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

Submission

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Submitted by

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Acknowledgment of Country

The Working with Women Alliance acknowledges the Traditional Custodians of the land on which we work and live.

We pay our respects to Aboriginal and Torres Strait Islander Elders past and present, and we value the enduring connection Aboriginal and Torres Strait Islander people have to this land.

We value Aboriginal and Torres Strait Islander histories, cultures, and knowledge.

About WwWA

The Working with Women Alliance (WwWA) represents two key portfolios: National Women's Safety (NWS) and National Women's Equality (NWE).

The WwWA connects the critical areas of gender-based violence prevention and the advancement of women's economic equality and leadership, bridging these important policy fields for greater impact.

We work with members and stakeholders, including the Australian Government, to provide expertise and advice on gender equality and women's safety.

Executive Summary

Australia's Suicide Prevention Strategy must be aligned with the National Plan to End Violence against Women and Children (the National Plan), acknowledging violence prevention as a key component of suicide prevention. People who experience violence, and those who use violence are at a significantly higher risk of developing mental health challenges and suicide ideation. Aligning both national frameworks will support suicide prevention, recognising that gender-based violence is a public health crisis.

This submission provides an overview of the existing national suicide data, demonstrating the impact of suicide on distinct communities who are at a higher risk of experiencing violence.

We recognise the complexity of the relationship between domestic, family and sexual violence and suicide, and recommend two framing considerations for the Committee to include in their report.

1) Avoid language that indicates suicide as an inevitable outcome of experiences of violence. This framing risks eliminating hope for victim-survivors, and does not acknowledge co-existing, compounding challenges faced by affected people.
2) Without distinguishing between different forms of violence and the corresponding populations they impact, we cannot design targeted, effective interventions.

The WwWA's core recommendation is to align Australia's Suicide Prevention Strategy with the National Plan. The submission will expand on how this would improve interventions and support the government in delivering comprehensive support for affected people.

Understanding the Relationship

Data Gap

Research demonstrates a strong correlation between exposure to violence and mental health conditions, many of which are associated with a risk of suicide. Women who have experienced domestic violence are three times more likely to have a depressive disorder, four times more likely to have an anxiety disorder and seven times more likely to have PTSD.[1] A UK study estimates that perpetrators of partner homicide are 2,000 times more likely to experience suicidal ideation than the general population.[2] Perpetrators also use threats of suicide as a tactic of coercion: 39% of Australian women who experience coercive control note the use of threats of self-harm as a coercive tactic.[3]

However, there is limited data to understand the relationship between experiences of violence and suicidality. This relationship is further complicated due to co-existing challenges associated with experiences of violence and suicidality, including comorbid

health and mental health conditions, financial stress and instability, gambling and substance dependencies, limited access to support, and homelessness.[4]

In Australia, intimate partner violence (IPV) is one of the leading contributors to ill health, disability, and death among women, especially those under the age of 45.[5] International research has shown that women who experience IPV are significantly more likely to attempt suicide than those who haven't experienced such violence.[6] A UK study estimates that women who have experienced IPV are three times more likely to die by suicide.[7]

This data is limited as it is exclusive to experiences of gender-based violence, is not disaggregated by demography, and does not represent rates of suicide among people who have experienced other forms of violence.

Australian Data

The strongest evidence Australia has to demonstrate the relationship between experiences of violence and suicide is from the Victorian Coroner's Court, which found that family violence was present in one in four suicides between 2009-2016.[8] The same data reveals that of the people who were exposed to interpersonal violence and took their own lives, 70.3% of women reported experiencing violence first-hand, and 63.5% of men reported perpetrating violence against a family member or intimate partner.[9] At least 500 male suicides per year are linked to family violence, with 10 men and boys dying per week.[10] There is no Australian data that isolates the link between experiences of violence and suicide on a national level and disaggregates by priority populations.

