

Inquiry into the relationship between Domestic, Family and Sexual Violence and Suicide: Northern Territory Government response

Background

The Domestic, Family and Sexual Violence Prevention Division within the Department of Children and Families (DCF) has coordinated the Northern Territory Government response to this inquiry, incorporating input from Northern Territory Police Force (NTPF), Department of Health (NT Health), Department of Corrections (DoC), Department of the Attorney-General (AGD), Department of Housing, Local Government and Community (DHLGCD) and the Department of People Sport and Culture (DPSC).

Inquiry Themes

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

The Northern Territory (NT) experiences disproportionately high rates of suicide and DFSV compared to the rest of Australia. The NT suicide rate is the highest nationally at 17.0 per 100,000 (Australian Bureau of Statistics, 2023), compared to the national average of 11.8 per 100,000. The suicide rate among Aboriginal people in the NT is approximately 30.8 per 100,000, almost three times higher than non-Indigenous Australians (Australian Institute of Health and Welfare (AIHW), 2023).

The NT also has the highest DFSV rates in the country, with Aboriginal women 31 times more likely to be hospitalised due to DFSV (AIHW, 2023; NT Coroner, 2024). There were 516 victims of sexual assault recorded in the Northern Territory in 2024, an increase of 9% (44 victims) from 2023. This was the highest number of sexual assaults recorded since the time series began in 1993. The victimisation rate also increased to the highest rate, from 187 to 198 victims per 100,000 persons from the previous year (Australian Bureau of Statistics, 2024). DFSV accounts for 60% of assaults in the NT, and 80% of police time is spent responding to DFSV incidents (AMSANT, 2025). From 2000 to 2024, 87 women died from DFV in the NT, and 82 of these were First Nations women (NT Coroner, 2024).

Many people who die by suicide or who are killed in a DFV context have had prior contact with mental health, legal or other support services. Yet the fragmented nature of these systems often means their needs go unmet. Greater coordination and information-sharing across services – including mechanisms to flag escalating risk – could increase opportunities for earlier intervention (Douglas et al., 2025). Further, comprehensive risk screening tools used for DFSV, mental health and suicide have the potential to ensure that wherever someone enters the service system, professionals are able to identify risk factors relevant to DFSV and suicide.

While a formal review has not been undertaken, anecdotal accounts from the NT Coroner's office indicate that almost all female suicides are DFV related.

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Vulnerable groups

Exposure to DFSV significantly increases the risk of suicide, particularly for women, Aboriginal people and LGBTQIA+ individuals, reflected in national and NT data on suicidal ideation, attempts and deaths in these groups. Aboriginal and Torres Strait Islander people are overrepresented as both victims and perpetrators of DFSV, reflecting the complex relationship between violence, trauma and mental health.

In 2023, the Australian Institute of Health and Welfare (AIHW) prepared a paper titled *Indigenous domestic and family violence, mental health and suicide*.^[1] The key findings of this paper included that there is limited research on DFV and mental health focused for First Nations Australians; and that studies show violent behaviour as a risk factor for suicide, irrespective of the presence of other mental health conditions.

The leading cause of death for 10- to 17-year-olds in Australia is suicide, and the NT has the highest rates of child and youth suicide, 3.5 times the national average. This is even higher for Aboriginal and Torres Strait Islander youth.

There is considerable contextual information around DFSV related suicides of young Aboriginal people in NT coronial reports, particularly the *Inquest into the deaths of James, Mamarika and Leering 2020*. The inquest was the first of two inquests that dealt with the deaths of Aboriginal children known to government agencies to be at significant risk within their community and receiving limited assistance. The red flags for the girls in this inquest were identified as sexual exploitation, sexual transmitted infections, suspicious injuries, behavioural issues, disengagement from school, child protection notifications. The inquest also examined the gaps in action to address and support their needs.

Strategic integration of DFSV and suicide prevention

The National Plan to End Violence Against Women and Children 2022-2032 (National Plan) highlights the need to integrate DFSV policy frameworks with other relevant strategies, including those addressing suicide prevention and children's mental health and wellbeing. The National Plan also recognises the role of health services to recognise and respond to DFSV victim survivors and perpetrators.

