Tasmanian
Family and
Sexual Violence
Alliance

Submission to the Consultation on the Towards Tasmania's next Mental Health Strategy

May 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 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.

Suggested citation: Tasmanian Family and Sexual Violence Alliance (2026) *Submission to the to the Consultation on the Towards Tasmania's Next Mental Health Strategy*. Hobart: TFSVA.

PREAMBLE

The Tasmanian Family and Sexual Violence Alliance welcomes this opportunity to contribute to the current consultation around Tasmania's refreshed Mental Health Strategy. As noted by our members who have made submissions, *Rethink* has made laudable steps towards a more integrated, responsive, and inclusive mental health system in Tasmania, including adopting dispersed models of care for rural and regional Tasmanians. We provide in this document our top-level thoughts about the next steps for *Rethink* as they relate to the needs of family and sexual violence victim-survivors.

In this submission we make a distinction between mental health services and the family and sexual violence (FSV) mental health support provided by specialist services, which are not recognised or considered in *Rethink and Beyond*. Integration of FSV mental health support into the service mapping and care continuum is essential if we are to drive the change required to end violence against women and children.

ABOUT THE TFSVA

The Tasmanian Family and Sexual Violence Alliance (herein, "the Alliance") 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 violence and sexual violence systems, influence policy, and drive cultural change to end gendered violence.

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EXECUTIVE SUMMARY

The Tasmanian Family and Sexual Violence Alliance (herein, "the Alliance") appreciates the significant innovations in practice over the term of *Rethink*, including the development of an emergency (non-policing) response services, dispersed service delivery outside of Hobart, foregrounding lived and living experience advocates and carers, and streamlining intake and referral. Our response to this consultation is focussed primarily on the intersections between *Rethink*, and *Survivors at the Centre*, *Change for Children*, *National Plan to End Violence against Women and Girls*, the CoI report, *Who was looking after me? Prioritising the Safety of Tasmanian Children*, *National Agreement on Closing the Gap*, *Tasmania's Plan for Closing the Gap*, and the *National Strategy to Prevent and Respond to Child Sexual Abuse*.[1]

We are deeply troubled that the guidance document for this consultation, *Towards Tasmania's Next Mental Health Strategy: Developing the next steps for Rethink and Beyond*, makes no reference to family violence, sexual violence, or child sexual abuse, or to victim-survivors. There is clear and resounding evidence about the lifecourse mental health impacts of violent, interpersonal victimisation, and while the discussion paper scopes important population groups requiring bespoke mental health responses, it seems remiss that one of the most impacted population groups is not considered at all.

Tasmania has the second highest rate of sexual violence in Australia, and highest rates of family violence and stalking. In this context, and in line with *Survivors at the Centre*, family and sexual violence must be front and centre in *Rethink and Beyond*.

[1] Tasmanian Government 2022, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022-2027*; Tasmanian Government 2025, *Change for Children: Tasmania's 10-year strategy for upholding the rights of children by preventing, identifying, and responding to child sexual abuse*; Commonwealth of Australia 2022, *National Plan to End Violence against Women and Children 2022-2032*; Commission of Inquiry into the Tasmanian Government's Responses to Child Sexual Abuse in Institutional Settings Report 2023, *Who was looking after me? Prioritising the safety of Tasmanian children*; Commonwealth of Australia 2020, *National Agreement on Closing the Gap*; Tasmanian Government 2025, *Tasmania's Plan for Closing the Gap 2025-2028*, Commonwealth of Australia 2021, *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*.

Table 1: Women's experiences of violence; comparison of Tasmanian and Australian rates[2]

VICTIMISATION	TASMANIA	AUSTRALIA	AUSTRALIAN RANK
Total violence	42.6%	39.2%	
Sexual violence	26.0%	22.2%	Second highest
Physical violence	32.7%	30.8%	Fourth highest
Intimate partner or family member violence	30.8%	27.4%	
Intimate partner violence	28.1%	23.3%	Highest
Violence by a cohabiting partner	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
Sexual harassment	56.8%	52.9%	Third highest
Stalking	21.1%	20.3%	Highest

Family and sexual violence (FSV) victim-survivors (and their children) carry enormous trauma, shame, and mental distress during and after victimisation, and their needs must be central to the development of the next mental health strategy for Tasmania. As noted in the discussion paper, adverse childhood events, especially before the age of five years, can have life-long mental health consequences if not addressed early. It seems a missed opportunity, therefore, that the strategy makes no reference to the Commission of Inquiry findings, nor the state and national plans and strategies for preventing and responding to child sexual abuse, sexual violence, and family violence.

The Royal Australian and New Zealand College of Psychiatrists[3], argue that there is a strong, evidenced, and complex relationship between family violence and mental health. They argue that

> …individuals who have experienced FV can suffer from a variety of long-term, chronic conditions such as post-traumatic stress disorder, major depressive illness, eating disorders, problematic substance use, chronic pain, generalised anxiety disorders and panic disorder.

As the Alliance noted in their submission to the Federal Inquiry into the relationship between domestic, family, and sexual violence (DFSV) and suicide[4]:

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2 Australian Bureau of Statistics 2023, *Personal Safety, Australia 2021-22*. Canberra: ABS

3 RANZCP 2021, *Family violence and mental health*. https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/family-violence-and-mental-health

4 Tasmanian Family and Sexual Violence Alliance (2026) *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*. Hobart: TFSVA.