As a deliverable under the National Plan, emerging data explores the deaths of people experiencing and using family, domestic, and sexual violence. Of the deaths by suicide in Australia between 2010 and 2024, people who experienced or used family violence made up 14.1% of the total figure.[11] The sample data revealed that people who experience or use violence are four times more likely to die by suicide than the general population, with suicide the leading cause of death in this subset (20.7%), followed by accidental poisoning (9.1%).[12]

The data was further disaggregated, illuminating distinct populations that face a higher risk of suicide. For all female deaths by suicide between the years 2010-2024, 37.8% occurred in women exposed to violence.[13] Comparatively, 6.4% of all male deaths by suicide occurred in men exposed to violence.[14] The proportion of deaths by suicide for people exposed to violence is higher for women than it is for men.

Older people also experience a higher risk, with those aged 55-64, 7.1 times more likely to die by suicide and those aged 15-34, 2.2 times more likely than the general population.

Identifying Priority Populations

Marginalised communities face a disproportionate risk of both experiences of violence and poor mental health. They also face intersecting layers of discrimination and systemic barriers to accessing support services. These systemic challenges could lead to a critical underrepresentation in data representing experiences of violence and suicide.

Young People

In 2023, 298 young people under the age of 24 died by suicide. 94 of those deaths occurred in adolescents under the age of 17.[15] Among the age cohort of 20-34 year olds, death by suicide accounted for 31% of all deaths – a two-fold increase since 2001.[16] Suicide was the leading cause of death for young people between 2013 to 2018, with marginalised young people disproportionately impacted by suicide.[17]

Men

The rate of death by suicide among Australian men is 2.8 times higher than for women.[18] The total number of male deaths by suicide has consistently been above 2000, with 2406 deaths in 2023.[19]

Women

Women experience higher rates intentional self-harm than men, and this has been a consistent trend since 2008. Young women between 15-24, Aboriginal and/or Torres Strait Islander women, and women from low socio-economic backgrounds present with especially high rates of intentional self-harm. Women also experience higher rates of suicidal thoughts than men (18% compared to 14.9%).[20]

People Experiencing Homelessness

Of the total number of people who accessed Specialist Homelessness Services (SHSs) in the last year of their life, approximately 13% died by suicide.[21] In 2024, the crude suicide rate for the general population was 12.2 per 100,000 people.[22] For those who accessed SHSs, the crude suicide rate was nearly ten times higher at 115.1 per 100,000 people.[23] People under 24 also comprise a large proportion of deaths by suicide: Of all deaths among people under 24, who accessed SHSs in their last year of life, suicide accounted for 39% of deaths.[24]

People with Disabilities

People under 65 who accessed disability services between 2013-2018 died by suicide at a rate three times that of the general population, with a crude suicide rate of 34 per 100,000.[25] The highest rate of suicide amongst this population was men aged 35-49, with a crude suicide rate of 62 per 100,000.[26] The rate of death by suicide for people with psychosocial disability was nine times greater than for the general population.[27]

LGBTIQ+ Community

2019 data demonstrates that people from the LGBTIQ+[1] community experience significantly higher rates of suicide and suicide ideation than the general population:

- 78% of the LGBTIQ+ community have experienced suicidal thoughts[28], compared to 17% of the general population.[29]
- 62% of the LGBTIQ+ community have self-harmed[30], compared to 8.7% of the general population.[31]
- 47% of the LGBTIQ+ community have made a suicide plan[32], compared to 7.5% of the general population.[33]
- 25% of the LGBTIQ+ community have attempted suicide[34], compared to 4.9% of the general population.[35]

The prevalence of suicidal thoughts among young people from the LGBTIQ+ community is greater than 55% among 14–21 year-olds.[36] Suicide plans are especially high for this age bracket.[37]

Transgender and non-binary people have the highest rates of suicidal thoughts, suicide plans, and suicide attempts, with approximately 80% of the non-binary community having experienced suicidal thoughts in their lifetime.[38]

People from the LGBTIQA+ community who have disabilities consistently experience a higher prevalence of suicidal thoughts, suicide plans, suicide attempts and self-harm. 35% of the LGBTIQ+ and disability community have attempted suicide.[39]

First Nations Community

Between 2011 and 2021, suicide rates for First Nations people increased from a crude rate of 16.9 deaths per 100,000 to 25.7 per 100,000.[40]

In 2023, suicide accounted for 5.2% of all deaths among First Nations people, with men disproportionately represented and experiencing a suicide rate 2.9 times higher than non-Indigenous men.[41] For total deaths among young Aboriginal and Torres Strait Islander people, 20% were due to suicide.[42]

Framing Considerations

The WwWA encourage the Committee to include the following framing considerations in their approach to understanding the relationship between experiences of violence and suicide.

