Australian Government
Australian Institute of Health and Welfare

AIHW

AIHW written submission

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

Standing Committee on Social Policy and Legal Affairs

30 January 2026

Caution: Some people may find some of this content confronting or distressing.

This content refers to information about family, domestic and sexual violence and suicide.

The information included in this submission places an emphasis on data, and as such, can appear to depersonalise the pain and loss behind the statistics. The AIHW acknowledges the individuals, families and communities affected by family, domestic and sexual violence and suicide each year in Australia

If the information presented about family, domestic and sexual violence raises any issues for you, or someone you know, contact 1800RESPECT on 1800 737 732. See also Find support for a list of support services.

Please carefully consider your needs when reading the information presenting here about suicide and self-harm. If this material raises concerns for you contact Lifeline on 13 11 14, or see other ways you can seek help.

Introduction

The Australian Institute of Health and Welfare (AIHW) welcomes the opportunity to provide a submission to The Standing Committee on Social Policy and Legal Affairs' inquiry into the relationship between domestic, family and sexual violence and suicide.

As Australia's national agency for health and welfare statistics, AIHW has over 35 years of experience collecting, managing, analysing, and disseminating data to inform policy, service delivery, and research. Our independent, high-quality evidence supports improvements in health and welfare outcomes, including in areas such as family, domestic and sexual violence, and suicide and self-harm. In addition to our analysis and reporting function, the AIHW works collaboratively with agencies and data providers to fill data gaps.

This submission outlines AIHW's role in strengthening evidence on suicide, self-harm and experiences of family, domestic and sexual violence. It highlights the importance of partnerships with people with lived experience, government agencies and research communities to enable robust, policy-relevant analysis. We also emphasise the critical role of data linkage and ongoing improvements in data quality to support better decision-making and outcomes.

This submission responds to the following terms of reference:

- The relationship between domestic, family and sexual violence (DFSV) victimisation, and suicide, and the extent to which DFSV victimisation contributes to suicide risk and incidence in Australia, including prevalence, patterns, and any identifiable at-risk groups, in order to improve understanding of the role of DFSV in suicides nationally **(Term of Reference 1)**
- Opportunities for improved reporting and investigation methodologies to accurately capture and report on deaths as a result of DFSV, including the adequacy of existing data collection practices related to DFSV and suicide, and the availability, quality, and consistency of data across jurisdictions **(Term of Reference 2)**

Our response centres on two relevant national data sources: the AIHW's FDSV Integrated Data System (FDSV IDS) and the AIHW's Australian Burden of Disease Study. Insights are focused on the relationship between suicide and violence that occurs in a family or intimate partner relationship, sexual abuse from any perpetrator, and child abuse and neglect from any perpetrator (noting a large proportion of child abuse and neglect occurs in the family context (ABS 2023a).

Further information on the AIHW, our work in this area, and supporting technical information on data sources and methods is provided in Attachment A.

1.The relationship between domestic, family and sexual violence (DFSV) victimisation and suicide (ToR 1)

Definitions

The term DFSV (or FDSV) can encompass a wide range of harmful behaviours that can occur in both family and non-family settings – for more information see What is FDSV? - Australian Institute of Health and Welfare .

In AIHW reporting:

- Family and domestic violence (FDV), or family violence (FV), are terms used for violence that occurs within family or intimate partner relationships.
- Sexual violence (SV) includes a wide range of sexually harmful behaviours that can be perpetrated by anyone but can also occur in an FDV context (AIHW 2023a).

A key challenge in national data related to FDSV is the under-reporting of FDSV experience. This is especially important to consider in the context of the FDSV IDS, given it is built on administrative data from selected health and human services data (excluding police, courts and corrections) and a large proportion of people who experience FDSV may not disclose violence to anyone, and may not come into contact with services (How do people respond to FDSV? - Australian Institute of Health and Welfare).

In addition, there can be a range of reasons why FDSV is not documented in a relevant dataset, for example information is not reported by, or on behalf of the person, or information is disclosed but not recorded, for example, for safety reasons.

The design of the FDSV IDS and known under-reporting limit the ability to generalise findings to all people experiencing or using these forms of violence. However, the findings are relevant for decision-making as they relate to a group of people that are engaged with government-funded services and are more likely to be experiencing complex life circumstances, including being at risk of homelessness and facing financial hardship.

