



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

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Introduction

The Childlight East Asia and Pacific Hub is a partnership between the University of New South Wales, the University of Edinburgh and the Human Dignity Foundation. The Hub was established in 2024 in the School of Social Sciences at the University of New South Wales to drive research for impact on child sexual exploitation and abuse (CSEA) in Australia and the region. Childlight has created the first global index on CSEA, [Into The Light](#), and produces the data dashboard [Searchlight](#) to make research evidence widely available to policy-makers and the public.

This submission addresses the Inquiry's terms of reference by identifying four evidence-based pathways linking CSEA, domestic, family and sexual violence (DFSV), and suicide:

1. CSEA is a prevalent form of sexual violence that increases suicide risk through long-term mental health impacts,
2. CSEA elevates the risk of DFSV revictimisation, compounding suicide risk, particularly among girls and women,
3. CSEA increases the risk of DFSV perpetration, particularly among men, shaping the role of suicidality in coercive control, and
4. Individuals accused of CSEA offences face elevated suicide risk during investigation and prosecution, creating a justice gap for survivors.

Recommendations in this submission aim to disrupt these pathways and strengthen responses across DFSV, mental health, justice, and prevention systems. We recommend trauma-informed suicide prevention reforms, stronger integration between DFSV and mental health systems, targeted prevention for high-risk survivor populations, and justice-based suicide prevention protocols for accused offenders.

1. CSEA is common and causes lasting mental health harm that can lead to suicide,

CSEA is a widespread form of sexual violence with profound, enduring impacts on mental health and suicide risk. In Australia, most recorded victims of sexual assault are under the age of 18 at the time of the offence (AIHW, 2025). Recent population research indicates that 28.5% of Australians experienced in-person CSEA before adulthood, with substantially higher prevalence among women (37.3%) than men (18.8%). Perpetration is also alarmingly common, with 9.2% of Australian men self-reporting at least one sexual offence against a child in an anonymous population survey (Salter et al., 2023). CSEA frequently occurs alongside other forms of maltreatment, including domestic and family violence (Olejníková et al., 2025), and can be understood as a form of family violence when perpetrated by family members. Adult caregivers within the home are the largest category of adult CSEA perpetrator in Australia (Mathews et al., 2024).

Despite its prevalence, CSEA is typically concealed and under-detected. Almost half of Australians who were sexually abused as children have never disclosed their experiences (Mathews et al., 2025). This pervasive non-disclosure means that many victim-survivors do not receive specialised trauma-informed support, and the ongoing effects of childhood sexual trauma are often missed or misrecognised in adult mental health presentations (Salter & Breckenridge, 2014; Salter et al., 2020).

The psychiatric sequelae of untreated CSEA are severe. Childhood sexual abuse is strongly associated with major depressive disorder, anxiety, post-traumatic stress disorder, substance misuse, and other forms of psychological distress (Lawrence et al., 2023; Scott et al., 2023) - all well-established predictors of suicidal ideation, attempts, and suicide mortality. International evidence links CSEA to markedly elevated rates of self-harm and suicidality (Devries et al., 2014). In Australia, child maltreatment, including CSEA, has been estimated to account for as much as 41% of suicide attempts (Grummitt et al., 2024). Adults who were sexually abused as children are estimated to be up to 18 times more likely to die by suicide (Cutajar et al., 2010), and seven times more likely to have attempted suicide in the past year (Lawrence et al., 2023).

Recommendations

1. Invest in primary prevention of CSEA as a suicide prevention measure: The prevention of CSEA will have a material impact on suicide risk, via strategies including challenging social attitudes that legitimise CSEA, institutional safeguards, strengthening online safety regulation, and offender disruption.
2. Make childhood sexual trauma a core component of suicide prevention policy: National and state suicide prevention strategies should explicitly recognise CSEA as a major upstream driver of suicidal behaviour.
3. Embed routine trauma-informed enquiry in adult mental health and suicide prevention services: Adult mental health services should implement safe, structured screening for CSEA histories in suicide-risk assessment.
4. Expand access to specialist trauma-focused care for CSEA survivors: Increase funding



and availability of evidence-based trauma treatments for adults with CSEA histories, including peer support services for survivors embedded in established services such as Survivors and Mates Support Network (SAMSN).

