

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

Domestic Violence NSW Submission
March 2026

Acknowledgement

This report was written on the stolen and unceded lands of the Gadigal People of the Eora Nation. We pay respects to the Elders past and present.

DVNSW acknowledges Aboriginal and Torres Strait Islander peoples as the first sovereign nations across the breadth and depth of Australia. We recognise that Aboriginal and Torres Strait Islander people have lived and cared for Country for over 60,000 years and continue to do so, honouring ancestors and knowledge holders within community, and observing ancient cultural practices. We acknowledge the damaging impacts of colonisation and hold their stories with great care.

We acknowledge that domestic and family violence are not part of Aboriginal culture and assert that the responsibilities of Aboriginal families and kinship systems do not align nor are reflected in current government policies. We work to position ourselves as allies and give voice and strength to the unique position that Aboriginal and Torres Strait people hold in their own family systems and communities.



About us

Domestic Violence NSW (DVNSW) is the peak body for specialist domestic and family violence (DFV) services in NSW. With approximately 200 member organisations across the state and diverse lived expertise advisory groups, we work to improve policy, legislative and program responses to domestic and family violence through advocacy and collaboration, while promoting good practice and primary prevention.

We exist to eliminate domestic and family violence from society.

DVNSW members represent the diversity of NSW specialist DFV services, working to support adults, children, families and communities impacted by domestic and family violence. Our member organisations consist of services such as crisis and refuge specialist homelessness services, domestic violence response enhancement, specialist DFV case management, Aboriginal controlled organisations, migrant and refugee specialist organisations, community housing, staying home leaving violence, women's legal and women's court advocacy services, men's behaviour change programs, and general community, women and children's support programs. It's our role to ensure our members are listened to, respected and heard by the change-makers in society.

We recognise that lived experience is central to change. We understand that DFV impacts some communities disproportionately – which is why we ensure the experiences of Aboriginal and Torres Strait Islander people, LGBTIQ+ people, migrant and refugee people and people with disability have a central voice in our advocacy. With guidance from lived experts, we elevate the experiences, voices and needs of victim-survivors through all work we undertake.

Together with victim-survivors, our members, our partners and our team – we will end gender-based violence in NSW.

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Contents

Acknowledgement	2
About us	3
Executive summary	5
Key recommendations.....	7
DFSV-related suicide: An under-recognised form of violence-related death	9
Identifying and supporting at-risk groups for suicide in the context of DFSV	9
Female victim-survivors	10
Aboriginal and Torres Strait Islander peoples	10
Migrant and refugee women.....	11
Children and young people who have experienced DFSV.....	12
Childhood sexual abuse (CSA) survivors	12
Out-of-home care leavers	13
Women with disability	13
Counting DFSV-related suicide deaths	14
National data linkage.....	14
Coronial and police screening.....	14
Improving system responses across DFSV, health, mental health and justice	16
Integrated DFSV–suicide pathways	16
What specialist DFSV services do well	16
Where other systems fail – and why it matters	16
Embedding trauma-informed practice to improve responses across systems	17
Integrating DFSV specialist responses and mental health responses.....	18
Whole-of-family support models for DFSV-related suicidality	19
Routine childhood safety enquiry	20
Gender-safe acute mental health settings.....	21
The use of suicide and threats of suicide as a tactic of coercive control.....	21
Improving prevention and early intervention efforts	23
Conclusion	24
A note on terminology	25
References	27

Executive summary

Domestic Violence NSW (DVNSW) welcomes the opportunity to contribute to the inquiry into the relationship between domestic, family and sexual violence (DfSV) and suicide.

Evidence from Australia, and from other countries, shows strong links between DfSV victimisation and suicidality, yet DfSV-related suicide remains under-recognised in policy, practice and data. Suicides linked to coercive control, post-separation abuse, sexual violence, stalking and systems abuse are frequently misclassified as generic “relationship problems” or treated solely through a mental health lens, obscuring the role of violence, entrapment and perpetrator tactics in driving distress and death.

DVNSW members report that specialist DfSV services are increasingly responding to suicidality that is deeply entwined with violence and entrapment. They are using integrated risk practice, perpetrator-focused approaches, and combining DfSV safety planning with suicide risk management. At the same time they are operating above and beyond capacity due to chronic underfunding (DVNSW 2025) and require training to manage suicide risk and improve integration with mental health services.

However, responses across health, mental health, alcohol and other drug (AOD), legal and justice systems are often inconsistent and siloed from DfSV expertise. There remains limited understanding of how suicidality can be driven by ongoing violence and coercive control. As a result, members report that system responses can be retraumatising, that victim-survivors continue to be mislabelled, and that systems default to a “mental health crisis” narrative that minimises the role of DfSV. In some cases, this system response can result in perpetrator needs being prioritised over victim-survivor safety.

Critically, high-risk victim-survivors can be screened out as “too complex” by both DfSV and mental health services when services are operating beyond funded capacity and staff are managing burnout and vicarious trauma. Without specialist advocacy, key risk information is frequently lost at major intervention points such as police callouts, hospital presentation and discharge, bail decisions and parenting proceedings.

This submission highlights cohorts facing compounded risk, including female victim-survivors; Aboriginal and Torres Strait Islander women; migrant and refugee women; children and young people; victim-survivors of childhood sexual abuse (CSA); out-of-home care leavers; and women with disability. Across these groups, repeated contact with multiple systems, fragmented responses and lack of culturally safe, disability-inclusive and trauma-informed pathways can intensify isolation, exhaustion and hopelessness over time.

DVNSW also draws attention to evidence that threats of suicide and self-harm can be used by perpetrators as deliberate tactics of coercive control, particularly during separation, custody disputes and other escalation points. Responses must recognise these threats as both a potential mental health crisis and a tactic of coercive control, as well as a marker of heightened lethality risk. Protocols should prioritise victim-survivor safety, trigger rapid risk assessment and perpetrator accountability measures, and ensure victim-survivors are not penalised for disclosing risk.

Where there are mental health concerns, timely and appropriate mental health assessment and intervention for the perpetrator should occur in parallel with safety planning; without shifting responsibility onto victim-survivors or minimising the occurrences of DfSV.

To address these gaps, DVNSW recommends a coordinated national response, that embeds equity and accessibility across reforms. This must prioritise DfSV-specific and trauma-informed responses and

include Aboriginal-led and culturally grounded approaches, disability-inclusive crisis accommodation and interpreter-supported pathways.