1.1 The relationship between DFSV and suicide

The AIHW used a linked administrative data set with six national sources where evidence of FDSV exists to explore the relationship between DFSV and suicide (Attachment A). It includes 850,014 people who have experienced or used FDSV between 2010 and 2024. Of this FDSV group, 591,591 (70%) were females and 258,423 (30%) were males. To assist with interpretation, a comparison group was created which had the same number of people with the same age and sex distribution as the FDSV group (Attachment A: Box A1).

Key finding

Between 2010 and 2024, there was a greater number of deaths, and deaths by suicide among people with a recorded experience of FDSV, compared to those without a recorded experience of FDSV.

Note: Interpretation of the preliminary results from the first version of the FDSV IDS should consider the data methods and limitations outlined in Attachment A: Box A1.

From 2010 to 2024:

Deaths

- The FDSV group had more deaths than the comparison group (3.3% of the FDSV group died compared with 1.9% of the comparison group, corresponding to 28,401 and 15,748 deaths, respectively). Among females, 2.7% of those in the FDSV group died compared with 1.7% in the comparison group. Among males, 4.9% in the FDSV group died compared with 2.3% in the comparison group.

Age

- The FDSV group were younger than the comparison group when they died (median age at death of 54 in females and 50 in males, compared with 59 in females and 58 in males in the comparison group).

Leading causes of death

- The FDSV group had leading causes of death of suicide (20.7% of deaths), accidental poisoning (9.1%) and coronary heart disease (5.9%), compared with coronary heart disease (7.0% of deaths), lung cancer (5.3%) and suicide (5.2%) in the comparison group (note cause of death information was available from 2010 to 2023).

Suicide

The FDSV group:

- Were 4 times as likely to die by suicide as the comparison group (20.7% of deaths compared with 5.2%), with a total of 5,892 and 817 deaths by suicide, respectively.
- Females were 3.4 times as likely to die by suicide as the comparison group (12.7% of deaths compared with 3.7%, corresponding to 2,003 and 371 deaths by suicide, respectively)
- Males were 4.1 times as likely to die by suicide as the comparison group (30.8% compared with 7.6%, corresponding to 3,889 and 446 deaths by suicide, respectively).
- Showed variation by age for deaths by suicide, with older people in the DFSV group more likely to die by suicide than older people in the comparison group. Among the FDSV group, those aged 15-34 were 2.2 times as likely to die by suicide, increasing to 7.1 times among those aged 55-64.

Missing cause of death

- Were 1.3 times as likely to have a missing cause of death. A missing cause of death occurs in the most recent year of data (2024) due to a data lag (78% of missing cause of death), while missing cause of death in earlier years can indicate an ongoing Coroners investigation, which includes deaths due to assault and suicide.

National context

From 2010 to 2023 in Australia, there were 41,814 deaths by suicide (Suicide deaths - Suicide & self-harm monitoring - AIHW), with 31,513 among males, and 10,301 among females. This means that of all deaths due to suicide in Australia, 14.1% were within the FDSV IDS group (that is, they were identified in one of the above datasets as having experienced or used FDSV). The FDSV IDS group accounted for 19.4% of all female deaths by suicide, and for 12.3% of suicide deaths among males.

1.2 The extent to which DFSV victimisation contributes to suicide and self-harm

The Australian Burden of Disease Study (ABDS) 2024 measures the impact of diseases and injuries on a population. It includes estimates of the disease burden due to suicide and self-harm injuries, and the burden attributed to the individual risk factors of child abuse and neglect, and intimate partner violence (estimated for women aged 15+ only).

Key finding

There is an association between suicide and self-harm and intimate partner violence, and suicide and self-harm and child abuse and neglect.

Of the risk factors examined for suicide and self-harm, child abuse and neglect was the greatest contributor to years of life lost (YLL) due to premature death for both males and females. Intimate partner violence was the second greatest contributor for females.

In 2024, around 26% of the estimated total fatal burden (YLL) due to suicide and self-harm was attributable to child abuse and neglect (41,208 of 159,811 YLL)

- For females, 33% of fatal burden was attributable to child abuse and neglect (13,313 of 40,551 YLL) and 18% for intimate partner violence (7,488 YLL)
- For males, 23% of fatal burden was attributable to child abuse and neglect (27,895 of 119,260 YLL). Data for intimate partner violence was not available (AIHW 2024a).

