

19 March 2026

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

Submitted via email: spla.reps@aph.gov.au

Dear Committee Members,

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

The Australian Psychological Society (APS) welcomes the opportunity to provide a submission to the *Inquiry into the relationship between domestic, family and sexual violence and suicide (the Inquiry)*, and commends the Committee for examining this critical issue.

The APS is the leading professional association for psychologists in Australia. Our members work across health, mental health, community and justice systems and frequently support individuals and families affected by domestic, family and sexual violence (DFSV) and suicide risk. Psychological expertise is critical to understanding the impacts of violence, coercive control and trauma, and to supporting effective prevention, risk assessment and recovery.

The attached submission outlines evidence and recommendations regarding the relationship between DFSV and suicide, drawing on relevant research as well as insights from psychologists working in this field.

We consent to this submission being made publicly available. Should further information be required, please contact me at the APS National Office on (03) 8662 3300 or via email at z.burgess@psychology.org.au

Yours sincerely,

Dr Zena Burgess, FAPS FAICD
Chief Executive Officer

Response to Terms of Reference

The Australian Psychological Society (APS) provides the following response to the Inquiry into the relationship between domestic, family and sexual violence and suicide.

Term of Reference 1

The relationship between domestic, family and sexual violence (DFSV) victimisation and suicide

Domestic, family and sexual violence as a major health and welfare issue

Domestic, family, and sexual violence (DFSV) is one of the most significant health and welfare challenges facing Australia¹. It encompasses behaviours used to exert power, control, or cause harm within intimate, family, or other relationships. These behaviours include physical, sexual, emotional, and psychological abuse, coercive control, financial abuse, technology-facilitated abuse, and stalking¹⁻³.

Coercive control refers to an ongoing pattern of behaviours that restrict a victim-survivor's autonomy and create an ongoing climate of fear, intimidation, and entrapment^{4,5}. Emotional abuse is the most prevalent form of partner violence experienced by women in Australia, with 1 in 5 women reporting emotional abuse by a partner since the age of 15⁶.

Despite its prevalence, DFSV is frequently not recognised or recorded as such by individuals, services or administrative systems. As a result, its contribution to other serious harms, including suicide, is likely to be significantly underestimated. National reviews have suggested that suicides related to DFSV victimisation may occur at least three times as frequently as female domestic homicide deaths⁷.

DFSV as a relational determinant of suicide

Suicide has historically been framed primarily as the result of individual mental illness⁸. Contemporary suicide prevention research recognises that suicide emerges from the interaction of individual vulnerabilities, interpersonal relationships, and broader social determinants⁹. Within this framework, DFSV represents a significant relational determinant of suicide risk.

Victim-survivors of family violence may experience prolonged exposure to coercion, fear, social isolation, financial insecurity, housing instability and loss of autonomy¹⁰. These conditions can create a sense of entrapment in which individuals perceive few pathways to safety or independence.

Research examining women's deaths by suicide in Victoria highlights that suicide risk in the context of family violence often arises through the interaction of individual, relational, systemic and temporal factors, including coercive control, trauma, legal stressors and barriers to accessing support¹¹.

Evidence of the relationship and contribution to suicide incidence

A growing body of international and Australian research demonstrates a clear association between DFSV victimisation and increased rates of suicidal ideation, suicide attempts, and suicide deaths¹²⁻¹⁴.

Suicide occurs among both victim-survivors and perpetrators of DFSV. Australian coronial and domestic violence death review data provide further evidence of this relationship. Analysis of the Victorian Suicide Register identified a history of family violence in 24.5% of suicide deaths between 2009 and 2016, with the proportion higher (28.2%) among women¹⁵.

Similarly, an investigation by the Western Australian Ombudsman found that 56% of women who died by suicide in 2017 had previously been identified as victims of family and domestic violence¹⁶.

Death review processes also highlight the complex social circumstances surrounding these deaths. The ACT Domestic and Family Violence Death Review (2025) found that individuals who died by suicide in the context of family violence frequently experienced multiple compounding stressors, including unemployment, housing instability, and financial hardship¹⁰.

Taken together, these findings indicate that domestic and family violence is a significant contextual factor in many suicide deaths, particularly among women.

