced Coordinated Support Frameworks**
   - Fund and expand multi-disciplinary, child-centred response teams that bring together mental health, child protection, education and community services to provide holistic support for affected children and families.

- Ensure continuity of care with long-term follow-up and case management for young people identified as at risk of suicide following exposure to family violence.

3. **Strengthened Education and School-Based Supports**
    - Support schools to play an active role in identification, early support and referral for students exposed to family violence, including through wellbeing staff training and strengthened partnerships with mental health and family violence services.
4. **Improved Data Collection, Reporting and Research**
    - Prioritise data linkage and research to map the pathways from family violence exposure to suicide attempts and deaths among children and young people.
    - Establish consistent national metrics for monitoring DFSV exposure and suicide risk outcomes in children to support evidence-informed policy and practice.

Suicide and threats of suicide as a tactic of coercive control by perpetrators

Suicide and threats of suicide are widely recognised across specialist family violence, mental health, and lived experience perspectives as a common and deliberate tactic of coercive control used by perpetrators.

In practice, people using violence frequently threaten suicide, self-harm, or overdose to induce fear, guilt, and compliance, particularly when a victim-survivor attempts to set boundaries, disclose violence, or leave the relationship. These threats often function to:

- prevent separation,
- silence disclosure,
- force ongoing contact,
- and position the victim-survivor as responsible for the perpetrator's safety.

Victim-survivors consistently report being compelled into a caretaker role, especially where children are involved, fearing that leaving or disengaging may result in the perpetrator's death — and that they will be blamed for it. This dynamic entrenches entrapment and reinforces control.

Observed tactics include:

- explicit threats of suicide or overdose,
- sending images or messages depicting suicidal behaviour to force immediate contact,
- repeated crisis presentations timed to moments of perceived loss of control,
- and the use of substance use and overdose risk to obscure accountability.

"A pattern that we have also observed is victim-survivors disclosing that the person using violence has sent them pictures relating to suicidal ideation (i.e.: the person using violence laying on a train track), as a mechanism to force the victim-survivor to call them and make contact." BPIFVP member

Practitioners note that these behaviours are frequently misinterpreted by systems as standalone mental health crises, rather than recognised as intentional strategies of control. This misinterpretation can unintentionally reinforce violence, displace responsibility onto victim-survivors, and increase risk for all parties.

"These behaviours are often interpreted by systems as mental health crises rather than recognised as intentional strategies of control. In my view, this misinterpretation allows violence to continue and increases risk for everyone involved" BPIFVP member

At the same time, all suicide threats are treated as serious indicators of risk. Evidence and practice experience demonstrate that suicide threats in the context of DFSV are associated with elevated risk of suicide and homicide–suicide, particularly during periods of separation, escalation, or loss of control. These behaviours therefore require an immediate safety response without minimising their coercive function.

Data

Reporting on deaths as a result of DFSV

Reporting practices are limited and inconsistent. Some organisations report deaths only where the deceased was an active client, meaning deaths connected to DFSV may go

unreported where individuals were not formally engaged with services at the time of death. This creates significant blind spots, particularly for people who disengage, are timed out of services, or never access formal supports.

Where applicable, deaths are reported in accordance with legislative requirements, including through coronial processes. However, reliance on client engagement status and fragmented reporting pathways means that DFSV-related deaths – including suicides – are likely undercounted.

Inadequacy of existing data collection practices related to DFSV and suicide

Existing data collection practices are widely viewed as inadequate and under-representative of the true relationship between DFSV and suicide.

Key limitations include:

- **Service visibility bias**: Data largely captures only those who are already engaged with services, excluding people who disengage, are excluded, or never access formal support.
- **Coronial classification constraints**: Determining suicide requires evidence of intent and capacity. In cases involving coercion, extreme distress, intoxication, or ongoing abuse, deaths may be classified as accidental or receive open findings, even where practitioners believe coercion or cumulative violence contributed.
- **Insufficient recognition of coerced suicide**: Practitioners report situations where professional judgement strongly suggests that a victim-survivor was coerced toward suicide, but this context is not adequately captured in investigations or datasets.
- **Limited integration of family violence information** into suicide determination processes, leading to the loss of critical contextual evidence.

As a result, DFSV-related suicide – particularly where coercive control is present – is likely systematically underestimated.

Issue with data across jurisdictions

Data collection and reporting are fragmented, siloed, and inconsistent across jurisdictions and systems. There is no shared platform or integrated dataset linking information held by

police, family violence services, mental health, child protection, emergency services, housing, or justice systems. Each operates with separate reporting requirements, definitions, and thresholds.

