

Tasmanian  
**Family and  
Sexual Violence**  
Alliance

**Submission to the House of  
Representatives Standing Committee on  
Social Policy and Legal Affairs' Inquiry into  
the Relationships between Domestic,  
Family, and Sexual Violence and Suicide**

February 2026

**Working together for a  
Tasmania free from family  
and sexual violence**



## **ACKNOWLEDGEMENT OF COUNTRY**

We acknowledge the Aboriginal and Torres Strait Islander peoples as the Traditional Custodians and first peoples on the land on which we live, work and play in lutruwita (Tasmania). We pay our respects to the Tasmanian Aboriginal community, to elders past and present and to all those who continue caring for country, sharing stories, and upholding rights. We acknowledge the impacts of colonisation and dispossession, and the contemporary disadvantage experienced by Aboriginal and Torres Strait Islander peoples. We also acknowledge the devastating impacts of family and sexual violence and child removal in Aboriginal communities and recognise the power of truth telling and ongoing leadership by Aboriginal communities in addressing and preventing family and sexual violence.

## **ACKNOWLEDGEMENT TO VICTIM-SURVIVORS**

We acknowledge Tasmania's victim-survivors of family and sexual violence. Victim-survivors hold the insights, knowledge, and expertise to inform primary prevention and systems change, and authentically embedding the lived expertise of victim-survivors is vital in addressing family and sexual violence in Tasmania. We acknowledge children and young people who are victim-survivors also hold expertise that must be valued and respected alongside that of adult victim-survivors. And we recognise the life-long impacts of trauma and acquired disability as a direct result of family and sexual violence.

## **SAFETY WARNING**

This report explores suicide, suicidal ideation, and self-harming behaviours in the context of family and sexual violence and may be distressing and traumatic. We advise readers to consider their personal contexts before proceeding and assess whether it is the right time to read about these matters.

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## **PREAMBLE**

We welcome this opportunity to contribute 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. As we document in this submission, the Tasmanian Family and Sexual Violence Alliance believes that there are critical points in responding to FDSV and suicidal ideation/intentional self-harm where knowledge of the relationship between the two is limited, and practice standards (including data collection) fail to grapple with the opportunities to prevent both. We appreciate the Standing Committee's attention to these matters, and look forward to working with the Tasmanian and Federal governments to address the research, policy, and practice gaps on FDSV and suicide.

## **ABOUT THE TFSVA**

The Tasmanian Family and Sexual Violence Alliance (TFDSVA) is the peak body for Family and Sexual Violence and represents the sector across the continuum of primary prevention, early intervention, response and healing and recovery. We amplify the voices of lived experience and practice knowledge to improve the family and sexual violence system, influence policy, and drive cultural change to end gendered violence.

## **TERMINOLOGY**

Throughout this submission, we use the term "family and sexual violence" (FDSV) to denote family violence, sexual violence, and child abuse. We use this term and acronym unless citing the title of this review, and other research, policy, and practice documents.

The terms 'people with disability' and 'women, girls, and gender diverse people with disability' are used in this submission. However, some people prefer other language, such as 'disabled woman' or 'woman with a disability'. We use person-first language as a default unless citing other research, policy, and practice documents.



## TERMS OF REFERENCE

- 1) The relationship between domestic, family and sexual violence (FDSV) victimisation, and suicide, and the extent to which FDSV victimisation contributes to suicide risk and incidence in Australia, including prevalence, patterns, and any identifiable at-risk groups, in order to improve understanding of the role of FDSV in suicides nationally;
- 2) Opportunities for improved reporting and investigation methodologies to accurately capture and report on deaths as a result of FDSV, including the adequacy of existing data collection practices related to FDSV and suicide, and the availability, quality, and consistency of data across jurisdictions;
- 3) How legal and justice systems, FDSV specialist services, health, mental health and other services recognise and respond to suicide in the context of FDSV;
- 4) The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of FDSV;
- 5) Opportunities to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of FDSV victimisation and perpetration; and
- 6) Any other related matters.



## EXECUTIVE SUMMARY

Domestic, family, and sexual violence (FDSV, including childhood abuse) are significant factors in the health and wellbeing of Australians, particularly women, girls, and non-binary people. FDSV is also a contributing factor to suicidal ideation, intentional self-harm, and suicide. While men and boys are more likely to die from suicide, women, girls, and non-binary people are more likely to engage in suicidal ideation and intentional self-harm. This means that for women, girls, and non-binary people, there are many more opportunities to intervene to prevent suicide.

As women, girls, and non-binary people are more likely than men and boys to experience FDSV, and are more likely to experience all forms of child sexual abuse apart from physical violence, a gendered and intersectional lens is necessary to understand the impact and consequences of this violence, including suicidal ideation, intentional self-harm, and suicide.

There is a mutually reinforcing relationship between childhood abuse, family violence, and suicide. Those Australians who experience childhood abuse are more likely to experience family and sexual violence (FDSV) as adults, and both childhood abuse and FDSV are strong predictors of suicidal ideation, intentional self-harm, and suicide. Additionally, some perpetrators of FDSV use threats of suicide as a form of coercive control, and this violence is under-reported to police and largely unrecorded by coroners.

As such, addressing the drivers of FDSV (including childhood abuse), and the contributing factors to both FDSV and suicide (such as victim-survivors being multiply marginalised, financial distress, and rurality) will contribute to preventing suicide in Australia. However, this requires that both mental health/suicide prevention and FDSV service providers are equally knowledgeable about the link between the two and are skilled in identifying the contributing factors to both.

Increasing workforce capability in both FDSV and suicide—especially first responders such as the police—along with more robust data collection and reporting are essential



to any suicide prevention strategy. This workforce development and resourcing is especially critical in Tasmania, where a significant proportion of the population lives in places where support services are scarce, with higher-than-average disadvantage and financial distress, and with high levels of functional illiteracy. Integrating the views of victim-survivors and adequately resourcing their contributions to policy and practice change is an essential first step to ensure that the strategies developed out of this consultation are fit-for-purpose in the Tasmanian context.



## BACKGROUND AND CONTEXT

### PREVALENCE OF SUICIDE, SUICIDAL IDEATION, AND SELF-HARM

#### Australia

According to the Australian Bureau of Statistics (ABS; 2022), in the previous 12 months:

- ➔ 3.3% had seriously thought about taking their own life,
- ➔ 1.2% had made plans to take their own life, and
- ➔ 0.3% had attempted suicide

Women (3.5%) were more likely than men (3.1%) to engage in any suicidal thought or intentional self-harm, however, men are more likely than women to die due to suicide.

Further:

- ➔ 8.7% of Australians aged 18-85 years had self-harmed in their lifetime
- ➔ 1.7% had self-harmed in the previous 12 months.

Again, women (2.2%, 10.4%) were more likely than men (10.4%, 6.8%) to self-harm in the previous 12 months or in their lifetime, respectively. Self-harming behaviours were more common for people aged 16-24 years, with 28% of girls and woman aged 16-24 years having engaged in self-harming behaviours in their lifetime.