Underestimation and data limitations

Despite the growing evidence base, the true prevalence of DFSV related suicides is likely to be substantially underestimated. Several factors contribute to this underestimation:

- Violence is frequently underreported by victim-survivors, often due to fear of retaliation, stigma, or surveillance by perpetrators^{17,18}.
- Victims may be misidentified as the predominant aggressor by police or statutory services¹⁹.
- Administrative systems often record incidents rather than patterns of coercive control.
- Coronial investigations may emphasise proximal factors, such as substance abuse or relationship breakdown, without identifying the underlying pattern of coercive control.

These limitations mean that the contribution of DFSV to suicide deaths is likely to be substantially under-recognised within current administrative and coronial datasets.

Patterns and identifiable at-risk groups

Evidence indicates that DFSV contributes to suicide risk in patterned ways across the population.

Women experience disproportionately high rates of DFSV, with 27% of women in Australia experiencing intimate partner or family member violence before the age of fifteen²⁰. Periods of transition, particularly separation or attempts to leave, represent established periods of heightened risk for both violence escalation and suicide risk^{21,22}.

Children and young people are also profoundly affected by DFSV, either as direct victims or through displays of violence within the home. Exposure to family violence during childhood is associated with increased risk of suicidal ideation, suicide attempts, and long-term psychological harm, including vulnerability to future interpersonal violence²¹⁻²³. A study of children exposed to DFSV in Western Australia found that by age 18, children who had been exposed to domestic and family violence were 79% likely to have had contact with mental health services, compared with just 16% of those who had not been exposed²⁴.

Aboriginal and Torres Strait Islander peoples experience heightened vulnerability to DFSV and suicide due to intersecting structural and historical determinants²⁵⁻²⁷. Aboriginal and Torres Strait Islander people are overrepresented as both victims and perpetrators of DFSV, with women and children particularly at risk²⁵. These harms occur within broader contexts of social disadvantage, which increase exposure to trauma and limit access to culturally safe supports. Colonisation, dispossession and the Stolen Generations have contributed to intergenerational trauma linked to cycles of violence and family disruption²⁸. Exposure of children and young people to DFSV further compounds trauma and vulnerability to later mental health harms²⁹. Together, these factors contribute to elevated suicide risk, with Aboriginal and Torres Strait Islander peoples dying from suicide by at least twice the rate of non-Indigenous Australians²⁶.

LGBTIQA+ people experience elevated rates of family violence and suicide-related behaviours^{30,31}. Transgender and bisexual individuals are at particularly elevated risk^{30,31}.

People from culturally and linguistically diverse (CALD) backgrounds may face heightened vulnerability to both DFSV and suicide due to intersecting structural and social stressors. Migration-related factors such as visa dependency, language barriers, and social isolation can increase vulnerability to abuse and create barriers to help-seeking. A national Australian survey of migrant and refugee women found that one in three respondents reported experiencing domestic and family violence³². CALD communities are also recognised as a priority population for suicide prevention in Australia due to elevated risks associated with mental health stressors and barriers to accessing care³³.

People with disability are disproportionately exposed to DFSV, with Australian data indicating they are more than twice as likely as those without disability to experience intimate partner or sexual violence^{34,35}. They are recognised as a priority population for suicide prevention in Australia due to elevated rates of suicide and self-harm. National monitoring data indicate that people who accessed disability services died by suicide at a rate approximately three times higher than the general population³⁶.

People living in rural, regional and remote communities may face heightened vulnerability to DFSV due to geographic isolation, limited service availability, and barriers to disclosure and help seeking³⁷. Research shows that victim-survivors in regional, rural and remote areas often face reduced access to specialist DFSV, mental health and crisis supports, alongside lower anonymity and stronger community visibility, which can make it harder to seek safety or support³⁸. Suicide risk is also higher outside major cities, with national monitoring data showing that suicide rates increase with remoteness in Australia³⁹.

Summary

Evidence from Australian and international research and data demonstrates a clear relationship between DFSV victimisation and suicide. Several consistent patterns emerge:

- Suicide risk in DFSV contexts is strongly gendered, with women disproportionately represented as victim-survivors.
- Periods of transition, particularly separation, represent high-risk points for both violence escalation and suicide.
- Structural disadvantage and intersecting inequalities compound vulnerability across population groups.
- Children are frequently affected where violence and suicide intersect.
- DFSV is systematically under identified within administrative and coronial data.