As part of the ABDS 2026, due for release in December 2026, the AIHW is undertaking a range of work to expand and update analysis, including work to:

- **update estimates for the risk factor for child abuse and neglect** including the addition of new linked diseases based on the latest evidence, and to consider reporting the estimates by the different types of violence (physical abuse, sexual abuse, emotional abuse, neglect).
- Include **a new risk factor** on sexual violence for both males and females linked to anxiety disorders and depression, and assessing the evidence of potential links to suicide and self-harm.

2. Opportunities for improved reporting and investigation methodologies to accurately capture and report on deaths as a result of DFSV (ToR 2)

In order to better understand the relationship between FDSV and deaths:

1. National linkage systems need to strengthen

Establish an enduring Family, Domestic and Sexual Violence Integrated Data System (FDSV IDS), that can be expanded to incorporate additional data sources and linked with other national linkage systems.

2. Consistent identification of people who have experienced or used FDSV in national deaths, hospitals, emergency departments and primary care data is needed

Support implementation of the International Statistical Classification of Diseases and Related Health Problems, version 11 in Australia, and continue to explore methods to improve identification of FDSV in existing deaths, emergency department and primary care data.

3. National evidence on FDSV and associated protective and risk factors needs to strengthen

Extend analysis in the Australian Burden of Disease Study and national linked data (via an enduring FDSV IDS) to improve understanding of risk and protective factors associated with FDSV.

As outlined below, the AIHW, in collaboration with relevant national research and statistical agencies, undertakes work in all these areas and has established capability and experience to support further development. In addition, the AIHW values the input of people with lived expertise who provide guidance on our work.

2.1 Strengthen national linkage systems, including establish an enduring FDSV IDS, to enable deeper investigations into the relationship between FDSV and mortality

With funding from the Australian Government Department of Social Services until June 2026, the AIHW has delivered the first version of the Family Domestic and Sexual Violence Integrated Data System (FDSV IDS) and demonstrated its use in analysing outcomes for people who have experienced and used FDSV. Specifically, the FDSV IDS has created the largest cohort of people experiencing and using FDSV in Australia for research purposes, covering 850,014 people.

The FDSV IDS was built using the AIHW National Health Data Hub, enabling access to a broad range of national data collections and linkage (interoperable) with other national linkage data systems, such as the ABS Person Level Integrated Data Asset (PLIDA) and the National Disability Data Asset (NDDA) in the longer term, with appropriate data governance. This national linkage system, in conjunction with the ABS Criminal Justice Data Asset, and additional state and territory data through their linkage systems, would further enhance the evidence base.

With the development of appropriate governance and ongoing funding, AIHW could implement an enduring FDSV IDS that is enhanced and expanded over time, as more relevant data on FDSV become available. For example, the inclusion of consistent data from state and territory-funded specialist FDV crisis services, building on a national pilot underway, would be beneficial in the longer term. Researchers would be able to use the

FDSV cohort group, with other linked data, to support person-based and longitudinal studies. Refer to section, *Strengthen national evidence on FDSV and associated protective and risk factors*, also.

2.2. Improve the consistent identification of people who have experienced or used FDSV in national deaths, hospitals, emergency departments and primary care data

Implement ICD-11 in Australia

ICD-11 (International Statistical Classification of Diseases and Related Health Problems, version 11) introduces improvements to better reflect advances in information technologies, medical knowledge and health care practices compared to ICD-10 (currently used in mortality data) and ICD-10 Australian Modification (AM) (used in hospital data). Australia endorsed ICD-11 at the World Health Assembly in 2019, but adoption and implementation timelines across various use cases are yet to be confirmed.

There are several enhancements in ICD-11 that will improve the coding of deaths related to family, domestic or sexual violence as ICD-11 includes a range of extension codes that are specific and dedicated to FDSV. These codes can be used in combination with cause of death to better understand whether FDSV was a contributing factor. For example, these extension codes may be used in deaths due to assault and suicide, accidental poisoning, or land transport accidents.

ICD-11 extension codes include information on the relationship of the victim to the perpetrator (e.g. partner, parent, other family) and contextual factors (e.g. conflict in relationships, dowry-related violence). In addition, ICD-11 has codes to allow recording of prior experiences of maltreatment or abuse, for example ‘History of spouse or partner violence’ (QE51.1), enabling more precise recording and analysis of experiences related to family and domestic violence.