5. Treat CSEA non-disclosure as the norm, not the exception: Systems should assume many suicidal adults have undisclosed trauma and design services accordingly.
6. Strengthen early identification and intervention for children exposed to CSEA: Invest in primary and secondary prevention of CSEA, including child-safe institutions, early detection, mandatory response capability and therapeutic support for abused children.
7. Integrate CSEA into public health approaches to self-harm and suicidality: Suicide prevention programs targeting substance use, depression, and self-harm should explicitly incorporate childhood trauma pathways.

2. CSEA elevates revictimisation risk and compounds suicide risk.

CSEA causes profound harm, but it also increases vulnerability to later revictimisation, including DFSV. This repeated exposure to interpersonal violence compounds psychiatric distress over time, intensifying pathways to self-harm, suicidality, and suicide mortality.

Australian evidence consistently demonstrates that individuals with histories of CSEA experience significantly higher odds of sexual and physical violence revictimisation across the life-course (Papalia et al., 2021; Werner et al., 2016). Revictimisation is associated with worse mental health outcomes than childhood victimisation alone, reflecting cumulative trauma and compounding disadvantage across adulthood (Arata, 2000; Herrenkohl et al., 2022).

These patterns are particularly pronounced among women. Longitudinal data from the Australian Longitudinal Study on Women's Health show that women exposed to CSEA were twice as likely to report recent sexual violence and had a 33–59% higher risk of domestic violence (Townsend et al., 2022). International research reports comparable effects, with CSEA survivors nearly twice as likely to experience later intimate partner violence even after accounting for family instability, socioeconomic disadvantage, and substance misuse (Jennings et al., 2015). Together, this evidence underscores revictimisation as a critical mechanism linking childhood sexual trauma to cumulative psychiatric harm and heightened suicide risk.

Recommendations

1. Expand coordinated responses between sexual assault, mental health, suicide prevention and DFSV systems: Governments should strengthen service integration across sexual assault counselling, domestic violence support, mental health and suicide prevention services.
2. Integrate CSEA history into DFSV planning and responses: Frontline DFSV and sexual assault services should adopt trauma- and violence-informed care models tailored to survivors of childhood sexual trauma. DFSV services should incorporate CSEA history into risk assessment and care frameworks.



3. Embed routine enquiry about current safety and violence exposure in mental health care: Mental health services treating CSEA survivors should proactively assess current IPV/DFSV exposure.
4. Treat revictimisation prevention as a suicide prevention priority: Suicide prevention strategies should explicitly address revictimisation and ongoing violence exposure among CSEA survivors.
5. Prioritise survivors of CSEA for targeted prevention and early intervention: DFSV and suicide prevention and support strategies should recognise that women exposed to CSEA face especially elevated risks of adult DFSV.
6. Improve data collection and monitoring of revictimisation outcomes: National surveillance should better track intersections between CSEA histories, adult violence exposure, and suicide outcomes.

3. CSEA, violence perpetration, and suicide threats within coercive control.

Men who perpetrate DFSV show higher average rates of childhood adversity, including CSEA, than non-perpetrators, and evidence indicates CSA is associated with increased risk of later IPV perpetration (Li et al., 2020). However, CSEA is neither necessary nor sufficient for offending: most male CSEA victim-survivors do not perpetrate violence, and elevated risk is concentrated within a minority whose trajectories are shaped by polyvictimisation, externalising problems, and broader developmental adversity.

Australian and international linkage studies suggest male survivors of CSEA are modestly over-represented among those later convicted of violent and sexual offences. For example, approximately 5.0% of male CSEA survivors were later convicted of a sexual offence, compared with 0.6% of non-abused males (Plummer & Cossins, 2018), with higher rates observed among those abused in early adolescence (Papalia et al., 2018). These findings should not be interpreted as a deterministic “cycle of abuse,” but as evidence of a small subgroup for whom trauma-related vulnerability intersects with later harmful behaviour.

Importantly, suicidality may sit at the intersection of trauma sequelae and coercive control. Men with histories of CSEA may experience genuine suicidal distress, particularly in contexts of relationship instability or abandonment. Yet within DFSV, threats or gestures of self-harm can also operate as coercive tactics: intimidating partners, forestalling separation, suppressing disclosure, and shifting responsibility for the perpetrator’s survival onto the victim-survivor (Kassing & Collins, 2026). In this way, suicidality may be both clinically real and functionally weaponised, requiring responses that hold together perpetrator suicide risk and victim-survivor safety.

Recommendations

1. Better integration of childhood trauma into DFSV and suicide prevention frameworks: Childhood trauma is a key risk for both DFSV perpetration and suicidality and should be explicitly addressed in policy frameworks that aim to prevent DFSV and suicide. This goal would be assisted by better integration across national policies to prevent CSEA,



DFSV, mental health and suicide.

