AASW
Australian Association of Social Workers

Hidden in Plain Sight: Family, Domestic and Sexual Violence as a Driver of Suicide in Australia

A submission on preventable deaths, system silos and missed intervention and prevention opportunities from the perspective of frontline social workers

January 2026

About the Australian Association of Social Workers

The Australian Association of Social Workers (AASW) is the national professional body representing more than 17,000 social workers throughout Australia. The AASW works to promote the profession of social work including setting the benchmark for professional education and practice in social work, while also advocating on matters of human rights to advance social justice.

Acknowledgements

This submission has been informed by the valuable feedback, experiences, and knowledges from AASW members. The AASW thanks members who contributed their professional expertise, including the substantial lived experience and lived practice insights held across the social work workforce, recognising that many social workers bring both professional and personal knowledge of domestic, family and sexual violence and suicidality to their practice. For the purposes of this submission, lived experience is defined as the experiences of people directly impacted by domestic, family and sexual violence, and suicidality.

The Australian Association of Social Workers (AASW) acknowledges the Traditional Owners of Country throughout Australia. This submission was written across Dja Dja Wurrung and Wurundjeri Country. We pay our deep respect to Elders past, present and emerging, and recognise their continuing connection to land, water and community.

For further information or questions relating to this submission, please contact:

Author(s) of the Submission
Emma Slater
Policy and Advocacy Officer
Emma.slater@aasw.asn.au

Executive Summary

The Australian Association of Social Workers (AASW) welcomes the opportunity to make this submission to the Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide in Australia. Social workers are a core professional workforce across family violence and domestic violence, sexual violence, mental health, child protection, AOD, homelessness, health, justice and community services, and routinely work with people experiencing acute suicide risk in the context of violence, coercive control and cumulative trauma. As a result, the social work profession brings critical frontline expertise to prevent harm and save lives in this complex area of practice.

Drawing on nationwide consultation with AASW members, this submission demonstrates that DFSV is a significant yet vastly under-recognised driver of suicidality and suicide deaths, particularly for women, children and young people, culturally and linguistically diverse peoples, Aboriginal and Torres Strait Islander peoples, LGBTQIA+ communities, people with disability, and those experiencing social and economic marginalisation. Despite strong practice and research evidence, DFSV and suicide continue to be treated as separate issues across policy, data and service systems, resulting in fragmented responses, misclassification of deaths, and missed prevention opportunities[1].

Members consistently report that suicide risk in the context of DFSV is frequently medicalised or minimised, with violence treated as a secondary issue rather than a primary driver of distress.[2] Data collection, medical and coronial systems often fail to capture the cumulative impacts of coercive control, child exposure to violence and long histories of abuse, leading to significant undercounting of DFSV-related suicides, particularly among marginalised communities. These gaps undermine effective, evidence-based suicide prevention.

The AASW submits that suicide in the context of DFSV is foreseeable and preventable. Addressing this national crisis requires coordinated national leadership, integrated suicide prevention and DFSV policy, strengthened data and accountability mechanisms, workforce capability building, and action on the social and structural drivers of risk. Without reform, siloed systems will continue to fail people already known to services, and preventable deaths will continue to occur.

Context for this Submission

The Australian Association of Social Workers (AASW) welcomes the opportunity to provide this submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into the relationship between domestic, family and sexual violence (DFSV) victimisation and suicide. The inquiry raises issues that intersect with violence prevention, suicide prevention, mental health, child and family wellbeing, and broader social policy.

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[1] Vasil, S., Fitz-Gibbon, K., & Segrave, M. (2024). *Family violence and women's deaths by suicide: A Victorian study*. Australian Catholic University; Sequre Consulting; University of Melbourne. https://doi.org/10.24268/acu.914zx .

Social workers are a key professional workforce involved in frontline responses to DFSV and suicidality across Australia.[2] Social workers are employed across health, mental health, alcohol and other drug (AOD), child protection, family violence, sexual assault, homelessness, justice, education and community service systems. In these settings, social workers routinely support individuals and families experiencing suicide risk in the context of violence, coercive control, cumulative trauma, and systemic disadvantages.

Social work practice is grounded in human rights, as well as trauma-informed and systems-based approaches that recognise the interaction between individual distress and broader social, cultural, economic, and structural factors. Social workers address both the immediate impacts of DFSV and suicidality and the underlying conditions that shape risk and recovery, including housing insecurity, financial stress, discrimination, legal system involvement, and intergenerational trauma. This perspective is relevant to understanding how suicide risk may emerge and escalate in the context of DFSV. Across jurisdictions, social workers (including Accredited Mental Health Social Workers (AMHSWs) play a central role in assessment, risk formulation, crisis intervention, safety planning, therapeutic support and coordination across service systems. Social workers are frequently among the first points of contact for people seeking assistance and are often involved in managing responses during periods of heightened risk.

Through their practice, social workers also observe systemic issues relevant to the Committee's inquiry, including service fragmentation, limitations in existing risk assessment frameworks, inconsistent data collection practices, and concerns about system consequences such as police involvement or child removal. These factors may influence help-seeking, disclosure, and service engagement, and have implications for prevention and early intervention.

This submission is informed by consultation with AASW members working across diverse settings nationwide and draws on professional practice knowledge and lived experience within the social work workforce. The AASW submits that the perspectives of social workers are directly relevant to the Committee's consideration of data quality, system responses, and opportunities to strengthen prevention and response to DFSV-related suicide.

Recommendations

The AASW recommends:

Recommendation 1 – Formal recognition of DFSV as a driver of suicide

1.1: Formally recognise domestic, family and sexual violence including coercive control, child exposure to violence, and family-of-origin violence as a significant contributing factor to suicidality and suicide deaths in Australia.

1.2: Ensure all national and state and territory suicide prevention strategies, mental health frameworks and public reporting explicitly acknowledge DFSV as a key suicide risk driver, rather than framing suicidality solely as an individual mental health issue.

[2] Hempel, V. (2022). *Exploring social work practice responses to domestic violence against women* (Doctoral dissertation, James Cook University). James Cook University ResearchOnline. https://researchonline.jcu.edu.au/77232/1/JCU_77232_Hempel_2022_thesis.pf

Recommendation 2 – National data, reporting and surveillance reform

2.1: The AASW calls for the establishment of an independent national body with responsibility for the collection, oversight and analysis of data on suicide and self-harm occurring in the context of domestic, family and sexual violence, to ensure these deaths and harms are properly identified, recorded and reported in Australia. This body would bring together the work of the state and territory Coroners Courts. The AASW suggests that this function could be appropriately embedded within the remit of the Domestic, Family and Sexual Violence Commission, to strengthen national accountability, data integrity and evidence-informed prevention and response.