DVNSW urges governments to make DFSV-related suicide visible and measurable through nationally consistent definitions and coding, structured DFSV screening in coronial and police suicide investigations, and privacy-safe national data linkage that connects coronial data with justice, health and specialist DFSV datasets. Without this, the scale, patterns and preventability of DFSV-related suicide will remain obscured, and critical opportunities for intervention will continue to be missed.

DVNSW also calls for:

- Coordinated DFSV-suicide prevention pathways across all systems, grounded in trauma-informed practice, that require structured DFSV enquiry, warm referral to specialist DFSV services, and shared safety planning with named follow-up responsibility.
- Joint training and clear guidance so all services, across all systems, can identify and respond to suicide risk in the context of DFSV and link victim-survivors quickly to safe, coordinated support.
- Whole-of-family models that support the non-offending parent and children alongside perpetrator accountability where appropriate.
- Trauma-informed routine enquiry on childhood safety/abuse/neglect at key service entry points.
- Minimum gender-safety standards in mental health settings to prevent further victimisation.

Together, these reforms would shift the system from reactive crisis responses to coordinated early identification, safety and accountability. Suicidal distress triggers would prompt enquiry into potential violence and entrapment, victim-survivors would receive timely access to specialist support, and perpetrators' tactics would be recognised and acted upon. Importantly, governments would be able to measure and prevent DFSV-related suicide with the seriousness it demands.

Key recommendations

Identifying and supporting at-risk groups for suicide in the context of DFSV

1. Embed an equity and accessibility framework across DFSV–suicide reforms, requiring culturally safe, disability-inclusive and trauma-informed pathways (including interpreter access, accessible crisis accommodation, and tailored responses for children/young people, migrant and refugee communities, care leavers and CSA survivors), supported by workforce training and consistent data capture to monitor outcomes by cohort.
2. Resource and embed Aboriginal-led, culturally grounded responses to DFSV-related suicidality, with sustained investment in Aboriginal-led research, truth-telling and data sovereignty. Policy and service responses must be informed by Aboriginal community understandings of suicide as linked to intergenerational collective trauma, dispossession and ongoing marginalisation, and must support holistic, community-led healing.

Counting DFSV-related suicide deaths

3. Fund national, privacy-safe data linkage connecting coronial suicide data with justice, health and specialist DFSV datasets to quantify prevalence and identify escalation pathways and missed intervention points.
4. Adopt a nationally consistent definition and coding framework for DFSV-related suicide and mandate a structured DFSV screening tool in coronial and police suicide investigations.

Improving system responses across DFV, health, mental health and justice

5. Establish and fund coordinated DFSV–suicide pathways across systems that are explicitly grounded in trauma-informed practice, requiring both structured DFSV enquiry and suicide/mental health risk assessment, warm referral between systems, and shared safety planning with joint case coordination.
6. Provide training and update practice guidance on assessing suicide risk through a DFSV lens across health, mental health, AOD, and legal/ justice systems, so suicidal distress triggers enquiry into violence, entrapment, threats, and perpetrator tactics.
7. Provide training to DFSV specialist services on recognising and managing suicide risk to improve understanding of suicidality in the context of DFSV and improve integration with mental health services and safe referral pathways where appropriate.
8. Fund whole-of-family models that can support the non-offending parent, children, and (where appropriate) the perpetrator accountability pathway in parallel, recognising longitudinal trauma impacts on employment, parenting, health and social connection.
9. Introduce trauma-informed screening questions about childhood safety/abuse/neglect at relevant entry points (youth, mental health, homelessness, AOD, custody exit, DFV services), with clear consent, referral pathways and documentation standards.

Addressing the use of suicide and threats of suicide as a tactic of coercive control

10. Implement minimum gender-safety standards in mental health settings, including women-only spaces, safe scheduling, and risk controls to prevent victimisation.

11. Build capability across police, courts, health and mental health to recognise and respond to perpetrator suicide threats as coercive control and a lethality marker – not a diversion from victim-survivor safety.
12. Mandate a perpetrator suicide-threat response protocol: immediate crisis assessment plus accountability actions (risk-informed Men's Behaviour Change Program referral, contact controls), with victim-survivor safety planning and advocacy kept central.

Improving prevention and early intervention efforts

13. Fund and expand perpetrator early-intervention across Australia, including access to risk-informed Men's Behaviour Change Programs with coordinated case management and contact controls, so escalation is interrupted early and responsibility is placed on men who use violence.
14. Invest in place-based prevention and social connection models including community programs and integrated local partnerships across health, justice, and DFSV services, to reduce isolation-driven suicidality and enable sustained, culturally safe responses.

DFSV-related suicide: An under-recognised form of violence-related death

Suicide in the context of domestic, family and sexual violence (DFSV) victimisation represents a significant, but largely invisible form of violence-related deaths in Australia (Vasil et al 2025). Despite clear evidence on the link between DFSV and suicidality ('suicidality' in this context refers to suicidal ideation, suicide planning, suicide intent and suicide attempts) and death by suicide, the relationship has been marginalised in research, policy and practice.

Only in recent years has increased attention – both internationally and domestically – begun to expose the possible scale and complexity of DFSV related suicide and the systemic gaps that allow it to remain under-recognised. For example, a study in 2023 revealed that women who had experienced intimate partner violence were three times more likely to have attempted suicide in the past year (Agenda Alliance 2023). Furthermore, international evidence increasingly identifies DFSV as a significant risk factor for suicidality and suicide. A systematic review found a strong and consistent association between intimate partner abuse and victim-survivors experiencing suicidal thoughts and behaviours (McLaughlin et al 2012). A global study similarly found intimate partner violence remained one of the most consistent risk factors for suicide attempts by victim-survivors, even after adjusting for mental health disorders (Devries et al 2011).

Australian findings point to a similar pattern. Data from the Victorian Suicide Register found DFSV present in 24.5% of recorded suicides (2009–2016), with women comprising 62.1% of victim-only cases (Vasil et al. 2025). The WA Ombudsman reported that in 2017, 56% of women who died by suicide had been identified by authorities as DFSV victims prior to death (WA Ombudsman 2022). In NSW, a pilot by the Domestic Violence Death Review Team identified recorded or apparent histories of DFSV, relationship conflict or relationship breakdown in 49% of female suicides (NSW Government 2017).

As well as drawing on Australian and international evidence, this submission has been informed by the experiences of DVNSW's member organisations including DVNSW advisory committees, the Lived Expertise Policy Advisory Committee (LEPAC) and the Migrant and Refugee Advisory Committee.

While available evidence demonstrates likely associations, the understanding of causation pathways and of the prevalence and characteristics of DFSV among people dying from suicide remains incomplete. Elements of this picture can be seen in our understanding of at-risk groups.

