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Submission to the Australian Parliament's Standing Committee on Social Policy and Legal Affairs

INQUIRY INTO THE RELATIONSHIP BETWEEN DOMESTIC, FAMILY AND SEXUAL VIOLENCE AND SUICIDE

February 2026

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Contents

Acknowledgement of Country

We acknowledge and respect Aboriginal people as the first people and nations and recognise Aboriginal people as traditional owners and occupants of land and waters in South Australia. Sovereignty has never been ceded. It always was and always will be Aboriginal land.

We recognise that Aboriginal peoples' spiritual, social, cultural and economic practices come from their traditional lands and waters; that they maintain their cultural and heritage beliefs, languages and laws of ongoing importance; and that they have made and continue to make a unique and irreplaceable contribution to South Australia.

We acknowledge that Aboriginal people have endured, and continue to endure, injustices and dispossession of their traditional lands and waters. We pay respect to the resilience and strengths of Ancestors and Elders past, present and emerging.

About Embolden South Australia

Embolden is the statewide peak body for organisations in South Australia that work to prevent and respond to domestic, family and sexual violence. Embolden members are services that specialise in supporting people experiencing violence to be safe, recover and thrive, and programs that work towards the elimination of gender-based violence. We recognise that domestic, family and sexual violence is most often perpetrated by men against women and children, and that gender-based violence impacts people across diverse gender identities, social and cultural contexts, and within various types of intimate and family relationships. Embolden represents providers of specialist services in South Australia's domestic, family and sexual violence sector, including services that work with me who use violence and Aboriginal specialist services.

Anglicare SA

Australian Refugee Association

Sanctuary House, The Salvation Army

Cedar Health Service, SA Health

Ceduna Regional Domestic Violence and Aboriginal Family Violence Services, Centacare Catholic Country Services

Coober Pedy Regional Domestic Violence and Aboriginal Family Violence Service, Uniting Country SA

54 Reasons

Family Violence Legal Service Aboriginal Corporation

Fleurieu and KI Domestic Violence Service, Junction SA

Kornar Winmil Yunti Aboriginal Cooperation Lutheran Care

Mt Gambier and Limestone Coast Domestic Violence Service, Centacare Catholic Community Services

Murray Mallee and Adelaide Hills Domestic Violence Service, Centacare Catholic Community Services

No to Violence

NPY Women's Council Domestic and Family Violence Service

First Nations Healing

OARS Community Transitions

Port Augusta Regional Domestic Violence and Aboriginal Family Violence Service, Uniting Country SA

Relationships Australia (SA)Riverland Domestic Violence Service, Centacare Catholic Community Services

The Yellow Gate

Thorne Harbour Health

Whyalla Regional Domestic Violence Service, Centacare Catholic Community Services

Women's Legal Service SA

Women's Safety Services SA

Yarredi Services

Yarrow Place, SA Health

Yorke and Mid North Domestic Violence Service, Uniting Country SA

Zahra Foundation Australia

About Embolden's submission

Embolden South Australia welcomes the Committee's Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide. We commend the Committee's focus on understanding the true scale of DFSV-related suicide and developing prevention-focused and trauma-informed policy and operational responses.

Embolden is the statewide peak body for organisations working to respond to and eliminate domestic, family and sexual violence in South Australia. This submission is made on behalf of, and was developed in collaboration with, Embolden members.

For South Australians, the Inquiry is particularly timely as the State government embarks on far reaching reforms from the 2025 *Royal Commission into Domestic, Family and Sexual Violence*. The Inquiry brings trajectories of harm and systemic drivers of DFSV suicidality into sharp focus, and our hope is this can help inform and shape reforms locally, as well as informing priorities and driving change nation-wide.

Embolden's submission shares the insights of specialists with extensive experience supporting victim-survivors to achieve safety and recover from domestic, family and sexual violence. It is informed by sector-wide consultation and a series of in-depth interviews with member organisations delivering specialist programs with communities where suicide prevalence is highest. Thematic analysis of members' insights is the basis of Embolden's central propositions to the Inquiry and suite of recommendations (pages 4 to 5).

