Submission on behalf of Blue Mountains Women's Health & Resource Centre (BMWHRC)

House of Representatives Standing Committee on Social Policy and Legal Affairs

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

Submitted: 28th January 2026

Introduction

Blue Mountains Women's Health & Resource Centre (BMWHRC) welcomes the opportunity to contribute to the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide.

BMWHRC strongly supports the intent of this inquiry and affirms that the intersection between DFSV and suicidality represents a critical and ongoing public health and human rights issue. From our frontline experience suicide risk is not an isolated or individual phenomenon. It is frequently shaped by prolonged exposure to violence, coercive control, cumulative trauma, structural inequality and systemic barriers to safety, recovery and justice.

As a regional women's health organisation embedded in a diverse and geographically dispersed community, BMWHRC brings a place-based perspective that reflects the compounded impacts of DFSV, housing insecurity, limited service access, poverty and social isolation. These factors are particularly acute for women living in outer-metropolitan, peri-urban and regional contexts and must be explicitly recognised in national policy responses.

About Blue Mountains Women's Health & Resource Centre (BMWHRC)

BMWHRC is a feminist, community-based organisation providing specialist services to women and gender-diverse people across the Blue Mountains and Lithgow regions of New South Wales. Our work is grounded in trauma-informed, strengths-based and intersectional practice.

BMWHRC delivers a broad continuum of services, including specialist domestic and family violence support, sexual violence counselling and advocacy, community-based mental health and wellbeing programs, health promotion and primary prevention initiatives and outreach and place-based engagement, particularly with women who experience barriers to accessing mainstream services.

We work alongside women experiencing multiple and intersecting forms of disadvantage, including poverty, disability, chronic health conditions, insecure housing and social isolation. Many of the women we support have experienced long-term coercive control and complex trauma, often over extended periods of their lives.

Frontline insights: DFSV and suicide risk

BMWHRC consistently supports women who experience suicidal ideation, self-harm or profound hopelessness in the context of current or historical DFSV. In this context, suicidality should not be understood primarily as a mental health disorder, but as a foreseeable response to prolonged exposure to violence, coercive control and structural abandonment. In our experience, suicide risk is rarely attributable to a single incident or diagnosis. Rather, it emerges from the cumulative impact of sustained abuse, loss of autonomy and dignity, and repeated failures of systems to provide safety, stability and meaningful pathways to recovery.

Women we support commonly identify the following as contributing to suicidality: prolonged coercive control, including psychological abuse, isolation and financial abuse; cumulative trauma and complex post-traumatic stress, fear of homelessness or housing instability following separation, barriers to accessing timely, affordable and trauma-informed mental health care, retraumatisation through legal, child protection and family law systems, and a lack of viable, coordinated pathways to safety and support.

Many women describe feeling trapped between ongoing violence on one hand and fragmented or inaccessible systems on the other. Where violence is ongoing and pathways to safety are blocked, despair deepens and suicide risk escalates, not as an individual failing, but as the consequence of sustained harm and unmet obligations to protect.

Regional and place-based disadvantage

Women living in regional and peri-urban areas face distinct and heightened risks in relation to DFSV and suicide. From BMWHRC's experience these include limited availability of specialist and trauma-informed mental health services, long waitlists and travel distances for counselling and other support, severe shortages of safe, affordable and crisis accommodation, reduced anonymity and increased safety concerns within smaller communities and service fragmentation across large geographic areas. In regional contexts, these conditions are frequently compounded by coercive control where perpetrators deliberately exploit geographic isolation, limited transport options, reduced digital connectivity, and women's dependence on local networks to restrict access to support and increase surveillance and entrapment.

These structural barriers intensify isolation, entrapment and hopelessness, particularly for women who are already marginalised. Suicide prevention strategies must therefore be responsive to place-based inequities and ensure equitable access to specialist support regardless of postcode.

Data, reporting and visibility

BMWHRC supports urgent reform to improve the accuracy, consistency and visibility of DFSV-related suicide and suicidality within national data systems.

From our perspective, DFSV is frequently recorded as a contextual or secondary factor in suicide data, rather than recognised as a primary driver of risk. This obscures the true scale of harm experienced by women and contributes to policy, funding and service responses that underestimate the prevalence and severity of DFSV-related suicidality.

Improved data collection must recognise coercive control, chronic abuse and housing insecurity as key suicide risk factors, capture non-fatal suicidality, chronic suicidal ideation and repeated crisis presentations, provide disaggregated data for Aboriginal and Torres Strait Islander women, women with disability, older women, culturally and linguistically diverse women, and women in regional locations and be developed in partnership with specialist women's services and women with lived experience ensuring cultural safety and data sovereignty.

Systems interaction and cumulative harm

Women supported by BMWHRC frequently report that engagement with legal, policing, child protection and mental health systems can exacerbate distress and suicidal ideation, particularly where responses are fragmented, adversarial or not trauma informed.

Common systemic issues include, delayed, costly and adversarial family law proceedings, inadequate recognition of coercive control and non-physical forms of abuse, unsafe or inappropriate mediation requirements and inconsistent risk assessment across systems.

The cumulative stress of navigating multiple systems without adequate specialist support compounds trauma and undermines women's sense of safety, agency and hope for the future.

Recommendations

BMWHRC recommends that the Commonwealth Government:

1. **Explicitly recognise domestic, family and sexual violence as a primary suicide risk factor** within national suicide prevention strategies, frameworks and funding priorities.
2. **Invest in specialist, community-based women's services** as critical suicide prevention infrastructure including sustained funding for counselling, advocacy, outreach and recovery-oriented group programs.
3. **Address housing insecurity as a core suicide prevention measure** through dedicated investment in crisis, transitional and long-term housing options for women and children escaping violence.
4. **Embed trauma-informed and coercive-control-informed practice** across legal, policing, mental health and child protection systems.
5. **Improve national data collection and reporting** to ensure DFSV-related suicide and suicidality are accurately identified, recorded and disaggregated.
6. **Ensure regional equity**, with targeted investment to address service gaps in regional, rural and peri-urban communities.
7. **Centre lived experience and intersectionality** in policy design and implementation, recognising the compounded risks faced by women experiencing multiple and intersecting forms of disadvantage.

Conclusion

BMWHRC urges the Committee to approach this inquiry through a lens that recognises suicide in the context of DFSV as a systemic and preventable outcome of violence, inequality and support failure.

Effective prevention requires sustained investment in women's safety, housing, healing and autonomy. When women are believed, supported and provided with genuine pathways to safety and recovery, suicide risk is significantly reduced.

BMWHRC welcomes the opportunity to provide further information or participate in ongoing consultation arising from this inquiry.

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