2. Gender-sensitive and trauma-informed DFSV prevention policies: Trauma-informed, gender-responsive, and accessible early intervention is essential to engage male CSEA survivors in DFSV prevention. For example, The InnerBoy app demonstrates a low-threshold approach, allowing men to reflect on trauma anonymously while connecting with specialist services, such as DVConnect's Mensline (Leonard et al., 2024).
3. Embed trauma-informed but accountability-focused approaches in perpetrator interventions: Perpetrator programs should be equipped to address trauma sequelae (including CSEA histories) without reducing responsibility for abusive behaviour.
4. Improve cross-system collaboration between mental health services and DFSV services: Governments should strengthen integration between services currently delivering care to male CSEA survivors, and services responding to DFSV victims and perpetrators.
5. Train frontline professionals on trauma-related suicidality in coercive control: Workforce development should equip practitioners to understand that suicide threats may be both genuine and coercive.

4. Perpetrator suicide risk and the justice gap

Individuals accused of CSEA offences face markedly elevated suicide risk, particularly during the acute stress of investigation, arrest, and prosecution. Reviews of Australian and international cases suggest that suicide rates among those accused of CSEA, or child sexual abuse material (CSAM) offences may be up to 100 times higher than in the general population (Key et al., 2021). Emerging evidence also indicates that individuals charged with CSAM offences may face even greater suicide risk than those charged with other violent or sexual crimes (Kothari et al., 2021).

Australian coronial findings underscore the severity of this risk. In the case of James Griffin, the coroner concluded that the criminal charges he faced were a motivating factor in his suicide attempt and subsequent death (Commission of Inquiry Tasmania, 2023). During the investigation period, Griffin contacted one of his victims and stated that he would not go to prison but would kill himself (Magistrates Court of Tasmania, 2020). Such cases highlight how suicide threats may intersect with accountability processes, and how offender suicide can prematurely end proceedings, leaving survivors without resolution and preventing formal findings of fact.

When accused offenders die by suicide, victim-survivors are left without the opportunity for justice, accountability, or validation through legal process. This creates a profound "justice gap," compounding harm and undermining confidence in institutional responses. The highest-risk points appear to occur at key justice milestones, including arrest, bail, charging, and sentencing (Kothari et al., 2021). Evidence suggests that timely, appropriate crisis intervention during these periods can reduce suicide risk and may also contribute to safer justice outcomes, including reduced opportunities for further offending (Key et al., 2020; Kothari et al., 2021).



Recommendations

1. Treat accused CSEA offenders as a distinct high-risk suicide prevention population: Suicide prevention frameworks should explicitly recognise individuals accused of CSEA/CSAM offences as an acute, high-risk cohort.
2. Embed suicide risk screening and crisis response at key justice milestones: Police, courts, and corrections should implement mandatory suicide risk screening and referral at critical points, including arrest, charging, bail decisions, court appearances, sentencing, and imprisonment entry.
3. Ensure victim-survivor interests are explicitly considered in suicide prevention responses: Justice agencies should recognise offender suicide as creating a “justice gap” and embed victim-centred planning into response protocols.
4. Prevent suicide threats from functioning as implicit coercion or accountability avoidance: Justice and mental health professionals should be trained to manage suicide threats carefully, so they do not become mechanisms to derail proceedings or contact victims.
5. Train frontline justice personnel in trauma-informed, suicide-aware responses: Police, prosecutors, judicial officers, and corrections staff should receive training in suicide risk indicators, de-escalation, referral pathways, maintaining procedural integrity and victim safety implications.
6. Develop “continuity of justice” responses when offender suicide occurs: When prosecution ends due to suicide, victim-survivors should be offered formal recognition of harm, access to restorative or alternative processes, specialist counselling and institutional accountability reviews.

Conclusion

CSEA is a pervasive but often hidden form of DFSV that contributes substantially to suicide risk across the life course. Its impacts extend beyond immediate psychiatric harm to include heightened vulnerability to revictimisation, intersections with later DFSV, and acute crisis points within justice processes that can create profound harms for victim-survivors. Suicide and DFSV prevention responses will remain incomplete unless they explicitly recognise childhood sexual trauma and its downstream effects as a major upstream driver of self-harm, suicide and DFSV. Addressing these interconnected pathways requires integrated, trauma-informed action across mental health, DFSV, justice and prevention systems, alongside sustained investment in early intervention and survivor-centred support.



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