2.2: Develop and mandate a national minimum dataset that requires consistent recording of DFSV indicators, including coercive control, stalking, technology-facilitated abuse, child exposure, and post-separation violence across:

I. coronial systems
II. police records
III. health and emergency department presentations
IV. mental health and alcohol and other drug (AOD) services
V. Justice services including prisons
VI. specialist DFSV services.

2.3: Enable ethical and secure linkage of administrative data, and when relevant risk data, across health, justice, child protection and social service systems to better identify cumulative risk trajectories.

2.4: Ensure all data reforms uphold:

- Aboriginal and Torres Strait Islander data sovereignty
- cultural safety
- lived-experience governance and oversight.

Recommendation 3 – Integrated DFSV and suicide risk assessment frameworks

3.1: Urgently develop and implement a nationally consistent, integrated DFSV–suicide risk assessment framework that is aligned with existing state and territory DFSV frameworks (including MARAM).

3.2: Mandate bi-directional screening across systems:

- where DFSV is identified, suicide risk assessment must be activated
- where suicide risk is identified, both current and historical DFSV assessment must be activated.

3.3: Ensure risk assessment tools include clear practice guidance on:

- interpreting suicide threats in the context of coercive control and a distinct form of family violence
- preventing misidentification of victim-survivors and of perpetrators, particularly for young people and Aboriginal and Torres Strait Islander people
- recognising heightened risk during separation, perinatal periods including in the vulnerable post birth period, court involvement, and perpetrator release.

3.4: Ensure that people presenting with suicidality are treated with care and dignity, and receive responses that are compassionate, validating and non-judgemental, so that individuals feel respected and supported by services rather than alienated or discouraged from seeking help when they disclose suicidality.

Recommendation 4 – Recognition of suicide threats as coercive control and a distinct form of DFSV

4.1: Explicitly recognise suicide threats and self-harm by perpetrators as a tactic of coercive control within national DFSV policy, legislation, practice guidance and competencies, and risk assessment tools.
4.2: Develop national practice guidance for frontline workers on:

- safely responding to perpetrator suicide threats
- maintaining focus on victim-survivor and child safety
- avoiding system responses that inadvertently reinforce coercive control.

4.3: Ensure perpetrator intervention, mental health, justice and AOD services are required to assess and manage suicide risk without diminishing accountability for violence or increasing risk to others.
4.4: Invest in justice system responses and men's behaviour change programs to strengthen perpetrator accountability where suicide threats and self-harm are used as tactics of coercive control, including through mandated involvement of qualified social workers to deliver and oversee trauma- and violence-informed assessment, case management and intervention.

Recommendation 5 – Child- and youth-specific reforms

5.1: Formally recognise children and young people exposed to DFSV as victim-survivors in their own right within suicide prevention, child protection, education and youth justice frameworks. The AASW calls on the government to comprehensively invest into this space.
5.2: Embed DFSV-informed suicide risk assessment across all youth-facing services, including:

- schools
- child and youth mental health services
- emergency departments
- child protection and out-of-home care.

5.3: Invest in early intervention and healing focused programs for children and young people exposed to DFSV, with a focus on:

- cumulative trauma
- poly-victimisation
- trauma impacts development including physical development, cognitive development, emotional development, and social, behavioural and relational functioning across the life course
- developmental impacts of chronic fear and instability.

5.4: Commit to dedicated investment in youth-specific DFSV and suicide-prevention responses for young people aged 16–18, recognising their heightened vulnerability as they transition out of child protection systems.

Recommendation 6 – Aboriginal and Torres Strait Islander community-led responses

6.1: Resource Aboriginal Community Controlled Organisations (ACCOs) to design, lead and evaluate DFSV and suicide prevention responses grounded in culture, cultural knowledges, kinship and connection to Country.
6.2: Ensure all national frameworks and initiatives embed:

- Aboriginal governance
- Aboriginal self-determination
- community-led decision-making
- culturally secure models of care.

6.3: Address structural drivers of risk for Aboriginal and Torres Strait Islander peoples, including housing insecurity, justice system over-representation, child removal and systemic racism within systems such as the Police, Child Protection, health, housing, and mental health services.
6.4: Embed formal power-sharing with ACCOs as a core requirement of DFSV and suicide-prevention reform, including:

- the transfer of decision-making authority, resource control and data governance to Aboriginal communities,
- the replacement of short-term, programmatic funding with sustained, flexible funding aligned to community-identified priorities, and

Recommendation 7 – Workforce capability, training and support

7.1: Fund nationally consistent, mandatory training for health, mental health, police, education, AOD, housing and child protection practitioners on:

- coercive control
- DFSV-informed suicide risk assessment
- child and youth victim-survivorship
- culturally safe practice.

7.2: Recognise and invest in social workers as a core professional workforce in responding to DFSV-related suicide risk, including through:

- expanded social work roles in emergency departments including within paramedic units, primary care, health, justice, courts, police and coronial settings
- access to specialist supervision and workforce support
- involvement in the design and governance of integrated response models
- social work led models across community services.

7.3: The Government must urgently invest in nationally consistent DFSV including a 24/7 national out-of-hours crisis service. While 1800RESPECT provides counselling and referral, there is a critical gap in immediate crisis response, requiring a national model comparable to Safe Steps and Shine in NZ.

Recommendation 8 – Prevention, early intervention and structural reform

8.1: Prioritise national investment away from short-term, crisis-only responses toward long-term, preventative and early-intervention approaches. This must include a substantial investment in this space.
8.2: Prioritise access to:

- safe, long-term housing, including access to appropriate crisis and short-term housing
- financial security and flexible crisis funding
- accessible mental health and AOD services, particularly for victim-survivors during high-risk periods such as separation and court involvement.

8.3: Ensure suicide prevention is treated as a whole-of-government responsibility, addressing the social, economic and structural conditions that drive both DFSV and suicidality. As it is a whole-of-government responsibility, it requires a whole-of-government response.
8.4: The Federal Government must incorporate a specific suicide prevention and response strategy addressing domestic, family and sexual violence within the National Plan to End Violence against Women and Children 2022–2032.
8.5: The Federal Government must amend the National Suicide Prevention Strategy to explicitly address suicidality within the context of domestic, family and sexual violence, and require alignment of all state and territory suicide prevention strategies with this

approach, to ensure nationally consistent, violence-informed prevention, risk assessment and accountability across jurisdictions.

Recommendation 9 – Accountability and continuous improvement

9.1: Establish national monitoring and evaluation mechanisms to assess reform efficacy and outcomes, including:

- improvement of early identification of DFSV-related suicide risk
- reduction in repeat crisis presentations
- prevention of avoidable deaths.

9.2: Require regular public reporting on progress, outcomes and system gaps to ensure transparency and accountability.