- There are significant relationships between suicide risk and the impacts of DFSV, 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 DFSV 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 DFSV 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.[5] Delays in prosecuting sexual violence or child abuse increase survivor precarity and suicidal ideation.
    - **Discrimination and Stigma**: The relationship between DFSV 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 Maltreatmen**t: 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 family violence and 55% were separated from a partner.[6]
- 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.[7]
- 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).[8]
- 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.[9]
- There is clear evidence of a relationship between DFSV and perpetrators' suicidal ideation and suicide.[10]

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5 Garrett, A & Stojcevski, V 2021, *Report to the Tasmanian Government on Suicide in Tasmania. 1 January 2012 - 31 December 2018*. Tasmania Government Department of Health: Hobart.

6 *ibid*.

7 *ibid*.

8 Das, A, Suresh, S, Desai, G, & Satyanarayana, VA 2023, Domestic Violence and Self-Injurious Thoughts and Behaviors Among Adults: A Global Systematic Review. *Crisis*, 46(6), 334-344.

9 Australian Institute of Health and Welfare 2022, Suicide and self-harm monitoring. Deaths by suicide among young people. Retrieved March 7, 2023, from https://www.aihw.gov.au/suicide-selfharm-monitoring/data/populations-age-groups/ suicide-among-young-people; Meyer, S, Atienzar-Prieto, M, Fitz-Gibbon, K, & Moore, S 2023, *Missing Figures: The Role of Domestic and Family Violence in Youth Suicide - Current State of Knowledge Report*. Griffith University: Brisbane.

10 Woolley, J 2024, Policing perpetrator suicide threats in family violence cases: competing priorities and contemporary challenges. *Policing and Society*, 34(10), 997–1010; Fitzpatrick, SJ, Brew, BK, Handley, T,

Additionally, as identified by Layard et al[11], the gap between suicidal ideation and attempted suicide almost disappears for those victim-survivors who have experienced violence across their lifecourse (i.e., childhood, adolescence, and adulthood). While these statistics are focussed on the extreme end of mental ill-health, they reflect the significant mental illness burdened carried by FSV victim-survivors across the continuum of mental health care. Engender Equality, in their guide for mental health professionals, identifies that recent exposure to violence from an intimate partner is strongly correlated with negative mental health outcomes, and more so than any other known predictor such as prior history of poor mental health.[12]

Family and sexual violence can initiate mental distress and trauma, and mental illness can be a driver and determinant of FSV victimisation.[13]

Understanding the two-way relationship between mental illness and FSV victimisation is critical in mapping the mental health care continuum for victim-survivors, including addressing gaps in service delivery, systems abuse and systems disablers, and in setting priorities now and over the next five years.

Additionally, one of the most dangerous times for family violence victim-survivors is during and after pregnancy. Perinatal mental health is already under pressure at this time, which requires specialist mental health services. When this fraught time is combined with the onset or escalation of family violence, the wellbeing of victim-survivors is at risk.[14] There is also clear evidence of a relationship between experiences of childhood abuse, postpartum depression and intimate partner violence, with those

and Perkins, D 2022, Men, suicide, and family and interpersonal violence: A mixed methods exploratory study. *Sociology of Health & Illness*, 44(6), 991-1008; Vasil, S, Fitz-Gibbon, K, & Segrave, M 2025, *Family violence and women's deaths by suicide: A Victorian study.* Australian Catholic University, Sequre Consulting and University of Melbourne.

11 Layard, E, Parker, J, Cook, T, Murray, J, Asquith, NL, Fileborn, B, Mason, R, Barnes, A, Dwyer, A, Mortimer, S 2022, *LGBTQ+ people's experiences and perceptions of sexual violence*. ACON, Sydney, NSW.

12 Engender Equality 2016, *Supporting Individuals Experiencing Violence: A Guide for Mental Health Professionals*. Hobart: Engender Equality.

13 Engender Equality 2026, *Delayed Support, Heightened Harm: The Impacts of Long Wait Times for Specialist Family Violence Services*. Hobart: Engender Equality.

14 Howard, LM, Oram, S, Galley, H, Trevillion, K, & Feder, G 2013, Domestic violence and perinatal mental disorders: a systematic review and meta-analysis. *PLoS Medicine*, 10(5), e1001452; Ankerstjerne LBS, Laizer SN, Andreasen K, et al 2022, Landscaping the evidence of intimate partner violence and postpartum depression: a systematic review. *BMJ Open* 12, e051426.

women with a history of childhood abuse up to 2.6 times more likely to experience postpartum depression, and up to 3.2 times more likely to experience intimate partner violence.[15]

Increased integration between perinatal, FSV, and mental health services is essential if we are to avoid victim-survivors falling between the gaps. Perinatal depression is experienced by one in five women and gender-diverse people, and as with FSV and mental health generally, there is a two-way impact on mental health.[16] Postpartum depression can be a trigger for onset or escalation of family violence, and family violence can increase the impact of postpartum depression.[17] Further, postpartum depression and family violence can have devastating impact on maternal-infant bonding and long-term child development.[18]

Foregrounding the mental health concerns of victim-survivors is essential if the plan is to achieve its goals in reducing the long-term consequences of mental ill-health in Tasmania. This is all the more important in the context of proposed Machinery of Government restructure that would shift responsibility for frontline FSV services from Department of Premier and Cabinet to the Department of Health. The failure to include any reference to the scope of work undertaken by government and non-government specialist services in preventing, and responding to, FSV victimisation does not bode well for the shift in accountability and responsibility for addressing the wicked problems of family and sexual violence in Tasmania.

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15 Gartland, D, Woolhouse, H, Giallo, R, McDonald, E, Hegarty, K, Mensah, F, Herrman, H, & Brown SJ 2016, Vulnerability to intimate partner violence and poor mental health in the first 4-year postpartum among mothers reporting childhood abuse: an Australian pregnancy cohort study. *Archives of Women's Mental Health*, 19(6), 1091-1100; Zhang, S, Wang, L, Yang, T, Chen, L, Qiu, X, Wang, T, Chen, L, Zhao, L, Ye, Z, Zheng, Z, & qin, J 2019, Maternal violence experiences and risk of postpartum depression: A meta-analysis of cohort studies. *European Psychiatry*, 55, 90-101.