These findings indicate that DFSV and suicide cannot be treated as separate issues managed by separate systems. Effective prevention requires coordinated responses across violence prevention, mental health and social policy systems.

Term of Reference 2

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

As outlined in our response to Term of Reference 1, a growing body of evidence demonstrates a relationship between DFSV and suicide. However, the extent of this relationship is difficult to quantify because national data systems do not consistently capture the role of DFSV in suicide deaths. Several structural limitations contribute to this gap:

- DFSV histories are not consistently recorded within coronial data systems. The National Coronial Information System does not include standardised or mandatory fields requiring documentation of family violence victimisation or perpetration in suicide deaths. As a result, the role of DFSV is often identified only through retrospective research or jurisdictional death reviews rather than routine national reporting.
- Data relating to suicide and DFSV are held across multiple systems that are poorly integrated, including police, health, coronial, child protection and specialist DFSV services. Differences in legislation, data definitions and reporting practices across jurisdictions limit the ability to conduct consistent national analysis.

- DFSV death review processes vary across jurisdictions. While several states operate domestic and family violence death review mechanisms, their scope and methodology differ. Some review homicide deaths only, while others examine a broader range of fatalities including suicide. This fragmentation limits the development of a comprehensive national evidence base.

Jurisdictional reforms demonstrate the potential for more integrated approaches to risk identification and information sharing. For example, Victoria's Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)⁴⁰ establishes a system-wide approach to identifying, assessing, and managing family violence risk across multiple sectors, supported by legislated information-sharing arrangements^{41,42}. While currently limited to Victoria, the framework illustrates how coordinated systems can strengthen identification and response to family violence risk.

We note that important contextual information about DFSV victimisation and suicide risk may be identified within psychological practice but is rarely captured within administrative datasets. Individuals may present to psychologists with symptoms such as anxiety or depression, with the underlying context of family violence emerging gradually through therapeutic work. Because psychological services, particularly in private practice, operate largely within therapeutic settings outside existing data linkage systems, this information rarely contributes to national reporting or death review processes.

Term of Reference 3

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

Evidence from DFSV death review processes indicates that both victim-survivors and perpetrators who die by suicide commonly have contact with multiple services in the months preceding their death¹⁰. This may include police, courts, health and mental health services, child protection, and specialist family violence services. These interactions represent important opportunities for early identification and intervention. However, current systems often struggle to recognise and respond effectively to suicide risks in the context of DFSV.

Separation of suicide and DFSV risk assessment

Across many service settings, suicide risk and family violence risk are assessed through separate frameworks.

In health and mental health services, suicide risk assessments typically focus on individual clinical factors such as mental health disorders, substance use and recent life stressors. Screening for DFSV is not always routine in suicide-related presentations, meaning that victim-survivors may present following a suicide attempt without the underlying context of violence being identified.

Conversely, family violence risk assessment processes often focus on immediate threats to victim safety without systematically considering suicide risk among either victim-survivors or perpetrators.

This separation can obscure the ways in which suicide risk and family violence risk interact. Suicide threats, for example, may represent both indicators of genuine distress and tactics of coercive control (see Term of Reference 4). When these risks are treated as separate issues, opportunities to identify escalating harm may be missed.

Fragmented service responses

Individuals experiencing DFSV frequently interact with multiple systems simultaneously, including police, courts, health services, housing providers and specialised support services. Despite this, coordination across these systems is often limited.

Police responding to incidents involving both DFSV and suicide threats must balance responsibilities relating to victim safety and the immediate welfare of the individual making the threat⁴³. In practice, responses may prioritise short-term crisis intervention through mental health pathways, without coordinated assessment of ongoing violence or long-term safety planning^{43,44}.

Death review findings also indicate that perpetrators are less likely to engage voluntarily with services designed to address their use of violence¹⁰. Contact with services is more commonly triggered by police involvement or court processes, limiting opportunities for earlier intervention.

Transitions between systems can also create gaps in risk management. For example, individuals discharged from hospital following suicide-related presentations may return to environments where DFSV risks remain unaddressed. Without structured information-sharing and coordinated responses across health and family violence systems, opportunities for prevention may be missed.

