Submission to the Inquiry into the relationship between Domestic, Family and Sexual Violence and Suicide

30 January 2026

Contact

Meg Bagnall
Lead AOD & Family Violence
mbagnall@vaada.org.au

Acknowledgement of Country

VAADA acknowledges the Traditional Owners of the land on which our work is undertaken. Our office stands on the country of the Wurundjeri people of the Kulin Nation. We pay our respects to all Elders past and present and acknowledge their continuing and ongoing connection to land, waters and sky.

About VAADA

The Victorian Alcohol & Drug Association (VAADA) is a member-based peak body and health promotion charity representing organisations and individuals involved in prevention, treatment, rehabilitation, harm reduction or research related to alcohol or drugs. VAADA aims to support and promote strategies that prevent and reduce the harms associated with alcohol and other drug (AOD) use across the Victorian community. Our vision is a Victorian community in which AOD-related harms are reduced and well-being is promoted to support people to reach their potential. VAADA seeks to achieve this through:

- Engaging in policy development
- Advocating for systemic change
- Representing issues our members identify
- Providing leadership on priority issues
- Creating a space for collaboration within the AOD sector
- Keeping our members and stakeholders informed about issues relevant to the sector
- Supporting evidence-based practice that maintains the dignity of those who use alcohol and other drugs and related services

---

VAADA acknowledges and celebrates people and their families and supporters who have a lived and living experience of alcohol, medication and other drug use. We value your courage, wisdom and experience, and recognise the important contribution that you make to the AOD sector in Victoria.

Contents

Executive Summary

The Victorian Alcohol and Drug Association (VAADA) welcome the opportunity to contribute to the Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide. As the peak body for alcohol and other drug (AOD) services in Victoria, VAADA holds a system-level view of how DFSV and substance use intersect, and how, in response to this, systems shape risk, safety and lethality over time. This submission examines suicide, overdose and homicide–suicide in the context of DFSV. It highlights how suicide risk is compounded and, at times, rendered invisible through structural responses that fail to recognise or interrupt these dynamics.

Contemporary evidence and practice experience demonstrate that suicidality rarely arises in isolation or solely from individual pathology. Rather, suicide risk most often emerges through sustained exposure to violence, constrained agency and system responses that do not enable safety at critical moments. Australian data indicate that a substantial proportion of suicide deaths occur in the absence of a diagnosed mental illness, while mental health distress and substance use frequently arise as responses to violence, trauma and deprivation rather than as primary causes of harm (AIHW, 2025). These findings underscore the importance of situating suicide risk within lived and relational contexts, alongside clinical identification.

Drawing on peer-reviewed research and practice-informed system evidence, including insights from VAADA's work coordinating the Specialist Family Violence Advisor (SFVA) Capacity Building Program in Victoria, this submission highlights how the convergence of DFSV, mental health experiences and substance use intersect and mutually reinforce risk pathways. It provides an evidence base on these risks, and offers a range of solutions for identifying DFSV-related suicide risk earlier, improving professional capability in responding to co-occurring factors, addressing service gaps and access barriers, and improving safety and accountability for women and groups disproportionately experiencing DFSV and suicide risk. Together, our recommendations are intended to support the efforts of the Standing Committee on Social Policy and Legal Affairs in its deliberations and final recommendations to the Parliament of Australia on how these systemic harms can be avoided.

Purpose, scope and framing of this submission

Since the Victorian Royal Commission into Family Violence, VAADA has held a central role in supporting the AOD sector to align with legislative and policy reforms requiring the identification, assessment and response to DFSV. This work recognises the AOD sector as a critical point of contact for people experiencing and using violence, and as a system uniquely positioned to identify intersecting and cumulative risk over time.

.This submission is informed by practice insights gathered through VAADA's ongoing work with the AOD sector, including workforce development, policy and systems reform, and sustained engagement with services responding to complex and intersecting risk across diverse community and clinical settings.

These insights are further strengthened through VAADA's role in supporting the statewide coordination of the Specialist Family Violence Advisor (SFVA) Capacity Building Program within AOD services, delivered in partnership with the Victorian Department of Health. SFVAs embedded across AOD services provide subject matter expertise, secondary consultation, workforce capability uplift and systems leadership to strengthen violence-informed practice and organisational alignment. Collectively, SFVAs have developed deep, practice-based expertise in recognising nuanced and intersectional risk, including how DFSV, substance use, mental health distress, housing insecurity, pregnancy and system responses interact to shape safety, escalation and lethality over time. This expertise has been critical in shaping the analysis presented.

VAADA's partnership in the Pregnancy and Homelessness Coalition, a cross-sector collaboration working to improve system responses for pregnant people and families experiencing homelessness, violence and intersecting disadvantage, has informed the submission's analysis of pregnancy, early parenting, housing insecurity and system-produced risk, particularly where substance use and DFSV intersect.

VAADA acknowledges and thanks the SFVA in the AOD workforce and the Pregnancy and Homeless Coalition for their contribution, leadership, and ongoing commitment to improving safety, accountability, and system responses for people who experience DFSV.