Additionally, the Australian Institute of Health and Welfare (AIHW; 2025a) found that:

- ➔ 64% of Australians hospitalised for intentional self-harm injuries were women and girls
- ➔ The rate of intentional self-harm hospitalisations was higher for women and girls (115 per 100,000 population) than men and boys (65 per 100,000 population)
- ➔ The rate of intentional self-harm hospitalisations for girls aged 0–14 increased from 41 per 100,000 population (2019–20) to 71 (2020–21; 2021–22), before lowering to 56 in 2023–24.



## Tasmania

Drawing on the Australian Institute of Health and Welfare (2021) monitoring data, the *Tasmanian Suicide Prevention Strategy 2023-2027* (Mental Health, Alcohol and Drug Directorate 2022) notes that 800 Tasmanians have died by suicide in the previous 10 years. According to the ABS (2022) the rates of self-harming behaviours in Tasmania are complementary to the national average:

Table 1: Rates of suicidal ideation and suicide, comparison between Tasmania and Australian averages (ABS 2022)

SELF-HARMING BEHAVIOURS IN LIFETIME	TASMANIA	AUSTRALIA
Serious thoughts about suicide	16.7%	16.7%
Made a suicide plan	7.7%	7.4%
Attempted suicide	4.8%	4.9%

However, Suicide Prevention Australia in their *Tasmania Pre-Budget 2025-2026* (2024) submission notes that in 2023, the Tasmanian age standardised suicide rate was 14.9 per 100,000 compared with the national average of 12.0 per 100,000.

Additionally, while girls and women are just as likely as boys and men to think about, plan, and attempt suicide (ABS 2022), boys and men are more likely than girls and women to die from suicide. In Tasmania, of those that died by suicide between 2012 and 2018, 78% were boys or men (Garrett & Stojcevski 2021).

Further, 38% of Tasmanians have been close to someone who attempted suicide or died by suicide. Given the unique Tasmanian contexts linked to suicidality, including higher than Australian average of socio-economic disadvantage, alcohol and other drug use, illiteracy rates, and rurality, addressing the link between FDSV and suicide may require bespoke strategies.

A critical driver, impact, and form of FDSV, and a leading contributor to suicide, is financial distress. In the AIHW (2025d) report on suicide rates of recipients of income support payment between 2011 and 2021, they note that apart from recipients of carer, parenting, and student payments, all other recipients have a higher-than-average suicide rate. In particular, the rate of suicide for people on disability support payments



is 78.7 per 100,000 (with a higher rate for men, 96.5 per 100,000) and unemployment payments is 48.3 per 100,000 (again with higher rates for men, 67.9 per 100,000). The Australia average is 17.2 per 100,000.

As will be explored in the following sections, there are clear institutional data and research evidence demonstrating that domestic, family, and sexual violence victimisation is a key risk factor in suicide, suicidal ideation, and intentional self-harm.

## **PREVALENCE OF FAMILY AND SEXUAL VIOLENCE**

### **Family and sexual violence**

According to the ABS' *Personal Safety, Australia (2023c)* approximately 8 million Australians have experienced some form of violence since the age of 15 years. There were 2.8 million (14%) Australians who have experienced sexual violence (occurrence, attempt and/or threat of sexual assault) since the age of 15 years, and 3.8 million (20%) Australian adults who have experienced physical and/or sexual family and domestic violence since the age of 15 years. In 2024, the ABS noted that recorded sexual assaults reached a 31-year high, with an increase of 11% from 2023 to 2024. This increase, however, may be due to the increasing likelihood of these assaults being reported to police, which in 2024 was 69% of incidents.

As can be seen in Table 2, prevalence of violence varies considerably by gender, with women and girls reporting higher rates of violent victimisation (since the age of 15 years) across all variables apart from physical violence. In the case of sexual violence and intimate partner violence, the rates for girls' and women's victimisation are 2-3 times higher than that experienced by boys and men. Based on these figures, between one in five and a third of girls and women experience some form of FDSV since the age of 15 years.



Table 2: Violence prevalence rates from *Personal Safety, Australia 2021-22* (ABS 2023c)

VICTIMISATION	WOMEN	MEN
<b>Prevalence since the age of 15</b>		
Violence	39.0%	43.0%
Sexual violence	22.0%	6.1%
Physical violence	31.0%	42.0%
Stalking	20.0%	6.8%
<b>Prevalence of intimate partner and family member violence since the age of 15</b>		
Violence by an intimate partner or family member	27.0%	12.0%
Violence by a family member	8.1%	5.9%
Violence by an intimate partner	23.0%	7.3%
Violence by a boyfriend, girlfriend, or date	9.3%	2.3%
Cohabiting partner violence	17.0%	5.5%
Cohabiting partner emotional abuse	23.0%	14.0%
Cohabiting partner economic abuse	16.0%	7.8%
<b>Experiences before the age of 15</b>		
Childhood abuse	18.0%	11.0%
Witnessed parental violence during childhood	16.0%	11.0%

The AIHW (2023) also reports that 13% of Australians report that they had witnessed intimate partner abuse against a parent, of which more women (16%) than men (11%) had witnessed this violence. Witnessed violence against a female parent was more common (12%) than a male parent (4.3%).

In their analysis of the Australian Longitudinal Study on Women’s Health, Townsend et al (2022) found that sexual violence rates varied considerably based on age, with 51% of women in their 20s, 34% in their forties, and 26% of women aged over 68 years reporting that they had experienced sexual violence in their lifetime.

A significant and under-reported form of family violence is adolescent family violence (AFV). In ANROWS-sponsored research, Fitz-Gibbon et al (2022) found that of the 5,000 young people (aged 16-20 years) who participated in the study, 20% reported that they had used violence against a family member, of which, 10% involved using physical violence. The average age of first incident was 11 years, however 42% noted that they started engaging in violence from 10 years or younger. The primary victim-survivors of AFV were siblings (68%), mothers (51%), and fathers (37%). Stepparents and carers were least likely to be victimised (8%). Importantly, though, young people reported



that their use of violence was primarily retaliatory, including 93% of sibling abuse, 68% of violence against mothers, and 54% of violence against fathers.

The prevalence of intimate-partner sexual violence is important to contextualise both the family violence and sexual violence data. Contrary to rape myths, the ABS (2023c) found that the predominant perpetrator of sexual violence was an intimate partner (11.4%; compared with 6.1% by strangers, 5% by acquaintances or neighbours, 4.9% from friends or housemates, and 2.1% from other family members). Thirty-nine per cent of all sexual assaults reported to the police were family and domestic violence related (ABS 2024). Additionally, the Image-based Abuse National survey found that 13% of this violence is perpetrated by an ex-partner (Office of the eSafety Commissioner 2017).

A critical factor in the experiences of sexual and family violence is financial distress following victimisation. Townsend et al (2022) found that women who had experienced sexual violence were more likely to have reported having high financial stress. Financial distress varied across age groups of victim-survivors, with women aged 24-30 years 43% higher, aged 40-45 years 30% higher, and those aged 68-73 years 45% higher financial distress than those who had not experienced violence.

### *Family and sexual violence in Tasmania*

As can be seen in Table 3 below, across all variables reported by the ABS (2023a) from *Personal Safety, Australian 2021-22*, Tasmanians report slightly higher prevalence rates than the Australian average in relation to violence experienced since 15 years of age, including intimate partner violence (28% v 23%) and sexual violence (43% v 39%). While these differences are not as pronounced when considering the prevalence rates in the last two years, Tasmanians report higher rates of victimisation than the Australian average on all variables.