16 Kippert, A 2019, Postpartum Depression Linked to Domestic Violence. https://www.domesticshelters.org/articles/identifying-abuse/postpartum-depression-linked-to-domestic-violence; Bryson, H, Perlen, S, Price, A, Mensah, F, Gold, L, Dakin, P, & Goldfeld, S 2021, Patterns of maternal depression, anxiety, and stress symptoms from pregnancy to 5 years postpartum in an Australian cohort experiencing adversity. *Archives of Women's Mental Health*, 24(6), 987-997.

17 Beydoun, HA, Al-Sahab, B, Beydoun, MA, Tamim, H 2010, Intimate partner violence as a risk factor for postpartum depression among Canadian women in the Maternity Experience Survey. *Annals of Epidemiology*, 20(8), 575-583.

18 Necho, M, Belete, A, Zenebe, Y 2020, The association of intimate partner violence with postpartum depression in women during their first month period of giving delivery in health centers at Dessie town, 2019. Annals of General Psychiatry, 19(59); Gilbert, AM, Bauer, NS, Carroll, AE, Downs, SM 2013, Child Exposure to Parental Violence and Psychological Distress Associated With Delayed Milestones. *Pediatrics*, 132(6), e1577-e1583.

In the following sections, we respond to the consultation questions in relation to how family violence (including intimate partner violence, sibling abuse, adolescent violence within the home, child abuse and maltreatment, and elder abuse) and sexual violence intersect with mental illness. In addition to our responses below, we highly recommend that our suggested actions are considered alongside those proposed by our member organisations, especially the comprehensive Laurel House submission that captures many of the frontline, service delivery concerns about existing mental health strategies, actions, and services.

Our response to the consultation discussion paper is also couched in terms of the significant under-funding of specialist FSV services such as those provided by our members. Engender Equality in their research brief on this matter, notes that "dangerously delayed and inadequate service responses" to disclosure of FSV can have devastating flow on effects to recovery and healing.[19] Long wait times for emergency and ongoing mental health services for FSV victim-survivors severely damages the relationships between victim-survivors and specialist services, undermines trust and rapport building, and compounds the harms caused by victimisation. Delays and gaps in mental health services for victim-survivors can reinforce perpetrators' narratives about worthiness and shame, and deepen isolation and feelings of abandonment. Failure to recognise the significant work undertaken by specialist services in furtherance of the goals of the Mental Health Strategy will create additional disablers and stall victim-survivors from transitioning out of survival and into recovery mode. We offer in the next section a case study provided by Engender Equality that illustrates the critical mental health issues faced victim-survivors in a context of dangerously underfunded FSV services.

As discussed in detail in following sections of our submission, given these contexts to mental health and FSV, the Alliance suggests that:

Suggested Action 1: Family violence, sexual violence, and childhood sexual abuse are integrated into conceptual frameworks as determinants of mental health.

19 *ibid*.

Suggested Action 2: Gender inequality is added to the map of prevention and social factors of mental health and aligned with state and Federal strategic plans for ending violence against women and children.

Suggested Action 3: Financial independence and safety of victim-survivors are integrated into models of care as critical factors in good mental health outcomes.

Suggested Action 4: Specialist FSV mental health support services are integrated into the architecture of *Rethink and Beyond*, including collaboration across government and private mental health services.

Suggested Action 5: Additional funding is allocated to address the long wait times for specialist FSV mental health support services.

Suggested Action 6: All mental health practitioners are provided the opportunity to enhance their knowledge and develop their skills in recognising and responding to FSV-enhanced mental illness.

Suggested Action 7: All mental health services are assisted in developing their staff capability and their practice guidelines to be violence-informed, trauma-transformative, and shame sensitive.

A CASE STUDY OF FALLING BETWEEN THE GAPS

ABOUT THEA

Thea is a 42-year-old woman who has diagnosis of borderline personality disorder (BPD), generalised anxiety disorder and clinical depression. Thea was diagnosed with BPD in her 30s and has experienced multiple intakes to psychiatric hospital wards. This has included involuntary intakes due to heightened risk of harm to herself. Thea has described her experience of suicidality as being so frightened that someone is targeting her with the intention to cause her severe harm, that the only way to resolve this is to end her own life.

Thea first self-referred to Engender in 2012, after she left an abusive relationship in her late 20s. Thea reported experiencing physical, emotional and sexually abuse from her former partner. She said the impact of this relationship "changed her forever". Thea attended three sessions at Engender at this time. Thea self-referred to Engender Equality again one year ago, in 2025, for support following leaving a different abusive relationship, with a 45-year-old man named James. Thea and James have a 5-year-old child together.

THEA'S EXPERIENCE OF FAMILY VIOLENCE & MENTAL HEALTH

Thea shared that she and James had been in a relationship for 7 years and had met around the time she was diagnosed with BPD. Thea said that at first James appeared very caring and understanding of what helped her to manage her BPD symptoms, but that this had changed over time. She shared that she wasn't aware of his behaviour changing at the time but could now see that he had become increasingly controlling of her.

Thea explained that if she started to question how James was treating her, he would say things like, "You know you need help and I know what's best for you, I'm just trying to help you." Thea said that this messaging was reinforced by the people around her, including hospital and support staff, who would praise James's behaviour and how attentive he was to her. Thea shared that she was hospitalised 1-2 times a year when she was with James. This was due to periods where she experienced an increase in suicidal ideation and paranoia. She said that these symptoms would increase at times that James's control and abusive behaviour escalated.