Embolden's propositions to the Inquiry are:

1. **Domestic, family and sexual violence victimisation is a significant contributor to suicide and suicidal distress.** Frontline specialist practitioners report that DFSV-related suicidality is strikingly common among the people they are supporting.
2. **Those facing the greatest barriers to disclosure, safety and recovery are most likely to be invisible in DFSV-related suicide data.** This includes Aboriginal people, LGBTIQA+ communities, migrant and refugee communities, young people, people with disability, and people in rural and remote settings.
3. **DFSV-related suicide risk often peaks after considerable time has passed from the point of crisis and/or the end of the relationship.** This period is least served in DFSV response system design and funding models, and least visible in suicide data.
4. **Responses to suicidality are inadequately DFSV-informed.** Absence of DFSV screening in suicidality assessment can lead to responses that exacerbate risk.
5. **Systems abuse is a significant contributor to DFSV suicidality.** Both systems abuse by the person using violence and systems that are unresponsive to DFSV victimisation can harm victim-survivors, erode their hope, and intensify suicide ideation.
6. **Absence of DFSV screening in suicide investigations is unjust, collusive and irresponsible.** Victims are failed, people who use violence evade scrutiny, and systems invest in responses that are misaligned to real-world trajectories of harm.

We are grateful for the opportunity to share insights from South Australia's DFSV specialist sector to support the Committee's work.

[redacted]
Maria Hagias
Embolden Board Co-chair

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Susie Smith
Embolden Board Co-chair

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Mary Leaker
Embolden CEO

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Summary of recommendations

1. **Include prevention of DFSV-related suicide in Action Plans**

Include a focus on prevention of DFSV-related suicide in the forthcoming Second Action Plan under the *National Plan to End Violence Against Women and Children 2022-2032*, and align with the *National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence 2026-2036*. The Plans must outline a cohesive set of commitments across the prevention, early intervention, response and recovery and healing action areas, and outline activities that will be delivered by Commonwealth, State and Territory governments to understand the true scale of DFSV-related suicide and reduce suicide deaths related to DFSV victimisation nation-wide.

2. **Fund healing and recovery support to align with unmet needs**

New investment is needed to make specialist healing and recovery supports accessible over time according to need, including:

- Community-led approaches that reduce isolation and stigma and promote help-seeking
- Invest in specialist, community-led programs to meet the unique needs of communities that face additional barriers to safety and recovery from DFSV – including Aboriginal people, LGBTIQA+ communities, migrant and refugee communities, young people, people with disability, and people in rural and remote settings.

3. **Sustainable funding for specialist Aboriginal community-controlled DFSV services in remote and cross-border contexts**

Equitable access to holistic, culturally safe safety and recovery supports in remote South Australia and cross-border contexts.

4. **Prioritise housing and financial security as protective factors in DFSV suicide prevention**

Explicitly recognise housing and financial security as DFSV suicide prevention priorities, and outline actions, activities and targets in the forthcoming Second Action Plan under the *National Plan to End Violence Against Women and their Children 2022-2032*, and align with the *National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence 2026-2036*.

5. **Recognise and address systems abuse as a DFSV suicide prevention priority**

Sustain and strengthen the prevention of systems abuse as a priority in forthcoming Action Plans, focusing on Commonwealth and state systems that are commonly weaponised by people who use violence (including family law, child support, migration/visa, social security, and service access barriers).

6. **National minimum standards for DFSV-informed suicide screening**

Introduce national minimum standards requiring that suicide risk screening in health and mental health settings includes best practice DFSV-informed prompts.

7. **Operational framework and workforce development to support DFSV-informed suicide screening**

Support health and mental health workforces to meet obligations in DFSV-informed suicide screening, with an implementation strategy that is:

- DFSV-informed, person-centred and strength-based
- culturally safe and responsive

- tailored by role, setting and context while maintaining consistency
- attentive to historical abuse, and long-term risk and harm
- capable of identifying sexual violence and shame-based abuse and risk

8. Build workforce capability to respond to DFSV-related suicidality system-wide

Build workforce capability across DFSV and mental health systems, including targeted training programs, joint communities of practice, supervision and debriefing, recognising the complexity and vicarious trauma risks in this work.

