The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Standing Committee on Social Policy and Legal Affairs

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

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Advocacy and collaboration to improve access and equity

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Royal Australian and New Zealand College of Psychiatrists submission

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is responsible for training, educating and representing psychiatrists in Australia and New Zealand. The RANZCP has more than 9000 members, including around 6300 fully qualified psychiatrists.

Recommendations

- Integrate family, sexual, and domestic violence training and initiatives focussing on identification and intervention at all levels across relevant areas including health, social and justice services and law enforcement.
- Increase funding of data gathering and research on family, sexual and domestic violence, mental health, and suicide.
    - Development of accessible data repositories.
- Streamline referral and reporting pathways, including co-location, between relevant services.
- Ringfence funding for mental, social, housing and justice services to address family, sexual and domestic violence as a public health issue which prioritise victim-survivor safety in line with best practice trauma informed care approaches.
- Identify and address failings in justice and court processes and systems that facilitate re-offending, re-traumatisation and creating ongoing fears for safety that drive violence related suicide and self-harm.

Introduction

The RANZCP welcomes the opportunity to contribute to the Standing Committee on Social Policy and Legal Affairs' Inquiry into the relationship between domestic, family and sexual violence and suicide (the Inquiry). The recommendations contained within this submission are based on extensive consultation with the RANZCP committees including the Family Violence Psychiatry Network Committee and the Faculty for Forensic Psychiatry Committee. These are made up of community members and psychiatrists with direct experience working with victim-survivors and perpetrators of Family, Sexual, and Domestic Violence (FSDV) and within the justice and forensic mental health systems. As such, the RANZCP is well positioned to provide advice about this issue due to the breadth of academic, clinical and service delivery expertise it represents.

The RANZCP has numerous resources publicly available on mental health, suicide, and FSDV which also outline our position on these issues and contain recommendations to address these key public health issues. These include our Family and Domestic Violence information page, Position Statement 101: Suicide prevention – the role of the psychiatrist and Position Statement 102: Family violence and mental health. We also have a history of liaising with the Australian Federal and State and Territory governments on these issues with various submissions available via our publication library.

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

FSDV is often discussed in the context of the criminal justice system and approaches and understandings of its impacts and causes are viewed through the lens of law and order. However, it should also be

understood as a significant public health concern which drives, and is driven by, complex socioeconomic and cultural issues. It is important to recognise the long term and pervasive impacts of FSDV on mental health. It is also an inherently gendered issue with 1 in 4 women in Australia having experiences of FSDV.[1] Between two-fifths and half of LGBTQIA+ individuals report experiences of FSDV.[2, 3] It's worse for Aboriginal and Torres Strait Islander women, who experience between 35-80 times the national average.[4]

The mental health impacts of FSDV are well documented and acknowledged. Individuals who have experienced FV can suffer from a variety of long-term, chronic conditions such as post-traumatic stress disorder, major depressive illness, eating disorders, problematic substance use, chronic pain, generalised anxiety disorders and panic disorder.[1, 5-7] The RANZCP acknowledges the growing evidence base of the short and long-term physical, mental, sexual, and reproductive health outcomes from experiencing FV across one's lifespan.

Suicide is another public health issue with complex drivers. In 2023, there were 3,214 deaths by suicide in Australia – which averages roughly 9 per day.[8] In 2024, suicide was the second leading cause of fatal burden of disease, and there are nearly 15,000 hospitalisations from intentional self-harm in a year.[8] Suicide also disproportionately affects certain populations – it remains the highest cause of death amongst young Aboriginal and Torres Strait Islander people, and one third of LGBTQIA+ people report having attempted suicide at some point.[2, 9]