Table 3: Women’s experiences of violence (*Personal Safety, Australia 2021-22*, ABS 2023a); comparison of Tasmanian and Australian rates

VICTIMISATION	TASMANIA	AUSTRALIA	AUSTRALIAN RANK
<b>Total violence</b>	42.6%	39.2%	
Sexual violence	26.0%	22.2%	Second highest
Physical violence	32.7%	30.8%	Fourth highest
<b>Intimate partner or family member violence</b>	30.8%	27.4%	
Intimate partner violence	28.1%	23.3%	Highest
<b>Violence by a cohabiting partner</b>	31.9%	27.3%	
Cohabiting partner violence	21.6%	16.9%	Highest
Cohabiting partner emotional abuse	28.3%	22.9%	Highest
Cohabiting partner economic abuse	19.6%	16.3%	Highest
<b>Sexual harassment</b>	56.8%	52.9%	Third highest
<b>Stalking</b>	21.1%	20.3%	Highest

Longitudinally, the reported rates of violent victimisation in Tasmania have fluctuated over the four *Personal Safety, Australia* survey from 2005 (ABS 2023c). As can be seen in Figure 1, Tasmania rates for reported sexual violence have remained relatively stable, whilst IPV has fluctuated with a low in 2016, decreasing, then increasing since 2005. Importantly, these fluctuating rates are as likely to be the result of external factors than an actual increase or decrease in the rates of victimisation. For example,

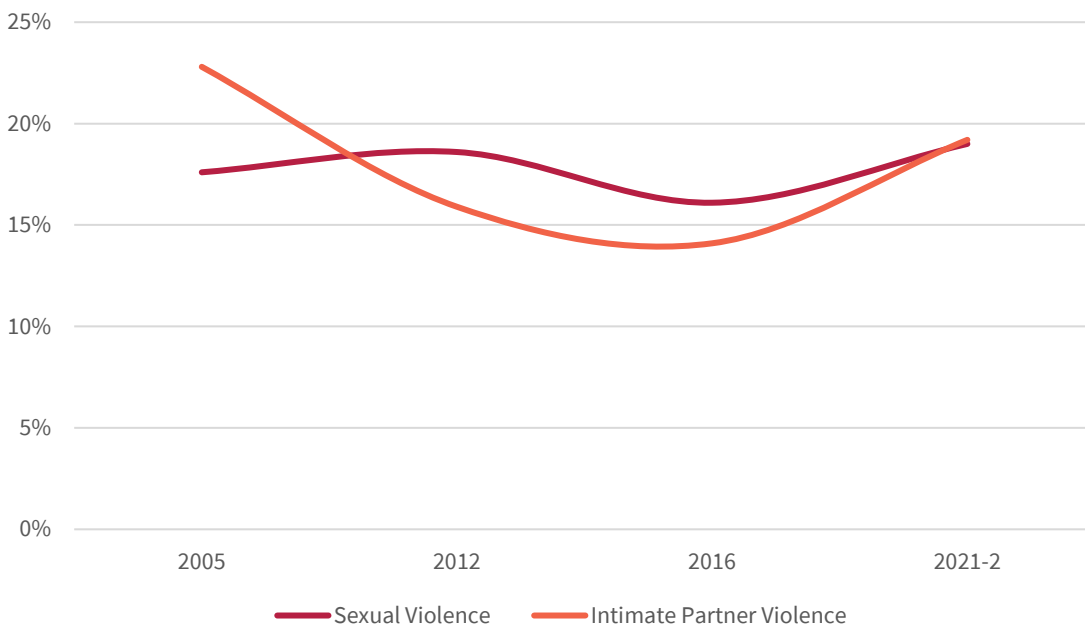


Figure 1: Tasmanian women’s experiences of violence (*Personal Safety, Australia 2021-22*, ABS 2023a); longitudinal



the uptick in IPV in the latest *Personal Safety, Australia* report may be an artefact of COVID19, as well as a possible increase in the recognition of what constitutes IPV.

## Child Abuse

While the ABS (2023b) found that 7.5% of Australians had experienced sexual abuse and 9.1% physical abuse as a child, and 13% had been exposed to domestic violence, the 2021 Australian Child Maltreatment Study (Mathews et al 2023) found much higher rates, including:

- ➔ 29% had experienced sexual abuse by any person
- ➔ 31% had experienced emotional abuse by a parent or caregiver
- ➔ 40% had experienced exposure to domestic violence as a child

Importantly, prevalence of child maltreatment varies considerably between genders, with gender diverse people and girls and women more likely to experience all forms of child maltreatment apart from physical abuse, which was more likely to be reported by boys and men.

As to child sexual abuse, of the 1.1 million Australian *women* who reported experiencing sexual violence as a child, 69% had experience more than one incident, 49% were between the ages of 5 and 9 years, and 15% had been abused by more than one perpetrator (ABS 2023b). Importantly, only 16% had reported their victimisation to the police. Perpetrators were known to the victim-survivor in 88% of all first instances of child sexual abuse, with family members (47%) being the predominant perpetrator; of which, non-immediate adult male relatives were the most likely perpetrator (25%), followed by father or step-father (16%).

Of the 343,500 Australian *men* who reported experiences of sexual violence as a child, 52% experience more than one incident, 51% were between the ages of 10 and 14 years, 6% of incidents involved more than one perpetrator, and only 1% had reported their victimisation to police (ABS 2023b). Perpetrators were known to the victim-survivor in 82% of first incidents, of which 32% of incidents were perpetrated by a family member.



The AIHW (2025c) found that child abuse substantiations increased with the remoteness of the child's residence (7.8 per 1,000 children in major cities, 23 per 1,000 children in remote and very remote areas). Further, Indigenous children were more likely than non-Indigenous children to have had a child abuse substantiation (48 per 1,000 children v 7.2 per 1,000 children, respectively). Additionally, Australians in the first (36%) and second (24%) socio-economic group (i.e. the most disadvantaged) were more likely to have at least one child abuse substantiation than those in the two highest SES groups combined (19%). It is important to note that these latter two results may not reflect a heightened rate of child abuse; rather, they may represent heightened rate of *reported* child abuse. Marginalised Australians are more likely than wealthier Australians to come in contact with law enforcement agencies and are subject to over-policing, especially First Nations people. For example, in their report, *Child Protection Australia 2021-22*, the AIHW (2025c) found that of the 1200 children who were subject to a substantiation of abuse in care, 46% were Aboriginal or Torres Strait Islander

While these statistics provide a good picture of FDSV, it is important to understand the local Tasmanian contexts to this violence, including the high level of illiteracy, high levels of rurality, and as a consequence, limited FDSV and suicide support services outside of the three major Tasmanian cities.

### *Child abuse in Tasmania*

In their report on the health and wellbeing of children and young people in Tasmania, the Australia Institute of Family Studies (2018) found that Tasmanian children lived with the highest levels of disadvantage in Australia, with two-thirds of Tasmanian children living in areas of relative disadvantage. Additionally, Tasmanian children were present in 50% of family violence incidents reported to Tasmania Police, and 15% of all victims of family violence-related assault were children and young people under the age of 19 years.