Properly resource each specialisation to contribute their frontline specialist expertise to the design and delivery of capacity building activities.

9. Resource specialist sexual violence services and build response capability system-wide

Effective responses to victim-survivors of sexual violence requires additional investment in specialist sexual violence services and building workforce capability to recognise and respond to sexual violence system wide. Building system-wide capability must include workforce training, screening tools that overcome misunderstandings and stigma, and integrated pathways between sexual assault services, DFV services, and mental health systems.

10. Mandate DFSV screening in suicide investigations nation-wide

The Committee advocate to the Standing Council of Attorneys-General for consideration of legislative reform and resourcing requirements to achieve nation-wide consistency in:

- routine screening for DFSV indicators in coronial suicide investigations
- broader information gathering (beyond medical practitioner/police) to inform findings and any further action

and consider whether amendments are required to manage potential that Senior Next of Kin is the person using violence.

11. Make high quality DFSV suicide data available to DFSV stakeholders

Deliver changes to national data collection and reporting systems to make accurate, useful DFSV-related suicide data available to DFSV stakeholders, to enable evidence-based design of programs to prevent DFSV harm, including suicidality.

12. Consistency in DFSV Death Review methodology and reporting, nation-wide

Increase investment to bring suicide within scope of DFSV death review processes, underpinned by consistency in methodology and reporting across all States and Territories.

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1. The relationship between DFSV and suicide

Suicidality related to domestic, family and sexual violence victimisation is strikingly apparent in the work of frontline practitioners across South Australia's DFSV specialist sector.

Practitioners observe that experiences of DFSV can lead to chronic trauma, loss of safety and agency, psychological distress, and profound forms of entrapment that can leave victim-survivors feeling they have no safe pathway out. Where violence is ongoing, unaddressed, or compounded by isolation and systemic barriers to safety and recovery, risk is magnified.

Population groups that face the greatest barriers to safety and recovery from DFSV are also the population groups with highest suicide prevalence. This includes Aboriginal people, LGBTIQA+ communities, migrant and refugee communities, young people, people with disability, and people in rural and remote settings.

Suicide prevalence for Aboriginal people is shockingly high.[1] Specialists from community-controlled DFSV services emphasise that harm caused to Aboriginal people from DFSV and from colonial violence are interconnected – contributing to high prevalence of DFSV, unique and compounded barriers to safety, and recovery needs that relate not only to DFSV but also to ways in which systems cause and compound harm in responding to their situations. While holistic, community-controlled responses to DFSV and access to culturally safe therapeutic assistance are crucial to Aboriginal women's safety and recovery, equitable access is an ongoing challenge in remote South Australia and cross-border contexts.

An estimated 63 per cent of LGBTQA+ South Australians have experienced violence in their family of origin, often connected to disclosure of sexuality and/or gender identity, and research indicates that high proportions of LGBTQA+ people have experienced intimate partner and/or family violence across their lifetime.[2] Practitioners observe that a broad range of factors contribute to high DFSV prevalence, such as feelings of shame, self-blame and rejection resulting from family of origin violence, creating vulnerability to coercive and controlling abuse in adulthood. Suicide ideation in South Australia's LGBTQA+ communities is alarmingly high – 76% of adults and 83% of young people have experienced suicidal ideation, and 35% of adults and 26% of young people have attempted suicide – and suicidality rates are consistently higher for LGBTQA+ people with a disability and trans and gender diverse people.[3]

For migrant and refugee communities, the relationship between DFSV and suicidality is often intensified by additional factors such as pre-migration trauma, language barriers, social isolation, visa insecurity, limited access to culturally safe services, and fear of authorities.

In the frontline work of DFSV specialists, it is clear that systemic marginalisation and structural disadvantage are not secondary to, but rather, fundamentally shape the perpetration of DFSV, the harm caused to victim-survivors, and the barriers to help-seeking and recovery they face – and is strongly correlated with the high prevalence of DFSV-related suicidality in marginalised population groups.