This fragmentation prevents:

- accurate identification of patterns,
- tracking of cumulative harm across systems,
- and a national understanding of how DFSV contributes to suicide risk and incidence.

Responding to suicide in the context of DFSV

Across practice settings, effective responses to suicidality in the context of DFSV prioritise safety, context, and agency, rather than treating suicide risk as an isolated mental health issue.

Current responses include:

- structured risk review processes following suicide threats, attempts, or deaths,
- multidisciplinary oversight and investigation,
- consultation between family violence and mental health specialists,
- psychoeducation for victim-survivors about suicide threats as a form of coercive control,
- and safety planning that explicitly considers coercion, escalation, and system-related risks.

"When working with a person experiencing violence, suicide threats used to prevent separation or enforce compliance are family violence and coercive control. These threats are treated as serious indicators of risk, including elevated risk of suicide or homicide–suicide, while the focus remains on the survivor's safety, agency, and access to supports"

BPIFVP member

However, there is strong consensus that policies and frameworks require significant improvement. Current approaches often:

- prioritise individual pathology over structural and relational drivers,

- fail to consistently identify coercive control and suicide threats as DFSV tactics,
- respond to substance use as instability rather than as a survival response,
- and escalate surveillance, compliance, or exclusion rather than safety and autonomy.

These responses can unintentionally increase suicide and overdose risk, particularly during separation, housing loss, or child protection involvement.
Suggested improvements include:

- Explicit recognition of DFSV as a driver of suicide risk within suicide prevention frameworks
- Routine identification of suicide threats, encouragement to self-harm, and coerced overdose as forms of family violence
- Violence-informed, harm-reduction approaches that do not exclude people from safety due to substance use
- Stronger cross-sector collaboration between DFSV, mental health, AOD, housing, justice, and child protection systems
- Greater integration of specialist family violence expertise to prevent misidentification and system-induced harm

Other related matters

The Impact of historical DFSV on suicide risk evidence and practice experience indicate that the impacts of DFSV are often cumulative and enduring, rather than time limited. Traumatic experiences of violence – including childhood exposure to family violence, intimate partner violence earlier in adulthood, and sexual violence – can have long-lasting effects on mental health and wellbeing, with suicide risk emerging or intensifying many years after the violence has ceased.

For some people, particularly victim-survivors who did not receive trauma-informed or specialist support at the time of the violence, the impacts may remain latent and resurface later in life. This can occur during periods of transition or stress, such as relationship breakdown, parenting challenges, menopause, ageing, physical illness, disability, housing insecurity, or bereavement. In these contexts, earlier DFSV-related trauma may be

reactivated, contributing to suicidal ideation, depression, substance use, or a renewed sense of entrapment and hopelessness.

"My experiences of trauma from over 30 years ago continue to shape my sense of self and impact my mental health. The feelings of worthlessness and shame can rise up when life's challenges compound, often leaving me feeling like there is no point in staying, and that those around me are better off without me. What he said and did to me all those years ago is still a dark shadow trailing after me" Lived experience advocate

Current data collection and suicide surveillance systems are poorly equipped to capture these pathways. Coronial processes and service data tend to focus on proximate risk factors, such as recent mental health presentations, substance use, or relationship stress, without adequately recognising the role of historical DFSV as an underlying driver. As a result, the contribution of DFSV to suicide risk is likely to be significantly under-identified, particularly for older people and those whose experiences of violence occurred decades earlier.

Failure to recognise historical DFSV risks misattributing suicide risk solely to individual pathology, while obscuring the structural and gendered violence that shaped vulnerability over time. This limits opportunities for prevention, early intervention, and accountability.

Key Recommendations

Relationship between DFSV and suicide (including risk factors and pathways)

Recommendation 1

That the Inquiry formally recognise domestic, family and sexual violence, particularly coercive control, cumulative trauma, and exposure across the life course, as a primary and preventable driver of suicide risk and incidence, rather than as a secondary or correlational factor.

Recommendation 2

That suicide prevention frameworks explicitly acknowledge entrapment, loss of agency, chronic fear, and system-induced harm as key pathways through which DFSV contributes to suicidal ideation and behaviour.

Prevalence, patterns, and at-risk cohorts

Recommendation 3

That national suicide prevention policy and data frameworks explicitly recognise heightened suicide risk during predictable escalation points, including:

- separation and attempts to leave,
- housing loss,
- child protection involvement,
- court and legal processes,
- service transitions, exclusions, or withdrawal of supports.