9.3: The government appoints an expert oversight body to ensure accountability and transparency.

Recommendation 10: Understanding suicide as protective response

10.1: Strengthen violence-informed guidance and training across suicide prevention, mental health, child protection and DFSV systems to ensure suicide and filicide occurring in the context of domestic, family and sexual violence are understood within frameworks of coercive control and systemic failure, rather than through stigmatising or punitive responses to victim-survivors, particularly for victim/survivors who are seeking to protect themselves and their children from the DFSV they are experiencing.

Response to the Terms of Reference

ToR1: The relationship between domestic, family and sexual violence (DFSV) victimisation and suicide

DFSV is a significant yet persistently under-recognised contributor to suicide risk and suicidality in Australia and internationally.[3] Despite this, suicide is still framed predominantly as an individual mental health issue in service systems and public discourse.[4] This narrow framing obscures the social, relational and structural drivers of suicide risk, particularly current and historical experiences of violence, coercive control and trauma. AASW member consultations consistently indicate that suicidality often arises from profound distress linked to violence, entrapment and loss of safety and autonomy, rather than solely from mental illness.

Frontline social workers report that coercive control and cumulative trauma frequently sit at the centre of suicidality, interacting with other pressures such as poverty, housing

[3] Bhavsar, V., & Dheensa, S. (2025). *The impact of domestic abuse on suicide*. The Lancet Regional Health – Europe, 55, Article 101376.

[4] Pirkis, J., Dandona, R., Silverman, M., Khan, M., & Hawton, K. (2024). *Preventing suicide: A public health approach to a global problem*. The Lancet Public Health, 9(10), e787–e795. https://doi.org/10.1016/S2468-2667(24)00177-5.

insecurity, social isolation and legal system involvement. When DFSV is not identified as a primary driver of suicide risk, responses tend to become fragmented or overly medicalised, and opportunities for early intervention, safety planning and violence-informed prevention are missed.[5] Members report that victim-survivors presenting with suicidality are too often assessed and treated primarily as "mentally unwell", without adequate inquiry into DFSV, resulting in misidentified risk and ongoing danger for victim-survivors and children, particularly in hospital, justice, and community health settings.

The AASW membership unequivocally asserts that all social work practice and suicide intervention must be grounded in evidence-based, violence-informed best practice. This requires responses to suicidality that are non-judgemental, compassionate and validating, and explicitly trauma- and violence-informed. AASW members emphasise that, at individual, organisational and systemic levels, responses must recognise suicidality not as a moral failing or individual pathology, but as a foreseeable and, in many cases, rational response to sustained trauma, distress and exposure to violence. Failure to adopt this approach risks compounding harm, reinforcing stigma, and undermining effective prevention and intervention efforts.

While state-based family and domestic violence frameworks such as Victoria's Multi-Agency Risk Assessment and Management Framework (MARAM) incorporate considerations of self-harm and suicide.[6] AASW members emphasise the need for stronger national coordination and more explicit integration of DFSV and suicide risk assessment across jurisdictions, including coordinated and nationally consistent legislation and response models.

Victorian practitioners consulted by AASW noted that although MARAM represents a significant improvement, gaps remain in how suicide risk is assessed and managed for victim-survivors, perpetrators and children. This concern is reflected in the literature. Vasil, Fitz-Gibbon, and Segrave (2024) identify critical limitations in how suicide risk is currently understood and operationalised within risk assessment practice, including an over-emphasis on perpetrator risk and insufficient attention to the cumulative impacts of coercive control and sustained violence on victim-survivor suicidality.[7] The authors conclude that without clearer guidance, stronger workforce capability and an explicit reframing of suicide as a core family violence risk, assessment practices will continue to miss key prevention opportunities.[8] Accordingly, the AASW calls on state and territory governments, led by the Federal Government, to urgently develop and implement integrated, comprehensive DFSV–suicide risk assessment guidance across service systems and create nationally cohesive legislation.

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[5] Ombudsman Western Australia. (2022). *Investigation into family and domestic violence and suicide: Volume 4 – The Need for Trauma-Informed Responses*. https://www.ombudsman.wa.gov.au/Publications/Reports/FDV-Suicide-2022-Volume-4-The-need-for-trauma-informed-responses.pdf

[6] Sexual Assault & Family Violence Centre. (2024). *MARAM summary guide: Best practice approaches in family violence risk assessment and management* (Version 3.2, June 2024). https://www.safvcentre.org.au/wp-content/uploads/2024/08/BAIFVC-MARAM-Summary-Guide_DIGITAL_Version-3.2_June-2024.pdf

[7] Vasil, S., Fitz-Gibbon, K., & Segrave, M. (2024). *Family violence and women's deaths by suicide: A Victorian study*. Australian Catholic University, Thomas More Law School. https://acuresearchbank.acu.edu.au/server/api/core/bitstreams/f8b40a07-b17c-4949-803d-2b75cf771753/content

[8] Ibid.

Distinctive and Foreseeable Risk Patterns

Suicide risk in the context of DFSV follows distinctive and identifiable patterns that must be explicitly recognised within suicide risk assessment and prevention approaches.[9] Australian and international evidence consistently shows that risk escalates during periods of ongoing or intensifying violence, particularly where coercive control increases and victim-survivors experience heightened entrapment and isolation.[10] Perinatal periods and pre- and post-separation are repeatedly identified as critical high-risk periods, during which violence often escalates in severity and frequency.[11] At these transition points, women and children may be exposed to intensified stalking, threats, legal abuse and financial control—factors that significantly elevate acute suicide risk.

For children and young people exposed to DFSV, cumulative harm across the life course, including direct exposure to DFSV within the family of origin, substantially increases vulnerability to suicidality.[12] Chronic fear, disrupted development and the enduring impacts of trauma, including post-traumatic stress, interact with ongoing instability, disrupted attachment relationships and repeated system involvement, progressively eroding protective factors over time.[13]

The body of evidence demonstrates that DFSV-related suicidality is not random or unpredictable. Rather, it follows recognisable trajectories that can be interrupted through timely, trauma-informed and coordinated system responses that address both immediate risk and the underlying conditions driving harm.

Undercounting and Misclassification of DFSV-Related Suicide

Research, supported by consultation with AASW members, strongly indicates that suicides related to DFSV are significantly undercounted.[14] While the AASW acknowledges the important work of Coroners Courts and Domestic and Family Violence Death Review programs and recognises that links between DFSV and suicide are increasingly being identified, a substantial gap remains.[15] This

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[9] Victorian Government. (2021). *Responsibility 3, Appendix 6: Recognising suicide risk in the context of adult people using violence* (MARAM Practice Guides). https://www.vic.gov.au/sites/default/files/2021-08/Responsibility%203%20Appendix%206%20-%20Recognising%20suicide%20risk%20in%20the%20context%20of%20adult%20PUV.pdf

[10] Li, C. K. W. (2024). A Qualitative Study on how Intimate Partner Violence Against Women Changes, Escalates, and Persists from Pre- to Postseparation. *Family Process, 63*(3), 1446–1468. https://doi.org/10.1111/famp.12923.