The direct links between mental health conditions, FSDV, and suicide are becoming better understood. In Western Australia, a review found that in 2017 alone, 56% of women and children who died by suicide were known to the state government as victims of FSDV.[10] A World Health Organisation (WHO) study found that when controlling for variables, FSDV was the most consistent risk factor for suicide attempts amongst women.[11] Other studies have shown that the risks of attempted suicide rise substantially amongst individuals who have experienced FSDV compared to those who have not. Women who have experienced FSDV are between 4 and 6 times more likely to attempt suicide, with 1 in 5 women who report FSDV having voiced or attempted suicide in their lifetime.[5, 12, 13] Young people who experienced FSDV in childhood and adolescence are 3 times more likely to attempt suicide, and twice as likely to experience suicidal ideation.[14]

2. Opportunities for improved reporting and investigation methodologies

In Australia there is no nationally consistent collection for data related to FSDV and deaths by suicide. Siloed data is available in some cases from States and Territories but reporting requirements, methods and definitions vary wildly, and are often unsuitable for comparison.[8] Data can be so underdeveloped that in some cases it is not reported whether the death was from a victim or perpetrator of FSDV.[8] Data is often gathered anecdotally, through coroner's reports, Coronial Inquests, death registers and other state inquiries.[14] However, the disjointed way in which this data can be gathered and is reported means that links and patterns are missed, and deaths and FSDV based causes are underreported.

The RANZCP acknowledges that there are improvements being made to data collection in line with the recommendations of the National Suicide Prevention Strategy 2025 -2035 and the National Plan to End Violence Against Women and Children. But, these data improvement processes are happening separately from one another, which will not aid in developing a clear data landscape of the link between FSDV and suicide. The RANZCP recommends that clear and public links are established between these two initiatives, and that data collection and repositories are developed with broad and simple access for researchers and key stakeholders at a federal level. Currently the development of the Family, Domestic and Sexual Violence – Integrated Data System shows some promise but restrictive access requirements through the National Health Data Hub, and the lack of suicide specific data hamper its utility for research, planning and projection.

Ringfenced funding at the federal and jurisdictional level to develop a clear methodology of investigating and reporting the presence of FSDV in the cases of all deaths by suicide is needed. This data should then be collated and distributed in a transparent and accessible way – such as through AIHW reporting. The structures for gathering this data already exist – it is centralised and standardised methods and distribution that are required.

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

Due to the way that FSDV and suicide are conceptualised across the various governmental systems at each level and jurisdiction, and how the public and body politic views them as separate issues, there is currently a poor response. As noted above, FSDV is thought of as a criminal issue perpetuated by individuals and is only recently being addressed as a socioeconomic and culturally driven problem. The ongoing mental health impact of FSDV is often overlooked – especially for victim-survivors who have escaped the specific circumstances of their experiences. This includes the ongoing risk of suicide which can continue across the lifespan.

Services are not well situated to collaborate regarding FSDV, mental health conditions and suicide. Research shows that victim-survivors are more likely to seek health services such as community health, emergency departments, or frontline medical help (such as through GPs) as opposed to other professional assistance.[4, 7] Dedicated mental health services support uptake is low amongst victim-survivors by some estimates – with fears about disclosure and lack of holistic support, as well as cost and confidentiality being barriers.[4]

Without dedicated mental health or FSDV services, help being sought in relation to experiences of FSDV, especially as these are occurring, means that recognising suicidality is reliant on non-specialists. What is needed is comprehensive training for frontline staff across a number of sectors and services which deal with victim-survivors in recognising and responding to the mental distress related to FSDV. The RANZCP recommends that frontline and emergency medical clinicians and support staff, as well as emergency services personnel, community, child and social services workers, and other key groups are trained to investigate the risk of mental distress and suicidality for victim-survivors. The WHO's LIVES principles have been shown to be incredibly effective for frontline responders to recognise and respond to FSDV, including the risk of self-harm and suicide.[15]

Improved reporting and referral pathways are also important. Psychiatrists have noted that even after recognising increased risk there are often multiple issues that need addressing to help mitigation beyond just mental health supports. FSDV is often associated with social isolation, economic distress, and housing

instability which all drive risk of suicide, are re-traumatising, and increase the rates of treatment discontinuation. One clear solution, outlined in the literature, and which the RANZCP supports wholeheartedly, is the co-location of services.[4, 12, 15] These should be culturally safe, trauma-informed, and dedicated to holistic long-term intervention and assistance.