With ICD-11 being designed for changing and differing health care models, ICD-11 can now allow for more detailed capture of data about the FDSV cohort. If implemented, this has the capacity to collect information in a consistent way across the whole healthcare continuum and to follow the patient journey, for example from primary care, hospitals and aged care, across a patient lifetime and/or disease duration.

The AIHW leads the Australian Collaborating Centre and the Australian ICD-11 Task Force on behalf of other agencies, including the Australian Bureau of Statistics, the Independent Health and Aged Care Pricing Authority and state and territory government agencies. We are developing a business case with our partners to inform governments about the scope and timing of ICD-11 implementation in Australia.

To inform the ICD-11 business case, AIHW, ABS, and other government agencies are running demonstration projects to gather evidence on whether ICD-11 meets Australia’s needs for various use cases and to show its benefits over ICD-10 and ICD-10-AM in addressing data gaps and supporting health policy development. The business case will include a demonstration project examining how ICD-11 can support reporting on deaths as a result of FDSV alongside insights from a literature review and consultations being done with national and international counterparts. The implementation of ICD-11 extension codes in primary health care would also provide a valuable addition to evidence on FDSV (refer to section on Primary care below also).

The ABS is responsible for the implementation of ICD-11 for deaths coding, including the demonstration projects, implementation decision and implementation dates. Please refer to the submission from the Australian Bureau of Statistics for further information on this.

Improve FDSV identification in key data sources

ABS National Mortality Dataset

While the longer-term implementation of ICD-11 in Australia is considered, options to improve the capture of information on FDSV in deaths data (using ICD-10) could be considered in the shorter term.

ICD-10 codes related to risk factors and contextual information related to the victim and/or perpetrator are critical to the accurate and high-quality capture of FDSV information in deaths data, including records related to a suicide.

With additional funding, and drawing on advice from experts, ABS and AIHW could work collaboratively to formulate a method to better identify FDSV in deaths data using ICD-10 codes, with the intention of making this information available in ABS deaths data collection, and therefore also in national linkage systems such as NHDH and PLIDA. For example, this work could consider the feasibility of adding a flag for when domestic violence is mentioned as a risk factor.

Additional work to explore the feasibility of identifying whether the person who died by suicide was a perpetrator, victim or both would also be useful.

Emergency department

Unlike for patients admitted to hospital, the national emergency department data contains very little information about the context in which injuries occur (that is the 'external cause'). While the nature of the injury (e.g. a fracture, ingestion of drug) is captured, information about the cause of the injury (e.g. assault, intent to self-harm), the place of occurrence, the activity underway when the injury occurred, and the relationship to assault perpetrator is not. Currently, this gap inhibits understanding of the extent and impact of several national priority areas, including FDSV and self-harm, on both the health system and the population.

Unstructured data, such as free text clinical notes, recorded in emergency department records offers some opportunities to capture greater information on injuries. The AIHW is partnering with the University of New South Wales in a Medical Research Future Funded National Critical Research Infrastructure initiative to test whether machine learning techniques applied to free text in emergency department records could classify and code external causes of injury in a standard way. Pending the outcomes of this project, and the establishment of appropriate governance and funding, this method could be used to enhance injury information available in the national emergency department collection in the future.

Primary care

Primary health care, that can include general practitioners, nurses, Aboriginal Health Workers and allied health professionals, may provide a formal point of contact and care for people experiencing FDSV. General practitioners are often a person's first point of contact for health care, and they are particularly well-placed to identify, support and refer people experiencing intimate partner violence (RACGP 2022). The 2021–22 ABS Personal Safety Survey (PSS) estimated that 1 in 5 women who experienced violence from a current partner sought advice or support from a general practitioner or other health professional (ABS 2023c).

The primary health care sector is rich in clinical data and information to support the management of individuals' health care, however, the availability of this data for national population research is limited. Nationally consistent primary health care data is a known information gap for effective population health monitoring, research, policy, and planning. The Australian Institute of Health and Welfare (AIHW) is working to address this gap by developing processes for the governance, standardisation, collection, analysis and reporting of primary health care data within Australia. This work will ultimately form a National Primary

Health Care Data Collection (NPHCDC) but requires ongoing funding and cooperation to bring primary care data together. This data collection could inform prevention and early intervention efforts to reduce deaths by suicide, and other causes, in the context of FDSV.