Exclusion of key professionals from coordinated risk management

Psychologists and other mental health professionals frequently support individuals affected by DFSV. Victim-survivors may disclose violence when utilising psychology services, and perpetrators may engage with mental health services following police or court involvement.

Despite this, psychologists working in private practice are often structurally excluded from coordinated risk management processes. Multidisciplinary responses are widely recognised as best practice in high-risk DFSV cases⁴⁵, yet current funding arrangements such as Medicare do not support psychologists to participate in case coordination meetings with other services. As a result, professionals who may hold important information about an individual's experience of violence and suicide risk are often absent from the forums where risk is assessed and managed across systems.

Children may also face barriers to accessing psychological support. In some cases, perpetrators may withhold consent for children to access psychology services in separated families where DFSV is present, delaying or preventing access to care for children exposed to violence.

These systematic limitations highlight the need for more integrated approaches to risk identification, information sharing and coordinated intervention across systems. Opportunities for strengthening these responses are discussed further in Term of Reference 5.

Term of Reference 4

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

Coercive control refers to a pattern of behaviours used by perpetrators to establish and maintain dominance over another person⁴⁶ through intimidation, isolation, surveillance, and threats that restrict autonomy and create ongoing fear^{3,4,43}. Within this pattern, threats of suicide or self-harm may be used as a tactic of control^{3,4,43,47,48}.

Australian research suggests that suicide threats are a common feature of coercive control. One study found that approximately 39% of women who experience coercive control reported being subjected to threats of suicide or self-harm by their partner⁴⁹. Research and death review evidence indicate that suicide threats frequently arise in DFSV contexts when perpetrators perceive a loss of control over the victim-survivor, such as during separation, attempts to leave the relationship, or legal proceedings⁵⁰⁻⁵². In these situations, threats of self-harm may function as implicit or explicit ultimatums intended to compel compliance, discourage disclosure of abuse, or prevent the victim-survivor from leaving the relationship^{43,44,52}.

The ACT Domestic and Family Violence Death Review found that suicide threats were commonly present among perpetrators who later died by suicide¹⁰. As with other findings, the ACT Review also noted that perpetrator suicides often occur during periods of relationship separation or in the context of legal proceedings, including criminal charges or family court matters¹⁰. The presence of substance misuse and mental health conditions have likewise been identified^{10,53}.

Importantly, **coercive intent and genuine suicide risk may coexist**. A perpetrator may simultaneously experience suicidal distress while using threats of self-harm as a mechanism of manipulation or control^{44,53}. This creates significant complexity for professionals responding to suicide threats in DFSV contexts. When such threats are interpreted solely as indicators of a mental health crisis, the coercive function of the behaviour may be overlooked, and the safety of victim-survivors deprioritised. Conversely, dismissing threats as purely manipulative risks failing to identify genuine suicide risk⁴⁴.

National risk assessment frameworks recognise suicide threats as an indicator of heightened risk in family violence contexts. The ANROWS National Risk Assessment Principles identify suicide threats as a lethality risk factor in intimate partner violence cases⁵⁴. However, there is currently no nationally consistent framework for assessing suicide risk and DFSV risk simultaneously.

Evidence also indicates substantial overlap between the risk profiles of perpetrators who die by suicide and those who commit intimate partner homicide. These include histories of coercive control, sexual violence, non-fatal strangulation, stalking, and threats to kill^{10,53}. The presence of suicide risk among perpetrators should therefore not be interpreted as reducing the risk of harm to others.

Recognising suicide threats within the broader context of coercive control is critical for effective risk assessment and prevention. Understanding these behaviours as both potential indicators of distress and tactics of coercion enables more balanced responses that address the safety of victim-survivors while also responding appropriately to suicide risk.

Term of Reference 5

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

Evidence outlined in Terms of Reference 1-4 indicates that individuals who die by suicide in the context of DFSV frequently have contact with multiple services prior to their death. However, these systems do not consistently recognise the intersection between suicide risk and DFSV risk, and opportunities for early intervention are often missed.

Reducing suicide deaths in this context requires earlier identification of risk, improved coordination between systems, and better access to psychological support for victim-survivors and affected children.