Thea described experiencing stigma associated with her BPD diagnosis, and said that when she became pregnant, she had hoped her support people to see her as a whole person, rather than someone who was unwell. Thea said that instead, James' control

intensified while she was pregnant. He demanded she have a tracking app on her phone and to update him regularly via text message on how she was “emotionally” when they were apart. She said she had shared this with her psychiatrist, who said that it made sense that James wanted her and the child to be safe.

Thea said that by the time her child was 2 years-old she felt “crazy” most of the time, but knew that being in the relationship was making her feel worse. She shared that she had felt scared to leave in case her mental health was weaponised against her. At the same she described feeling trapped and didn’t know if she would survive because her suicidal ideation felt so urgent.

Over the year that Thea has been separated from James and engaging with Engender, she has reflected on how many of the symptoms and behaviours that had been attributed to her BPD diagnosis are better explained by trauma and impact of family violence in two relationships.

She said that she now understands that James targeted her hypervigilance to threat, hoping to trigger an increase in paranoia, leading to hospitalisation. James used this lack of stability in Thea’s mental health, as justification for his control and abuse of her.

Thea has shared that since leaving the relationship she has continued to be connected to mental health supports. However, when she tries to explore the interaction of her mental health with her experiences of abuse, that it is minimised and disbelieved.

This has meant that Thea has a diminished trust in mental health services and is starting to rely on Engender for generalist mental health support, which falls outside the scope of the organisations practice. This is placing Thea at risk if she is to need acute mental health support in the future.

GAPS OR AREAS FOR IMPROVEMENT

FSV DETERMINANTS OF MENTAL HEALTH

As a significant contributor to mental illness, family violence, sexual violence, and childhood sexual abuse (FSV) must be foregrounded in our conceptual models of the determinants of mental health. As noted above, FSV are some of the most impactful factors in women's burden of mental illness. Integrating FSV as a determinant of mental health would bring to light not only the significant mental health burden carried by victim-survivors, but also the significant load carried by specialist services who are desperately underfunded to do this work.

Foregrounding FSV as a mental health determinant would also initiate a series of flow on effects (some of which are discussed in more detail in following sections), including:

- increased recognition of gender inequality as a driver of mental illness, which in turn offers a mechanism for developing more appropriate prevention strategies
- greater recognition and response to FSV-enhanced mental illness by mental health practitioners, and the need to address the FSV knowledge and skill gaps of mental health practitioners
- impetus for increased skills development of mental health practitioners in violence-informed, trauma-transformative, and shame-sensitive[20] care and practice
- better reporting of the contribution of FSV to burden of mental illness
- increased recognition and knowledge of the crisis and long-term mental health needs of victim-survivors
- integration of lived and living experience of FSV victim-survivors within lived experience mental health advocacy frameworks
- enhanced professional networks between mental health and specialist FSV services
- enhanced recognition and response to the intersectional gaps in mental health services
- greater recognition and response to the mental health needs of people who use violence, including the use of threats of suicide as a form of coercive control[21]

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20 Wu, Q & Salter, M 2025, Women's experiences of shame while seeking care for complex trauma: Towards shame-sensitive practice. *The British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcaf101

21 Smith, K, Kebbell, MR, & Howard, RA 2026, Suicide and Perpetrators of Intimate Partner Violence: Insights from the Queensland Suicide Register 2000–2017. *Violence Against Women*. https://doi.org/10.1177/10778012261443479.

Across the lifecourse, violence can initiate or enhance psychological harm. As illustrated in Table 2 below, adapted from Tarzia et al[22], there are lifecourse mental health indicators of victimisation that exist independently at each developmental phase and concurrently layered across the lifecourse.

Table 2: Psychological clinical indicators of abuse (adapted from Tarzia et al).

TYPE OF FSV	PSYCHOLOGICAL INDICATORS OF ABUSE
Child abuse and neglect	➲ Insomnia ➲ Bedwetting ➲ Behavioural/conduct issues in adolescents: ○ depressive/anxiety symptoms ○ suicide ideation ○ drug and alcohol misuse ○ sexual/risky behaviour
Intimate partner violence	➲ Depressive/anxiety symptoms ➲ Suicidal ideation ➲ Drug and alcohol misuse ➲ Insomnia ➲ Somatoform disorder ➲ Post-traumatic stress disorder ➲ Eating disorders
Elder abuse	➲ Depressive/anxiety symptoms ➲ Insomnia ➲ Rigid posture and avoidance of contact (including eye contact) ➲ Reluctance to talk

These indicators are not unique to FSV victimisation; they are mental health indicators that all mental health practitioners should be aware of, and are able to link to, possible FSV victimisation. Recognising these indicators will enhance mental health practitioners' capacity to provide the right violence-informed, trauma-transformative, and shame-sensitive support, including recognising that a specialist mental health service may be required.

22 Tarzia, L, Hindmarsh, E, & Hegarty, K 2014, Family violence across the life cycle. *Australian Family Physician*, 43(11).

INTERSECTIONALITY

FSV victim-survivors are not a heterogenous population group even if they share the experience of victimisation. Good mental health outcomes for FSV victim-survivors relies on an understanding of how both victimisation and mental illness are shaped not only by individual psychological injury or condition, but by wider social and political factors. As illustrated below in our adaptation of McNeish and Scott's Venn diagram[23], FSV-enhanced mental illness cannot be understood without understanding the broader contexts of gender inequality.

