CENTRE FOR
Women's Safety
and Wellbeing

Preventing violence
Promoting health
Advancing gender equality

Submission to inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide

Acknowledgement of Country

The Centre for Women's Safety and Wellbeing acknowledges the Whadjuk Nyoongar people as the Traditional Owners of the land where our office is located. We acknowledge Aboriginal and Torres Strait Islander peoples of this nation, and we pay respect to Elders past and present. We acknowledge the continued deep spiritual attachment and relationship of Aboriginal and Torres Strait Islander peoples to this country and commit ourselves to the ongoing journey of reconciliation.

Recognition of Victims and Survivors

The Centre for Women's Safety and Wellbeing recognises the strength and resilience of adults, children, and young people who have experienced domestic, family, and sexual violence and acknowledge that it is essential that responses are informed by their expert knowledge and advocacy. We pay respect to those who did not survive and acknowledge friends and family members who have lost loved ones to the preventable and far-reaching issue of domestic, family, and sexual violence.

About the Centre for Women's Safety and Wellbeing

The Centre for Women's Safety and Wellbeing (CWSW) is grateful for the opportunity to contribute to this important inquiry into the relationship between domestic, family and sexual violence and suicide.

CWSW is the leading voice for women and children affected by gender-based violence in Western Australia and the peak body for domestic, family and sexual violence services and community-based women's health services in WA. We work to ensure that the evidence is taken up in policy and practice to further the safety, health and wellbeing of women and their children. We advocate for systems and structures that enable and support the safety, wellbeing and economic security of women and their children.

Email
admin@cwsw.org.au

Phone
08 9420 7264

Address
2 Delhi St, West Perth, 6005

A note on terminology

Family and domestic violence and sexual violence are deeply interconnected forms of gendered violence that frequently co-occur but are not interchangeable terms. Family and domestic violence is any incident or pattern of abuse, violence and/or restriction or control designed to instil fear or control in the context of an intimate partner, family or family-like relationship. Although sexual violence is a form of family and domestic violence when it occurs in that relationship context, it can also occur outside intimate partner relationships and includes a broader range of violations such as sexual assault, child sexual abuse, image-based abuse, sexual harassment and exploitation. Many victim-survivors have experienced both forms of abuse, and the impacts on mental health and suicidality are often cumulative and compounding.

This submission will at times refer to specific elements that impact exclusively victim-survivors of family and domestic violence or sexual violence, and at times refer to both forms of abuse simultaneously. Maintaining a clear distinction of understanding between family and domestic violence and sexual violence is important to ensure the full breadth of victim-survivor experiences is recognised in policy, data and service responses.

When sexual violence is considered only through family and domestic violence frameworks, forms of abuse that occur outside of intimate partner relationships, particularly those affecting children and young people, women in community settings, workplaces and online spaces, can be overlooked. It also risks obscuring or conflating the drivers and causes of sexual violence. This risks under-identifying key drivers of suicidality linked to sexual violence, the shame and social stigma attached, and can lead to gaps in prevention, data collection and the required specialist responses. Likewise, it is important that sexual violence in an intimate partner context receives a specialist sexual violence response too. Recognising both the intersection and the distinctions is essential to accurately understand and address the pathways from experiences of violence to suicide.

Introduction

"Suicide in the context of sustained coercive control is frequently classified as an individual mental health crisis rather than recognized as a trajectory outcome of escalating abuse"[1]

[1] https://zenodo.org/records/18664072

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

We know from the evidence, victim-survivors, and our frontline specialist services that family and domestic violence and sexual violence are significant risk factors for suicide. While threats of suicide may be used by a perpetrator as a form of coercion and control, there are many victim-survivors of family, domestic and sexual violence who experience suicidal ideation and suicidality due to the profoundly harmful experiences they have experienced.

"In many cases, victims communicated feelings of entrapment, fear, or exhaustion prior to death. Survivor perception often precedes formal statutory risk recognition. When individuals state that they "cannot cope anymore," such disclosures may indicate advanced escalation across multiple axes rather than spontaneous psychological collapse. Failure to interpret these statements within a trajectory-based framework constitutes a significant safeguarding gap."[2]

There is an urgent need for a whole-of-government commitment to the implementation and coordination of trauma-informed practice across all sectors.