Identifying and supporting at-risk groups for suicide in the context of DFSV

Recommendation 1:

Embed an equity and accessibility framework across DFSV–suicide reforms, requiring culturally safe, disability-inclusive and trauma-informed pathways (including interpreter access, accessible crisis accommodation, and tailored responses for children/young people, migrant and refugee communities, care leavers and CSA survivors), supported by workforce training and consistent data capture to monitor outcomes by cohort.

Lived- and service-experience points to cohorts facing compounded risk:

- Aboriginal women, children and young people particularly – especially given over-representation in out-of-home care and the impacts of grief, loss and structural oppression.
- Women and young people in regional and remote communities where access to mental health care is limited, DFV is more prevalent and dynamics of coercive control are often missed.
- Migrant and refugee women, where DFV and suicide are highly stigmatised and help-seeking is constrained by language barriers, social isolation, cultural and religious pressure, and precarious visa status.
- People with disability, particularly where the perpetrator is also a carer.
- Women experiencing post-separation abuse, parental alienation and child removal concerns, where the fracture of mother–child attachment can drive profound hopelessness and suicidality.

In practice, housing insecurity and the broader housing crisis further intensify risk, particularly where victim-survivors face homelessness or are blamed as “not protective” while perpetrators’ behaviour remains unaddressed.

Embedding an equity and accessibility framework across DFSV suicide reforms would ensure people facing the highest barriers are not excluded from protection and care, by making pathways culturally safe and disability-inclusive from the outset and enabling governments to track whether reforms are reducing DFSV-related suicidality across priority cohorts.

Female victim-survivors

The gendered nature of DFSV places women at heightened suicide risk. Women who experience intimate partner violence are substantially more likely to experience suicidal tendencies and mental health concerns including depression, anxiety and Post Traumatic Stress Disorder (PTSD) (Guggisberg et al. 2006; ANROWS 2020; Vasil et al. 2025; Maclsaac 2017).

DVNSW members highlighted that risk of suicide escalates where coercive control and isolation are compounded by post-separation abuse, parental alienation and system responses that fracture mother–child attachment, producing profound grief, entrapment and hopelessness. Victorian research similarly identifies pathways including fear, isolation, lack of safety and repeated system failures, as well as tactics such as coercion to suicide and perpetrator manipulation of a woman’s suicidality as part of a pattern of control (Vasil et al. 2025).

Aboriginal and Torres Strait Islander peoples

Recommendation 2:

Resource and embed Aboriginal-led, culturally grounded responses to DFSV-related suicide, with sustained investment in Aboriginal-led research, truth-telling, and data sovereignty. Policy and service responses must be informed by Aboriginal community understandings of suicide as linked to intergenerational collective trauma, dispossession and ongoing marginalisation, and must support holistic, community-led healing.

Suicide is a leading cause of death for Aboriginal and Torres Strait Islander people, yet the evidence base linking DFSV histories to suicide remains limited (Douglas et al. 2025). Without culturally safe identification and recording of DFSV context, the scale of harm remains under-recognised and the opportunity to put appropriate supports in place at key prevention points continues to be missed.

Aboriginal members emphasised that suicide must be understood in the context of colonisation and ongoing structural oppression, including collective trauma, racism, and cultural disconnection, and that DVNSW Submission: Inquiry into the relationship between DFSV and suicide

responses must be Aboriginal-led and healing-focused. Mainstream mental health services are often inaccessible for First Nations people for reasons including cost, geographical locations, mistrust of government systems and subsequent government funded care, fear of child removal, and lack of understanding of Aboriginal culture in healing and recovery.

Members also highlighted heightened risk for Aboriginal children and young people, compounded by over-representation in out-of-home care and the impacts of loss, grief and disrupted cultural connection.

The following lived experience case study contains references to sexual violence, coercive control and systems harm and may be distressing for some readers. It illustrates how these experiences can compound suicide risk across the life course:



Fiona (pseudonym), an Aboriginal woman, experienced sexual violence in childhood. The case proceeded through the justice system soon after, and Fiona was required to participate in court processes which she described as deeply distressing and re-traumatising.

While some counselling support was available, Fiona experienced significant harm from systems responses and long-term impacts within her family. Her family relationships fractured in the aftermath, and she was exposed to severe distress and suicidal behaviour within the home. Ongoing isolation and limited effective support compounded the impacts over time.

In late adolescence, Fiona entered an intimate relationship that quickly became controlling and abusive, including coercive control, isolation from family and verbal abuse. She reflected that earlier trauma did not cause the domestic and family violence, but it did increase her vulnerability to coercive control and make it harder to recognise and exit the abuse early.

When Fiona tried to leave, the violence escalated. The perpetrator also used threats of self-harm as a tactic to maintain control. She ultimately left and sought refuge with her children. Following this, she faced further system involvement that resulted in her children being removed for a period, linked to concerns about her substance misuse. This triggered a severe mental health crisis, including suicidal thoughts. Fiona described drawing on her past experiences to choose a different outcome for her children and to keep working toward healing, safety and stability.

This case study reinforces the need for Aboriginal-led, culturally grounded responses, including routine, culturally safe childhood safety/CSA enquiry designed and governed with Aboriginal communities, delivered by culturally capable practitioners, and linked to Aboriginal-led healing and specialist supports, with safe pathways and documentation. It also reinforces the need for system protocols that recognise perpetrator suicide threats as coercive control and a lethality marker.

Migrant and refugee women

Newly arrived migrants, refugees and people on temporary visas can face compounding risks: isolation, housing insecurity, limited access to legal/settlement supports, and dependence on a sponsor who may be the perpetrator.

DVNSW members reported that visa insecurity and threats of visa cancellation can deter police contact, due to fear of immigration consequences. Stigma about DFSV and mental health reduce disclosure and the likelihood someone will access support. Language barriers can also contribute to misidentification and unsafe responses. These dynamics point to the need for culturally responsive pathways, with interpreters available, that address visa-related fear and cultural barriers, and safely connect women to practical protection and longer-term supports.

The following case study, provided by Settlement Services International, illustrates how cumulative violence, migration-related vulnerability and disrupted attachment can elevate suicide risk and shape help-seeking pathways.



Sana (pseudonym) is a 25-year-old woman from Bangladesh with a long history of domestic, family and sexual violence across childhood and adulthood. Following her mother's death, she experienced chronic physical, emotional and sexual abuse by family members, creating an ongoing environment of fear, powerlessness and disrupted attachment.

After arriving in Australia at 16, she was later deceived into returning to Bangladesh, where she was forcibly married and subjected to severe intimate partner violence. She escaped and returned to Australia with humanitarian support, but the cumulative impacts of coercive control, betrayal and life-threatening abuse have contributed to complex PTSD and severe depression.