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

The RANZCP acknowledges that suicide and threats of suicide are serious forms of coercive control. The need to balance the real threat of suicide from perpetrators with the need to protect victim-survivors and discourage and police the use of coercive control is crucial.[16] Regardless of whether a perpetrator is experiencing mental ill health or mental distress, with the use of suicidal threats to influence or control another person must be understood and addressed as a form of violence. Improvements in screening and training outlined for victim-survivors may also help reduce the risk of suicide amongst perpetrators. However, the RANZCP rejects any efforts to mitigate or address suicidality which increases the risk of harm or re-traumatisation of victim-survivors, such as increased visitation rights, ignorance or reversal of no-contact orders, or failure to adequately monitor and restrict perpetrators when released from justice or custodial settings. These measures are reported by victim-survivors as causing increased danger of continued violence and enhancing their own mental distress and suicidality.[6, 12] The RANZCP has long advocated for changes to the criminal and family law court systems to prevent them being used as weapons of abuse and places of re-traumatisation – see more resources in our publications library including our submission to the Legal and Constitutional Affairs Legislation Committee regarding the Family Law Amendment Bill 2024, submission to the Senate Standing Committee on Social Policy and Legal Affairs regarding the Inquiry into Family Violence Orders, and submission to the Australian Law Reform Commission regarding Justice Responses to Sexual Violence.

5. Opportunities to enhance prevention and early intervention efforts

As noted above, broad training on how to recognise and respond to experiences of FSDV and related mental health and suicide risks across all frontline responder groups is key. These should be supported by dedicated funding for co-located services with clear referral pathways and standardised data gathering practices. However, comprehensive system changes need to occur to ensure that these are effective, as individual initiatives such as training or policy changes at a service level will not create lasting or impactful change.[4]

One way for these three key improvement areas to be implemented on a system wide scale is through the development of designated screening policies backed by standardisation and enhancement of documentation practices. Psychiatrists working with victim-survivors have noted that the current health services documentation procedures do not adequately account for FSDV. Psychiatrists have noted that due to the way standardised electronic medical records have developed, there is often no way to record and adequately flag FSDV in patient records outside of secondary narrative notes. However, unlike standard input fields, these notes are not flagged by automatic systems and due to poor training and service pressures such as understaffing and limited clinical time, they can go unnoticed. This issue with standardised documents is not solely a health services issue – in Victoria the Multi-Agency Risk Assessment and Management (MARAM) system has been noted as needing improved suicide and mental health data input options when addressing FSDV.[6] Psychiatrists have noted similar issues with the Multi-

Agency Protection Service (MAPS) in South Australia. Standardised data input fields that "auto-flag" for FSDV which would support the implementation of screening practices that recognise and adequately respond to FSDV.[7]

Another opportunity to enhance early intervention is the deployment of mental health trained FSDV specialist officers in key locations.[7] Community-based services located in police stations have been shown to be broadly successful, especially when paired with cultural-safety efforts.[12] This program was a pilot in New South Wales born out of the National Plan to Reduce Violence Against Women and Children, and the RANZCP supports the literature's recommendation that this be extended and expanded.[12]

6. Related Matters

The RANZCP would like to highlight an often-overlooked system that can contribute to the perpetuation of FSDV, its associated mental health impacts, and increased suicide risk. Emerging evidence indicates that aspects of the migration system may be used by perpetrators to inflict serious and lasting harm on victim-survivors.[17] People from migrant and multicultural communities may face additional barriers to accessing FSDV services for a number of reasons including cultural loading, a lack of appropriate services, lack of understanding or rights or accessibility, and fear of deportation or separation from families.[17, 18] However, there has been little dedicated research to FSDV related suicide amongst migrants in Australia, nor are current data collection methods or practices designed to include this population specifically. It is crucial that migration services officers and immigration enforcement practices are included as part of the recommended improvements to screening and training practices. It is also important that mental health, domestic violence, community and social services are built around culturally safe practices for multicultural and migrant communities.