This submission responds to suicidality as systemic phenomena rather than expressions of individual pathology. It draws on peer-reviewed research, policy analysis, coronial material and practice-informed evidence across intersecting systems, including DFSV, mental health and wellbeing, AOD, housing, and perinatal services.

While the experiences of and the complexity of trauma from DSFV are noted, this analysis does not rely on trauma as an individualised response. Instead, it centres DFSV and system responses as considerations through which suicide risk can be impacted.

An intersectional feminist, trauma and violence informed, and substance-informed lens is applied throughout. Substance use is considered structurally embedded within experiences of DFSV.

Introduction

Suicide in the context of Domestic, Family and Sexual Violence (DFSV) cannot be understood as in isolation from substance use and mental health. Australian and international evidence shows that suicide risk most commonly emerges through the interaction of DFSV, substance use, distress and social disadvantage, rather than from any single factor alone[1,2,3,4]. Australian studies demonstrate a clear cumulative effect, with people exposed to repeated or multiple forms of DFSV significantly more likely to attempt suicide[5,6]. These patterns reflect compounding harm arising from violence and coercion, rather than individual pathology.

Substance use and mental health distress, like suicidality, often emerge as responses to DFSV[7]. They are predictive indicators of risk in the context of DFSV, and they frequently interact, each increasing the likelihood and severity of harm. While these experiences are closely connected in people's lives, they are typically treated as separate issues within policy, research, service systems and prevention frameworks. This separation means current prevention and response approaches do not always reflect how these factors combine in people's lives, particularly in communities experiencing elevated suicide rates, including regional and remote areas[3,6].

Victorian data show that many suicide deaths occur without a diagnosed mental illness, and that risk increases when substance use is present, particularly in the context of DFSV[8,9,10] . In the context of DFSV, this risk is often deliberately exploited as a tactic of control[11],[12].

Suicide is not only a possible outcome of harm but is frequently weaponised as a tactic of control. Threats of suicide, encouragement to self-harm, coerced

---

[1] Taylor, R., Page, A., Morrell, S., Carter, G., & Harrison, J. (2004). Socio-economic differentials in mental disorders and suicide attempts in Australia. *British Journal of Psychiatry*, *185*(DEC.), 486–493. https://doi.org/10.1192/bjp.185.6.486

[2]Australian Institute of Health and Welfare (AIHW). (2025). *AIHW Suicide and Self harm Monitoring*.

[3] Pirkis, J., Bantjes, J., Dandona, R., Knipe, D., Pitman, A., Robinson, J., Silverman, M., & Hawton, K. (2024). Addressing key risk factors for suicide at a societal level. In *The Lancet Public Health* (Vol. 9, Issue 10, pp. e816–e824). Elsevier Ltd. https://doi.org/10.1016/S2468-2667(24)00158-0

[4] Cutajar, M. C., Mullen, P. E., Ogloff, James. R. P., Thomas, Stuart. D., Wells, David. L., & Spataro, J. (2010). Suicide and fatal drug overdose in child sexual abuse victims: a historical cohort study. *The Medical Journal of Australia*, *192:4*.

[5] McLaughlin, J., O'Carroll, R., & O'Connor, R. (2012). Intimate partner abuse and suicidality: A systematic review. *Clinical Psychology Review*, *32*(8), 677–689.

[6] Gold, Katherine. J., Singh, V., Marcus, S. M., & Lancaster, C. (2012). Mental health, substance use and intimate partner problems among pregnant and postpartum suicide victims in the National Violent Death Reporting System. *General Hospital Psychiatry: Psychiatric–Medical Comorbidity*, *34*(2), 139–145.

[7] Australian Institute of Health and Welfare (AIHW). (2025). *Suicide among people receiving specialist homelessness services: A last year of life study*.

[8] Australian Institute of Health and Welfare (AIHW). (2023). *Family, Domestic and Sexual Violence*.

[9] World Health Organization. (2014). *Preventing Preventing suicide suicide Executive summary*.

[10] Guntuku, S. (2020). The Need for Shift in Approach to Suicide Prevention in Australia. *Open Journal of Social Sciences*, *08*(08), 150–157. https://doi.org/10.4236/jss.2020.88013

[11] Indu, P. V. , Remadevi, S. , Vidhukumar, K. P. , Shah Navas, P. M. , Anilkumar, T. V. , & Subha, N. (2020). Domestic Violence as a Risk Factor for Attempted Suicide in Married Women. *Journal of Interpersonal Violence*, *35*, 5753–5771.

[12] Bagnall, M. (2025). *Strengthening the Role of the Alcohol and Other Drug (AOD) Sector in Responding to Gendered Violence*.

overdose and the deliberate cultivation of fear and entrapment function to silence disclosure, enforce compliance, or punish resistance by people using DFSV**Error! Bookmark not defined.**. These tactics directly undermine autonomy and safety, yet remain largely invisible within suicide prevention frameworks, AOD responses and coronial systems that are not designed to identify coercive harm[8].