Despite the extensive work of the Commission of Inquiry (2023), Tasmania still has a dearth of research evidence on the prevalence of child abuse. While some data exists



on child abuse in out of home care, broader statistics on child abuse are not publicly available, and/or a subsumed in larger data sets such as those relating to sexual assault (which includes adults, with no capacity to filter for children and young people). In the Commission's report, they note that in 2019-2020, 2,234 Tasmanian children received child protection services, which represents 19.8 per 1,000 Tasmanian children. The national average is 31 per 1,000 children.

The AIHW 2022-23 (2025c) reports that of the Tasmania children with substantiated maltreatment, 37% relate to neglect, 31% emotional abuse, 15% physical abuse, and 6% sexual abuse. Most substantiated child abuse occurred in the first four years of the child's life, and there was nearly an equal rate for boys (48.4%) and girls (48%). Unlike the national picture that sees substantiation rates higher in remote and very remote areas (7.8 per 1,000 children in major cities, 23 per 1,000 children in remote and very remote areas), rates were higher for inner regional (4.4 per 1,000 children) than either outer regional (3.6) or remote (3.8). This may be due to the dispersed population in Tasmania.

In recent research by the National Centre for Action on Child Sexual Abuse (NSACSA 2024), the authors found that 81% of Tasmanians likely, very likely, or certainly to have known someone who has been sexually abused as a child, which was higher than all other Australian jurisdictions. Further, 16% of Tasmanians reported that a child had disclosed CSA to them, but 22% of Tasmanians did not agree that children should always be believed if they disclosed child sexual abuse. In the context of risk factors for suicide, the NCACSA (2024) noted that while there was good knowledge about CSA, Tasmanians reported problematic attitudes about victim responsibility, disclosure process and children's credibility, impacts and appropriate responses, and protective/preventative actions including the ability to detect risk. Problematic attitudes to the disclosure of CSA are red flags in terms of preventing suicide and responding appropriately to suicidal ideation and self-harm.



## THE RELATIONSHIP BETWEEN FDSV & SUICIDE

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### OVERVIEW

- ➔ There are significant relationships between suicide risk and the impacts of FDSV, with trauma present across all circumstances. The primary areas of consideration are:
    - **Economic Insecurity and Financial Abuse:** Financial distress represents a critical issue in the relationship between FDSV and suicide. Unemployment and low income are risk factors for suicide, and financial abuse is a primary barrier preventing women from leaving violent relationships.
    - **Separation and Divorce:** Emerge as key risk factors for both suicide and FDSV escalation. The greatest risk for violence occurs 6-12 months before divorce, with abuse often continuing for up to five years post-separation.
    - **Justice System Contact:** Justice system interaction appears as a stressor in 48% of Tasmanian suicides. Delays in prosecuting sexual violence or child abuse increase survivor precarity and suicidal ideation.
    - **Discrimination and Stigma:** The relationship between FDSV and suicide is most acute among specific population groups who face both structural and interpersonal violence due to systemic discrimination and stigma.
    - **Children and Adult Survivors of Child Maltreatment:** Childhood maltreatment—including abuse, neglect, and exposure to family violence—emerges as the leading predictor of suicide across the lifespan.
  - ➔ The Tasmanian Suicide Register reports that of the people who have died by suicide, 48% had experienced violence and 55% were separated from a partner.
  - ➔ 23% of women and 18% of men in Tasmania who died by suicide had experienced violence involving a *partner*, and 23% of women and 19% of men had experienced violence involving a *family* member.
  - ➔ The likelihood of suicide *attempts* and *ideation* increased significantly if exposed to partner violence (3.45 to 37.01 times, and 2.03 to 8.0 times more likely, respectively)
  - ➔ Suicide accounts for 32-38% of deaths of young people in Australia, which makes it the leading cause of death among Australian young people, including the leading cause of death for First Nations children aged 5-17 years.
  - ➔ There is clear evidence of a relationship between FDSV and perpetrators' suicidal ideation and suicide.
-



Given the level of suicide and self-harm reported by the ABS (2023a; 2023b; 2022) and AIHW (2025b; 2025d; 2025f; 2022b; 2021), understanding the contexts of suicide, suicidal ideation, and self-harm is essential in preventing these behaviours, supporting FDSV victims, and understanding the weaponisation of suicidal ideation in FDSV.

The Tasmanian Suicide Register reports that of the people who have died by suicide between 2012 and 2018:

- ➔ 48% had experienced abuse or violence
- ➔ 55% were separated from a partner
- ➔ 48% had contact with police, courts, or corrections over their lifetime
- ➔ 35% experienced financial stress
- ➔ 47% accessed a mental health care plan in the six weeks prior to their death
- ➔ 64% had at least one previous diagnosis of a mental illness
- ➔ 55% lived with alcohol or substance use issues
- ➔ 38% were isolated (physical/social)

Each of these characteristics are also factors in FDSV perpetration and victimisation. Further, using the Tasmanian Suicide Register 2012-2018 data, Garrett and Stocjcewski (2021) identified that of the 505 suicides in Tasmania during this period of analysis:

- ➔ 41% of women and 43% of men had experienced conflict with their *partner* prior to their death
- ➔ 23% of women and 18% of men had experienced violence involving a *partner* (whether as victim-survivor or perpetrator).
- ➔ 48% of women and 38% of men had experienced *family* conflict prior to their death
- ➔ 23% of women and 19% of men had experienced violence involving a *family* member (whether as victim-survivor or perpetrator).

**Family and intimate-partner violence are significant risk factors for suicide, with violence and abuse being a risk factor in approximately 50% of Tasmanian suicides.**



## Family and sexual violence

In their systematic review of international research on domestic violence and self-injurious thoughts and behaviours, Das et al (2025) found that a significant association between the two, with odds ratios (OR)<sup>1</sup> varying between 1.15 and 63.17. They also found that the likelihood of suicide *attempts* and *ideation* increased significantly if exposed to partner violence (3.45 to 37.01 times, and 2.03 to 8.0 times more likely, respectively). McManus et al (2022) found that any form of intimate partner abuse (physical, emotional, sexual, or economic) was strongly associated with suicidal ideation (OR 4.61) and non-suicidal self-injury (OR 6.97), and that partner rape had the strongest correlation with suicide attempts (OR 9.4). Additionally, these thoughts and behaviours were mediated by childhood trauma, PTSD symptoms, hope, agency, coping style, post-partum depression, and depressive symptoms (Das et al 2025).

The National Suicide Prevention Advisor (2020) also notes that risk of suicide varies considerably across the lifecourse, with family violence identified as a risk factor for children and adults, whilst young people may be influenced by “challenges with family and peer-based relationships”. Family violence was not identified as a risk factor for older people who had taken their own lives.