The WA context

Ombudsman of Western Australia Investigation into Family and Domestic Violence and Suicide:

Tabled in 2022, the Ombudsman of Western Australia (OWA) undertook an Investigation into Family and Domestic Violence and Suicide. The report presents the findings of the OWA's independent investigation into the relationship between family and domestic violence and suicide and was initiated after reviewing deaths where family and domestic violence had been previously recorded. The report includes a set of state-wide data relating to 68 women and child victims of family and domestic violence who died by suicide in 2017 and their prior interactions with State government departments and authorities.

The investigation found that while there is ongoing work by state government agencies to support the safety of women and children experiencing family and domestic violence, there are significant and systemic gaps in how family and domestic violence and related suicide risk are identified and responded to across services. The report highlights that many individuals who died by suicide had substantial contact with police, courts, health, child protection and other authorities, revealing opportunities for earlier and more effective intervention. The report

[2] https://zenodo.org/records/18664072

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

emphasises the need for trauma-informed, coordinated and victim-centred approaches across the service system to better prevent and reduce suicides linked to family and domestic violence. The Ombudsman made nine recommendations to four government agencies aimed at improving identification of family and domestic violence, service responses and suicide prevention.

Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region:

The Inquest into the 13 Deaths of Children and Young Persons in the Kimberley Region, delivered by Western Australian State Coroner in February 2019, examined the deaths of 13 Aboriginal children and young people that occurred between 2012 and 2016 across several Kimberley communities. The inquest was conducted because of the similarities in the circumstances surrounding the deaths and the broader social issues affecting children and families in the region. The children and young people involved were extremely young, with five aged between 10 and 13 years old. The inquest found that many had experienced significant adversity in their lives, including exposure to trauma, family instability and intergenerational disadvantage. While each child's circumstances were unique, the coroner identified common patterns in their experiences, including trauma, poverty, exposure to domestic and family violence, alcohol misuse within communities, and sexual abuse.

The inquest emphasised that the deaths were not the result of a single factor but rather reflected complex and cumulative disadvantage affecting many families in the Kimberley region. The coroner noted that many of the children had been exposed to repeated traumatic events during their childhoods, which affected their emotional wellbeing and ability to cope with distress. These experiences were compounded by broader structural issues including overcrowded housing, limited access to services, and the ongoing impacts of colonisation and intergenerational trauma. In response to these findings, the coroner made 42 recommendations focused on strengthening culturally appropriate, community-led services, improving access to mental health and suicide prevention supports, addressing alcohol-related harm, improving screening and support for FASD, and enhancing child protection responses.

Overall, the inquest concluded that the deaths of these children and young people were not isolated tragedies but reflected deep and longstanding social and structural challenges affecting many Kimberley communities. The coroner stressed that meaningful prevention requires sustained investment and solutions developed in partnership with Aboriginal

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

communities, recognising the importance of culturally grounded approaches to supporting the wellbeing of children and families.

The Lifetime Price of Harm: Economic Costs of Sexual Violence and the Case for Timely Intervention in Australia

This report released in WA in 2025 highlights the profound and long-lasting impacts of sexual violence on victim-survivors and the broader community. It finds that sexual violence leads to significant lifelong harms, including physical and mental health issues, reduced educational attainment, barriers to employment, and long-term economic insecurity. Importantly, the report emphasises that many of the financial costs associated with sexual violence are not borne by governments or systems, but by victim-survivors themselves through lost income, disrupted career pathways, ongoing health care costs, and reduced life opportunities.

The research also identifies the severe mental health impacts of sexual violence, including increased risks of depression, trauma, and suicide, underscoring the devastating personal consequences that can follow experiences of abuse. While these harms also generate substantial costs across health, justice, and social service systems, the report argues that delayed or fragmented responses compound both human suffering and public expenditure over time. It concludes that timely intervention, trauma-informed support, and stronger investment in prevention and recovery services are critical to reducing the long-term impacts of sexual violence and ensuring that victim-survivors receive the support needed to recover and rebuild their lives.