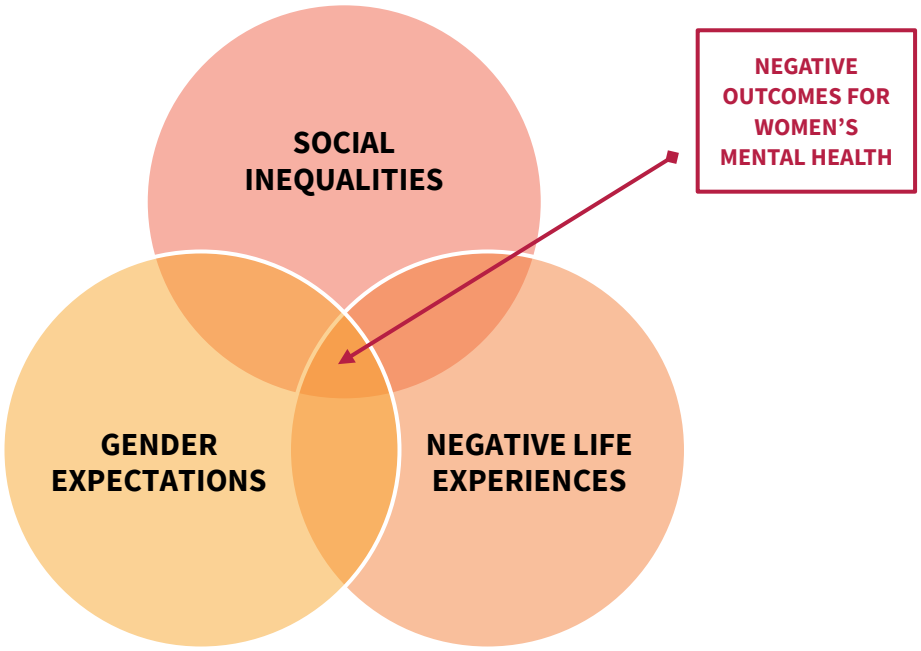

Figure 1: Gender-specific determinants of FSV-enhanced mental health outcomes for women and girls

In this model, social inequalities include poverty, social exclusion, racism, geography, sexuality, ability, while the impacts of negative life experiences capture the lifecourse experiences of violence, abuse, and trauma. Critically, these two factors are overlayed by gender expectations that make women responsible for the care of others, within a context of subordinated and vilified social status. While gender expectations also impact on men and boys' negative mental health outcomes—especially, their heightened propensity for suicide—and men and boys can experience violence across their lifecourse, gender inequality across social life and disproportionate experiences

[23] McNeish, D & Scott, S 2014, Women and Girls at Risk: Evidence Across the Life Course. *DMSS Research*. https://www.racgp.org.au/getattachment/7c7fc050-a7b4-4670-8771-3075d0a49692/Family-violence-across-the-life-cycle.aspx

of interpersonal violence, exacerbate the harms and impacts of violence on women and girls. These harms are heightened for women and girls who have intersectional identities, including First Nations, LGBTIQA+,[24] and disabled people,[25] along with those who are migrants or refugees, culturally, religiously, or linguistically diverse,[26] and those with experiences of out-of-home care.[27]

The mental health needs of people experiencing compounded disadvantaged is most explicit for Aboriginal and Torres Strait Islander victim-survivors, who not only have heightened rates of intimate partner and family violence,[28] but also postpartum depression, which the evidence indicates is 87% higher for First Nations women.[29] Experiences of FSV are further heightened for First Nations LGBTIQA+ people, and Sistergirls and Brotherboys, and First Nations people with disability.[30] This mental illness load is layered over culture-bound syndromes—such as being sung, sorry time, longing for Country—and the intergenerational trauma and harm of colonisation, dispossession, and genocide.[31] Target 13 of the *National Agreement on Closing the Gap*[32] requires all Australian governments—including Tasmania[33]—to work towards a 50% reduction by 2031 of all forms of family violence. In order to achieve this target,

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24 Australian Institute of Health and Welfare 2025, Family, domestic, and sexual violence: LGBTIQA+ people. https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/lgbtiqa-people.

25 Australian Institute of Health and Welfare 2026, Family, domestic, and sexual violence: People with disability. https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/people-with-disability.

26 Australian Institute of Health and Welfare 2025, Family, domestic, and sexual violence: People from culturally and linguistically diver backgrounds. https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/cald.

27 Royal Commission into Institutional Response to Child Sexual Abuse 2017, *Final Report: Contemporary out-of-home care* (Volume 12). Canberra; Commonwealth of Australia.

28 Australian Institute of Health and Welfare 2026, Family, domestic, and sexual violence: Aboriginal and Torres Strait Islander people. https://www.aihw.gov.au/family-domestic-and-sexual-violence/population-groups/aboriginal-and-torres-strait-islander-people; Cripps, K 2023, *Indigenous domestic and family violence, mental health and suicide*. Canberra: Australian Institute of Health and Welfare.

29 Black, KA, MacDonald, I, Chambers, T, & Ospina, MB 2019, Postpartum Mental Health Disorders in Indigenous Women: A Systematic Review and Meta-Analysis. *Journal of Obstetrics and Gynaecology Canada*, 41(10), 1470-1478. Importantly, while heightened rates of postpartum depression are reported, there is still debate over whether the standard tool (the Edinburgh Postnatal Depression Scale) to assess postpartum depression is culturally appropriate for Aboriginal and Torres Strait Islander women and girls. Prandl, KJ, Rooney, R, & Bishop, BJ 2012, Mental health of Australian Aboriginal women during pregnancy: identifying the gaps. *Archives of Women's Mental Health*, 15, 149-154; Kotz, J, Marriott, R, & Reid, C 2021, The EPDS and Australian Indigenous women: A systematic review of the literature. *Women and Birth*, 34(2), e128-e134.

30 *op. cit*. AIHW 2026

31 Too often these culture-bound syndromes are missed by mental health services, and pathologised in Western models of mental health. Westerman, T 2021, Culture-bound syndromes in Aboriginal Australian populations. *Clinical Psychologist*, 25(1), 19-35; *op. cit*., Kotz et al.