In addition to marginalisation and vulnerability, suicide risks emerge at transitional points. As noted by the National Suicide Prevention Adviser (2020), suicide and suicidal ideation often occurs when there is:

- ➔ divorce or a change in family structure
- ➔ disengagement and transition from school, TAFE, or university
- ➔ change in work status due to unemployment, illness, or injury
- ➔ discharge from hospital following a suicide attempt
- ➔ discharge from the Australian Defence Force
- ➔ release from a correctional facility

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<sup>1</sup> An odds ratio (OR) is a statistical measure of association that compares the likelihood of an event (e.g., suicide) occurring in an exposed group to the likelihood of it occurring in an unexposed group. An OR >1 indicates higher odds, <1 indicates lower odds, and 1 implies no association. For example, an OR of 5.21 means that the odds of being diseased in the exposed group are 5.21 times higher than in the unexposed group.



Of these transitional context factors, divorce or change in family structure are linked to experiences of FDSV. Divorce or separation from an intimate partner are key risk factors in family violence, with the greatest risk occurring 6-12 months before divorce (i.e., during separation) (Einiö et al 2022). However, as noted by ANROWS (2017), some forms of DFV are sustained long after separation and divorce, with 20% of men and 30% of women reporting that DFV continued for up to five years post-separation. ANROWS also found in qualitative research that two-thirds of their female participants reported continuing or escalating DFV post-separation. Twenty-five per cent of women and 17% of men report experiencing physical harm before separation, and 50% of men and 67% of women report experiencing emotional abuse before and during separation (ANROWS 2017). This means the risk of suicide and suicidal ideation may extend long after the initial change to family structure.

Beyond lifecourse factors, Garrett and Stocjcevski (2021) found that partner-related and other family member-related stressors (such as separation from partner [actual or threatened], conflict with and violence involving a partner or family member) were present in approximately 70% of suicide cases. Further, of the 505 suicides between 2012 and 2018 in Tasmania, violence or abuse were experienced by nearly 50% of those who died by suicide.

### **Child abuse**

Child maltreatment as measured by Adverse Childhood Events (ACE) and Cumulative Childhood Maltreatment (CCM) is highly predictive of *lifetime* self-harm, non-suicidal self-injury, suicidal ideation, suicide attempts, and deaths from suicide (Steine et al 2020; Maniglio 2011; Fedina et al 2023; Butler et al 2020; Spinhoven et al 2009). Fedina et al (2023) found that young people who have experienced both interpersonal and structural violence were 42 times more likely than those who have not experienced any violence to attempt suicide (OR 42.05, 95% CI [15.45, 114.42]). They were also 8.5 times more likely to attempt suicide than those who have experienced only interpersonal violence (OR 8.52, 95% CI [3.47, 20.94]).



Importantly, childhood abuse was also highly predictive of intimate partner abuse and sexual violence later in life, with those who experienced multiple forms of childhood abuse being six times more likely to experience IPV and seven times more likely to experience sexual violence since the age of 16 years (Butler et al 2020). The ABS (2023b) reported that Australians who had experienced child abuse before the age of 15 years (43%) were more likely than those who had not experienced child abuse (17.4%) to later experience intimate partner violence.

Spinhoven et al (2009) noted that childhood sexual abuse was significantly related to higher Suicide Cognition scale scores. Butler et al (2020) found that child psychological and physical abuse was associated with intimate partner abuse later in life, and child psychological and sexual abuse was associated with sexual violence victimisation later in life.

## **IDENTIFIABLE POPULATION GROUPS**

There are multiple identifiable at-risk groups who are over-represented in both the FDSV and suicide statistics. The race (especially, indigeneity), ethnicity, sexuality, gender, disability, and age characteristics of FDSV victim-survivors, whether considered independently or intersectionally, are all factors that increase the risk of suicide, suicidal ideation, suicide attempt, and deliberate self-harm. Here we enumerate some of the critical issues identified for young, First Nations, LGBTIQ+, and disabled people.

### **Young People**

Suicide is the fourth leading cause of death for young people worldwide (WHO 2021) and suicide accounts for 32-38% of deaths of young people in Australia, which makes it the leading cause of death among Australian young people (AIHW 2022b; Meyer et al 2023). These rates are heightened for LGBTIQ+ and First Nations young people, which are at least twice the rate of other young people. It is believed that one in two Australian young people have experienced and/or witnessed some form of DFV (Fitz-Gibbon et al 2022). It is therefore critical that any response to FDSV-related suicide



considers the unique factors that are driving young people's suicidal thoughts and behaviours, including their primary and secondary experiences of family violence. Meta-analyses of the relationship between child maltreatment and suicide have shown that young people aged five to 24 years who had experience adverse childhood events such as violence were three times more likely to attempt suicide than their peers (Meyer et al 2023). Additionally, there is a dearth of research or evidence around the experiences of young people as primary victim-survivors and/or perpetrators of family violence (see Hobbs 2022) and sexual violence, including lateral childhood abuse and adolescent violence in the home. Hobbs (2022) found that internationally it is estimated that 20% of young people experience physical violence and 10% experience sexual violence from their current or former partner.

As with adults, previous intentional self-harm and suicidal ideation are highly predictive of death by suicide (Meyer et al 2023), and that for every suicide of a young person, there are approximately 200 suicide attempts. Experiences of physical and sexual violence doubles that risk, with 14% of young people who attempt suicide having experienced childhood sexual abuse (cited in Meyer et al 2023). This means that if services are adequately funded and resourced—and they are available to young people across Tasmania—there are many opportunities for families, friends, and service providers to intervene before intentional self-harm or suicidal ideation progresses to a suicide.

Apart from specific inquiries, studies, and policy development on childhood abuse, young people are too often missed in our considerations of FDSV. Young people under the age of 16 years are not recognised in Tasmania's *Family Violence Act*, and youth services for victims of FDSV in Tasmania are scant. As identified by Meyer et al (2023), the reliance on tools such as the Adverse Childhood Events (ACE) scale to assess the impact of violence on young people means that we may miss the granular details of the relationship between specific forms of violence and suicide. As suggested by Vasil et al (2024), it is critical that we enhance our "...understandings and awareness of the circumstances within which children and young people die by suicide following family violence victimisation, and that we must understand and respond to young people's



experiences of family violence “in their own right” and not only as secondary victims of parents’ experiences of FDSV.

## First Nations

First Nations people in Australia experienced higher rates of all forms of intimate or interpersonal violence (family, sexual, and child abuse), and are at increased risk of suicidal ideation and suicide. Most critically, data holdings for First Nations people in Australia are scant, with the ABS *Personal Safety Australia* survey not seeking information on Indigenous status, which means comparative rates are difficult to provide. In place of these data, the AIHW relies on data collected by the ABS in their National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) and National Aboriginal and Torres Strait Islander Social Survey (NATSISS).

AIHW (2025g) reports that two in three First nations people in Australia over the age of 15 years have experienced physical harm in the last 12 months from an intimate partner or family member, and that 72% of hospitalisations for assault were due to family violence. Sixty-five to 82% of all assault of First Nations people were family violence related, and partners or ex-partners were identified as the perpetrator of 48-64% of all assaults. In 66%-87% of sexual assault incidents reported to police, First Nations victim-survivors knew their perpetrator. These rates are significantly higher than those reported by non-Indigenous Australians. In their 2022 report, *Our Watch* notes that Aboriginal and Torres Strait Islander women experience violence at 3.1 times the rate of non-Indigenous women, and that three in five women experience physical or sexual violence from a male intimate partner. Additionally, First Nations women are 11 times more likely than non-Indigenous women to die due to assault, and 32 times more likely to be hospitalised.