Currently, if information is recorded on FDSV in clinical data, it is usually recorded in free text fields, in a non-standardised way. Therefore, analysis of free text, using complex computing techniques, provides the most likely opportunity to identify FDSV in primary care. AIHW are investigating techniques to convert information from free text to ICD-11 to provide consistent data.

2.3 Strengthen national evidence on FDSV and associated protective and risk factors

Additional work to improve understanding of the burden of FDSV and associated risk factors

Over time, the Australian Burden of Disease Study has expanded the number of risk factors included and their links to health outcomes based on the latest available evidence. The latest study published (ABDS 2024) includes the contribution of intimate partner violence and child abuse and neglect to overall health burden, and the 2026 study will include sexual violence as a new risk factor.

Further work that could be undertaken, pending additional funding, includes reviewing the evidence for emotional abuse and patterns of behaviours (including coercive control) and its association with different health outcomes; and intimate partner violence in men and its associations with anxiety, depression and suicide and self-harm. Projections and scenario modelling could also be undertaken to estimate for example, the impact of reductions in child abuse and neglect, intimate partner violence and sexual violence on future disease burden under different policy scenarios.

Additional analysis of national linked data to provide new insights.

Future analysis of the FDSV IDS, combined with an expanded NHDH, could enable deeper investigation of the relationship between FDSV and mortality from any cause, including suicide, to inform policy and service delivery decisions**.** For example:

Mortality analysis

- What is the association between cause-specific mortality (e.g. chronic illness) and FDSV in Australia?
- What is the average time between a record of FDSV experience, and death? Are there any patterns that may inform service interventions?

Population characteristics

- How common is disability among people who died?
- Are some people more at-risk of death within the FDSV cohort? What may this mean for allocation of resources and timely service intervention?

People's journey through service systems

- How did people interact with the broader health, welfare and justice systems prior to death and do these interactions represent prevention opportunities?
- What was a person's level of engagement with the income support system prior to death?

Protective and risk factors

- How many people in the FDSV cohort were hospitalised for self-harm, and how many had a subsequent death due to suicide?

- What factors are associated with improved outcomes for people who have experienced FDSV?

Evaluation and monitoring

- Are certain system-level responses effective in reducing suicide risk among people with a history of FDSV?

Contacts

Should the Committee have any queries about the information we have provided in this submission or wish to seek additional information from the AIHW, please contact Ms Louise Gates, Executive Director, Health Insights Division, via telephone on [redacted] or email [redacted].

Attachment A

About the AIHW

The AIHW plays a pivotal role in supporting evidence-based decision-making and research by:

- Developing and maintaining national health and welfare data standards, ensuring consistency and comparability across jurisdictions and sectors.
- Collecting and integrating data from Australian, state, and territory government agencies, enabling comprehensive insights into health, community services, and housing assistance.
- Providing advanced data linkage services, including cross-sectoral and longitudinal data integration, to support complex research questions and policy evaluations.
- Collaborating with universities, research institutes, and government bodies to facilitate access to linked data assets through secure and ethical data sharing frameworks and share AIHW's analytic, health and welfare systems and subject matter expertise.
- Producing high-quality analytical outputs, including reports, dashboards, and datasets, tailored to the needs of policymakers, service providers, and the research community.
- Expanding and enhancing national data holdings, including the development of new data assets to address emerging gaps in health and welfare information.
- Modernising data access and dissemination, offering user-friendly platforms and tools that support diverse audiences – from government agencies to academic researchers and NGOs.

Through its data linkage infrastructure and partnerships, AIHW enables deeper understanding of population health and welfare trends and system performance, supports longitudinal studies, and contributes to national and international research efforts.

AIHW's role in reporting and statistics related to DFSV and suicide

Family Domestic and Sexual Violence

The AIHW has a long-standing work program on family, domestic and sexual violence (FDSV), primarily supported by the Department of Social Services (DSS). This work includes national reporting to strengthen the evidence base, improve understanding, and deliver data enhancement initiatives such as a prototype specialist crisis FDV services collection and a linked FDSV data asset.

The AIHW maintains a dedicated FDSV website that consolidates information from multiple sources to provide a comprehensive national picture and support reporting under the *National Plan to End Violence Against Women and Children 2022–2032*. While the AIHW's FDSV reporting focuses on national quantitative data, contributions from people with lived experience are used to provide context and complement statistical insights.