[11] Baird, K. M., Phipps, H., Javid, N., Bradley, S., & de Vries, S. (2024). *Domestic and family violence and associated maternal and perinatal outcomes: A population-based retrospective cohort study*. Birth, 52(1), 89–99. https://doi.org/10.1111/birt.12863,

[12] Campo, M. (2015). *Children's Exposure to Domestic and Family Violence: Key issues and responses* (CFCA Paper No. 36). Child Family Community Australia, Australian Institute of Family Studies.

[13] Margolin, G., & Vickerman, K. A. (2007). Post-traumatic stress in children and adolescents exposed to family violence: I. Overview and issues. *Professional Psychology: Research and Practice, 38*(6), 613–619. https://doi.org/10.1037/0735-7028.38.6.613.

[14] Vasil, S., Fitz-Gibbon, K., & Segrave, M. (n.d.). *Family violence and women's deaths by suicide: A Victorian study*. Australian Catholic University, Thomas More Law School. https://acuresearchbank.acu.edu.au/items/24e29bde-2aa9-48c0-b7d4-ea18832ed0d0 .

[15] Buxton-Namisnyk, E., & Gibson, A. (2024). *The contribution of domestic and family violence death reviews in Australia: From recommendations to reform?* Journal of Criminology, 57(2), 161–186. https://doi.org/10.1177/26338076231223580.

ongoing under-recognition reduces the visibility of DFSV as a driver of suicide, weakens public reporting and accountability, and limits governments' capacity to design effective, evidence-based prevention strategies grounded in lived experience. The AASW recognises that Coroners Courts are the primary sites of investigation for DFSV-related suicides, and notes that while national bodies such as ANROWS play an important role in synthesising insights from state and territory death review mechanisms, the absence of a nationally coordinated coronial approach continues to drive systematic under-identification of DFSV-related suicide across jurisdictions.

Disproportionate and Compounding Impacts

The burden of suicide risk linked to DFSV is not evenly distributed. AASW members consistently report that women are disproportionately impacted by suicidality in the context of DFSV and coercive control, particularly high-risk transition points. This aligns with broader evidence showing that women experience DFSV within contexts of structural patriarchy, gendered violence, power imbalances and intersecting social and economic disadvantage factors that compound risk and restrict pathways to safety and recovery.[16]

Aboriginal and Torres Strait Islander peoples experience disproportionate and compounding suicide risk due to the intersecting impacts of DFSV, intergenerational trauma, systemic racism, child removal and over-representation in the justice system. This underscores the urgent need for culturally governed, community-led responses. The AASW calls on governments to substantially and sustainably invest in ACCOs to ensure Aboriginal and Torres Strait Islander peoples can access self-determined, culturally grounded and culturally safe supports. Without this investment, communities remain at heightened risk of exclusion from mainstream systems, contributing to under-reporting of DFSV-related suicide deaths and perpetuating preventable harm.

Other marginalised populations—including LGBTQIA+ communities, people with disability and people on temporary visas, also face heightened vulnerability to suicidality in the context of DFSV. LGBTQIA+ communities especially experience additional barriers to safety, service access, legal protection and social support, and may face discrimination, fear of repercussions or ineligibility for assistance.[17] These barriers include discrimination within service systems, lack of inclusive and affirming responses, fear of being disbelieved or misidentified as the primary aggressor, and concerns about outing, retaliation or further harm if they seek help.[22]

Many LGBTQIA+ victim-survivors report reluctance to engage with police, courts or mainstream services due to prior experiences of stigma, hostility or cultural incompetence, while others face practical barriers such as ineligibility for gendered services, lack of appropriate crisis accommodation, or exclusion from family-based support pathways.

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[16] Australian National Research Organisation for Women's Safety (ANROWS). (2018). *National risk assessment principles for domestic and family violence* (ANROWS Insights Paper). https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2018/07/19030421/ANROWS_NRAP_National-Risk-Assessment-Principles.1.pdf.

[17] Lim, G., Lusby, S., Carman, M., & Bourne, A. (2025). Affective barriers to accessing professionalized intimate partner violence services among LGBTQ people in Australia. *Violence Against Women*. Advance online publication. https://doi.org/10.1177/10778012251323237 .

These systemic failures contribute to under-reporting of violence, delayed help-seeking, and prolonged exposure to harm, significantly increasing suicide risks.[18] The AASW emphasises that without explicit recognition of LGBTQIA+ experiences within suicide prevention and DFSV frameworks—and without targeted, inclusive and culturally safe responses existing systems will continue to fail this population, perpetuating preventable distress, violence and loss of life.

Culturally and linguistically diverse (CALD) peoples are also a particularly vulnerable population with distinct suicide and family violence risk profiles that require specialised responses. People from CALD backgrounds often face cultural stigma, language barriers, immigration-related stressors, experiences of trauma and discrimination, and differing cultural understandings of help-seeking, all of which can increase psychological distress and barriers to accessing support services.[19] CALD communities are disproportionately impacted by suicide and self-harm, yet reliable data are limited and suicide behaviours are often under-identified due to cultural taboos and reporting challenges, obscuring the true scale of need.[20]

CALD people, including temporary visa holders, women in communities where patriarchal and honour-based norms create barriers to reporting, newly arrived migrants and refugees, young people navigating cultural conflict, people with disability, and older CALD adults, experience heightened and intersecting risks of domestic, family and sexual violence and suicidality. These distinct risk profiles require specialised, culturally safe, linguistically accessible and community-led prevention and response approaches tailored to specific community contexts.[21] Likewise, AASW members state many CALD victim-survivors of DFSV encounter heightened obstacles in seeking help, including visa insecurity, family and community pressures, and mistrust of systems, which compound distress and suicidality. Effective prevention and intervention for CALD peoples must therefore be culturally safe, linguistically accessible, tailored to specific community contexts, and co-designed with CALD communities to ensure services are respectful, relevant and capable of addressing intersecting risk factors.

In rural and remote communities, victim-survivors often encounter acute isolation, long distances to specialist services, limited transport and constrained police and service responses, further intensifying entrapment and escalating suicide risk for women and children.[22]

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[18] Ibid.

[19] Cultural & Indigenous Research Centre Australia. (2020). *CALD lived experience research final report: Suicide prevention* (Final Advice to the National Suicide Prevention Taskforce, 2 December 2020) [PDF]. National Suicide Prevention Taskforce. https://cdn.lifeinmind.org.au/assets/src/uploads/Final-Advice-CALD-Suicide-Prevention.pdf.