First Nations children are also more likely to be exposed to family violence, with two-thirds of Aboriginal and Torres Strait Islander adults who experience violence sharing the household with children, and family violence being the primary reason for the disproportionate numbers of First Nations children being removed from their families (*Our Watch* 2022). The reasons for First Nations overrepresentation in child protection



data is complex, as colonialism and the intergenerational effects of forced removal continue to shape both experiences and responses to child abuse. First Nations children (57 per 1,000) were significantly more likely than non-Indigenous children (4.7 per 1,000) to come in contact with child protection systems (AIHW 2025h).

Where ABS data is available (2022; NSW, QLD, SA, NT), the *reported* rates of family violence-related homicide ranges from 1 in 100,000 (NSW) to 10.1 per 100,000 (NT), and for family violence-related sexual assault (2023, NSW, QLD, SA, NT) ranges from 255.9 per 100,000 (NSW) to 91.6 per 100,000. As these only relate to reported rates, and First Nations people are significantly less likely to report to police, it is expected that these figures are an under-estimation of the extent of violence experienced by First Nations people in Australia.

The AIHW (2024) reports that suicide is the fifth leading cause of death for First Nations people in Australia, which accounts for 4.6% of all deaths (compared with 1.6% of all deaths of non-Indigenous Australians). Most critically, suicide is the leading cause of death for First Nations child aged 5-17 years. First Nations people are twice as likely as non-Indigenous Australians to die from suicide.

According to the ABS (2019) and WHO (2014), 'problems in relationship with spouse or partner' is the number one psychosocial risk factor for Aboriginal and Torres Strait Islander people identified in coroner-certified suicide deaths in 2017. Yet, the experiences and needs of First Nations people are largely ignored or not reported in the research on the relationship between FDSV and suicide (see for example, Vasil et al 2025).

Exploring the relationship between FDSV and suicide in First Nation communities necessitates different approaches to both research and capacity building. Unless Aboriginal Community Controlled Organisations (ACCO) are funded to do this work in partnership with governments, service providers, and researchers - the situation and our responses to this violence will remain opaque.



## LGBTQIA+

*Private Lives 3* (Hill et al 2020) reports that 42% of LGBTIQ have experienced at least one incident of intimate partner abuse, and 39% reported having experienced abuse by a family member. Non-binary people (29% physical violence - 52% verbal abuse) and transgender men (27%-46%) are more likely to experience physical, verbal, and sexual violence than cisgender men and women and transgender women. Queer (29%-52%) and pansexual (31%-51%) respondents reported higher rates than other sexualities. These results are similar to those of family violence, where non-binary and transgender men, and pansexual and queer respondents reporting higher rates of physical, verbal, and sexual violence from family members.

Gender diverse people's experiences of child maltreatment were significantly higher, and in many cases reported rates were 2-4 times that of cisgender men/boys and women/girls. For example, drawing on data from the Australian Child Maltreatment Study, Higgins et al (2025) found that 91% of gender diverse people and 85% of sexuality diverse people had experienced at least one form of childhood maltreatment. Additionally, trans and gender diverse Australians report significantly higher rates of sexual violence, with approximately 50% experiencing sexual violence or coercion at some point in their lives, with trans and gender diverse people assigned female at birth more likely sexual violence than those assigned male at birth (62% v 39%) (Ussher et al 2020). Parker et al (2024) found that 21% of trans and gender diverse participants had experienced sexual violence in childhood, adolescence, and adulthood, and Callander et al (2019) found that 53% of trans and gender diverse people had experienced sexual violence (compared with 13% of general Australian population). A

The AIHW (2025b), drawing on data from *Private Lives 3* (2020) and *Writing Themselves In* (2021) found that that between 64% (gay men) and 91% (trans men) of LGBTQIA+ Australians had thought about suicide, and more than half of trans men had attempted suicide in their lifetime. In their Australian study, Asquith et al (2024) found that 55% of respondents who had experienced sexual violence in their lifetime had engaged in *thoughts* of self-harm or suicide, and 22% had *acted* on those thoughts of self-harm



and suicide. The risk of attempted suicide was heightened for those who identified as bisexual (37%), non-binary (35%), cisgender female (38%), Aboriginal and/or Torres Strait Islander (58%), or disabled (58%) (Asquith et al 2024). These rates of suicidal thoughts and behaviours are significantly higher than the Australia average of 16.7% (thoughts) and 4.9% (acts). Similarly, Lhomond and Saurel-Cubizolles (2006) found that women who have sex with women are nearly five times more likely to attempt suicide than heterosexual women.

### Victim-Survivors with Disability

The Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability (2021) found that:

- ➔ Two in five (40% or 1.2 million) women with disability have experienced physical violence after the age of 15, compared with 26% (or 1.7 million) without disability.
- ➔ From the age of 15, 46% of women with cognitive disability and 50% of women with psychological disability have experienced sexual violence, compared to 16% of women without disability.
- ➔ Disabled First Nations women are 34 times more likely than non-Indigenous women to be hospitalised due to family and domestic violence.
- ➔ Women with disability are twice as likely to experience sexual violence over one year compared to women without disability.
- ➔ Of the L(G)BTIQ+ people who reported harassment or violence in the last 12 months, 46% had a disability.
- ➔ In 2016, the cost of violence against women with disability was estimated as \$1.7 billion.

The Queenslanders with Disability Network (2022) suggest that when compared to abled women, women with disability experience significantly higher levels of violence, and that this violence is more intense and frequent. In their study of the victimisation of people with disability in NSW, Ringland et al (2022) found that 11.1% victims of reported DV had experienced five or more incidents, and that FDSV victim-survivors were 2.57 times more likely to experience repeat victimisation within 12 months when compared with abled victim-survivors (Rahman 2017).



Their experiences of violence last longer, resulting in more severe injuries, and that women with disability are far less likely to receive service support to address violence, are often not believed when reporting FDSV, and are often denied the right to legal capacity and effective access to justice. This means that women with disability “...have considerably fewer pathways to safety” (Queenslanders with Disability Network 2022).

As can be seen in Table 4, in the two previous years, disabled women were more likely to experience partner abuse, physical violence, sexual violence, and emotional and economic abuse from their partner, and in the previous 12 months, sexual harassment (AIHW 2025e). These heightened rates of victimisation are compounded for women with a psychosocial disability, who experience these forms of violence at 2-3 times the rates of other women with disability, and 3-4 times the rate of abled women.

Table 4: Women’s Reported Experiences of Violence (18+ years; AIHW 2024)

Violence Type	Non-Disabled	Disabled	Psychosocial Disability
Partner Abuse (last 2 years)	1.5%	2.2%	6.1%
Physical Violence (last 2 years)	4.2%	5.8%	15.0%
Emotional Abuse by Partner (last 2 years)	4.6%	7.0%	13.0%
Economic Abuse by Partner (last 2 years)	2.4%	4.6%	11.0%
Sexual Violence (last 2 years)	2.5%	4.0%	12.0%
Sexual Harassment (last 12 months)	12.0%	14.0%	33.0%

Based on Australian Bureau of Statistics data from 2021-22, the AIHW (2025e) also notes that the prevalence of violent victimisation experienced by women varies depending on the level of support required by women with disability. Physical and sexual violence, emotional abuse, and sexual harassment rates are almost doubled for those with severe or profound disability. There is no data for this sub-group of women and girls with disability on partner abuse, which is a significant gap in the research evidence.