Recommendation 4

That targeted and culturally safe responses be strengthened for groups experiencing intersecting disadvantage and heightened suicide risk, including:

- women and gender-diverse people,
- First Nations people,

- culturally and linguistically diverse victim-survivors,
- LGBTQIA+ communities,
- people with disability or neurodivergence,
- pregnant and early-parenting people,
- children and young people,
- people experiencing homelessness or substance use, particularly where multiple systems are involved simultaneously.

Early identification, prevention, and child-centred responses

Recommendation 5

That standardised, trauma-informed screening and risk assessment tools be developed and implemented across healthcare, education, and child protection settings to identify children and young people exposed to DFSV and monitor suicide risk over time.

Recommendation 6

That assessment of family violence exposure and mental health risk be integrated into routine clinical, school-based, and community service responses for all children and young people, rather than relying on disclosure during crisis.

Suicide and threats of suicide as a feature of coercive control

Recommendation 7

That suicide threats, encouragement to self-harm, coerced overdose, and repeated suicide attempts used to induce fear or compliance be formally recognised in policy, risk frameworks, and practice guidance as tactics of coercive control and family violence.

Recommendation 8

That service systems be supported to respond to suicide threats in the context of DFSV as both:

- serious indicators of suicide and homicide–suicide risk, and
- intentional strategies of control,

without mischaracterising them as merely manipulative or as isolated mental health crises.

Data collection, coronial processes, and national consistency

Recommendation 9

That data collection practices be improved to better capture DFSV-related suicide, including:

- integration of family violence histories across the life course into suicide data,
- improved recognition of coerced suicide and cumulative harm,
- reduced reliance on service engagement as a proxy for prevalence.

Recommendation 10

That coronial processes be strengthened to ensure investigations consistently consider:

- coercive control,
- psychological abuse,
- and patterns of DFSV,

particularly where deaths are classified as accidental or receive open findings despite indicators of coercion.

Recommendation 11

That a nationally consistent, cross-jurisdictional approach to DFSV and suicide data be developed, enabling appropriate information sharing across police, health, education, family violence, housing, child protection, and justice systems.

System responses, prevention, and service improvement

Recommendation 12

That suicide prevention and DFSV responses adopt violence-informed, trauma-informed, and harm-reduction approaches, particularly for people who use substances or experience mental health complexity, to prevent exclusion from safety and support.

Recommendation 13

That specialist family violence expertise be embedded within suicide prevention, crisis response, school wellbeing, and post-incident review processes to reduce misidentification, victim-blaming, and system-induced harm

Recommendation 14

That sustained investment be made in integrated, trauma-informed mental health and suicide prevention supports for children and young people impacted by DFSV, including:

- multidisciplinary, child-centred response teams,
- continuity of care and long-term follow-up,
- and targeted supports for children with disability or neurodivergence.

Appendix

BPIFVP Members

Member Organisation	Community Services Sector/s
Alfred Health	Health Services Mental Health & Alcohol & Other Drug Services
Anglicare	Perpetrator Services (Men's specialist family violence services)
Better Health Network	Perpetrator Services (Men's specialist family violence services)
Better Place	Elder abuse services
BPA Child & Family Services Alliance	Child & Family Services Alliances
City of Port Phillip	Maternal and child health services
Department of Education	Education
Department of Families, Fairness and Housing	Child Protection
Department of Justice and Community Safety	Court services
Emerge	Specialist family violence services
Family Life	Child and family services Perpetrator Services (Men's specialist family violence services)
Good Shepherd	Specialist family violence services Risk assessment and management panels
inTouch	Multicultural services
JewishCare	Multicultural services

Member Organisation	Community Services Sector/s
Peninsula Community Legal Centre	Community legal centres
Peninsula Health	Perpetrator Services (Men's specialist family violence services) Mental Health & Alcohol & Other Drug Services
Victoria Police	
Sacred Heart Mission	Housing and homelessness services
SECASA	Sexual assault services
South Port Community Housing Group	Housing and homelessness services
Southern Homelessness Services Network	Local area service networks (homelessness)
Southside Justice	Community legal centres
The Orange Door	
The Salvation Army	Specialist family violence services
Thorne Harbour Health	Specialist family violence services
Uniting Vic.Tas	Child and family services
Women's Health in the South East (WHISE)	Community and women's health services
Windana	Mental Health & Alcohol & Other Drug Services