[20] Australian Institute of Health and Welfare. (2025). *Suicide & self-harm monitoring: Migrants and refugees*. https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/migrants-refugees.

[21] Australian Multicultural Action Network. (2025). *Submission to the Inquiry into the Relationship Between Domestic, Family and Sexual Violence Victimisation and Suicide* (Submission No. 6) [PDF]. Australian Multicultural Action Network.

[22] Osuagwu, U. L., & Vines, R. (2025). Service providers' perspectives on delivering support for domestic violence victims in rural New South Wales. *Inquiry: The Journal of Health Care Organization, Provision, and Financing, 62*, Article 00469580251366958. https://doi.org/10.1177/00469580251366958.

Members report that the vast majority of incarcerated people—particularly women—have experienced significant histories of DFSV. Yet systems frequently fail to identify, record, or respond to these experiences. Screening for DFSV is inconsistent or absent across police, courts, and corrections, offences are rarely labelled or analysed through a family violence lens, and suicide risk is often assessed in isolation from histories of coercive control, trauma and victimisation. In custodial settings, suicide risk is especially complex, with members reporting heightened risk following arrest, charging, court proceedings and separation from children, alongside limited workforce capacity to deliver trauma and violence informed responses. AASW members therefore emphasise the need for mandatory DFSV and suicide-informed screening, specialist social work roles, and sustained workforce training across justice and corrections systems to ensure responses promote safety, accountability and rehabilitation, rather than compounding harm or entrenching cycles of trauma.

Further, AASW members consistently report a pervasive mistrust of service systems among people experiencing DFSV and suicidality, driven by repeated experiences of unintended and unsafe system responses. Members emphasise that disclosures of DFSV or suicidality frequently trigger punitive or surveillance-based interventions, most notably automatic child protection notifications. These responses can result in increased monitoring of victim-survivors, fear of child removal, criminalisation or system escalation, rather than protection or support.

As a result, many people, particularly Aboriginal and Torres Strait Islander peoples, CALD communities and women with insecure housing or visa status, actively avoid disclosing violence or suicidality, even at points of acute risk. The AASW therefore calls for mandatory safe-disclosure pathways, with clear safeguards to prevent system enabled harm, including guidance on thresholds, information-sharing and child protection notification processes, so that disclosure leads to safety and support rather than fear, surveillance or service system disengagement.

ToR 2: Opportunities for improved reporting and investigation methodologies

Despite increasing recognition of the links between DFSV and suicide, Australia's current data systems remain inadequate to accurately capture, analyse and respond to DFSV-related suicide and self-harm. While important work is being undertaken by Coroners Courts, Domestic and Family Violence Death Review mechanisms and national research bodies, including specialist review panels and research led by ANROWS, The AASW calls for significantly greater investment to address the current inadequacies in the scope, consistency and integration of data collection.

AASW members consistently report that existing data systems are fragmented, jurisdictionally siloed and overly reliant on narrow classifications that prioritise individual mental health diagnoses over social, relational and structural drivers of distress. As a result, suicide deaths linked to current or historical DFSV are frequently under-identified, misclassified, or rendered invisible within official data and public reporting. Frontline services require clearer guidance on capturing data related to DFSV-linked suicidality, including consistent definitions, reporting standards and mechanisms that enable the identification of coercive control, cumulative harm and DFSV as contributing factors.

In practice, AASW members report that deaths involving women experiencing DFSV are often framed as misadventure, accidental overdose or solely attributed to mental illness, without adequate assessment of whether the individual was experiencing violence,

coercive control, stalking, legal abuse or cumulative trauma at the time of death.[23] When DFSV is recorded, it is frequently treated as contextual rather than causal, with limited consideration of cumulative harm across the life course. This misidentification reflects significant gaps in training, awareness and assessment processes within coronial and death review systems and reinforces an overly medicalised understanding of suicidality.

Without more comprehensive and consistent data, governments are unable to accurately quantify the scale of DFSV-related suicide, identify systemic failures, or design effective prevention strategies grounded in lived experience. The absence of national consistency further limits public accountability and obscures opportunities for early intervention. AASW members also strongly emphasise that current data systems fail to adequately reflect the disproportionate and compounding impacts of DFSV on Aboriginal and Torres Strait Islander peoples.

Data collection processes frequently lack cultural safety, fail to account for the impacts of colonisation, intergenerational trauma and systemic racism, and do not sufficiently support ACCOs to govern, access and use data for their own communities. Strengthening Aboriginal data sovereignty is essential to ensuring that data reforms do not perpetuate harm, mistrust or exclusion, and instead support self-determination and community-led responses.

Without significant reform, suicide deaths linked to current or historical DFSV will continue to be systematically undercounted and poorly understood, limiting Australia's capacity to prevent avoidable deaths.

ToR 3: How systems recognise and respond to suicide in the context of DFSV

AASW members consistently report that responses to DFSV and suicidality in Australia remain highly fragmented across health, mental health, police, ambulance, justice, DFSV, housing and social service systems. These systems frequently operate in silos, with limited coordination, shared understanding or integrated risk assessment.[24] This fragmentation extends within service workforces themselves, where DFSV and suicidality are often treated as separate practice domains, resulting in people being moved between services without a coordinated, whole-of-person response.

Members further report that victim-survivors presenting in acute distress are commonly experiencing poly-crisis—combining violence, housing insecurity, legal stress, child protection involvement, poverty and social isolation—yet are required to navigate multiple disconnected systems to access support. In the absence of integrated responses, this fragmentation can intensify entrapment, hopelessness and loss of options, with suicide perceived as the only means of escape. AASW members therefore emphasise the urgent need for a comprehensive, whole-of-government approach that recognises suicidality in the context of DFSV as a cross-system issue requiring coordinated action across health, justice, housing, family violence and social support systems.

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[23] Douglas, H., Vasil, S., Cripps, K. & Fitz-Gibbon, K. (2025). Deaths by suicide in the context of domestic and family violence: Examining context, prevention and responses. Workshop Final Report. Academy of Social Sciences Australia and CEVAW. doi:10.26188/30156139 .
[24] Edmunds, M., Patroni, J., & Olorunnisola, T. S. (2025). Family and domestic violence in Australia: What is missing and what do we know? A scoping literature review. *Trauma, Violence, & Abuse*. Advance online publication. https://doi.org/10.1177/15248380251343188.