Links between suicidality and family, domestic and sexual violence

There is a strong and consistent body of international and Australian research demonstrating a significant association between experiences of family, domestic and sexual violence and suicidal ideation, self-harm and suicide attempts.

Victim-survivors of sexual violence and family and domestic violence experience markedly higher rates of suicidal thoughts and behaviours compared to the general population:

- *Suicidal behaviour is significantly more prevalent among women exposed to intimate partner violence compared to non-exposed populations*[3].

[3] https://pubmed.ncbi.nlm.nih.gov/21535096/

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

- *A study that examined 2,153 suicides in Victoria found that 42% of women have been exposed to intimate partner violence with 16% experiencing sexual abuse*[4].
- *Data by the AIHW found that people who have had a hospital stay due to family and domestic violence were twice as likely to die by suicide compared to a comparison group*[5].
- *Recent data from the UK found that suicide following intimate partner violence has for the first time exceeded intimate partner homicide in recorded prevalence*[6].
- *Data shows that women who had experienced sexual violence were 39–62% more likely than other women to report a recent diagnosis of and/or treatment for depression and around 50% more likely to report a recent diagnosis of and/or treatment for anxiety*[7].
- *A 40-year longitudinal study of survivors of child sexual abuse concluded that female survivors were 40 more times at risk of suicide than the general population and for male survivors 14 times greater risk*[8].

Suicide data collections poorly capture whether the person had a history of family, domestic or sexual violence victimisation, meaning these deaths are largely invisible in official statistics. This lack of evidence collection means there is insufficient analysis of how the experience of family, domestic or sexual violence contributed to the death of the victim.

Research has found that risk is escalated in intimate partner suicide cases by the erosion of psychological, social and institutional restraints that previously limited the perpetrator's behaviour. For example, his increasing indifference to visible victim-survivor distress, encouraging self-harm, violating court orders or weaponising child-contact agreements[9].

This results in suicide prevention policy being built without recognising one of the most significant drivers of suicidality for women and children. As a result, the scale of the issue is underestimated, under-reported and under-responded to.

[4] https://pubmed.ncbi.nlm.nih.gov/29172643/
[5] https://www.aihw.gov.au/reports/family-domestic-and-sexual-violence/examination-of-hospital-stays-due-to-family-and-do/summary
[6] https://zenodo.org/records/18664072
[7] https://www.wa.gov.au/media/158127/download?inline
[8] https://pubmed.ncbi.nlm.nih.gov/20888636/
[9] https://zenodo.org/records/18664072

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

Victim-survivors with acute mental health presentations are often treated in a clinical way that is divorced from their living reality

Victim-survivors frequently present to emergency departments, GPs and acute mental health services reporting anxiety, depression, self-harm or suicidality without the underlying violence being explored, identified or responded to. Distress responses are often pathologised as mental illness rather than understood as a normal response to fear, coercion, trauma and serious bodily violations.

Clinical responses frequently focus on symptom management (medication, admission, safety contracts) rather than addressing ongoing risk, safety and violence. Without identifying family, domestic or sexual violence, clinicians may inadvertently return victim-survivors to unsafe environments or exacerbate feelings of distress. This disconnect can increase feelings of hopelessness, shame and entrapment, which are key drivers of suicidality. Failing to identify these underlying causes of distress can also mean critical opportunities for intervention and connection with specialist supports are missed. Clinicians must be trained to identify when family, domestic and/or sexual violence factors are present, and equipped to make appropriate and timely referrals to specialised support.