Practitioners identified several significant factors that contribute to DFSV-related suicidality, discussed in following sections, which also contribute to its invisibility and go some way to explain why the true scale of DFSV-related suicidality is unknown. Where there are barriers to disclosure and help-seeking, victim-survivors needs and experiences go unrecognised; where abuse is ongoing yet perpetrated via legal and administrative systems, victim-survivors' experience of this abuse as DFSV is obscured; where

[1] Australian Institute of Health and Welfare, Suicide and intentional self-harm hospitalisations among First Nations people, https://www.aihw.gov.au/suicide-self-harm-monitoring/population-groups/first-nations-people
[2] Hill, A. O., Bourne, A., McNair, R., Carman, M. & Lyons, A. (2020). Private Lives 3: The health and wellbeing of LGBTIQ people in Australia. ARCSHS Monograph Series No. 122. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.
[3] Amos, N., Hinton, J. D. X, & Bourne, A. (2025). LGBTQA+ mental health and suicidality: South Australia Briefing Paper. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University., https://www.latrobe.edu.au/arcshs/work/lgbtiq-health/private-lives-3

heightened DFSV-related suicide risk is not proximate to the relationship ending or period of "crisis", identifying DFSV as a causal or contributing factor becomes less likely. It seems reasonable to speculate that victim-survivors who are at greatest risk of suicide and suicide ideation are also those who are least visible in suicide data.

While these are significant challenges that go some way to explain the invisibility of the relationship between DFSV and suicide, the shortcomings in identifying DFSV in suicide investigations is another element that requires urgent attention. The absence of routine screening for DFSV indicators in coronial investigations means there is no reliable statistical data, nor the ability to properly understand harm trajectories and develop evidence-based responses to prevent DFSV-related suicide. These issues are discussed in section 4.

Embolden advocates that urgent action be taken to introduce changes to suicide investigations and related administrative systems, while concurrently taking urgent action to address the known contributors to DFSV-related suicidality, based on the outcomes of this Inquiry. While only prevention of DFSV can prevent DFSV-related suicide, a great deal can be done that will improve outcomes for victim-survivors. The extent of improvements required nationally necessitates a commitment by the Commonwealth and all States and Territories to meaningful, coordinated action and substantial investment. Only then can the true scale of DFSV-related suicide be understood and evidence-based policy and operational responses developed to prevent profound harm, including preventable suicide.

RECOMMENDATION

1. **Include prevention of DFSV-related suicide in Action Plans**

Include a focus on prevention of DFSV-related suicide in the forthcoming Second Action Plan under the *National Plan to End Violence Against Women and Children 2022-2032*, and align with the *National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence 2026-2036*. The Plans must outline a cohesive set of commitments across the prevention, early intervention, response and recovery and healing action areas, and outline activities that will be delivered by Commonwealth, State and Territory governments to understand the true scale of DFSV-related suicide and reduce suicide deaths related to DFSV victimisation nation-wide.

2. Key issues and patterns observed by specialist DFSV practitioners

2.1 Suicidality heightens in "healing and recovery"

A striking observation from Embolden members' frontline practice is that victim-survivor suicidality is commonly most acute after considerable time has passed from the point of crisis and/or the end of the relationship.

> *"Suicide ideation is huge. Of the people I'm seeing, there's not one where I don't have concerns about suicide – and in the higher risk category. In the healing and recovery space, one of the things that happens is you're dealing with is shame. Shame has a massive role to play"*
>
> Specialist DFSV practitioner, Embolden member organisation

Some of the factors contributing to this include therapeutic supports being less available or not DFSV-informed, unresolved trauma emerging once immediate crisis has stabilised, enduring or worsening

financial hardship and/or housing instability, and, as discussed in the next section, experiences of systems abuse with "no end in sight".

Specialists note that trauma that was previously suppressed by crisis-mode survival often resurfaces or intensifies over time. Paradoxically, this is also the stage when support and help is less available. Once "imminent risk" is perceived to have passed, long term recovery needs, which are complex, enduring, and resource-intensive, can go unmet. This leaves victim-survivors navigating unresolved trauma, ongoing abuse, and growing financial uncertainty with diminishing support.