Sana has used self-harm to manage overwhelming trauma symptoms and has made multiple suicide attempts requiring hospitalisation.

Sana's experience also illustrates how sustained DFSV across developmental stages can compound trauma and entrapment, elevating risk of self-harm and suicidality, and underscoring the need for culturally responsive, trauma-informed pathways that identify violence as a key driver of suicidal distress.

Children and young people who have experienced DFSV

Evidence indicates elevated suicidality among young people from families with experiences of DFSV. Indeed, one review noted young people who experienced DFSV by parents were almost twice as likely to report suicidal ideation and almost three times as likely to attempt suicide during adolescence (Rapid Review Expert Panel 2024).

DVNSW members emphasised the need for dedicated child workers in refuges and accessible DFSV supports for children and young people, noting that when systems fail to recognise children and young people as victim-survivors in their own right, it can deepen isolation, undermine self-worth, and leave trauma unaddressed. NSW's Specialist Workers for Children and Young People (SWCYP) program effectively supports children in refuges through dedicated case planning and tailored assistance, but it is only funded in some locations and should be expanded statewide.

Members also stressed that perpetrators may use children as instruments of coercion through manipulation, withholding and post-separation abuse, with enduring impacts on attachment, wellbeing and safety.

Childhood sexual abuse (CSA) survivors

CSA is a major and often under-identified factor of DFV and later suicidality.

One study by ANROWS showed that CSA survivors were twice as likely to have experienced domestic violence (as well as sexual violence and physical violence) as an adult.

A meta-analysis of published studies found that CSA in young people is associated with a 3.41-fold increase in suicide attempts and a 2.42-fold increase in suicidal ideation (Angelakis et al. 2020). Other evidence similarly indicates an elevated risk of serious and repeated attempts among women with CSA histories (Guggisberg 2014; Hebert 2025; Tsur 2022).

This evidence underscores the importance of routine, trauma-informed enquiry and targeted pathways that recognise the long tail of childhood trauma and its interaction with DFSV, mental health and substance use.

Out-of-home care leavers

Out-of-home care increases later DFV risk (Katz 2020). It is also linked with substantially elevated suicide risk compared with peers, reflecting cumulative trauma prior to care, the impacts of removal, and placement instability (Cameron et al. 2020; Russell 2021).

DVNSW members noted limited access to tailored supports for care leavers and an evidence gap on effective prevention programs designed specifically for this cohort (Cameron et al. 2020). This points to the need for targeted transition supports and trauma-informed, culturally safe responses for young people exiting care.

Women with disability

Women with disability face compounded risk due to higher exposure to violence, disability-related entrapment tactics, dependence on perpetrators for care and supports, inaccessible safety pathways, higher rates of pre-existing mental health concerns and systemic barriers to help-seeking (AIHW 2024a; AIHW 2024b; Maher et al. 2018).

Disability-specific coercive control can include withholding mobility aids, medication, access to mental health professionals, communication devices, transport or personal care, creating entrapment where leaving is tied to forgoing basic daily living needs (Australian Government Attorney-General's Department 2024; People with Disability Australia and DVNSW 2021).

DVNSW Lived Expertise Policy Advisory Committee (LEPAC) members also noted that psychosocial disability, such as prolonged, function-limiting mental ill-health, can increase dependence and isolation, and that suicidality may reflect cumulative deterioration over time rather than an impulsive event.

Counting DFSV-related suicide deaths

National data linkage

Recommendation 3:

Fund national, privacy-safe data linkage connecting coronial suicide data with justice, health and specialist DFSV datasets to quantify prevalence and identify escalation pathways and missed intervention points.

While evidence consistently shows that exposure to DFSV is associated with elevated suicidality, establishing prevalence and causal pathways at a population level remains difficult. Australia's data collection systems are not designed to systematically identify suicides that occur in a DFSV context.

Indeed, the Australian Institute of Health and Welfare (AIHW) notes there is no nationally consistent dataset that measures how many suicides are linked to DFSV, and no nationally agreed definition or coding framework for identifying DFSV-related suicide within mortality data (AIHW 2025). As a result, national reporting cannot reliably determine prevalence, characteristics, or high-risk pathways.

Current suicide reporting therefore relies on proxy psychosocial indicators recorded through death registration and coronial processes. These indicators provide insight but do not capture violence-related contexts without structured DFSV enquiry. For example, "problems in relationship with spouse or partner" is recorded as a common psychosocial risk factor, present in 14% of male and 13% of female suicide deaths in 2023 (AIHW 2025). Yet this category can mask coercive control, intimidation, sexual violence and ongoing abuse that are not routinely identified through a DFSV lens. This contributes to systematic under-identification and inconsistent classification of DFSV-related suicides, limiting prevention, accountability and system reform.

A critical additional limitation is the lack of routine linkage between suicide mortality data and administrative/service datasets held by police, courts, health, mental health, alcohol and other drug services, child protection and specialist DFSV services. Without linked data, patterns of repeated system contact, escalation across agencies, and missed intervention points prior to death remain obscured—directly constraining prevention and early intervention.

Findings from the Centre of Excellence for the Elimination of Violence Against Women (CEVAW) workshop reinforce this, noting that many women who died by suicide in the context of DFSV had extensive contact with multiple systems prior to death (Douglas et al 2025). This is why national, privacy-safe data linkage is essential; it can make visible cumulative risk and system failure patterns that cannot be detected through stand-alone datasets.

Coronial and police screening

Recommendation 4:

Adopt a nationally consistent definition and coding framework for DFSV-related suicide and mandate a structured DFSV screening tool in coronial and police suicide investigations.

Coronial investigations are a critical source of information for understanding suicide deaths, yet research identifies significant limitations in their capacity to identify DFSV through current processes. Vasil et al (2025) and Douglas et al (2025) identify barriers including the non-linear nature of violence, widespread

under-reporting, limited recognition of psychological abuse and coercive control, and the absence of routine linkage between coronial investigations and relevant administrative or service datasets.

Coronial processes can also prioritise immediate circumstances of death, mental health diagnoses or substance use, rather than examining how violence shapes distress, isolation and risk over time (Rapid Review Expert Panel 2024). Vasil et al (2025) further note that trauma and mental health are frequently interpreted in isolation, which risks individualising responsibility and obscuring DFSV as a structural driver of harm.

DVNSW members raised concerns that where intent to die by suicide is unclear, for instance in some road deaths in remote contexts – insufficient consideration of DFSV histories can contribute to misclassification of death, further obscuring the intersection between DFSV and suicide and limiting prevention learning.