> *For example, a woman presents at a local hospital with injuries consistent with self-harm, and a history of previous admissions for assault-related injuries. Clinicians within the mental health system assess her based solely on her presentation and risk of future self-harm or suicide, do not identify the link between past admissions, current presentation and the presence of family and domestic violence as a connecting factor. She is discharged without discussion about family violence supports, safe accommodation options or other family and domestic violence interventions and referred back to her GP. At no point does the hospital record the possibility of family and domestic violence as a factor in her mental health presentation.*
>
> *For example, if a young girl at a local high school is subjected to image-based abuse through the non-consensual sharing of intimate images across her school and online community, it is entirely understandable that she may experience suicidal thoughts in response to this profound violation, particularly given the intense social shame, stigma and isolation that can follow. Framing her suicidal ideation as a "behavioural" issue, without recognising the abuse and the broader social context in which it occurred risks compounding her distress and deepening her sense of isolation and disempowerment.*

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

Attendance at medical services can present an opportunity for victim-survivors to safely disclose and seek support for family, domestic and sexual violence. It is well established that victim-survivors of these types of abuse are far less likely to report their abuse to police than other offence types, meaning other non-police services have a critical role in identifying, intervening and supporting victim-survivors. However, those experiencing violence must feel comfortable and safe to make such disclosures, and clinicians must be skilled in identifying signs of abuse in absence of such disclosures.

The acute mental health system and suicide prevention landscape is devoid of family and domestic violence and sexual violence considerations

Suicide prevention frameworks, strategies and clinical guidelines rarely include explicit recognition of family, domestic and sexual violence as a core suicide risk factor.

For example, the Western Australian Suicide Prevention Framework 2021–2025 acknowledges that WA had the third-highest rate of suicide for all Australian states and territories (14.7 deaths per 100,000 people) and its rate has been consistently higher than the national average (12.1 deaths per 100,000 people) since 2008[10]. Yet the framework makes limited reference to family and domestic violence and no reference to sexual violence (including no reference to child sexual abuse). This is despite the wealth of evidence and research that demonstrates that domestic, family and sexual violence are key drivers of suicidality.

Risk assessment tools used in mental health settings often do not include screening for domestic, family or sexual violence[11]. Mental health practitioners often receive limited training in identifying and responding to family, domestic and sexual violence. Even when practitioners are able to identify family, domestic and sexual violence, they often lack confidence as to how to appropriately respond and refer those victim-survivors. This is particularly true with victim-survivors of family and domestic violence, as fear of increasing risk or exacerbating symptoms adds another barrier for mental health professionals to appropriately support and engage with these clients.

[10] https://www.mhc.wa.gov.au/awcontent/Web/Documents/2015-2024/wa-suicide-prevention-framework-2021-2025.pdf
[11] https://www.healthywa.wa.gov.au/~/media/Files/Corporate/general%20documents/art%20therapy/Word/Brief_Risk_Assessment_Form.ashx

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

A woman is conveyed to hospital by police after being assessed as experiencing an acute mental health episode. Police had attended after a neighbour called to report a possible family and domestic violence incident. Police at the time misidentify her to be the primary aggressor, as she presented as extremely heightened and verbally abusive. Both parties have visible injuries and there was recent damage to the property. Upon arriving at hospital, the victim-survivor was assessed using mental health frameworks only, despite previous admissions for assault-related injuries. Her partner later attends the hospital. Hospital staff assess her to be suitably stabilised for discharge, but complete no assessment for family and domestic violence, do not alert police or family and domestic violence services and do not make efforts to speak to her in absence of her partner or discuss family and domestic violence supports. Hospital staff speak directly to her partner about her condition. She is discharged back to an unsafe home.

There is little integration between family, domestic and sexual violence specialist services and mental health/suicide prevention services. Policy and service systems operate in silos, with family, domestic and sexual violence seen as a "social issue" and suicide as a "clinical issue". This separation fails to reflect the lived experience of victim-survivors, where violence and suicidality are deeply interconnected.

Similarly, mental health providers must be equipped to identify and respond to male perpetrators of harm, beyond a solely clinical approach. It is well established that threatening self-harm or suicide can be used as a form of control and emotional abuse that is indicative of a family and domestic violence dynamic. Currently, men with such presentations are being largely provided only a clinical response, with practitioners reporting a lack of confidence identifying when these presentations may indicate perpetration of family and domestic violence, and, in circumstances where family and domestic violence is identified as present, concern about risk to either the clinician, children or the victim-survivor partner if conversations or referrals to address family and domestic violence are required. This again means that the underlying family and domestic violence is not captured clinically, and an opportunity for intervention and support, both for the victim-survivor and the perpetrator, are missed.