There are significant implications associated with specialists' observation that suicidality commonly peaks during "healing and recovery" from DFSV. If lethality risk is elevated not only at separation but also long after, then the current crisis-centred DFSV system architecture is inadequately resourced to respond to this reality. The period of long-term recovery is the least visible in data, the least recognised in system design, and the least resourced across funding models. Yet it is precisely where sustained, coordinated support could prevent profound harm, including preventable suicide.

RECOMMENDATIONS

2. **Fund healing and recovery support to align with unmet needs**

   New investment is needed to make specialist healing and recovery supports accessible over time according to need, including:
   - Community-led approaches that reduce isolation and stigma and promote help-seeking
   - Invest in specialist, community-led programs to meet the unique needs of communities that face additional barriers to safety and recovery from DFSV – including Aboriginal people, LGBTIQA+ communities, migrant and refugee communities, young people, people with disability, and people in rural and remote settings

3. **Sustainable funding for specialist Aboriginal community-controlled DFSV services in remote and cross-border contexts**

   Equitable access to holistic, culturally safe safety and recovery supports in remote South Australia and cross-border contexts.

4. **Prioritise housing and financial security as protective factors in DFSV suicide prevention**

   Explicitly recognise housing and financial security as DFSV suicide prevention priorities, and outline actions, activities and targets in the forthcoming Second Action Plan under the *National Plan to End Violence Against Women and their Children 2022-2032*, and align with the *National Aboriginal and Torres Strait Islander Plan to End Family, Domestic and Sexual Violence 2026-2036*.

2.2 Systems abuse contributes to DFSV suicidality

Embolden emphasises that systems abuse is crucial to understanding the relationship between DFSV and suicidality.

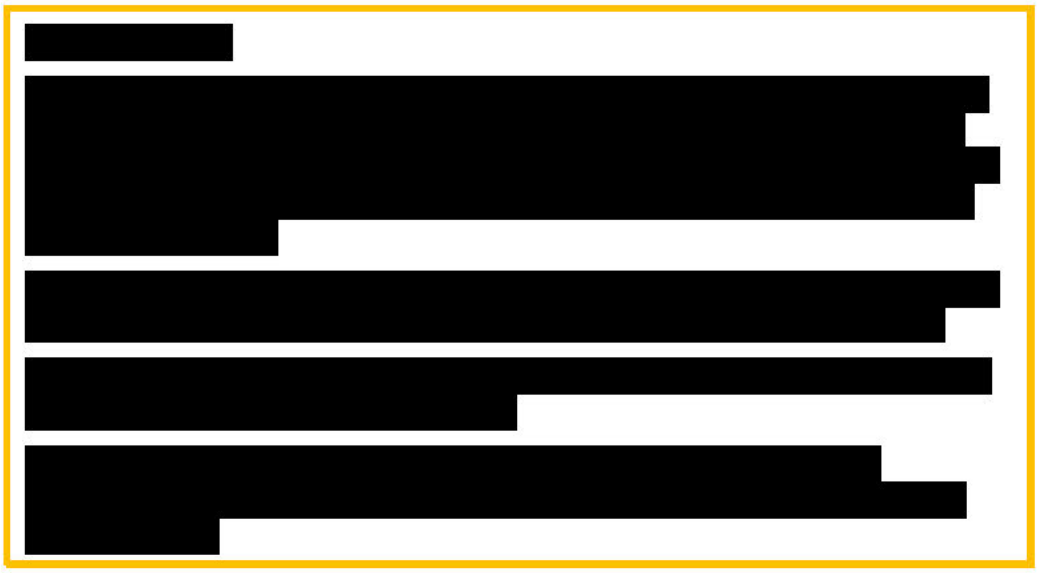
Use of legal and administrative systems to maintain control and cause harm by people who use violence can endure many years after separation. It can profoundly impair victim-survivor wellbeing, impede capacity to recover, and cause hope to be lost that the abuse will ever end. While systems abuse was once understood primarily as vexatious use of court processes, particularly within the family law system, it is increasingly recognised as encompassing multiple, discrete ways in which people who use violence manipulate institutional processes. This includes leveraging unconscious biases within policing, child protection, and other statutory systems to undermine victim-survivors' credibility and safety. Domestic

Violence Order (Intervention Order in the SA context) and criminal law systems that are inadequately responsive to the lived realities of domestic and family violence and the needs of victim-survivors can create and increase risks to safety.