Consequences of Siloed Responses

The continued separation of DFSV and suicide prevention responses has significant and measurable consequences. AASW members report that siloed systems contribute to the over-medicalisation of distress, misidentification of risk, and unsafe outcomes for victim-survivors. When suicidality is addressed in isolation from experiences of violence and coercive control, interventions are more likely to focus narrowly on symptom management rather than addressing the underlying conditions driving risk. This can result in inappropriate clinical responses, missed opportunities for safety planning, and failure to intervene at critical escalation points. In the absence of a comprehensive, integrated response, individuals experiencing ongoing violence and cumulative harm are at a heightened risk of suicide.

The Role of Social Workers in an Integrated System Response

Social workers are uniquely positioned to act as core integrators within effective, violence-informed suicide prevention responses. AASW members consistently report that social workers operate at the intersection of health, mental health, education, AOD, housing, justice and child protection systems, and already lead trauma-informed, rights-based and person-centred practice across these settings.

Social work recognises that suicidality cannot be separated from a person's social context, relationships, structural conditions and exposure to harm. Social workers routinely support individuals and families experiencing overlapping crises and are therefore well placed to coordinate integrated responses that avoid siloed assessments and fragmented care. Risk assessment approaches that consider DFSV, suicidality, or mental ill health in isolation are insufficient to capture this complexity and intersectionality.

AASW members emphasise the need for integrated DFSV–suicide risk assessment and service models that centre social work leadership, operate through comprehensive service hubs, and respond holistically to cumulative risk over time. These models must be accessible, culturally safe and responsive for children and young people, Aboriginal and Torres Strait Islander peoples, and LGBTQIA+ communities, who are disproportionately impacted by both DFSV and systemic fragmentation.

Gaps in the service system response

The AASW has identified an urgent and critical gap in nationally consistent DFSVs, particularly the absence of a 24/7 national out-of-hours crisis service. While 1800RESPECT provides counselling and referral, the lack of an immediate crisis response leaves victim-survivors highly vulnerable at times of greatest risk. AASW members report that this gap creates serious barriers for people attempting to move across jurisdictions to escape violence, results in fragmented and inconsistent support depending on location, and leaves young people and other at-risk cohorts without access to timely, life-saving care. Without a national model comparable to Safe Steps in Victoria or Shine in New Zealand, victim-survivors are too often left navigating crisis alone, increasing the risk of further harm, prolonged exposure to violence and preventable loss of life.

ToR 4: Suicide and threats of suicide as a tactic of coercive control

AASW members consistently report that suicide threats and self-harm are frequently used by perpetrators as tactics of coercive control. Members described extensive

practice experience of perpetrators threatening to kill themselves, and their children and pets, or engaging in self-harm to maintain control, instil fear, and prevent victim-survivors from leaving violent relationships. Across consultations, members identified suicide threats as a common, pervasive, and entrenched feature of DFSV.

These threats are often used to entrap victim-survivors by invoking guilt, fear and a perceived responsibility for the perpetrator's wellbeing. AASW members highlighted that perpetrators may frame suicide threats in ways that carry devastating consequences for families, including leaving children without care, income, housing, life insurance or visa security. In some cases, perpetrators' suicide operates either implicitly or explicitly as a final act of punishment and control. Members shared practice experiences in which a perpetrator's death by suicide following system intervention caused profound distress for victim-survivors, including guilt and fear, and contributed to disengagement from support services, while also placing significant emotional burden on practitioners involved.
AASW members expressed strong concern that suicide threats and self-harm by perpetrators are increasing, yet service systems lack the guidance, training and frameworks required to respond safely, consistently and effectively to this form of abuse.

Implications for Risk Assessment and Practice

The use of suicide threats and self-harm as a tactic of coercive control has profound implications for risk assessment and frontline practice. AASW members consistently emphasise that existing suicide risk frameworks do not adequately account for the relational and violent context in which these threats occur, nor do they provide sufficient guidance on how to balance perpetrator suicide risk with victim-survivor and child safety. In the absence of clear, violence-informed guidance, systems risk misinterpreting coercive behaviours, prioritising perpetrator vulnerability, and overlooking escalating danger to others.

There is an urgent need for an integrated, nationally consistent, violence-informed risk assessment framework that explicitly recognises perpetrator suicide threats and self-harm as forms of DFSV and coercive control. Frontline practitioners across police, courts, health, mental health, alcohol and other drug services, child protection and specialist DFSV services require clear guidance, training and accountability mechanisms to navigate this complexity safely, without reinforcing coercive control or increasing risk to victim-survivors and children.

The Australian Government's development of a National Risk Assessment Framework presents a critical opportunity to address these significant gaps.[25] The AASW is broadly supportive of the development of a National Risk framework. However, to ensure this is grounded in practice and experience, social workers must be engaged in the co-design of any risk assessment frameworks.

To be effective, the National Risk Assessment Framework must explicitly incorporate guidance on suicide threats and self-harm used as coercive control and ensure that suicide risk assessment is not treated in isolation from DFSV risk. Without this explicit integration, there remains a significant risk that suicide threats will continue to be

[25] Council of Social Service Australia. (2025, August 11). *National Risk Assessment Framework: Information paper* (Final). https://cssa.org.au/wp-content/uploads/2025/09/National-Risk-Assessment-Framework-Information-Paper-11-August-2025-Final.pdf.

misclassified as standalone mental health crises, rather than recognised as foreseeable indicators of escalating violence and entrapment.

This approach to suicidality is strongly supported by emerging research which provides evidence that victim/survivor suicidality in the context of DFSV is not an isolated mental health issue, but a foreseeable outcome of sustained coercive control, cumulative trauma and perpetrator-driven psychological harm. Studies examining women's deaths by suicide in DFSV contexts show that perpetrators' suicide threats, encouragement of self-harm and ongoing intimidation operate as extensions of coercive control, progressively eroding victim-survivors' agency, self-worth and sense of future.[26]

Fear of imminent harm, entrapment, isolation, and the absence of a safe pathway out are repeatedly identified as drivers of suicidality, particularly during prenatal periods, separation, post-separation abuse and changes in perpetrator access. Without clear, nationally consistent, violence-informed risk assessment guidance, such as that envisaged through the National Risk Assessment Framework.

Social workers role within the perpetrator response workforce

AASW members consistently emphasise the critical importance of embedding qualified social workers within the justice system to support effective, trauma and violence informed responses to perpetrators of DFSV, including those who use suicide threats or self-harm as tactics of coercive control. Members highlight that many perpetrators present with complex trauma histories, substance use, mental health distress and entrenched patterns of harm, which if left unaddressed can increase risk to victim-survivors and children.

Social workers play a vital role in ensuring accountability is maintained while also facilitating meaningful assessment, intervention and behavioural change, and helping to prevent system responses that either default to punitive incarceration without rehabilitation or allow perpetrators to evade accountability through inappropriate diversion into mental health pathways.