Developing and mandating a structured DFSV screening tool for deaths by suicide investigated by police and coroners would enable consistent capture of key indicators such as ADVO history, prior police callouts, child protection involvement, coercive control markers, recent separation and stalking.

A consistent definition, coding framework and structured screening tool are prerequisites for accurate identification – without them, data linkage cannot reliably quantify DFSV-related suicide or reveal escalation pathways. The resulting information would strengthen prevention by identifying common trajectories and missed opportunities for earlier intervention and improved system responses.

There is also inconsistency in how Australian jurisdictions investigate and review DFSV-related deaths. While all unexpected deaths are subject to coronial investigation, only some jurisdictions have dedicated DFV death review mechanisms (Douglas et al 2025). Where death review processes exist, they typically focus on homicides, with limited and inconsistent inclusion of suicide deaths linked to DFSV. Definitions, thresholds, data sources and analytical approaches vary, resulting in non-comparable findings and limiting national analysis (Rapid Review Expert Panel 2024). Consequently, DFSV-related suicides are inconsistently identified and reported across Australia, obscuring the true scale of the issue and weakening prevention learning.

Improving system responses across DFSV, health, mental health and justice

Integrated DFSV–suicide pathways

Recommendation 5:

Establish and fund coordinated DFSV–suicide pathways across systems that are explicitly grounded in trauma-informed practice, requiring both structured DFSV enquiry and suicide/mental health risk assessment, warm referral between systems, and shared safety planning with joint case coordination.

What specialist DFSV services do well

DVNSW members report responding to victim-survivors through integrated risk practice that treats suicidality as inseparable from violence and entrapment.

This includes perpetrator-focused approaches such as Safe and Together™ style practice and perpetrator mapping to identify patterns of behaviour, reduce misdirected scrutiny on the non-offending parent, and document evidence that supports victim-survivors in systems engagement.

Services described developing management plans for suicidality alongside trauma-informed DFV safety planning; balancing timely escalation to emergency services while maintaining client trust and safety. This is important in keeping clients engaged with support and locating them when risk escalates. However, limited funding means many services are operating beyond capacity, leaving some women unable to access support and the most complex cases sometimes screened out. DVNSW has therefore called on the NSW Government to deliver a 50% core funding increase to stabilise services, expand capacity, and ensure women and children experiencing DFV can access critical support when they need it (DVNSW 2025).

Where other systems fail – and why it matters

Across health, mental health, legal, child protection and justice systems, DVNSW members report that responses are often inconsistent and siloed from DFSV expertise, with DFSV experiences frequently disconnected from suicide risk assessment and care. At times, this contributes to retraumatising interactions for victim-survivors.

The following case study from a Women’s Domestic Violence Court Advocacy Service and DVNSW member illustrates how fragmented responses across police, family law and acute mental health settings can leave DFSV-driven suicide risk unrecognised and unaddressed.



Hazel (pseudonym) was referred to a specialist DFV service after an incident at a family member’s home, where she had sought safety a few weeks earlier after deciding to leave her partner. She had experienced an extended pattern of coercive control and escalating abuse.

Following separation, the perpetrator withheld Hazel’s child, monitored her movements and communications, isolated her from family and friends, and used systems abuse through family law processes to maintain control. She also disclosed physical violence, including a serious incident involving a vehicle while the perpetrator was intoxicated.

Hazel's family described ongoing fears of the perpetrator, including intimidation and verbal abuse directed at relatives who supported her to leave. Hazel reported previous attempts to seek police protection, but said she was advised the evidence she provided was not enough to obtain a protection order. Hazel was highly distressed and conflicted about leaving, particularly due to being separated from her child, and returned to the perpetrator in order to be with the child.

Some time later, the service was advised that Hazel had died by suicide while receiving inpatient mental health care, and that the perpetrator was obstructing the family's access to her belongings. Her family later sought the service's records as part of legal proceedings relating to the child. The service subsequently received referrals for other family members after the perpetrator allegedly used tracking technology connected to the child to monitor contact arrangements. Police laid stalking/intimidation charges and applied for a protection order, however the matters were ultimately dismissed.

Hazel's case demonstrates why suicidality must trigger structured DFSV enquiry, warm referral and shared safety planning with named follow-up responsibility.

Members and LEPAC emphasised that lived expertise is essential to designing pathways that people will use and trust. They also called for DFSV–suicide responses to be co-designed and co-evaluated with lived experts.

Responses must be paired with workforce understanding, training and capability, including clear practice guidance, training, supervision and escalation protocols – so services can respond safely, consistently and without shifting risk onto victim-survivors.

A joint DFSV–suicide pathway should require all relevant services (health, mental health, AOD, child protection and police) to apply a consistent trauma-informed response where any presentation of suicidality triggers:

1. Structured DFSV enquiry
2. Warm referral to specialist DFSV services
3. A shared safety plan that covers both suicide risk and DFV risk (including post-separation escalation), with named follow-up responsibility.

This would ensure victim-survivors receive holistic treatment and support that considers their whole context and is not limited to a siloed mental health response. Identifying DFSV risk and entrapment early will enable timely, coordinated support with clear accountability for follow-up and ongoing safety.

Embedding trauma-informed practice to improve responses across systems

DFSV-related suicide cannot be effectively prevented through coordination alone. Without embedding trauma-informed practice, service systems will continue to produce fragmented responses, miss critical risk indicators, and re-traumatise victim-survivors.

DFSV causes profound and long-term mental health impacts, including depression, anxiety, PTSD and complex trauma, which shape how survivors experience risk, engage with services, and disclose abuse. These impacts can affect memory, communication, trust, help-seeking and the ability to present experiences in a linear or consistent way.

Embedding trauma-informed practice across all participating systems is therefore essential to ensure policies, environments and frontline responses are not only coordinated, but safe, responsive and

grounded in the lived realities of survivors. This would reduce re-traumatisation, improve trust and safety, and support earlier, more effective identification and intervention.

Integrating DFSV specialist responses and mental health responses

Further, it is important to recognise the complexity of integrating specialist DFSV services within mental health services. DVNSW members report that while some DFSV services can hold this complexity and work effectively in partnership with mental health services, others are effectively screening out the highest-need cases. This can be driven by pressures related to operating far above funded capacity, workforce burnout and vicarious trauma, and concern about managing high-risk clients.

The result is a service gap where victim-survivors are deemed “too complex” by both systems and left without support – often with serious consequences for already traumatised and marginalised people who have nowhere else to turn.