DFSV specialists find the significance of systems abuse lies not only in misuse of processes by people who use violence and abuse to control and harm victim-survivors, but in the conditions that allow misuse to succeed, and ways in which institutions mimic patterns and tactics of harm and become part of the harm landscape for victim-survivors and their families.

> *"When you have a person who has experienced abuse in childhood, then by their intimate partner, and then by the system they expected help from... they've never known safety. There can be long term passive suicidal ideation, then that one thing happens and 'boom'"*
>
> Specialist DFSV practitioner, Embolden member organisation

When systems are not DFSV informed, responses to substance use, parenting concerns or child protection contact can heighten shame, hopelessness and risk, rather than enhancing safety and recovery, particularly for those experiencing ongoing coercive control. The following case example illustrates the lived impact of looped engagement that fails to consider DFSV in responding to suicidality, which can result in system responses that inadvertently reinforce entrapment and worsen risk.



Systems abuse is a significant contributor to DFSV-related suicidality. It erodes victim-survivors' strength, resilience and hope, and intensifies shame and isolation. This can lead to feelings of entrenched despair and suicidal ideation. Specialists describe systems abuse as pernicious and one of the most challenging areas of their work with victim-survivors of DFSV, due to the pervasive harm and intense despair it causes, and the severely limited options to address its causes.

RECOMMENDATION

5. **Recognise and address systems abuse as a DFSV suicide prevention priority**

   Sustain and strengthen the prevention of systems abuse as a priority in forthcoming Action Plans, focusing on Commonwealth and state systems that are commonly weaponised by people who use violence (including family law, child support, migration/visa, social security, and service access barriers).

3. Service systems responding to DFSV suicidality

3.1 DFSV screening in suicidality assessment

Suicide screening and risk assessment practices differ markedly across sectors, settings and jurisdictions, resulting in fragmented and inconsistent identification of DFSV. These inconsistencies are most acute for communities at heightened risk, where indicators of coercion, control and cumulative harm are often not recognised outside specialist services. Specialists note the risk posed to victim-survivors when failure to identify DFSV means tactical suicide threats as a form of coercive control go unrecognised. Historical abuse, particularly childhood sexual abuse, is significant to DFSV-related suicidality and often out of scope in assessments. For LGBTIQA+ communities, identity-based abuse (whether by an intimate partner and/or within family of origin) is significant and can trigger profound shame, despair and isolation; yet suicide screening is ill-equipped to safely elicit this crucial information.

The practice experience of specialist services suggests that the absence of DFSV-informed screening in suicidality assessment contributes to poorly informed responses that can exacerbate drivers of DFSV-related suicidality, and contribute to its invisibility.

> *"The shame factor is big. Once the person can speak up after identifying 'this is harming me and is wrong', then the response puts it back on the individual and they're already spiralling. The message sent is 'You were abused and it's your fault'."*
>
> Specialist DFSV practitioner, Embolden member organisation

When DFSV goes unrecognised, victim-survivors' distress can be misinterpreted as an individual mental health issue rather than a consequence of ongoing patterns of abuse and compounding harm. This leads to critical DFSV indicators being missed and responses to victim-survivors' needs that can be inappropriate and exacerbate risk. Mental health responses that focus on isolated incidents rather than recognising the ongoing, patterned dynamics of abuse can inadvertently locate the "problem" within the individual, replicating coercive dynamics and missing critical DFSV context.

While awareness of the nature and dynamics of DFSV has improved markedly in the last decade, and policy mechanisms to drive change exist, this has not yet translated with consistency into practice frameworks and systems design. It is Embolden's view that Commonwealth leadership and investment is required to bring response systems into alignment with expectations.