ToR 5: Opportunities to enhance prevention and early intervention

Current suicide prevention and family violence prevention approaches in Australia remain largely crisis-driven and threshold-limited. While the AASW acknowledges that responding to suicidality in the context of DFSV is complex and emotionally challenging, members consistently report that existing strategies treat suicide prevention and DFSV prevention as separate policy and service domains.

This separation results in prevention frameworks that focus either on preventing DFSV or preventing suicide, without adequately addressing how the two intersect. As a result, responses are often reactive and triggered only once risk has escalated to crisis points, rather than proactively addressing the cumulative harm, entrapment and distress that place victim-survivors at risk of suicide over time. The AASW calls on the Federal Government to demonstrate leadership in addressing this gap by developing carefully tailored, integrated approaches that recognise DFSV as a key driver of suicidality.

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[26] Vasil, S., Fitz-Gibbon, K., & Segrave, M. (2025). *Family violence and women's deaths by suicide: A Victorian study* (Report). Australian Catholic University, Sequre Consulting & University of Melbourne. https://doi.org/10.24268/acu.914zx.

Requirements of Effective Early Intervention

AASW members emphasise that effective early intervention must extend beyond specialist crisis services and be embedded across universal and early-contact settings, including primary care, emergency departments, schools, maternal and child health services, and child protection systems. Evidence and practice experience demonstrate that exposure to DFSV significantly increases suicide risk across the life course.

Despite this, current prevention and response strategies remain largely invisible to children, and opportunities for early identification and support are frequently missed. Far more comprehensive, child-centred prevention and early intervention work is required to address the long-term impacts of violence and reduce preventable harm.

The AASW calls for sustained investment in trauma-informed, school-based prevention and response strategies that recognise children as victim-survivors, strengthen protective networks, and provide clear, accessible pathways to support for children experiencing DFSV.

High-Risk Periods Requiring Targeted Intervention

AASW members consistently identify specific high-risk periods that require targeted and proactive intervention, including separation, pregnancy, court involvement and periods of heightened perpetrator surveillance or control. During these times, victim-survivors frequently experience escalating violence, coercive control, housing instability, financial insecurity and legal stress, all of which significantly elevate suicide risk.

Effective prevention requires suicide and DFSV responses to be deliberately embedded within community services, health services, maternal and child health, legal assistance and housing supports. This cannot be achieved through isolated programmatic responses; it requires a coordinated, whole-of-government approach that recognises risk escalation and intervenes before crisis thresholds are reached.

Integrated DFSV–Suicide Prevention Models

The AASW strongly calls for an all-of-government response to DFSV-related suicidality, underpinned by integrated prevention models that address the social, economic, and structural drivers of harm. The *National Plan to End Violence against Women and Children 2022–2032* provides the overarching national policy framework to guide action toward ending violence within a generation and must explicitly incorporate suicide prevention and response in the context of DFSV. In this context, the development of the next National Risk Assessment Framework represents a critical opportunity to strengthen national consistency in identifying, assessing and responding to family and domestic violence risk across jurisdictions and service systems.

The Framework must explicitly recognise suicidality, including perpetrator suicide threats and self-harm, as a core DFSV risk, and support bi-directional, violence-informed assessment that prioritises victim-survivor and child safety alongside perpetrator accountability. The AASW stresses the urgency of the development of this national risk assessment noting that delays in embedding suicide-informed, violence-responsive risk assessment will perpetuate fragmented responses and contribute to ongoing, preventable harm to victim-survivors, children, and the broader community.

ToR 6: Any other related matters

Children as victim-survivors in their own right

The AASW asserts that children and young people exposed to DFSV must be formally recognised as victim-survivors in their own right. Children's experiences of violence are direct, cumulative and enduring, with profound impacts on safety, wellbeing and suicide risk across the life course. Government prevention and response strategies must therefore place children and young people at the centre of decision-making and be explicitly child-centred, trauma-informed and developmentally responsive.

AASW members working across child, youth and family services consistently report that most young people presenting with mental health distress, self-harm or suicidality have been exposed to, or experienced DFSV from an early age. These experiences commonly involve coercive control, chronic fear, instability, disrupted caregiving and repeated system involvement, with harms compounding over time to increase vulnerability to suicidality, further victimisation and long-term disadvantage.[27]

In membership consultations, AASW members consistently highlighted the critical role of teachers and educational providers in identifying, assessing and responding to distress among children and young people who have experienced DFSV. Members emphasised that educators are often among the first adults outside the home to observe changes in behaviour, learning engagement, emotional regulation and peer relationships, yet are frequently under-resourced and insufficiently trained to interpret these indicators through a trauma- and violence-informed lens.

AASW members therefore stress the need for comprehensive training for teachers and education providers in DFSV and mental health identification, to support accurate assessment of how trauma may manifest in classroom settings and to enable timely, appropriate intervention, referral and support, rather than responses that are punitive, pathologising, or exclusionary.

Young women and girls as a priority population

AASW members further identify young women and girls aged 16–18 as a critical priority population experiencing suicidality within the context of DFSV for whom there is a significant and dangerous gap in current service responses. Members report that this cohort frequently falls between child and adult systems, as many are no longer engaged with child protection services and are inconsistently supported across formal education settings, including schools, TAFE and universities, as well as within community-based services.

Young women in this age group are often navigating increased exposure to coercive control, sexual violence, housing insecurity and system disengagement, while simultaneously being expected to exercise adult autonomy without access to age-appropriate, violence-informed supports. AASW members emphasise the urgent need for targeted research, youth-specific service models and public-facing education and prevention campaigns to better identify, protect and support this particularly vulnerable

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[27] Papalia, N., Mathews, B., Sheed, A., Fortunato, E., Spivak, B., & Turanovic, J. J. (2025). *Associations between childhood abuse, exposure to domestic violence, and the risk of later violent revictimization in Australia*. Child Abuse & Neglect, 161, Article 107314. https://doi.org/10.1016/j.chiabu.2025.107314 .

and emerging cohort, and to ensure system responses are proactive rather than crisis-driven.

Aboriginal and Torres Strait Islander community-led responses

AASW members consistently emphasise that any effective response to DFSV and suicidality for Aboriginal and Torres Strait Islander peoples must be grounded in self-determination, cultural safety and community control, in alignment with the Closing the Gap framework. Through consultations, AASW members report that misidentification of the primary aggressor remains a pervasive and dangerous issue for Aboriginal women across policing, child protection, courts and service systems.[28]

Aboriginal women experiencing violence are frequently criminalised, surveilled, or blamed, rather than recognised as victim-survivors, increasing their risk of further violence, child removal, justice system involvement and profound distress. These failures significantly elevate suicide risk and undermine trust in mainstream systems.