The AIHW FDSV web page, Health outcomes, includes a section on family and domestic violence-related deaths by suicide including an overview of available state and territory data.

Suicide and Self-harm Monitoring

The National Suicide and Self-harm Monitoring System (the System) has been established as part of the national effort to address suicide and self-harm in Australia. The system will improve the quality, accessibility and timeliness of data on deaths by suicide and on self-harming and suicidal behaviours. It aims to provide a better understanding of suicide and self-harm in Australia by:

- explaining the nature and extent of suicidal and self-harming behaviours
- improving the quality and breadth of data available to help identify trends, emerging areas of concern and to inform responses
- highlighting those at increased risk.

Dedicated work about First Nations people

Information and statistics about the health and welfare of Aboriginal and Torres Strait Islander (First Nations) people can be found in most AIHW products. AIHW products that include a substantial focus on First Nations people are listed on First Nations – Reports.

Resources related to Family domestic and sexual violence and suicide among First Nations people:

The Indigenous Mental Health and Suicide Prevention Clearinghouse website was established to enhance access to First Nations mental health and suicide prevention evidence. It operated from 2021 to 2025.

Overseen by the Indigenous Mental Health and Suicide Prevention Clearinghouse Steering Committee from 2019, the Clearinghouse contributed to a series of actions supported by the Australian Government to improve mental health and suicide prevention through the Fifth National Mental Health and Suicide Prevention Plan. The final release on the Clearinghouse website was on 20 June 2025.

The Clearinghouse includes a report on Indigenous domestic and family violence, mental health and suicide. This report highlights how First Nations peoples' experiences of domestic and family violence (DFV) are affected by current law, policy, programs and services. It discusses research and programs where DFV intersects with mental health and/or suicide and focuses on best practice and ways to improve outcomes for Indigenous Australians.

The Aboriginal and Torres Strait Islander Health Performance Framework Summary report summarises the latest information on health outcomes, health system performance and the broader determinants of health for Aboriginal and Torres Strait Islander people, drawing from the Health Performance Framework (HPF) measures. This includes measures related to both FDSV (measure 2.10), and mental health and suicide (measure 1.18)

Key national data sets

Because there is no single, comprehensive, nationally consistent database that can be used to examine the relationship between FDSV and deaths by suicide, this submission focused on 2 national data sources that provide partial insights into the relationship:

- AIHW's Family Domestic and Sexual Violence Integrated Data System (FDSV IDS)
- AIHW's Australian Burden of Disease Study.

The Family Domestic and Sexual Violence Integrated Data System

The AIHW has created the first version of the FDSV Integrated Data System (IDS) by linking data from six national administrative data collections where evidence of FDSV exists. Funded by the Australian Government Department of Social Services until 2025-26, the FDSV IDS represents the largest FDSV group, or cohort, for analysis in Australia. The data sources linked to create the FDSV IDS include:

- The Specialist Homelessness Services Collection (SHSC)
- Hospitals – Admitted patient care
- Hospitals - Emergency department presentations
- Data Over Multiple Individual Occurrences (DOMINO-Centrelink FDV crisis payment data)
- Data Exchange (Australian Government-funded programs, usually delivered by non-government organisations, that deliver services to people experiencing FDV)
- National Death Index.

The FDSV cohort is being developed using the AIHW's National Health Data Hub, a larger linkage system that encompasses national health, welfare and outcomes data, including causes of death. The NHDH is progressively expanding as new collections are approved for inclusion.

Initial results showing the rate of suicide among the FDSV cohort derived from this system are presented in the section 1.1: *The relationship between domestic, family and sexual violence (DFSV) victimisation and suicide (ToR 1).* Interpretation of these results should consider data methods and limitations in Box A1.

The Australian Burden of Disease Study

Burden of disease analysis is an internationally recognised method that measures the impact of diseases and injuries on a population. It combines the years of healthy life lost due to living with ill health (non-fatal burden) with the years of life lost due to dying prematurely (fatal burden). A portion of this burden is preventable because it is due to modifiable risk factors (AIHW 2025).

The Australian Burden of Disease Study (ABDS) 2024 includes estimates of disease burden due to 220 diseases and injuries, as well as the disease burden attributed to 20 individual risk factors. This includes suicide and self-harm injuries, and the individual risk factors, of child abuse and neglect, and intimate partner violence. Evidence from this study demonstrating the relationship between FDSV and suicide and self-harm is covered in the section 1.2:*The extent to which DFSV victimisation contributes to suicide and self-harm (ToR 1)*

For more information on methods used in the study, see the ABDS Technical Notes.