32 *op. cit*., Commonwealth of Australia 2020

33 *op. cit*., Tasmanian Government 2025

mental health services in Tasmania must be culturally capable of addressing the unique, multiple, and layered impacts of FSV experienced by First Nations women, girls, and gender diverse people. This requires that *Rethink* fully integrates the specialist mental health needs of Aboriginal Tasmanians, along with the specialist mental health needs of victim-survivors.

VIOLENCE-INFORMED, TRAUMA-TRANSFORMATIVE & SHAME-SENSITIVE WORKFORCE

Violence- and trauma-informed practice is the hallmark of specialist FSV service delivery. The Alliance has heard from our members that victim-survivors have, at times, experienced further harm after seeing a mental health service, reportedly due to practice limitations in understanding the depth of trauma carried by victim-survivors during, and long after, victimisation. Understanding the ways in which systems, including mental health systems, are used by perpetrators to extend their violence—and how systems that are not violence-informed, trauma-transformative, and shame sensitive deepen the harms to victim-survivors—is critical in facilitating healing and recovery. In the absence of this knowledge and practice, mental health services can inadvertently empower perpetrators and contribute to the further harm of victim-survivors.

Family and sexual violence can compound trauma and mental illness. These impacts can show up in many ways, including:

- Distort trust
- Create confusion
- Hijack relationships
- Create isolation
- Leave relational needs unmet
- Evoke shame
- Silence dissent and resistance
- Debilitate meaning making[34]

[34] Tucci, J, Mitchell, J, Porges, SW, Tronick, E 2024, Looking beyond: Examining the contribution and future of the trauma-informed approach. In Tucci et al (eds), *The Handbook of Trauma-Transformation Practice:*

As noted by Tucci et al, "despite the early promise, there are emerging signs that trauma-informed approaches have been limited in their scope of influence".[35] While trauma-informed practice is the bare minimum required for working with victim-survivors, the mental health workforce and their services should be enabled to be trauma-transformative. Trauma-transformative practice is a new paradigm that requires knowledge and skills beyond understanding the impact of violence and trauma. It compels mental health practitioners and services to build capacity and practice that prioritises safety, compassion, and meaning-making, and challenges institutional or social structures that perpetuate trauma.

- **Trauma-integrated** mental health services are familiar with the impact of trauma and have "fused these principles with their own mission and vision".
- **Trauma-transformative** mental health services "…extend this knowledge and skills to develop a theory of change that realistically supports how children, young people and families affected by violence come to experience their lives differently… [and] oppose broader community narratives that serve to trap those affected by the effects of trauma in identities that are shaming".[36]

A further innovation in knowledge and practice is shame-sensitive service delivery to FSV victim-survivors. In their work on shame-sensitive practice, Wu and Salter[37] suggest that:

> Recognizing that shame is an important emotional correlate of trauma, shame-sensitive practice seeks to prevent and repair shame in service and clinical encounters with traumatized clients… and emphasizes the dynamic interplay between the traumatic shame of interpersonal violence, the structural shame of service systems that are not attuned to complex trauma, and direct and indirect forms of shame in the service encounter.

Mental health systems that do not recognise the ways in which shame can disable help-seeking, healing, and recovery can create "betrayal trauma" or "institutional betrayal". Such betrayal not only hampers recovery and healing at the time of intervention, but it can also create a level of distrust of mental health services that disable victim-survivors from accessing essential support when they experience more

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Emerging Therapeutic Frameworks for Supporting Individuals, Families or Communities Impacted by Abuse and Trauma. London: Jessica Kingsley Publishers.

35 *ibid*.

36 *ibid.*

37 Wu, Q & Salter, M 2025, Women's experiences of shame while seeking care for complex trauma: Towards shame-sensitive practice. *The British Journal of Social Work*. https://doi.org/10.1093/bjsw/bcaf101; p2 of 21.

violence. Importantly, the structural shame felt by victim-survivors is deepened when they cannot afford essential mental health service due to financial constraints, which may be "…a source of humiliation, especially when they had to prioritize immediate needs over their longer-term aspirations and goals".[38] In these contexts, as suggested by Dolezal,[39] victim-survivors may experience "shame anxiety" as an artefact of chronic shame, which increases victim-survivors' anticipation of judgement, labelling, and misunderstanding by mental health services.

The RANZCP[40] advocates for mental health services (and their workforce) to be enabled to create "a holistic FV system" that embeds collaboration across mental health and specialist FSV services and enhances referral pathways across the care continuum. Facilitating this networked service delivery requires that all sections of the mental health response and prevention system work towards the same goals, and have a shared language about violence-informed, trauma-transformative, and shame sensitive practice. In citing Moran and Salter,[41] Wu and Salter[42] argue that:

> **A shame-sensitive service system, therefore, is one that understands, anticipates, and seeks to address shame anxiety through proactive practices that do not remind clients of prior experiences of abuse and humiliation, but offer reparative and perhaps unexpected experiences of dignity and individualized attention.**

DISPERSED MODELS OF CARE

Given that the Tasmanian population is highly dispersed—and highly networked—it is critical that *Rethink and Beyond* consider and invest in dispersed models of mental health care. In the context of cost-of-living pressures (including petrol costs), rural and remote victim-survivors are making decisions about their mental health that would

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38 *ibid*., p15 of 21

39 Dolezal, L 2022, Shame anxiety, stigma, and clinical encounters. *Journal of Evaluation in Clinical Practice*, 28(5), 854-860

40 RANZCP 2021, *Family violence and mental health*. https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/family-violence-and-mental-health

41 Moran, R & Salter, M 2022, Therapeutic Politics and the Institutionalisation of Dignity: 'Treated Like the Queen'. *Sociological Review*, 70, 969–85;

42 *op. cit*. Wu & Salter, p16 of 21.

not otherwise be a factor in FSV healing and recovery. Relatedly, specialist FSV services working with rural and remote victim-survivors have not received additional funding to accommodate the extra costs they have incurred with recent cost increases in servicing victim-survivors outside the capital and regional cities.