The AIHW (2025f) found that the rate of suicide for people who use disability services (which may not include all Australians with disability) was significantly higher than the



general population, with 38.2 per 100,000 for disabled men and 26.7 per 100,000 for disabled women compared to 17 per 100,000 and 6 per 100,000, respectively. As noted earlier in relation to financial distress and suicide, the rate of suicide for recipients of disability support payments (78 per 100,000) is significantly higher than all other the general population (17.2 per 100,000) (AIHW 2025d). Across all measures, men with disability are significantly more likely to suicide than women with disability. Suicide rates were significantly higher for those Australians with an acquired brain injury (58.5 per 100,000) or a psychosocial disability (100.6 per 100,000). Death by suicide account for 5.2% of all deaths of disability service users, which makes this the fourth leading cause of death for people with disability in Australia (AIHW 2025f).

### **SUICIDE AS A TACTIC OF FDSV COERCIVE CONTROL**

There is clear evidence of a relationship between FDSV and perpetrators' suicidal ideation and suicide. As identified by Woolley (2024), Fitzpatrick et al (2022), and Vasil et al (2025), in their close analyses of Australian coronial data and investigations, and in research with service providers, threats of suicide in the context of family violence are linked to both poor mental health and suicidal ideation *of* perpetrators, and coercive and controlling behaviours *by* perpetrators. In the Victorian Family Violence Multi-Agency Risk Assessment and Management (MARAM; 2019) Framework, threats of suicide are recognised as a form of coercive control that further limits and controls victim-survivors' freedom, choice, and autonomy. This violence creates conditions in which victim-survivors are made to feel responsible for the outcomes of perpetrators' actions and feel entrapped and obliged to "maintain the relationship with the perpetrator to prevent them taking their own lives" (Woolley 2024).

Fitzpatrick et al (2022) found that in 32% of suicides of rural Australian men, "disruption of family by separation or divorce" was a contributing factor. Further, threats of suicide were a high-risk predictor of family violence-related murder-suicide (cited in MARAM 2019). This risk of suicide is heightened during times of violence escalation, recent separation, when perpetrators engage in stalking and controlling behaviours post-separation, or when perpetrators are required to engage with legal



systems such as family court matters and family violence orders. Importantly, as noted by Fitzpatrick et al (2022), in responding to suicide risk in family violence matters, police often adopt a health system pathway rather than a criminal justice pathway. This leads in some cases to a perception that perpetrator accountability for violence is minimised (Vasil et al 2025).



## OPPORTUNITIES FOR INTERVENTION

### IMPROVED REPORTING & INVESTIGATION of FDSV

In their analysis of NSW data on sexual violence, BOSCAR (2025) found that of the 5,869 sexual violence incidents reported in 2018, in only 15% of incidents were criminal charges laid, 7% were proven, and only 5% resulted in a custodial sentence. Leaving aside the approximate 31% of sexual violence incidents not reported to police (ABS 2023c), this rate of attrition sends the message that sexual violence is both hard to prove and hard to prosecute. With 85% of incidents not proceeding beyond reporting, there are many opportunities for improving police practices given they are gatekeepers to justice for victim-survivors. Similarly, in Victoria, it was found that only one in seven incidents of sexual assault reported to police were proven in court and that attrition was “...highest during the police investigation stages of the justice system process” (cited Commission of Inquiry into the Tasmanian Government’s Responses to Child Sexual Abuse in Institutional Settings [hereafter, Commission of Inquiry] 2023).

Unlike the situation with attrition of sexual violence incidents (cited above), the Tasmanian Department of Public Prosecutions in their *2021-22 Annual Report*, noted that of the child sexual assault cases referred from Tasmanian Police between 2017 and 2021, 67% resulted in a conviction (compared with 5% of adult sexual assault offences). The reasons given for this extraordinary outcome for victim-survivors of child abuse was simply “...ensuring early contact with complainants, [and] the conduct of matters by experienced prosecutors and the pre-charging advice service” provided to Tasmania Police. With data holdings on attrition between police and prosecutors not being available (and another gap to be addressed), the full picture of attrition of child abuse cases is unclear, as too the relationships between this violence and suicide.

Multi-disciplinary centres, such as Arch in Tasmania, can contribute to better justice outcomes for victims-survivors with specialist sexual violence services working alongside a criminal justice response. The Arch model enables greater capacity to build expert knowledge and practice in the criminal justice system, and information



sharing between criminal justice providers, that were identified by the Commission of Inquiry (2023). However, more can be done across the broader Tasmanian police force in responding to victim-survivors given that often victim-survivors report, initially at least, to general duties officers. Tasmania Police have already made significant changes to the *Tasmania Police Manual* in response to the Commission of Inquiry findings. However, more can be done to ensure the policing workforce (sworn and unsworn) can better respond to FDSV victim-survivors. Addressing this opportunity to upskill the workforce may reduce the concerning rates of misidentification of the primary aggressor, disbelief of victim-survivors, especially children, and facilitate better justice outcomes, and reporting on FDSV in Tasmania.

As noted by the AIHW (2022a), data holdings for child abuse substantiations in Tasmania are scant, and were not reported on in their national study into child abuse and neglect. The Tasmanian Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings highlighted the critical data gaps in understanding child abuse in Tasmania (2023; see volume 7).

### **Opportunity 1: Enhance Justice System Investigation and Data Collection**

Explore opportunities for comprehensive training for all police officers (not just specialists) to improve initial responses to victim-survivors, addressing any sexist attitudes at recruitment and dispelling sexual and family violence myths during training so that FDSV-related incidents are appropriately recorded. Align risk assessment frameworks with national frameworks to support consistent understanding of FDSV across the country.



### **Opportunity 2: Collect Comprehensive Intersectional & Social Determinant Data**

Require major national surveys like the *Personal Safety Survey* to capture intersectional data (e.g., Indigeneity, LGBTIQ+ identity, disability status, rurality, cultural and linguistic diversity) for accurate comparative rate analysis and upstream social determinants (financial distress, housing insecurity, justice system contact, loneliness) to enable proactive prevention strategies. This longitudinal data is essential for designing culturally safe, inclusive services and identifying early intervention points before crises escalate.

### **Opportunity 3: Improve Child Maltreatment Data Systems**

Establish robust data collection systems for child abuse substantiations and implement mandatory tracking of FDSV case attrition at every stage from initial report through prosecution. Consider the adoption of the child sexual assault prosecution model for adult sexual assault cases, and develop data collection models that specify children as primary victim-survivors of FDSV (not secondary witnesses) to ensure appropriate intervention approaches. This must ensure that all children are included in data collection (e.g., family violence incidents with children as witnesses could translate to multiple children as victim-survivors).