Members further highlight that Aboriginal and Torres Strait Islander peoples experience intersecting and compounding disadvantage, including housing insecurity, poverty, racism within policing and the courts, over-representation in the justice system and disproportionate child removal. These structural conditions intensify the impacts of DFSV and contribute to heightened suicidality, particularly where culturally safe and accessible supports are unavailable.

The AASW asserts that ACCOs are best placed to respond to these complexities. Culture, kinship, community, and connection to Country are consistently identified as critical protective factors for both DFSV and suicide risk. However, ACCOs remain chronically under-resourced, limiting their capacity to deliver prevention, early intervention, and healing-focused responses at the scale required. There must be significantly increased and sustained investment in Aboriginal-led responses, including greater recognition and resourcing of Aboriginal social and emotional wellbeing frameworks. These models provide holistic, strengths-based approaches that recognise the interconnection between culture, identity, land, spirituality, family and community, and are essential to addressing both DFSV and suicidality in culturally meaningful and effective ways.

AASW members further emphasise that genuine self-determination cannot be achieved without formal power-sharing between governments and ACCOSs. Drawing on the Victorian Self-Determination Reform Framework, members highlight that self-determination requires Aboriginal communities to have decision-making authority, control over resources, and leadership across policy design, service delivery, data governance and accountability mechanisms.[29]

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[28] Australia's National Research Organisation for Women's Safety. (2020). *Accurately identifying the "person most in need of protection" in domestic and family violence law: Key findings and future directions* (Research to policy and practice, 23/2020). Sydney: ANROWS.
[29] Victorian Government. (2019). *Self-Determination Reform Framework* (August 2019) [PDF]. Department of Premier and Cabinet. https://www.firstpeoplesrelations.vic.gov.au/sites/default/files/2019-09/Self-Determination-Reform-Framework-August-2019.PDF

Workforce capability and lived experience

AASW members consistently emphasise that effective responses to DFSV-related suicidality require sustained investment in the workforce and the deliberate dismantling of silos across social service systems. Fragmented workforce structures, inconsistent training and limited opportunities for integrated practice continue to undermine early identification, comprehensive assessment and safe, timely intervention.

Members report that when either DFSV or suicidality is identified, systems too often fail to undertake a holistic, violence-informed assessment that considers the full context of a person's experiences. Integrated assessment of DFSV and suicide risk must be standard practice across settings, rather than reliant on individual practitioner expertise or geographic location.

The AASW highlights the essential role of lived-experience expertise. People with lived experience of DFSV and suicidality provide critical insight into how systems function in practice, where harm occurs, and what supports are effective. Meaningful inclusion of lived-experience voices is necessary to ensure responses are culturally safe, trauma-informed and grounded in reality.

Social workers form a core professional workforce across family violence, child and youth services, mental health and community settings, and are uniquely positioned to integrate responses across health, justice, housing and social support systems. However, their expertise remains under-recognised and under-resourced. The AASW calls on governments to work in genuine partnership with social workers and people with lived experience to design, govern and implement integrated, evidence-based responses to DFSV-related suicidality.

Structural drivers and whole-of-government responsibility

AASW members consistently emphasise that suicidality in the context of DFSV cannot be understood or addressed without confronting the structural conditions that entrap victim-survivors. Housing insecurity, poverty, financial dependence and visa precarity are repeatedly identified as primary drivers of distress and suicide risk. Members report that many victim-survivors present in acute crisis not because of mental illness alone, but because they have no safe place to go, no income security, insecure migration status, and limited access to supports. In these circumstances, suicide may be perceived as the only means of escape or protection reflecting systemic failure rather than individual pathology.

Housing is consistently identified as one of the most immediate and decisive determinants of safety and suicide risk. The absence of safe, affordable and long-term housing forces victim-survivors into untenable choices between homelessness, returning to violence, or remaining in unsafe conditions. These risks are intensified for people on temporary visas, who are often excluded from income support, housing assistance, and specialist services. AASW members report that reliance on crisis accommodation and hotels frequently exacerbates isolation, distress and hopelessness, increasing suicide risk rather than providing safety or stability.

Members stress that these intersecting pressures include violence, poverty, housing instability, legal insecurity and social exclusion. These pressures cannot be addressed through crisis-only or service-specific responses. DFSV-related suicidality demands a sustained, preventative, whole-of-government approach that addresses the structural conditions driving risk and enables genuine pathways to safety and recovery.

Accountability must also be embedded across all reform areas outlined in this submission, including data collection and oversight, integrated risk assessment, workforce capability, and child-centred responses.

Suicide as a protective factor

AASW members also highlighted that victim/survivor suicide, including instances where children are killed by a mother experiencing DFSV, must be understood within the broader context of extreme violence, coercive control and systemic failure. Members emphasised that in some cases, these acts are perceived by the victim-survivor as a protective response, shaped by an absence of viable alternatives to keep herself and her children safe. Participants noted that women in these circumstances are often facing severe and escalating violence alongside profound barriers to support, particularly in relation to income security, housing and access to timely, effective services.

Members stressed that service systems must be equipped to understand this complexity and respond with nuance, care, and accountability, rather than defaulting to pathologising or criminalising mothers and victim-survivors without addressing the structural conditions that contributed to the harm.

Conclusion

DFSV-related suicidality is not an isolated mental health issue, it is a foreseeable and preventable outcome of violence, coercive control, cumulative trauma and system failure. When DFSV and suicide prevention are treated separately, people are pushed between siloed services, distress is medicalised, violence-related risk is missed, and opportunities for early intervention are lost, thus resulting in preventable deaths.

The AASW calls on the Federal Government to lead a whole-of-government response that integrates DFSV and suicide prevention across health, mental health, justice, child protection, education, housing and community services. This must include stronger national data and reporting, integrated and bi-directional risk assessment, and clear guidance recognising perpetrator suicide threats as coercive control to ensure systems keep victim-survivors and children safe.

Reform must also include sustained investment in child and youth responses, Aboriginal and Torres Strait Islander community-led solutions, and workforce capability, including recognition and resourcing of social workers as a core professional workforce in integrated responses. Finally, strong national oversight, monitoring, and public reporting are essential to ensure reforms are implemented, evaluated, and improved over time.

AASW

Melbourne office
Level 7, 14–20 Blackwood St
NORTH MELBOURNE 3051
PO Box 2008
Royal Melbourne Hospital VIC 3050

ACN 008 576 010
ABN 93 008 576 010

T: 03 9320 1000
W: www.aasw.asn.au
For general enquiries please contact:
social.policy@aasw. asn.au

For enquiries relating to the
Submission, please contact:
Emma Slater, Policy and Advocacy Officer
emma.slater@aasw.asn.au

AASW
Australian Association
of Social Workers