Closing this service gap requires a cultural shift from risk averse and siloed practice, to sharing responsibility across sectors through shared safety planning and shared case coordination, where appropriate.

In NSW, the *Common Approach to Risk Assessment and Safety* (CARAS) framework provides a shared approach for the DFV sector and related systems including child protection, housing and homelessness, health, education, justice, disability, and children and young people.

DVNSW recommends funding implementation of the CARAS, for a consistent, coordinated, and effective response to DFV throughout NSW, with clearly defined roles and stronger cross-agency practice. Similar frameworks exist in other jurisdictions, such as Victoria’s Family Violence Multi-Agency Risk Assessment and Management (MARAM) Framework.

While these frameworks strengthen DFV risk assessment and safety planning, a broader national approach is needed to better align DFV and mental health responses where suicidality is present. Shared responsibility and active case coordination are critical, so victim-survivors are not screened out by one system and left without care by the other.

Recommendation 6:

Provide training and update practice guidance on assessing suicide risk through a DFSV lens across health, mental health, AOD, and legal/ justice systems, so suicidal distress triggers enquiry into violence, entrapment, threats, and perpetrator tactics.

Recommendation 7:

Provide training to DFSV specialist services on recognising and managing suicide risk to improve understanding of suicidality in the context of DFSV and improve integration with mental health services and safe referral pathways where appropriate.

Training is needed to build capability in specialist DFSV services and adjacent sectors to recognise and manage suicide risk across cohorts. In particular, updated practice guidance and targeted training for health, mental health, alcohol and other drug (AOD) and legal/justice systems is critical so suicidality is assessed through a DFSV lens. This would ensure suicidal distress consistently triggers enquiry into violence, entrapment, threats and perpetrator tactics, enabling earlier identification of DFSV drivers and faster referral to specialist risk assessment and practical safety supports. This approach would also

reduce mislabelling and retraumatising responses, strengthen cross-system coordination, and improve safety planning and follow-up for victim-survivors at highest risk.

Members of the DVNSW Migrant and Refugee Advisory Committee and the broader membership reported that in migrant and refugee communities, language barriers, stigma and mistrust of institutions can distort responses to suicidal distress. Children may be relied on to interpret and navigate systems for parents, while fear of community repercussions and disownment can reinforce silence and isolation. In these contexts, services often default to a mental health framing and miss the DFSV drivers of distress – particularly coercive control, entrapment and ongoing threats – resulting in responses that focus on the victim-survivor’s mental health at the exclusion of the perpetrator’s tactics of violence.

Sana’s experience (page 12) underscores how suicidality in migrant and refugee contexts can reflect cumulative violence and entrapment, requiring culturally responsive support, consistent DFSV-informed assessment, interpreter-supported enquiry and warm referral rather than mental-health-only responses.

Regional and remote examples similarly highlighted inconsistent and sometimes dismissive practice, including young people being labelled “attention seeking”, brief presentations leading to rapid discharge, long waitlists, and limited DFSV capability within health and mental health services.

In addition, funding targeted training for specialist DFSV services to recognise, assess and respond to suicide risk within a DFSV framework would strengthen practice, support consistent risk documentation and shared safety planning, and improve integration with mental health services through clearer referral thresholds, warm referrals and joint follow-up where appropriate.

LEPAC members highlighted that this risk is particularly acute in sexual violence and family law contexts, where disclosure can carry immediate perceived legal consequences. Victim-survivors may limit what they disclose to sexual violence services for fear it will be subpoenaed, while retraumatising forensic processes can deter engagement altogether – especially where regional options are constrained.

In family law, suicidal ideation can be treated as a credibility or parenting “risk” issue rather than a safety signal linked to DFSV and trauma. This increases fear that seeking help will be used against the non-offending parent. These dynamics reinforce the need for cross-system practice guidance that recognises suicidal distress as potentially violence-driven, supports safe disclosure, and ensures responses remain anchored in perpetrator behaviour, coercive control and child safety – not victim-blaming interpretations of mental health.

Whole-of-family support models for DFSV-related suicidality

Recommendation 8:

Fund whole-of-family models that support the non-offending parent, children, and (where appropriate) the perpetrator accountability pathway in parallel, recognising longitudinal trauma impacts on employment, parenting, health and social connection.

Members of the LEPAC reported that service systems are often siloed and unable to support the whole family, while pathways for mental health safety and wellbeing have been stripped back or are inaccessible due to delays and waitlists.

Victim-survivors can be left with nowhere to turn when distressed, particularly when responses focus narrowly on incident-based events rather than the longitudinal impact of trauma on employment, parenting, health and social connection. These gaps are compounded for children exposed to DFSV, and where the impacts can persist into adulthood and increase vulnerability to further victimisation and self-harm.

By contrast, Aboriginal members highlighted that Aboriginal community-controlled services are designed to support the whole person and the whole family. With more flexible, holistic models, they can respond to interconnected needs including mental health and alcohol and other drug issues, while also supporting family members, including men (and holding the perpetrator accountable). Their approach prioritises healing, wellness and ongoing connection to culture, family and community, rather than narrow incident-based responses that can miss risk and fail to support recovery.

Funding integrated whole-of-family models, similar to the model used in Aboriginal services, would deliver practical benefits by reducing fragmentation. Harm caused by DFSV is ongoing and interconnected: it affects parenting, children's safety, mental health, housing and employment at the same time, and siloed services miss risk, retraumatise families and leave gaps that perpetrators can exploit.

Supporting the non-offending parent and children alongside perpetrator accountability (where appropriate) creates a coordinated pathway that reduces repeat crises, strengthens safety and stability, and addresses the long-term impacts of trauma rather than treating DFSV-suicidality as a one-off incident.

Routine childhood safety enquiry

Recommendation 9:

Introduce trauma-informed screening questions about childhood safety/abuse/neglect at relevant entry points (youth, mental health, homelessness, AOD, custody exit, DFV services), with clear consent, referral pathways and documentation standards.

As Fiona's story shows (page 11), when childhood sexual violence and subsequent systems harm are not identified and responded to early, risk can compound across adolescence and adulthood, shaping later vulnerability to coercive control, trauma and suicidality.

Many service settings including youth, mental health, homelessness, alcohol and other drugs, and women leaving custody, do not routinely collect information about childhood safety, abuse or neglect. This is a critical gap given available evidence indicates that CSA survivors have markedly elevated suicide attempt risk (Hebert 2025, Angelakis 2020, Tsur 2022). When this history is not identified, presentations are more likely to be treated as isolated mental health issues, and services may miss the underlying trauma drivers that shape risk, help-seeking and engagement over time.