Conclusion

The RANZCP would welcome the opportunity to be further involved in this inquiry, and in developing the services and practices we have recommended to address the relationship between FSDV and suicide. Suicide and FSDV are serious public health concerns which are both individually and collective linked intrinsically to mental health and the mental health systems. To engage further please contact Ivy Kioko, Manager of Bi-National Policy, via policy@ranzcp.org.

References

1. Australian Institute of Health and Welfare. Family, domestic and sexual violence 2026 [Available from: https://www.aihw.gov.au/family-domestic-and-sexual-violence/types-of-violence/intimate-partner-violence#common.
2. Adam O Hill Adam Bourne Ruth McNair Marina Carman and Anthony Lyons. Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. Melbourne; 2020.
3. Lusby S, Lim G, Carman M, Fraser S, Parsons M, Fairchild J, Bourne A. Opening Doors: Ensuring LGBTIQ-inclusive family, domestic and sexual violence services. La Trobe; 2024.
4. Hegarty KL, Andrews S, Tarzia L. Transforming health settings to address gender-based violence in Australia. Medical Journal of Australia. 2022;217(3):159-66.
5. Indu PV, Remadevi S, Vidhukumar K, Shah Navas PM, Anilkumar TV, Subha N. Domestic Violence as a Risk Factor for Attempted Suicide in Married Women. (1552-6518 (Electronic)).
6. Stafani Vasil Kate Fitz-Gibbon Marie Segrave. Family violence and women's deaths by suicide: A Victorian study. . Melbourne; 2025.
7. Gillespie K, Branjerdporn G, Tighe K, Carrasco A, Baird K. Domestic violence screening in a public mental health service: A qualitative examination of mental health clinician responses to DFV. Journal of Psychiatric and Mental Health Nursing. 2023;30(3):472-80.
8. Australian Institute of Health and Welfare. Suicide, self-harm and mental health: AIHW; 2025 [Available from: https://www.aihw.gov.au/mental-health/topic-areas/health-wellbeing/suicide-and-self-harm.
9. Australian Institute of Health and Welfare. Australian Burden of Disease Study: impact and causes of illness and death in Aboriginal and Torres Strait Islander people 2018. AIHW, Australian Government; 2022.
10. Suicide Prevention Australia. Submission to the South Australian Royal Commission into Domestic, Family, and Sexual Violence Adelaide; 2024.
11. World Health Organisation. Brief intervention: Information session about suicide. In Multisite intervention study on suicidal behaviour—SUPRE-MISS: Protocol of SUPRE-MISS. Geneva: WHO; 2002.
12. Cripps K. Indigenous domestic and family violence, mental health and suicide. AIHW, Australian Government; 2023.
13. Cavanaugh CE, Messing Jt Fau - Del-Colle M, Del-Colle M Fau - O'Sullivan C, O'Sullivan C Fau - Campbell JC, Campbell JC. Prevalence and correlates of suicidal behavior among adult female victims of intimate partner violence. (1943-278X (Electronic)).
14. Silke Meyer Maria Atienzar-Prieto Kate Fitz-Gibbon and Shorna Moore. Missing figures: The hidden role of domestic and family violence in youth suicide - The current state of knowledge report. Brisbane: Griffith University; 2023 March 2023.
15. Oram S, Fisher HL, Minnis H, Seedat S, Walby S, Hegarty K, et al. The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy. The Lancet Psychiatry. 2022;9(6):487-524.
16. Woolley J. Policing perpetrator suicide threats in family violence cases: competing priorities and contemporary challenges. Policing and Society. 2024;34(10):997-1010.
17. Segrave M. Temporary Migration and Family Violence: How Perpetrators Weaponise Borders. International Journal for Crime, Justice and Social Democracy. 2021;10:26-38.
18. Jude McCulloch JaneMaree Maher Kate Fitz-Gibbon Marie Segrave and James Roffee. Review of the Family Violence Risk Assessment and Risk Management Framework (CRAF). Melbourne: Monash University; 2016.