Embolden supports the development of national minimum standards requiring routine screening for DFSV indicators in suicide risk assessments in health and mental health settings. An operational framework and workforce development strategy for the target sectors is crucial to the efficacy of screening obligations, and must be:

- trauma-informed, person-centred and strength-based
- culturally safe and responsive
- tailored by role, setting and context while maintaining overarching consistency
- attentive to historical abuse, and long-term risk and harm
- capable of identifying sexual violence and shame-based abuse and risk

RECOMMENDATIONS

6. **National minimum standards for DFSV-informed suicide screening**

Introduce national minimum standards requiring that suicide risk screening in health and mental health settings includes best practice DFSV-informed prompts.

7. **Operational framework and workforce development to support DFSV-informed suicide screening**

Support health and mental health workforces to meet obligations in DFSV-informed suicide screening, with an implementation strategy that is:

- DFSV-informed, person-centred and strength-based
- culturally safe and responsive
- tailored by role, setting and context while maintaining consistency
- attentive to historical abuse, and long-term risk and harm
- capable of identifying sexual violence and shame-based abuse and risk

3.2 Screening and responding to DFSV-related suicidality system wide

DFSV specialists report that suicide risk screening is routine practice and is conducted alongside DFSV risk assessment.

While specialists bring expertise to screen for and respond to suicide risk when working with people affected by DFSV, there is significant risk of variation in skill and practice standards. Where suicide risk screening is dependent upon practitioners' experience, the absence of universally applied suicide risk screening can mean suicide ideation goes unnoticed.

It is Embolden's view that effective prevention of DFSV-related suicide requires investment to promote universal, high-quality dual screening for DFSV risk and suicide risk across all workforces that support people affected by DFSV.

RECOMMENDATION

8. **Build workforce capability to respond to DFSV-related suicidality system-wide**

Build workforce capability across DFSV and mental health systems, including targeted training programs, joint communities of practice, supervision and debriefing, recognising the complexity and vicarious trauma risks in this work.

Properly resource each specialisation to contribute their frontline specialist expertise to the design and delivery of capacity building activities.

3.3 Relationship between sexual violence and suicidality

There is a very strong relationship between experiences of sexual violence and suicidality. Embolden commends to the Inquiry the submission of the National Association of Services Against Sexual Violence (NASASV), the peak body for diverse specialist organisations working to prevent and respond to sexual violence in Australia.

Efforts to reduce DFSV suicidality must prioritise adequate resourcing for specialist sexual violence response services, alongside building sexual violence response capability system wide. This must include increased investment in services for people with experiences of childhood sexual abuse.

Embolden has previously highlighted the lack of focus within SA's Royal Commission on supports for both child and adult victim-survivors of childhood sexual abuse[4]. Given the Australian Child Maltreatment Study finding that 1 in 3 women and 1 in 5 men experienced sexual abuse in childhood[5], specialist sexual violence services must be properly resourced to respond to this reality. The ACMS also found that people who experienced sexual abuse in childhood are 2.3 times more likely to have attempted suicide in adulthood.[6]

Disclosure of sexual violence, including experiences of childhood sexual abuse, can be delayed for many years and sometimes decades, and secrecy and "masking" behaviours can increase suicide risk. There is urgent need for greater investment in specialist services to provide long-term therapeutic support for victim-survivors of sexual violence, including children and young people and people living regionally and remotely.

> *"Young people who grow up knowing how to hide what's happening for them, carry that into adolescence and into adulthood. Risk is so present."*
>
> Specialist DFSV practitioner, Embolden member organisation

Alongside adequate resourcing for specialist services, there is urgent need to build capability to recognise and respond to sexual violence system wide. Non-specialist workforces often lack resourcing and capacity to identify and respond to sexual harm safely, and sexual violence response is often siloed or treated as "specialist only". It is neither reasonable nor viable for specialist sexual violence services to hold that level of risk.