Compounding harm caused to Aboriginal and Torres Strait Islander victim-survivors

Aboriginal and Torres Strait Islander women experience family, domestic and sexual violence at a far higher rate than other community groups, and current policing, justice and health

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

systems are not only failing to appropriately engage and support those women but are often compounding the harm they experience.

The over-policing of Aboriginal and Torres Strait Islander communities, the high prevalence of misidentification of victim-survivors as perpetrators and catastrophic levels of incarceration and child removal are beyond the scope of this submission. However, it is critical to acknowledge not only that current mainstream systems fail and can cause harm to these victim-survivors, but that mainstream mental health structures and assessments that do not truly understand and incorporate understanding of Aboriginal and Torres Strait Islander experience, barriers and the ongoing impact of colonial oppression are a part of this harm and can lead to lifelong impacts on victim-survivors.

Broader system impact of mental health treatment when divorced from family, domestic and sexual violence context

When clinical assessment and treatment of victim-survivors with mental health presentations do not include understanding of the context of violence in which the presentations are occurring, there can be repercussions for victim-survivors beyond the immediate risks outlined in the previous section.

Women with children who have experienced family and domestic or sexual violence may be required to engage in a variety of legal proceedings to which both their mental health and experiences of violence can be relevant. When mental health clinicians and services are able to identify and document the experience of violence underlying or related to mental health presentation, this documentation can be used evidence to corroborate her experience in future legal proceedings, such as criminal or family court processes and criminal injuries compensation claims.

Conversely, clinical notes can be weaponised by perpetrators in these same criminal justice proceedings to undermine the credibility of a victim-survivor. For example, , by implying that ill mental health renders her unreliable or that allegations of assault were fabricated as part of an acute mental health episode. In family law proceedings, perpetrators often rely on clinical notes or evidence of mental health admissions as evidence a victim-survivor is unable to safely care for children or even, in extreme cases, make decisions for themselves. If such clinical records captured the context of violence that led to or underpin the mental health presentation, it not only ensures accurate capture of the victim-survivors personal context to inform treatment and intervention options, but also ensures her experience of ill mental health is not able to be weaponised against her.

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

Women who seek support for mental health or enter the health system on a voluntary or involuntary basis are often responded to by health and then child protection systems that do not see, acknowledge or understand the context of violence in which ill mental health is occurring. Too often, women with mental health challenges related to abuse are met by child protection systems that see her only as a 'risk' to children, rather than a strength-based approach that understands the role of violence in her experience. The behaviours of the perpetrator also become lost when viewed through this lens, despite that violence being the key driver of risk to children and the bigger factor impacting on mental health of protective parents. At best, this approach stigmatises victim-survivors for their mental health challenges, which may be caused by or linked to violence they could not control. At worst, this approach can lead to a perpetrator being viewed as the safer or protective parent and then having children placed in his care. Systems continually silence the voices of survivors and work in ways which ensure the actions of perpetrators remain invisible.

There is clear evidence of a need for change in practice/systematic approaches to child protection that understands the impact of family and domestic violence and works with the non-offending parent to keep her and her children safe. It also highlights the need for further research on the experience of women who have experienced complex trauma as parents in the child protection system. This should include questions about whether assessments of parenting reflect current knowledge and practice on trauma and attachment and the lack of access to non-stigmatising early intervention and family support services[12] [13].

Importance of specialist services

Specialist family, domestic and sexual violence services are uniquely skilled at understanding the link between violence, trauma, entrapment and suicidality. These services do not separate a person's presentation from the reality of ongoing and historical experiences of violence.

Specialist services prioritise safety, validation, and practical support alongside emotional and psychological support. They are often the first to identify a person's suicidal ideation that is directly linked to their experiences of family, domestic and sexual violence. Specialist services can also play a key role in building the capability of mental health and suicide prevention services through training, secondary consultation and partnership models.