We note that in future stages of the *Rethink and Beyond* consultations, accessibility of mental health services will be considered in more detail. However, we want to note that a dispersed model of mental health care for FSV victim-survivors is not a marginal or tangential issue, but one that speaks directly to the inequitable service provision to the 58% of Tasmanians that do not live or work in the capital city. A dispersed model of care must be central to the reimagination of mental health services in Tasmania, and a core component of the *Rethink and Beyond* strategy.

SYSTEMS ABUSE

Mental health systems can be used to extend the violence experienced by FSV victim-survivors. Systems abuse by perpetrators (and their families) is almost ubiquitous in family violence, and the weaponisation of victim-survivors' existing mental illness—or the pathologisation of victim-survivors' responses to FSV as mental illness—has far reaching effects, including disengagement with care providers, distrust of practitioners' intent, and wariness about what to say in fear of what will be done with what has been said in counselling. Coercive control—of which, systems abuse is one form—was found to be moderately associated with both PTSD and depression in victim-survivors, and a trigger for enhanced mental health issues.[43] Engender Equality[44] found that 12% of respondents had experienced systems harms from mental health service providers, and/or the weaponisation of their mental health needs by perpetrators.

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[43] Lohmann, S, Cowlishaw, S, Ney, L, O'Donnell, M, & Felmingham, K 2023, The Trauma and Mental Health Impacts of Coercive Control: A Systematic Review and Meta-Analysis. *Trauma, Violence & Abuse*, 25(1), 630-647; Fitch, E & Easteal, P 2017, Vexatious Litigation in Family Law and Coercive Control: Ways to Improve Legal Remedies and Better Protect Victims. *Family Law Review*, 103, 103-115.

[44] Engender Equality 2025, *Systems abuse and family violence in Tasmania: Evidence and Recommendations for Action*. Hobart: Engender Equality.

Perpetrators of FSV can:

- weaponise mental health help-seeking in family court matters,
- use mental illness diagnosis to evidence that victim-survivors are attention-seeking and “unhinged”,
- deploy coercive control, fear tactics, and intimidation to undermine a victim-survivor’s belief in themselves and the veracity of their FSV experience, and
- withhold vital mental health services and medications.

As with other forms of FSV systems abuse, *Rethink and Beyond* must integrate an understanding of how the mental health system can be used against those most in need of its recognition and support.

SYSTEM DISABLERS & ENABLERS

INTEGRATION OF FSV FRONTLINE SERVICES

As noted by our member, Laurel House, in their submission to this consultation, specialist FSV services are often considered external to the mental health system, and their role in providing mental health services is not recognised in system mapping. Recognising the allied work of specialist FSV services, increasing collaboration across all mental health and FSV services, and ensuring a continuum of care across these services is critical to better outcomes for victim-survivors.

Victim-survivors do not experience specialist FSV services as separate to mental health services; from their perspective, the work of frontline FSV services is part of the overall mental health system. Recognising the two systems is especially important in the transition from crisis intervention services to long-term healing and recovery services. As noted by Laurel House in their submission to this consultation, "These are critical points in a person's journey where distress can intensify, uncertainty is high, and the potential for re-traumatisation is significant".[45] Victim-survivors may fall between the gaps of the two systems or encounter mental health services that do not respect the recovery pathway already traversed via specialist FSV services.

Victim-survivors engaging with the criminal justice system may also lose the critical psychosocial support offered by specialist FSV services when they move from a specialist FSV services to a mental health service. The disconnect is further layered for rural and remote victim-survivors who may have to grapple with a lower level of care once they have addressed the crisis and are referred to local mental health services that do not collaborate with specialist FSV services and/or do not have a violence-informed, trauma-transformative, and shame sensitive lens to the work that they do. It is therefore critical that mental health and specialist FSV services are better integrated into a continuum of care for victim-survivors of family and sexual violence within *Rethink and Beyond.*

[45] Laurel House 2026, *Submission: The next Tasmanian mental health strategy*. Launceston: Laurel House.

PREVENTION AND EARLY INTERVENTION

Early intervention and prevention of mental illness must account for the drivers and enablers of family and sexual violence. The absence of FSV victim-survivors, and the FSV determinants of mental health, from the discussion paper appears counterintuitive given the high burden of mental illness linked to FSV victimisation. Prevention of mental illness in the FSV context requires that the conceptualisation of mental health prevention incorporates the known factors in preventing FSV, including actions to reduce, then eliminate, gender inequalities in health service provision and access. Engender Equality,[46] in their report on *Delayed Support, Heightened* Harm, argue that failure to invest in primary, secondary, and tertiary FSV prevention, along with inadequate funding for this work, increases the costs of healing and recovery from FSV-enhanced mental illness. When the mental health impact of FSV are not addressed early, "a higher level of specialisation and knowledge [are] required to provide adequate and relevant support [which increases] the demand for organisations to provide services beyond funding and resources constraints".[47]

Addressing the drivers of FSV will also enhance prevention strategies for childhood sexual abuse. As noted in the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030*,[48] violence against children and young people can be averted by increasing the opportunities for children and young people to be raised in families without violence, abuse, or neglect, by parents and guardians who can be trusted to have their best interests at heart. Children and young people—as with adults—who understand personal safety and consent are less likely to experience violence and abuse, and to have agency to speak up when they are unsafe. In the absence of safe families, connection with wider community and school networks may offer some preventative measures to averting childhood abuse. Preventative measures also require mental health services to be child safe and child-centred, irrespective of whether they are specialist child mental health services or not.