The DFSV Reduction Framework 2018-2028 (the Framework) is the NT Government's strategy to reduce all forms of DFSV and aligns with the National Plan. It has been implemented through three action plans, with the final plan (the DFSV Reduction Strategy 2025-28) released in November 2025.

While the Framework does identify DFSV impacts include a higher risk of suicide, addressing the intersection of suicide and DFSV has not been specifically identified in the implementation of action plans. Similarly, the NT Suicide Prevention Implementation Plan 2023-28 and the NT Mental Health Strategic Plan 2019-2025 do not currently highlight DFSV or gender-based violence as a risk factor for suicide. The NT has an opportunity to improve strategic inclusion of DFSV as a risk factor for suicide and include more targeted responses.

Opportunities to accurately capture and report on DFSV-related suicides

Data and reporting limitations

DFSV-related suicides are often underreported due to fragmented data collection across jurisdictions. Data recording processes are currently not fit for purpose to record, extract and interpret deaths to a degree that allows for the meaningful monitoring of or evaluation of the possible relationship between DFSV and suicide.

Currently in the NT, there is a lack of consistent coding for DFSV in coronial and health datasets, with many indicators appearing only in free-text fields, making it difficult to accurately track trends. Data entry and collection rely heavily on patient disclosure, which is affected by barriers such as limited access to services and ICT infrastructure in remote communities, vulnerable populations including people in care or living with

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disabilities, and low health literacy and mistrust of services. Improved data would help identify service gaps and inform resource allocation.

There is a need for integrated digital systems across NT Government agencies to support improved responses in relation to DFSV and suicide. For example, if a patient presents to an NT Health emergency department with injuries from a DFSV event, a clinician could apply a flag on the patient file that sends a secure notification to nominated NTG systems (such as child protection or police) for follow-up. This would improve continuity of care, create secure and instant referral pathways, and strengthen joint responses.

There is limited information on how NT legal assistance service providers specifically respond to suicide or suicide risk in the context of DFSV. The current reporting obligations under the National Access to Justice Partnership (NAJP) and AGD funded programs do not require reporting explicitly on suicide related matters. There is limited capacity to influence improvements or the inclusion of this dataset for the NAJP funded organisations, as the data is predefined by the Data Standards Manual for all Commonwealth funds. It is anticipated the Data Standards Manual will be reviewed in 2026-27 following the completion of the Data and Outcomes Strategy under the NAJP, with the opportunity to include new reporting measures that could be replicated in the NT funding context to improve DFSV and suicide data.

National opportunities

Developing national standards for recording data on DFSV-related deaths and suicidal behaviour would improve accuracy. Investment in linked datasets is needed to capture co-occurrence of DFSV and suicide for better policy design.

To support this in future, there would need to be consideration for nationally accepted definitions, such as DFSV related suicide, what constitutes a domestic relationship, investigative expectations, commonality of language and an agreed point of data collation and reporting.

Data integration

Further work is required across portfolios to accurately capture data on the connection between DFSV and suicide. This would require linking health records (including suicide data) and police records (including DFSV victimisation data). This may require many steps, including determining the relevant scenarios under which a suicide should be identified as a DFSV death (this would have to also be informed by whether Police record information that would enable the scenario to be assessed). Further, any data system used by the agency with the responsibility for reporting suicides would also need to store the DFSV information (each scenario should be stored separately). A process would need to be instituted by which the agency reporting suicide information obtains information from the agency with DFSV information as to whether the suicide victim meets any of the scenarios identified in step 1.

How legal and justice systems, DFSV specialist services, health, mental health and other services recognise and respond to suicide in the context of DFSV

Legal, health, and DFSV services often operate in silos, limiting coordinated responses. Frontline workers lack training to identify suicide risk in DFSV contexts. Mandatory cross-sector training and protocols for early identification and referral are needed. Trauma-informed and culturally safe practices should be embedded across all service responses.