[12] https://www.anrows.org.au/publication/pathways-and-research-into-collaborative-inter-agency-practice-collaborative-work-across-the-child-protection-and-specialist-domestic-and-family-violence-interface-the-patricia-project-final-report/
[13] https://www.anrows.org.au/project/invisible-practices-intervention-with-fathers-who-use-violence/

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

It is also critical that Aboriginal and Torres Strait Islander victim-survivors of family, domestic and sexual violence have access to community-designed, led and delivered specialist service support, that includes cultural healing and recovery. Aboriginal and Torres Strait Islander victim-survivors face daily systemic barriers and discrimination when navigating mainstream systems, especially law enforcement and justice structures, that compound the damage of the abuse. The strength of culture and community is a powerful healing force that is critical to supporting the recovery of Aboriginal and Torres Strait Islander victim-survivors and must be centred in specialist responses. These responses must be led by the needs and experiences of Aboriginal and Torres Strait Islander communities.

Investment in specialist services is a suicide prevention strategy. However, both the specialist family and domestic violence, and sexual violence sectors are chronically underfunded to do vital healing, recovery and re-establishment work, particularly in Western Australia.

As a result, sexual assault and family and domestic violence services are not resourced adequately to manage acute risk within their settings, despite their expertise. When acute mental health care is required, services often have no option but to transfer victim-survivors to emergency departments or other acute mental health services, where long wait times and exposure to distressing or unsafe behaviours in waiting areas can occur. In these environments, victim-survivors may not receive care that is trauma-informed or responsive to the context of violence they have experienced.

Specialist sexual violence services identify suicidality and suicide risk as a common presenting factor requiring intake assessment and safety planning. As a result, these services work with victim-survivors in order to assess risk, implement safety planning, and mitigate immediate harm.

Similarly, specialist family and domestic violence refuge services regularly report receiving referrals from hospitals seeking to discharge women to refuge immediately or shortly after admission for an acute mental health episode or suicide attempt. In many instances, these referrals are made solely because the patient is homeless and has no accommodation to be discharged to, rather than due to current risk of family and domestic violence. These referrals are outside of scope for family and domestic violence services, but refuges regularly report feeling pushed into accepting them to avoid a patient being discharged into homelessness.

Even when referrals from hospitals do identify current risk of family and domestic violence in a patient being referred into refuge, there are critical gaps in information sharing from the

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

hospital system to refuges about the clinical history and current needs of these clients. Refuge services regularly report being sent referrals almost entirely devoid of information from hospital services. This lack of coordination or communication from the hospital or treating team to the refuge staff mean the refuges are unaware of the acute clinical history of the patient and any crucial safety or safekeeping measures that need to be taken to ensure her wellbeing. These patients often require highly specialised support that family and domestic violence services are not resourced to provide, putting additional strain on an already highly stressed system.

> *For example, a refuge in a regional area receives a referral for a woman being discharged from a local hospital, after the client identified family and domestic violence risk should she be discharged to her home. The refuge accepts the referral but is not advised by the hospital that the client had made a serious suicide attempt earlier that same day. The client is still expressing suicidal ideation upon her arrival at the refuge. Attempts to contact the hospital to clarify their risk assessment and any safeguarding measures necessary for that client's safety are unsuccessful, and the hospital is unwilling to readmit her in absence of further self-harm. The client's history of family and domestic violence is comprehensive and long-term, and the client expresses recent violence as the trigger for her suicide attempt. No further follow up or communication from the hospital is received, and the refuge staff allocate additional resources to supervise the client in refuge 24 hours a day.*

In major Western Australian locations victim-survivors are currently having to wait more than 12 months to access specialist sexual violence support, and in many locations there is no specialist service at all. This can worsen anticipated trauma symptoms and deepen feelings of hopelessness, both of which are closely linked to increased suicidality.

This delay in access to sexual assault and family and domestic violence services nationally also mean that important opportunities to screen, assess and provide timely therapeutic responses to victim-survivors experiencing suicidal ideation can be missed.

Recommendations

1. **Recognise specialist family, domestic and sexual violence services as essential partners in suicide prevention, not adjunct services.**
   Mental health and suicide prevention responses must acknowledge the pervasive nature of family, domestic and sexual violence in the community, and recognise it as a

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

major, preventable driver of suicidality among women, children and young people. This requires mandating the inclusion of family, domestic and sexual violence considerations across all suicide prevention policies, frameworks and clinical guidelines, and ensuring the specialist family, domestic and sexual violence sectors are engaged as essential stakeholders in the consultation, development and implementation of these approaches.