Recommendation 1: Integrate suicide and DFSV risk assessment

The APS recommends that the Commonwealth Government support the development of national guidance for integrated risk assessment, ensuring that suicide and DFSV risks are assessed together rather than through separate frameworks. This guidance should:

- Require routine screening for DFSV, including coercive control in suicide-related presentations across health and mental health services.
- Require consideration of suicide risk within DFSV risk assessments, including risk among both victim-survivors and perpetrators.
- Provide practical guidance for professionals responding to suicide threats that may function both as indicators of distress and tactics of coercive control.

Recommendation 2: Improve national data collection on DFSV related suicide

The APS recommends that the Commonwealth Government work with states and territories to strengthen national data collection on suicide deaths occurring in the context of DFSV. This should include:

- Introducing standardised recording of DFSV victimisation and perpetration within coronial investigations and national suicide datasets.
- Supporting national data linkage between coronial, police, health, child protection and specialist DFSV service datasets.

- Developing nationally consistent methodologies for DFSV death review processes, including examination of suicide deaths where DFSV is a contributing factor.

Improved national data infrastructure would support more accurate monitoring of DFSV-related suicide and inform more effective prevention strategies.

Recommendation 3: Strengthen intervention at high-risk transition points

The APS recommends that the Commonwealth Government work with states and territories to establish structured intervention protocols at key transition points associated with elevated risk, including:

- Separation or attempts to leave a violent relationship.
- Family law proceedings.
- Release of perpetrators from custody.
- Discharge from hospital following suicide-related presentations.

These protocols should support information sharing, coordinated safety planning, and multi-agency risk management where DFSV risks are identified.

Recommendation 4: Support multidisciplinary responses in high-risk cases

The APS recommends that the Commonwealth Government support greater participation of psychologists and other relevant professionals in multidisciplinary DFSV risk management processes. This could include:

- Introducing Medicare funding to support psychologist participation in case coordination meetings and multidisciplinary care arrangements.
- Supporting formal referral pathways between psychology services and specialist family violence services in high-risk cases.

These measures would support the inclusion of clinical insights about violence and suicide risk in coordinated responses.

Recommendation 5: Improve access to psychological support for victim-survivors

The APS recommends that the Commonwealth Government improve access to trauma-informed psychological services for victim-survivors of DFSV. This should include:

- Allowing access to Medicare-funded psychology services without a general practitioner referral where DFSV is identified. This recognises that requiring GP referral may be impractical or unsafe for some victim-survivors (e.g. high-control perpetrators may accompany partners to GP appointments). Access should be supported through flexible identification pathways, including self-identification, referral from recognised support services, or identification by another appropriate service or qualified professional.
- Increasing the number of Medicare-funded psychology sessions available to victim-survivors of domestic and family violence, recognising that recovery from trauma and coercive control often requires longer-term support.

Improved access to psychological care supports both recovery and suicide prevention.

Recommendation 6: Support children affected by DFSV

The APS recommends that the Commonwealth Government work with states and territories to address barriers preventing children from accessing psychology services in DFSV contexts, including situations where perpetrators withhold consent for treatment. Children exposed to DFSV face increased risk of psychological harm and later suicidal behaviour. Early and timely access to psychological support is critical and should be recognised as a core prevention and early intervention strategy.

Recommendation 7: Build workforce capability and sustainability

The APS recommends that the Commonwealth Government support initiatives that strengthen workforce capability and sustainability across relevant sectors. Professionals working with people experiencing DFSV are frequently exposed to critical risk situations, distressing material, and high levels of responsibility for safety planning. The complexities of this work are heightened by the presence of suicide risk. Without appropriate support, professionals who provide DFSV services can experience burnout, vicarious trauma, and workforce attrition. Initiatives should include:

- National training to improve professional capability in recognising and responding to the intersection of suicide risk and DFSV.
- Funding for the APS to develop and deliver advanced DFSV training for psychologists and other health professionals.
- Establishing an APS-led national professional support service for practitioners working with DFSV.

The APS is well positioned to support the development and delivery of these initiatives through its national membership, training capability, and experience supporting psychologists working in high-risk practice areas. Partnering with the APS would enable the development of targeted training and professional support measures that strengthen workforce capability while promoting practitioner wellbeing and sustainability across sectors.

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time, knowledge, experience and evidence-based research to the development of this submission

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