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[1] Language note: AIHW data uses *LGBTIQ+*. We have used LGBTIQ+ in this section for accurate data representation, but recognise that asexual people, sister-boys, brother-girls and other gender diverse people are also marginalised in distinct but sometimes similar ways.

Prescriptive Definition of the Relationship Between Violence and Suicide

The WwWA emphasises the risks associated with framing experiences of violence as directly and causally linked to suicide. While a contributing factor, experiences of violence are not an inevitable indicator of suicide. Research has proven hope as a preventative factor in people experiencing suicide ideation.[43]

This framing also overlooks the formerly mentioned co-existing challenges faced by people experiencing violence and/or suicide ideation. Also, framing violence as a direct determinant of suicide may have complex legal implications.

Conflating Different Forms of Violence

Different demographics are impacted by different forms of violence. Framing domestic, family, and sexual violence as a homogenous experience overlooks this, failing to recognise that different people require different types of support.

- Children and young people are much more likely to experience family violence both directly and as witnesses, and have specific support needs when processing trauma and experiencing suicidal ideation.[44] For example, children are likely to have experienced repeated exposure to violence, and may be involved in legal disputes about parenting arrangements.
- Young people and young adults are especially impacted by technology-facilitated abuse and sexual violence, which calls for different interventions.

Aligning Australia's Suicide Prevention Strategy with the National Plan

Integrating Health and Safety Services

From a policy context, aligning Australia's Suicide Prevention Strategy with the National Plan would enhance the coordination and collaboration of services addressing both experiences of violence and suicide ideation.

This would include the provision of services that are trauma-informed, with a specific understanding of experiences of violence and the associated risk of suicide. It would allow for more comprehensive wraparound support, ensuring that people at risk of suicide are supported into safe housing, and therapeutic support, which are all crucial in breaking cycles of violence and reducing suicidality.

Evidence-Based Prevention and Early Intervention

Aligning Australia's Suicide Prevention Strategy with the National Plan would acknowledge the necessity of mental health support for perpetrators as well as victim-survivors. Services and programs designed to respond to perpetrators and intervene early play a

significant role in addressing mental health crises that may escalate to acts of violence, self-harm and suicide.

Threats or suicide attempts by a perpetrator is a risk factor for murder-suicide.[45] Identifying the use of self-harm and suicide threats is not only relevant to addressing coercive control, but in identifying the risk of escalating and potentially fatal acts of violence. Understanding the relationship between the perpetration of violence, suicide ideation, and suicide threats or attempts will support frontline services in prevention and early intervention efforts to reduce violence and death by suicide.

Data

Improved data on the correlation between experiences of violence and suicidality is essential for informed public health responses, policymaking, and support systems. Understanding the relationship between experiences of violence and suicide must draw from both quantitative and qualitative data. Without accurate and comprehensive data, we risk underestimating the true scope of the problem and failing to allocate adequate targeted resources for prevention and support.

Conclusion

Efforts to address the intersection of gender-based violence and suicidality in Australia require a holistic approach, integrating mental health support with trauma-informed care and services tailored to both survivors and perpetrators of violence. Public health campaigns, education, and accessible crisis interventions are crucial to breaking the cycle of violence and mental health crises, offering hope and support to those affected.

Integrating Australia's Suicide Prevention Strategy with the National Plan to End Violence against Women and Children will acknowledge the correlation between experiences of violence and increased vulnerability to suicidality. This will in turn, support the government in providing integral responses to prevailing national crises - mental health and safety.

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