## **SYSTEMS' RESPONSE TO FDSV-RELATED SUICIDE**

In addition to the practice priorities identified by sexual violence services (such as those proposed by Laurel House submission to this inquiry), Vasil et al (2025) identified critical gaps in our knowledge about the relationship between FDSV and suicide, many of which stem from the investigatory processes after the death of a victim-survivor and/or perpetrator. Coronial inquiries take into consideration “sufficiently proximate” and “causally related” factors in deaths by suicide. Unless details of FDSV matters prior to death are captured and evidenced, it is difficult for inquiries to report on the



relationship between FDSV and suicide. Similarly, if police do not report on FDSV matters (or as discussed in the previous section, opt for a health pathway to perpetrators' suicide attempts), the proximate impact of FDSV on a suicide outcome may not be recorded. Increasing the capacity of coroners and police to recognise and record threats of suicide/suicide attempts *and* FDSV matters will ensure that services have the necessary evidence to act to prevent both FDSV and suicide.

Further, as standard practice, coroners are required to engage with the senior next of kin of the deceased, which in many cases is the deceased's (ex-)intimate partner. In cases of FDSV-related suicide, this presents critical issues with the reliability of evidence provided by that next of kin. Unless coroners are aware of the proximate factor of FDSV, and seek the views of other next of kin, the relationships between FDSV and suicide will be hidden from consideration.

Increasing the capacity for frontline police to recognise and identify the use of suicide threats as a form of coercive control in family violence, sexual violence, and child abuse, is critical given they are justice gatekeepers *and* often mental health first responders. This requires more robust and nuanced first responder training in the complexity of coercive control in relation to suicide threats, and the upskilling of both recruits and serving officers (Woolley 2024).

Importantly, police and other first responders are often required to assess whether to apply a health or justice pathway when they encounter a perpetrator who threatens suicide in the context of family violence. Woolley (2024) found that “police are challenged in upholding the competing priorities associated with family violence perpetrators utilising suicide threats as a coercive and controlling behaviour”. Most importantly, Woolley suggests that attention needs to be directed to when a family violence order is applied in these cases. If not applied before hospitalisation of the perpetrator, police may not be aware that they have been released from hospital, and an order may not be issued in a timely manner, and further incidents of FDSV may occur. Juggling the “hierarchy of priorities” when a perpetrator threatens suicide requires clear standard operating procedures, so police are empowered to take actions to ameliorate the risk of further FDSV and suicide attempts.



#### **Opportunity 4: Reform Coronial Investigation Practices**

Explore how coroners can be supported to look beyond immediate cause of death to identify sufficiently proximate FDSV factors, seeking views from family and friends beyond the senior next of kin, as they may be the perpetrator or have conflicts of interest. Ensure police reports of FDSV matters prior to suicide are systematically captured and linked in coronial records to reveal patterns and prevention opportunities, including the use of threats of suicide as a form of coercive control.

#### **Opportunity 5: Implement FDSV-Informed Suicide Prevention in All Policies**

Ensure that the 'Suicide Prevention in All Policies' framework explicitly identifies FDSV as a risk factor, requiring all government portfolios—including housing, social services, and justice—to assess policies for their impact on both suicide risk and FDSV victimisation. Provide mandatory training to all policy officers in FDSV risk identification using national risk frameworks to ensure whole-of-government accountability moves beyond health departments alone.

#### **Opportunity 6: Expand and Evaluate Co-Responder Models**

Consider opportunities to expand on or develop co-responder models where police respond to suicidal crises alongside mental health clinicians. Include FDSV specialists in response models who can identify coercive control tactics, assess victim-survivor safety, and prevent perpetrators from weaponising mental health crises to avoid accountability. Establish evaluation frameworks to measure the effectiveness of these models in addressing the complex intersection of mental health crisis, trauma, and violence, ensuring all crisis responders are trained to recognise when suicide threats function as coercive control rather than solely as mental health emergencies.



## ENHANCE PREVENTION & INTERVENTION

As with all work in preventing and responding to interpersonal violence, the most significant opportunity open to governments to reduce both violence and suicide is to integrate the views and work of victim-survivors at all points in the systems governing these experiences. Victim-survivors bring embodied experience to our work, and when combined with the practice wisdom of practitioners, these perspectives are essential in the development of a national strategy for reducing FDSV and suicide.

Financial insecurity can exacerbate FDSV, and isolation tactics and coercive control such as economic abuse can have an enhanced effect on rural and remote Tasmanian communities. The complex interplay between FDSV, financial insecurity, and suicide was particularly impactful in rural and remote communities (Fitzpatrick et al 2022; Woolley 2024). In this context, the limited FDSV and suicide prevention services available to both victim-survivors and perpetrators outside of large cities, often means that there is higher risk of suicidal ideation and suicide. Further investment in FDSV and suicide prevention strategies and frontline services, and the creation of bespoke strategies for those living outside of Australian cities, are critical in addressing this complex interplay between rurality, financial distress, FDSV, and suicide.

Beyond the well-documented opportunities to prevent and intervene in FDSV—including macro factors such as gender inequality—there are systems-based opportunities to intervene in reducing the rates of suicide by both victim-survivors and perpetrators. Delays in justice, especially in sexual violence and child sexual abuse matters, can increase the precarity of victim-survivors and contribute to suicidal ideation and suicide, as too, outcomes of justice processes, such as the imminent release of a FDSV perpetrator from detention. Incorporating suicide in risk assessment tools in all justice processes may assist in early intervention and prevention. Additionally, given that intentional self-harm is a predictor of suicide, especially for women and girls, increased attention to these behaviours, and person-centred service delivery may prevent suicide.



### **Opportunity 7: Implement Suicide Risk Assessment in Justice Processes**

Implement mandatory suicide risk assessment tools at every justice stage—from initial police contact through prosecution, sentencing, and detention—to enable early intervention, and establish comprehensive data tracking systems for attrition rates between police and prosecutors to identify systemic barriers and inform understanding of the relationship between justice failures and suicide risk.

### **Opportunity 8: Prioritise Economic Security and Housing Interventions**

Implement large-scale government interventions addressing financial distress and housing insecurity immediately as primary prevention strategies for both FDSV and suicide, as sufficient evidence exists regarding these shared social determinants to justify action without waiting for perfect data. Develop bespoke strategies for rural and remote communities accounting for geographic isolation, service scarcity, and the enhanced impact of economic abuse as a coercive control tactic, while continuing to refine data collection systems in parallel to support long-term evaluation.

### **Opportunity 9: Increase Attention to Intentional Self-Harm as Suicide Predictor**

Establish enhanced screening, referral, and person-centred service delivery protocols for intentional self-harm behaviours, particularly among women and girls, recognising these behaviours as significant predictors of suicide requiring immediate intervention. Ensure all health, mental health, and FDSV services have capacity to respond therapeutically to self-harm while simultaneously addressing underlying violence and trauma.



### **Opportunity 10: Integrate Lived Experience into Strategy and Design**

Ensure meaningful integration of FDSV victim-survivor experience and specialist practitioner practice knowledge at all decision-making levels in national and state FDSV and suicide prevention strategy development, implementation, and evaluation processes. Establish formal mechanisms including paid advisory roles and co-design processes to ensure prevention efforts are grounded in the real-world complexities of navigating both violence and suicidal distress. Include population groups who have a deep understanding of the stigma and discrimination that impacts on both power, abuse, and suicidal distress.



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