It has been recognised that current services are primarily focused on responding to immediate violence, due to the high level of risk and demand. There is a need to consider how services can be supported to prioritise prevention (in suicide, abuse, homicide and crime) through the provision of services and programs to keep families safe and improve their wellbeing (Cripps, 2023).

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DFV risk identification, assessment and management

The Northern Territory Domestic and Family Violence (DFV) Risk Assessment and Management Framework (RAMF) is a key action under the [Northern Territory Domestic, Family and Sexual Violence Reduction Framework 2018-2028 Safe, Respected and Free from Violence](#) (DFSV Reduction Framework). The purpose of the RAMF is to provide consistent and evidence-based practice guidance to all workers who come into contact with DFV, to increase the safety and wellbeing of victim survivors of DFV, and to increase the accountability of people who commit DFV. The RAMF includes the Common Risk Assessment Tool (CRAT) which is an evidence-based tool used to assess DFV risk, particularly the risk factors which are predictive of harm or death of a DFV victim survivor. The CRAT is also used to refer victim survivors at serious risk to the Family Safety Framework, a multi-agency risk management mechanism for those identified as being at serious and imminent risk through the CRAT.

The RAMF is designed for the entire DFV service system, including specialist DFV services (such as women's safe houses, specialist legal services and men's behaviour change programs), universal services (such as health, education, homelessness and mental health), and statutory services (such as police, judiciary, corrections and child protection).

The RAMF does include specific guidance on the interaction between DFV and suicide, including guidance for professionals on the psychological impacts of DFV on victim survivors, and the identification of suicide thoughts or attempts as indicators when screening for DFV (Practice Tool 3). The RAMF and CRAT also identify threats or attempts to self-harm or suicide are identified as a high-risk factor in assessing risk for people using DFV.

Ensuring that screening, risk assessment and management includes consideration for risks of suicide for people experiencing and using DFV is an opportunity to strengthen the RAMF. Ensuring that both DFV and mental health service systems consider the intersections between mental health, suicide and DFSV will support a more comprehensive response to people experiencing or using DFSV. Supporting universal services, particularly mental health services, to screen for DFV is also a critical action.

This could also be considered as part of the National Risk Assessment Principles and Risk Factors work being led by Department of Social Services within input from states and territories.

Referral pathways between DFSV services and mental health supports, including aftercare, need strengthening.

Policing perspective

Police responses to suicide presentations in a DFV context depend on the presenting circumstances – including whether the suicide was completed or otherwise and by whom the actions were conducted (for example, an alleged perpetrator or the person most in need of protection (PMINOP)).

A suicide attempt by an alleged perpetrator may be considered as a form of coercive control against the PMINOP. It could also be considered and responded to as a mental health incident with elements of DFSV influence. Suicidal behaviour by a victim-survivor, or PMINOP, may be understood as an attempt to escape violence. It may be dealt with as a mental health incident with an isolated and incident-based response, if the DFSV context is not understood.

A strong response framework relies on knowledgeable and empowered members who can recognise, respond and record the incidents appropriately – including that DFSV and suicidality are not a *one or the other* incident and may often present together. NT Police are improving as an organisation and membership in awareness of these tactics as a mechanism of control or revenge. In the NT context, this is supported through the introduction of PART training.

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The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFSV

It is well recognised that perpetrators of DFSV may use suicide threats as a form of coercive control to manipulate victims, maintain power and prevent separation, often increasing victims' psychological distress and isolation. Recognising suicide threats as a deliberate control tactic is critical, and they should be explicitly included in definitions of coercive control and incorporated into risk assessment frameworks, as they are in the CRAT. This also highlights the need for targeted training for mental health, suicide prevention and DFSV practitioners to identify and respond effectively to this form of abuse.