This "missing history" limits risk identification, obscures root causes, and contributes to fragmented responses, particularly where trauma intersects with disability, homelessness, substance dependence and entrenched social disadvantage. It can also increase the likelihood of stigmatising labels and punitive service responses that replicate experiences of disempowerment and control, further deterring help-seeking.

By contrast, trauma-informed screening questions about childhood safety/abuse/neglect at relevant entry points would create a consistent opportunity to identify elevated risk early and connect people to the right supports, including specialist trauma counselling, culturally safe care, and integrated DFSV and suicide prevention pathways, rather than cycling through crisis services without resolution.

Importantly, routine enquiry must be implemented ethically: with clear consent, options to decline, safe documentation standards, and well-defined referral pathways so disclosure leads to support rather than harm. The aim is not to force disclosure, but to ensure people are given the opportunity to disclose if they choose – and that systems have the capability and pathways to respond appropriately, safely and consistently when they do.

Gender-safe acute mental health settings

Recommendation 10:

Implement minimum gender-safety standards in mental health settings, including women-only spaces, safe scheduling, and risk controls to prevent victimisation.

Members reported that some women were placed in mental health settings that they experienced as frightening or unsafe, including being scheduled alongside acutely unwell men. There were significant concerns about the risk of further victimisation within these inpatient settings.

Participants also highlighted how CSA survivors are often funnelled into stigmatised diagnostic categories (such as borderline personality disorder), which can shape dismissive or inadequate care and obscure the role of trauma and violence in driving distress.

Implementing gender-safe environments – including women-only spaces, safe scheduling and risk controls in acute mental health settings – will reduce harm, increase help-seeking, and support effective stabilisation while keeping DFSV risk in view. These measures also create safer conditions for disclosure and enable more accurate trauma-informed assessment and referral to specialist DFSV supports.

The use of suicide and threats of suicide as a tactic of coercive control

Emerging research in Australia shows how threats of self-harm and suicide are used as a tactic of coercive control, most commonly by men against their female intimate partners (Barlow and Walklate 2022, Wooley 2024, Fitzpatrick et al 2022). A study by the Australian Institute of Criminology found that approximately 39% of women who experience coercive control are subject to perpetrators' threats of self-harm.

Fitzpatrick et al (2022) found that violence and suicidal behaviour are, at times, used as deliberate and calculated strategies through which some men seek to maintain influence or control over their female partners. Alongside other forms of physical, emotional, economic and psychological controlling behaviour, threats of self-harm and suicide were used to instil fear, punish, exert power, seek revenge, and or place blame and guilt over women. Specifically, the study found:

- The use of violence and suicide threats by men occurred primarily during times of separation, divorce, and custody battles. Men's actions appeared to be driven by the belief that threats of self-harm would compel their partners to change their behaviour.
- When behavioural changes did not occur, suicide became a final act through which some men sought to punish their female partners, whom they perceived as having wronged them. In some cases, men left hostile messages or damaged the personal belongings of their (ex) partners.

Recommendation 11:

Build capability across police, courts, health and mental health to recognise and respond to perpetrator suicide threats as coercive control and a lethality marker – not a diversion from victim-survivor safety.

Recommendation 12:

Mandate a perpetrator suicide-threat response protocol: immediate crisis assessment plus accountability actions (risk-informed Men’s Behaviour Change Program referral, contact controls), with victim-survivor safety planning and advocacy kept central.

Recent high-profile cases demonstrate how threats of suicide can function as a tactic of coercive control. The murder of Hannah Clarke and her children demonstrates the extreme risks associated with family violence perpetrators who articulate suicide threats or intent. As the coronial inquest found, the perpetrator had threatened suicide multiple times in the lead up to their murders. Clarke feared that he might kill both her and himself, and was equally concerned that by engaging in court processes to protect herself and her children, his behaviour would escalate (Wooley 2024).

When perpetrators use suicidal or self-harm threats as tactics of coercion, systems can default to a “mental health crisis” narrative that minimises the role of violence and coercive control. This framing can prioritise the perpetrator’s needs and obscure the risk to the victim-survivors (women and their children), who may remain unsafe unless there is active specialist DFV advocacy.

This presents an equity problem: without a specialist advocate, critical risk information may not be communicated or acted on at discharge and follow-up points.

Members of the LEPAC highlighted that prior exposure to violence in childhood can increase susceptibility to coercive control in adulthood, where untreated trauma, complex PTSD and related mental health impacts are exploited by perpetrators to discredit victim-survivors as “unstable” or “unreliable”.

Perpetrators may also weaponise suicide and threats of suicide as a tactic of coercive control, alongside financial abuse and gendered power dynamics. In this context, LEPAC members shared that victim-survivors may feel pressured to manage the perpetrator’s mental health as a form of obligation or due to fear of blame, while also worrying that any disclosure of suicidality – by either party – will be used against them by systems.

Appropriate interventions must treat perpetrator suicide threats as both a potential mental health crisis and a coercive control tactic, managing acute risk while protecting the victim-survivor and holding the perpetrator accountable without rewarding the behaviour.

Responsibility and accountability must remain with the perpetrator, victim-survivors must not be penalised for disclosure, and suicide threats should be recognised as a risk and indicator of lethality rather than treated as mitigating factors.

In practice, perpetrator suicide threats should trigger an immediate crisis assessment alongside accountability actions – including referral to risk-informed Men’s Behaviour Change Programs (MBCPs) and appropriate contact controls – while keeping victim-survivor safety planning and specialist advocacy central, so the threat cannot be used to maintain influence or control.

This prevents systems defaulting to a “mental health crisis” narrative that sidelines violence, ensures risk is acted on at key intervention points (police callouts, hospital presentation/discharge, bail and protection

orders), strengthens evidence and accountability in decision-making, and reduces retraumatising blame being placed on victim-survivors.

Improving prevention and early intervention efforts

Opportunities for prevention and early intervention centre on shifting responsibility and resources toward perpetrator accountability and earlier intervention with men who use violence. This should include broader access to men's behaviour change programs alongside robust victim-survivor safety planning.

DVNSW members emphasised the need for intersectional, place-based practice, particularly through justice and health systems, supported by strong interagency relationships. Frontline services also noted structural pressures: risk management and commissioning approaches have become increasingly corporate, while services remain under-resourced to deliver the sustained, relational and culturally safe work required to reduce DFSV-related suicidality and deaths.

Recommendation 13:

Fund and expand perpetrator early-intervention across Australia, including access to risk-informed Men's Behaviour Change Programs with coordinated case management and contact controls, so escalation is interrupted early and responsibility is placed on men who use violence.