Box A1: Data methods and limitations

Coverage of services included in the first version of the FDSV IDS

These preliminary data provide insights on relative rates of death for a subset of people who have experienced or used FDSV. As the first version of the FDSV IDS includes data from select health and human services, the number of people in the FDSV cohort is conservative relative to all people in Australia who experience or use FDSV. The services included in the FDSV IDS do not represent all services accessed by people experiencing or using FDSV (for example state- and territory-funded specialist services, police, courts, corrections are excluded) and a large proportion of people who experience FDSV may not disclose violence to anyone (AIHW 2023b). The ABS 2021-22 Personal Safety Survey estimates 3.8 million adults have experienced FDV since the age of 15 (ABS 2023c).

Information on types of abuse and patterns of behaviours

Due to limitations in the recording of FDSV in the data collections in the FDSV IDS version 1.0, information on certain types of abuse, such as financial, economic and emotional abuse, or patterns of behaviours, such as coercive control, is largely unavailable.

Identification of victim survivors and people who use violence

It is estimated that most people in the FDSV IDS are victims or victim-survivors, rather than people who have used FDSV. The largest data source contributing to the FDSV IDS is the Specialist Homelessness Services Collection (around 643,000 out of a total 850,014 people in the IDS). In 2023-24, most FDSV clients of the SHSC received a service due to their experience of FDSV, rather than their use of FDSV; 1 in 33 female and 1 in 5 male FDV SHSC clients aged 18 and over received a service for their use of FDV (see Housing and homelessness services RoGS 2025).

Another data source for the FDSV IDS is family and domestic violence crisis payment data. (around 78,000 people). This crisis payment data payment is provided to people in severe financial hardship who have experienced changes in their living arrangements due to family and/or domestic violence, and are receiving, or are eligible to receive, an income support payment or ABSTUDY Living Allowance. In 2023-24 around 2% of the people who received a crisis payment were the perpetrator of violence (see Financial and workplace support).

Data improvement work is underway to enable, where possible, disaggregation between people who have experienced violence and people who have used violence, based on their service activity. However, these groups are not always mutually exclusive, and misclassification can occur (see *Accurately identifying the 'person most in need of protection' in family and domestic violence law*).

Comparison group

The comparison group was constructed using a method known as stratified random sampling. This sampling was done on a 1:1 ratio with stratification (matching) on year of birth, sex, First Nations status, and Socioeconomic index of areas. This means that for every 1 person in the FDSV IDS, a person was selected from the Australian population in the National Health Data Hub that matched on these characteristics. However, there may be some people in the comparison group who have experienced FDSV (for example those who had not accessed the selected services or disclosed their experience of FDSV). Furthermore, not all factors that influence the FDSV cohort results can be accounted for in the stratification method, and therefore differences between the FDSV group and the comparison group may not be due to the experience of FDSV alone.

Other limitations

It is important to note that the analysis does not consider the time between FDSV identification and death; documentation of FDSV may date back to 2010, while deaths can be recorded up to and including 2024. Cause of death information (including suicide) was available up to 2023. These results cannot determine whether FDSV influenced the decision

to end life, as FDSV often occurs alongside social, economic, health, and environmental factors that contribute to distress and suicide risk.

National Mortality Database

The AIHW's National Mortality Database (NMD) includes all deaths registered in Australia from 1964. The database comprises information about causes of death and other characteristics of the person, such as sex, age at death, area of usual residence and Indigenous status. The cause of death data are sourced from the Registrars of Births, Deaths and Marriages in each state and territory, the National Coronial Information System and compiled and coded by the Australian Bureau of Statistics (ABS). Information in the NMD includes the 'underlying cause of death' which is the disease or external mechanism that initiated the train of events leading to death, and additional 'multiple causes of death' which includes injuries, and risk factors such as mental health, co-morbidities and social factors (psychosocial risk factors) listed on the death certificate. Data about the cause of death is coded to an international standard, called the International Statistical Classification of Diseases and Related Health Problems (ICD), and version 10 is currently used.

Cause of death information from the NMD is used in the National Death Index, included in the FDSV IDS. For further detail on national mortality data, including data relating to FDSV and suicide, please refer to the submission from the ABS.

References

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