Sustained, long-term funding for specialist services is critical to addressing the complex, lifelong impacts of trauma, as acute mental health crises are not the only pathways to suicide or suicidal ideation. Victim-survivors who experience extensive abuse, often across childhood and adulthood, are more likely to face intersecting challenges such as poor mental and physical health, disability, substance misuse, poverty, housing insecurity, homelessness and discrimination. Specialist services play a vital role in preventing suicide by providing holistic, long-term support that addresses physical, psychosocial and mental health needs, alongside practical assistance and support to navigate complex systems such as policing and the NDIS.

2. **Improve data and evidence**
   This includes requiring routine collection of family, domestic and sexual violence history in suicidality data sets, coronial investigations, hospital data and mental health records. CWSW also recommends improving data linkage and information sharing between family, domestic and sexual violence and suicide systems to inform evidence-based, best-practice responses.

3. **Improve workforce capability**
   Addressing suicide risk in family, domestic and sexual violence cases requires more than mental health interventions; it demands integration within multi-agency safeguarding, lethality assessment, and post-separation risk management. Family, domestic and sexual violence literacy should be established as a core competency for clinicians working in acute mental health, emergency departments, primary care and suicide prevention services. This includes embedding routine family, domestic and sexual violence screening into suicide risk assessment processes, alongside protocols for the compassionate treatment of self-harming individuals across settings such as emergency departments. Preventing and reducing complex trauma must also be a priority across the life course. This includes strengthening pre- and post-natal care

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

through routine screening for abuse and violence, expanding trauma-informed parenting and family support programs, and ensuring early intervention for children and young people exposed to trauma. Integrating trauma-informed care and family, domestic and sexual violence literacy into health and medical education and professional training is essential to equip practitioners to identify, respond to and prevent the long-term harms associated with violence and abuse.

4. **Commit to system integration**

CWSW strongly recommends that victim-survivors presenting with suicidality are offered referral pathways to specialist family, domestic and sexual violence services as part of standard care, through embedding referral pathways and ensuring that these frontline services are adequately funded. Funding formal partnerships between specialist family, domestic and sexual violence services and mental health and suicide prevention services is critical to the success of this recommendation.

We also recommend explicitly funding secondary consultation models where clinicians can seek advice from family, domestic and sexual violence specialists, and vice versa, to prevent the continuous referral cycle between acute mental health and family, domestic and sexual violence services. In addition, victim-survivors must have access to comprehensive and sustained treatment for complex trauma under current policy arrangements, including through Medicare and the NDIS, to minimise short-term and disjointed interventions and ensure coordinated, long-term therapeutic support that reflects the cumulative impacts of violence and abuse.

5. **Other considerations for the inquiry**

Culturally safe responses must be embedded across suicide prevention and intervention efforts in the context of family, domestic and sexual violence. Victim-survivors from Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, migrant and refugee backgrounds, and other marginalised groups may experience additional barriers to seeking support, including racism, discrimination, language barriers, visa insecurity, and distrust of institutions.

Mental health and suicide prevention responses must prioritise culturally safe, trauma-informed and community-led approaches that recognise the intersecting impacts of violence, colonisation, displacement and systemic disadvantage. This includes

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005

supporting and resourcing Aboriginal community-controlled organisations and culturally specific services, ensuring access to interpreters and bicultural workers, and embedding cultural capability and anti-racism training across the mental health, suicide prevention workforces. Ensuring culturally safe pathways to support is critical to enabling victim-survivors to disclose violence, access help, and receive responses that respect their cultural identity, safety and self-determination.

Systems abuse by perpetrators is a key contributing factor to suicidality, Governments across Australia must address abuse of courts and other systems by perpetrators which are used to inflict enduring harm to victim-survivors. For example, protracted court proceedings, weaponisation of counselling notes in court proceedings against victim-survivors are frequently used by perpetrators to silence and harm victim-survivors.

Email
admin@cwsw.org.au
Phone
08 9420 7264
Address
2 Delhi St, West Perth, 6005