Misclassified deaths as an example of coercive control

Misclassified deaths (for example, where a DFV death is framed as a suicide) is a further example of coercive control and systems abuse, whereby a perpetrator may engage in long-standing and, in some instances, highly convincing strategies of image management, deception and manipulation, sometimes over several years. Research into suicide and the miscategorisation of women's deaths raises critical questions around perpetrator efforts to influence investigative processes surrounding a death, noting that how a death is reported can shape subsequent narratives for police and witnesses (Douglas et al., 2025). Perpetrators may also capitalise on a victim's social isolation or experience of mental ill health – often consequences of coercive control – to frame them as 'unstable' or 'suicidal', which can shape how a death is perceived or reported.

Opportunities to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV victimisation and perpetration

To enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV, an effective and responsive workforce and community-led, culturally safe programs integrating DFSV and suicide prevention should be expanded.

DFSV Workforce Training

Effective DFV responses rely on a workforce with the necessary knowledge, skills and support. The RAMF provides a foundation and tools to guide effective practice by workers and services in screening, assessing and managing DFV risk. The development of a DFSV Training and Resource Centre (TRC) is a key action in the DFSV Strategy 2025-2028 to strengthen capability of the DFSV workforce. The TRC will provide a centralised structure for developing, delivering, and coordinating locally relevant, sustainable, and accessible DFSV training to address the professional development needs of workers across the NT. The NT Budget 2025 allocated \$1.5 million per year from 2025-26 to 2030-31 and \$1 million ongoing to this initiative.

As the TRC is established and develops, the opportunity to incorporate training that covers DFSV victimisation and suicide will be considered.

Suicide prevention

Suicide prevention must go beyond preventing death and should address suicidal distress, reduce attempts and tackle underlying drivers of harm such as gender inequality, violence, discrimination, poverty, disability, homelessness, and social exclusion.

Non-fatal suicide attempts among women and gender-diverse people are serious and often involve significant injury, trauma, and repeated system contact. Gendered stereotypes compound harm, with women's distress frequently minimised or dismissed, including in DFSV contexts.

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An intersectional approach is essential. Analysis of suicide risk in DFSV must consider structural inequalities and gendered power relations shaping exposure to violence, distress, help-seeking, and service responses (avoiding misattribution of risk to personal characteristics).

National suicide discourse, focused on men's mortality, overlooks other harms. Reliance on death data obscures high rates of suicidal distress and non-fatal attempts among women and gender-diverse people (particularly young women, where rates have risen sharply).

Research

There is a need for ongoing research and education around recognising where suicide fits in the context of DFSV victimisation and perpetration. This must include the scope of exposure to DFSV and other trauma and its effect on suicidality.

It is recommended the Committee look to strengthen data collection, reporting and investigation methods to better reflect the gendered and intersectional realities of DFSV-related suicide and suicidal behaviour:

- Recognising suicide and threats of suicide as tactics of coercive control.
- Systematically identifying DFSV contexts in coronial, health and justice data.
- Elevating voices of people with lived experience, as well as those bereaved by death.

Kunga Stopping Violence Program (KSVP)

The KSVP was designed to align with the Northern Territory DFSV Reduction Framework and is a good example of how programs can respect the intersectionality of DFV with mental health. Operating out of Alice Springs, the KSVP is one of the few programs focused on the throughcare of Indigenous women on remand or serving sentences in the Alice Springs Correctional Centre. This voluntary program provides responsive holistic case management for 12 months or longer following release, via assistance with safety planning; medical treatment; employment; family reunification; legal assistance; and court support. There is a significant focus placed on developing trusting relationships (Bevis et al. 2020). Many of these women also have untreated mental health issues; suicidal ideation; acquired brain injuries; and/or other disabilities from the violence they have endured. An evaluation of the KSVP indicates that the program was client-focused and used a compassionate approach. The program provided effective trauma-informed training and is well-regarded in the Alice Springs community as it is able to provide support not only to those incarcerated, but to their families as well (Anderson 2021).

Any other related matters

Addressing compounded risk factors including poverty, remote location, and lack of service access is essential to improving DFSV related suicide in the NT.

Most importantly there is the need to embed lived experience voices in policy and program design, including to inform tools and resources, such as digital tools for safe disclosure and support in remote communities.

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