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46 *op. cit.*, Engender Equality
47 *op. cit.*, Engender Equality
48 *op. cit.*, Commonwealth of Australia 2022

Whilst additional resourcing of crisis intervention, and secondary and tertiary prevention, is essential, so too is funding for primary prevention in addressing gender-based violence, and violence against children. Moving upstream to primary prevention offers the generational change required to end violence and reduce pressures on the mental health system (see for example, *National Plan to End Violence against Women and Children 2022–2032: Ending gender-based violence in one generation*). Respectful Relationships and Consent education in Tasmanian schools offer a generational blueprint to changing attitudes and beliefs about gender, violence, and abuse. However, raising the awareness and capability of adults to recognise and foster respectful relationships is equally important given that a FSV context will shape the mental health of children within those families. Extending this important work to post-secondary education, workplaces, social and sporting groups, religious communities, and in all aspects of government services will dovetail with the primary prevention work already undertaken with children and young people.

Prevention of FSV-enhanced mental illness also requires that the mental health system and its workforce play a proactive role in addressing the harmful beliefs and attitudes of perpetrators, including the harmful sexual behaviours used by young people. Mental health services who work with perpetrators must ensure that they do not reinforce, or minimise, perpetrators' skewed and dangerous views about women and children. Addressing these views early and often may also prevent systems abuse in family court matters. Early intervention by way of mandated men's behaviour change programs for first time offenders is critical to averting escalation and intensification of FSV, and the consequent FSV-enhanced mental illness experienced by victim-survivors and their children.

Further, as noted by the Alliance in their submission to the federal inquiry into DFSV and suicide:

> There is clear evidence of a relationship between FDSV and perpetrators' suicidal ideation and suicide. As identified by Woolley,[49] Fitzpatrick et al,[50] and Vasil et al,[51] in their close analyses of Australian coronial data and investigations, and in

[49] *op. cit.*, Woolley
[50] *op. cit.*, Fitzpatrick et al.
[51] *op. cit.*, Vasil et al.

> 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… 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".[52]

Fitzpatrick et al[53] identified that in nearly a third of suicides by Australian men, "disruption of family by separation or divorce" was a significant factor, and that threats of suicide were a predictor of lethal family violence. Vasil et al[54] also found that when presented with a suicide risk, police often deflected perpetrators to the health—rather than criminal justice—system, which could be perceived as minimising perpetrator accountability for the harms they cause. It is therefore critical that a joint mental health and criminal justice response is initiated in these circumstances to ensure perpetrator accountability and the safety of victim-survivors.

WORKFORCE DEVELOPMENT & CAPACITY BUILDING

Underpinning the recognition and response to FSV-enhanced mental illness is the development and upskilling of all mental health practitioners. As noted throughout our submission, victim-survivors may seek help via mental health services, and in the absence of robust training and development of practitioners, the harms carried by victim-survivors may be inadvertently deepened. Increasing the capability of mental health practitioners—and their organisations—to be violence-informed, trauma-transformative, and shame sensitive, as noted above, would also enhance the mental health outcomes of victim-survivors.

A fully integrated mental health system that recognises and acknowledges specialist FSV services—and increasing the capability of mental health practitioners to work collaboratively with, and are aware of referral pathways to, specialist FSV services—may avert any additional harms. Specialist FSV services offset the downstream costs and service load of mental health services across the lifecycle of healing and recovery from FSV, and victim-survivors often remain within the specialist FSV service system

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52 *op. cit.,* Woolley
53 *op. cit.,* Fitzpatrick et al
54 *op. cit.,* Vasil et al

long after crisis intervention. Failure to acknowledge this expertise and the contexts of working in desperately and dangerously underfunded specialist FSV services will result in worse outcome for victim-survivors with mental illness, and gaps in service delivery to victim-survivors.

The training and professional development of mental health practitioners must include dedicated training on:

- FSV risks
- FSV mental health determinants,
- mental health impacts of FSV,
- perinatal intersections with mental illness and FSV,
- specialist FSV services, and
- FSV pathways to recovery and healing.

Lived experience advocates

Increasingly, the experiences of victim-survivors with lived experience of FSV are being integrated into the work of specialist FSV services and are now recognised as central to responding and preventing FSV.[55] Complementary development and integration of FSV lived experience advocates into mental health services work is essential. However, as noted by Laurel House in their submission, the work of lived experience advocates must be supported by robust governance and policy/practice development training and benchmarked renumeration. Ad hoc stipends or reimbursements are no longer adequate or appropriate for the lived experience and systems wisdom that lived experience advocates bring to their engagement with mental health systems and organisations. In their submission, Laurel House has provided a guide for the minimum ethical standards of engaging lived experience advocates, which the Alliance endorses.

[55] See, for example, Tasmanian Government 2022, *Survivors at the Centre: Tasmania's Third Family and Sexual Violence Action Plan 2022-2027*;

INITIAL PRIORITIES

The Alliance believes that there are four initial priorities that must guide the development of *Rethink and Beyond*.

1) Increased funding to specialist FSV services to address the dangerous wait times in accessing these services at times when the safety and wellbeing of victim-survivors is most at risk.
2) Integration of specialist FSV services into the wider health and mental health systems, including collaboration, information sharing, and robust referral pathways between specialist FSV and mental health services.
3) Increased professional development and practitioner training on the FSV mental health determinants, pathways to healing and recovery, and the role of specialist FSV services
4) Upskill and fully renumerate lived and living experience advocates and integrate FSV lived experience advocates into existing models of engagement.