Responsibility to recognise and respond appropriately to sexual violence must be shared across sectors – including private practitioners in health and mental health settings – as part of an integrated system. While system fragmentation and siloes was a significant focus of SA's Royal Commission and some action is underway to improve referral pathways, responding to sexual violence also requires workforce training, screening tools, shared practice principles, and integrated pathways between sectors. Strengthened responses to sexual violence system-wide is crucially important to improving victim-survivor outcomes and preventing suicidality.

RECOMMENDATION

9. Resource specialist sexual violence services and build response capability system-wide

Effective responses to victim-survivors of sexual violence requires additional investment in specialist sexual violence services and building workforce capability to recognise and respond to sexual violence system wide. Building system-wide capability must include workforce training, screening tools that overcome misunderstandings and stigma, and integrated pathways between sexual assault services, DFV services, and mental health systems.

[4] Embolden-statement_State-Governments-response-to-Royal-Commission-recommendations.pdf
[5] Haslam et al, op cit
[6] Haslam D, Mathews B, Pacella R, Scott JG, Finkelhor D, Higgins DJ, Meinck F, Erskine HE, Thomas HJ, Lawrence D, Malacova E. (2023). The prevalence and impact of child maltreatment in Australia: Findings from the Australian Child Maltreatment Study: Brief Report. Australian Child Maltreatment Study, Queensland University of Technology.

4. DFSV in suicide investigations, data collection and reporting

Embolden submits that current DFSV-related suicide data is limited not only by coding or reporting, but by a deeper issue: what investigation of suicide deaths is required to look for.

If coronial processes do not consistently screen for DFSV indicators and source reliable information about DFSV histories, then poorly informed conclusions will inevitably be drawn.

- DFSV will not be recorded as a factor in suicides
- "associated factors" will skew toward individual pathology rather than contextual harm
- aggregated national datasets will misrepresent suicide prevalence and patterns
- policy will continue to under-invest in long-term recovery, system reform, and prevention measures

In the South Australian context, Embolden members also raised concerns about how difficult it is to locate detailed, accessible information about suicide investigation processes and how DFSV indicators are (or are not) sought and recorded.

Further, there is a significant need to increase investment in domestic and family violence death review mechanisms nationally, and to drive increased standardisation and harmonisation across jurisdictions. South Australia currently has no dedicated formal mechanism to research and investigate deaths where there is a context of domestic and family violence. A dedicated role - Senior Research Officer (Domestic Violence) – was previously established within the SA Coroner's Office through a partnership with the SA Office for Women. This position was defunded in 2021. Noting the intention of the Australian Domestic and Family Violence Death Review Network to broaden their reporting to include DFSV-related suicide deaths[7] – which Embolden fully supports – it is crucial that adequately resourced domestic and family violence death review mechanisms are in place in each state and territory. This is essential for the development of an accurate national picture of DFSV-related suicide, to effectively inform policy action, service responses and prevention approaches.

RECOMMENDATIONS

10. Mandate DFSV screening in suicide investigations nation-wide

The Committee advocate to the Standing Council of Attorneys-General consideration of legislative reform and resourcing requirements to achieve nation-wide consistency in:

- routine screening for DFSV indicators in coronial suicide investigations
- broader information gathering (beyond medical practitioner/police) to inform findings and any further action

and consider whether amendments are required to manage potential that Senior Next of Kin is the person using violence.

11. Make high quality DFSV suicide data available to DFSV stakeholders

Deliver changes to national data collection and reporting systems to make accurate, useful DFSV-related suicide data available to DFSV stakeholders, to enable evidence-based design of programs to prevent DFSV harm, including suicidality.

[7] Australian Institute of Health and Welfare, Family, domestic and sexual violence: Health outcomes, https://www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/health-outcomes

12. Consistency in DFSV Death Review methodology and reporting, nation-wide

Increase investment to bring suicide within scope of DFSV death review processes, underpinned by consistency in methodology and reporting across all States and Territories.

Contact for Embolden's submission

Embolden commends the Committee for undertaking this Inquiry.

In making this submission, our goal is to assist the development of policy and operational measures that will prevent DFSV-related suicides, and enable victim-survivors to be safe, recover and thrive.

We are grateful for the opportunity to share insights from South Australia's DFSV specialist sector to support the Committee's work.

Please contact:

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