Recommendation 14:

Invest in place-based prevention and social connection models including community programs and integrated local partnerships across health, justice, and DFSV services, to reduce isolation-driven suicidality and enable sustained, culturally safe responses.

Members identified rebuilding social inclusion and community connection as a protective factor, particularly for victim-survivors living with PTSD or severe trauma who may rarely leave the house. Low-barrier, routine-based programs (such as art, exercise, or other structured group activities) can provide belonging, accountability and a reason to engage – critical buffers against isolation and suicidality.

A DVNSW member in a regional service described a pattern in which some men who later die by suicide have histories of abusive or violent behaviour, alongside limited access to early intervention and supports that could have interrupted escalation. The absence of men's behaviour change programs, relationship education and other preventative supports was described as stark, alongside the broader erosion of community connection points that previously provided informal scaffolding for families. When additional stressors are layered in – parenting pressures, disability, job loss, or financial strain – risk can escalate further, particularly in the context of the housing crisis and widening financial stress.

Prevention and early intervention approaches should avoid one-dimensional framings of perpetrators. While acknowledging male privilege and the ways some men seek to reclaim power through control and violence, members noted that a subset of men experience intense shame, want to change, and lack accessible pathways to do so. Without timely intervention, this mix of stress, isolation and untreated abusive behaviour can culminate in both increased violence and suicide risk. The point is not to excuse violence, but to recognise that prevention requires earlier, accessible mechanisms to identify risk, build accountability and support behavioural change before harm escalates.

State and territory governments should invest in regional, place-based DFSV–suicide prevention models that combine early perpetrator intervention (risk-informed MBCPs with coordinated case management and contact controls) with integrated local partnerships and low-barrier social connection programs. This

will interrupt escalation – especially post-separation – while reducing isolation and despair that drive suicidality, and keep victim-survivor safety central. Together, these measures shift systems from reactive crisis management to earlier, coordinated prevention that reduces harm for women, children and communities.

Conclusion

DVNSW submits that DFSV-related suicide is a preventable form of death that has remained largely invisible because systems are not designed to recognise, record or respond to suicidal distress as potentially violence-driven. Victim-survivors' suicidal risk is intensified where coercive control, post-separation abuse and systems abuse intersect with siloed responses across health, mental health, AOD, justice and family law – particularly for cohorts facing compounded barriers, including Aboriginal and Torres Strait Islander peoples, migrant and refugee women, children and young people, CSA survivors, care leavers and women with disability.

The reforms proposed in this submission provide a clear pathway to stronger identification and prevention. They would embed equity, accessibility and trauma-informed frameworks across all DFSV–suicide responses; establish joint pathways so that suicidality triggers structured DFSV enquiry, warm referral and shared safety planning with accountable follow-up; and strengthen shared responsibility between DFSV and mental health systems for high-complexity cases.

These reforms would also ensure perpetrator suicide threats are recognised and responded to as tactics of coercive control and markers of heightened lethality risk, while improving system visibility through consistent definitions, structured coronial screening and privacy-safe national data linkage.

Together, these measures would shift systems from fragmented crisis management to coordinated early identification, safety and accountability – reducing harm and saving lives.

A note on terminology

Domestic violence

Interpersonal violence or abuse perpetrated by an intimate partner or ex-partner. Domestic violence can include a variety of forms of abuse including but not limited to, physical, sexual, psychological, financial abuse, physical stalking, and intimidation. Domestic violence is gendered and is most commonly underpinned by coercive control, which is a pattern of behaviour utilising many different tactics to create a web of entrapment, often involving the exploitation of power imbalances.

Family violence

Violence perpetrated by a family member, carer, guardian, child, or kinship carer. Family violence can include a variety of forms of abuse including but not limited to, physical, sexual, psychological, financial abuse, physical stalking, and intimidation. Family violence is gendered and is most commonly underpinned by coercive control, which is a pattern of behaviour utilising many different tactics to create a web of entrapment, often involving the exploitation of power imbalances.

Gendered violence

Gendered violence or gender-based violence refers to harmful acts directed at an individual or a group of individuals because of their gender. It is rooted in gender inequality, the abuse of power and harmful norms. The term is primarily used to draw attention to the fact that structural, gender-based power differentials place women and girls at risk for multiple forms of violence. While women and girls suffer disproportionately from gendered violence, men and particularly boys can also be victims. The term is inclusive of LGBTIQ+ populations, referencing violence related to norms of masculinity/femininity and/or gender norms.

Intimate Partner Violence (IPV)

Abuse perpetrated by a current or former intimate partner such as a partner, husband, wife, girlfriend, boyfriend, or person who someone is dating. Term is often used interchangeably with domestic violence.

People with lived expertise

People with lived expertise are people who have experience of sexual, domestic and/or family violence whose expertise as context experts due to their lived experience is noted.

Specialist sexual, domestic, and family violence sector

The specialist sexual, domestic, and family violence sector includes crisis and refuge services, transitional accommodation and community housing providers, family support services, Aboriginal controlled organisations, specialist multicultural community organisations, specialist LGBTIQ+ organisations, counselling services, sexual violence services, specialist homelessness service providers, men's behaviour change programs and networks, community organisations working with high-risk communities, specialist women's legal and support services, women's health centres, women and children's support services, Safe at Home programs and the Women's Domestic Violence Court Advocacy Services.

Victim-survivor

Victim-survivor refers to a person who is being or has experienced violence, acknowledging that people who have been victimised are survivors and are also victims of crime. We acknowledge that people who

have been victimised are survivors and are also victims of crime. This is not intended as an identity term. In the specialist domestic and family violence sector, the preferred term is victim-survivor.

DVNSW notes that the justice sector and legislation use the term victim. In this submission, although used interchangeably, the emphasis has been placed on the term victim-survivor, with victim used at times particularly when discussing the justice system or legislation.

Coercive control

Coined by Evan Stark, Buzawa and Stark (2017, p. 105) define coercive control as “a strategic course of gender-based abuse in which some combination of physical and sexual violence, intimidation, degradation, isolation, control and arbitrary violations of liberty are used to subjugate a partner and deprive her of basic rights and resources”. This web of abuse has the end goal of entrapment and is a conscious, concerted effort by the abuser. Also known as intimate terrorism, this coercive control is the foundational underpinning of domestic and family violence, not simply another form of violence. Another way to think about this comes from Emma Katz, who describes coercive control as a toolbox, and the forms of abuse (financial, technological, humiliation and degradation etc.) as the individual tools. This is different to rarer instances of situational couple violence, which can be just as lethal, but are not motivated by the desire to entrap their victim.

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