Suicide and overdose deaths in the context of DFSV are shaped by distress, fear and constrained choice, rather than a clear or singular intent to die[10,11]. However, investigative and support systems have not consistently adapted to recognise how DFSV and the exploitation of substance use interact, creating gaps in scrutiny and accountability for people using DFSV[10, 11]. Eliminating violence against women and children requires systems that are accountable by design, not by exception.

Homicide–suicide must also be understood within this continuum of harm. Australian domestic and family violence death review data show that substance use is commonly present in homicide–suicide cases, highlighting its role in escalating severity and lethality in the context of DFSV[13]. Homicide–suicide should therefore be understood not as an isolated event, but as part of the same pattern of harm that includes suicidality and overdose in the context of DFSV[14].

Overall, the evidence shows that suicidality most often arises in response to DFSV and social conditions, rather than mental illness alone, reinforcing the need for prevention and response systems that address DFSV and substance use together[2,3,11].

Response to Terms of Reference

TOR 1 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

1.1 Prevalence of Suicide in Australia, in the Context of DFSV

DFSV is a significant yet under-recognised contributor to suicidality[7]. In Victoria, approximately 700–800 people die by suicide each year, while overdose deaths now exceed road trauma fatalities and continue to rise[7,15]. Nationally, more than

[13] Australia's National Research Organisation for Women's Safety Limited (ANROWS) Australian Domestic and Family Violence Death Review Network Data Report, & Australia's National Research Organisation for Women's Safety. (2022). *Australian Domestic and Family Violence Death Review Network Data Report Intimate partner violence homicides 2010–2018* (second). www.anrows.org.au

[14] Hunter, E., & Milroy, H. (2006). Aboriginal and Torres Strait Islander suicide in context. In *Archives of Suicide Research* (Vol. 10, Issue 2, pp. 141–157). https://doi.org/10.1080/13811110600556889

[15] Coroners Court of Victoria. (2024). *Coroners Court 2023 Annual Suicide Data Report*. https://www.coronerscourt.vic.gov.au/sites/default/files/2024-02/Coroners%20Court%202023%20Annual%20Suicide%20Data%20Report%20-%20December%202023.pdf

3,000 people die by suicide annually, or around nine deaths per day[16]. These deaths cannot be understood in isolation from DFSV.

International evidence consistently identifies DFSV as a strong driver of suicide, suicidal ideation, suicide attempts and suicide deaths across diverse populations5,11, [17]. In this context, suicide risk is not random or individualised, but patterned, escalating where violence is sustained, credibility is eroded and safety is withdrawn.

Professionals within the AOD workforce consistently report that:

"people experiencing DFSV feel destabilised by controlling behaviour that reframes their use, fear, despair, or suicidality as their issue, rather than a result of their experience of DFSV"

Recognising people who use substances as an identifiable group at increased risk is essential to reducing DFSV related suicide. Evidence shows substantial overlap between DFSV, substance use, housing instability, mental health complexity and suicidality, particularly for people experiencing systemic inequity16, [18].

Substance use plays a dual role in suicide risk in the context of DFSV. It often functions as a survival response to trauma[19]. At the same time, it may be deliberately exploited within DFSV through pressure to use, unsafe or insecure use and the escalation of overdose risk.

Stigma within service and investigative systems compounds this harm. When substance use is present, suicidality and death are more likely to be misinterpreted as accidental or behaviour driven, rather than recognised as indicators of DFSV, controlling behaviour and punishment within a person's lived experience[19,20].

[16] Australian Institute of Health and Welfare (AIHW). (2025). *AIHW Suicide and Self harm Monitoring*.
[17] Iovine-Wong, P., Nichols-Hadeed, C., Stone, J., Gamble, S., Cross, W., Cerulli, C., & Levandowski, B. (2019). Intimate Partner Violence, Suicide, and Their Overlapping Risk in Women Veterans: A Review of the Literature. *Military Medicine*, *84*.
[18] Backhouse, C., & Toivonen, C. (2018). *National Risk Assessment Principles for domestic and family violence Companion resource*.
[19] Petty, J., & Biondo, S. (2022). *Victorian Suicide Prevention and Response Strategy*.
[20] Gezinski, L. B., Gonzalez-Pons, K. M., & Rogers, M. M. (2021). Substance Use as a Coping Mechanism for Survivors of Intimate Partner Violence: Implications for Safety and Service Accessibility. *Violence Against Women*, *27*(2), 108–123. https://doi.org/10.1177/1077801219882496

1.2 Populations at Heightened Risk

Among people accessing AOD treatment and engaging with mental health and wellbeing services, exposure to DFSV is common rather than exceptional[21]. Many present with long histories of DFSV, and for some, DFSV is ongoing at the point of service engagement.

In these contexts, suicide risk most often escalates during periods of acute instability. This includes housing loss, child protection involvement, escalation or withdrawal of controlling behaviour, physiological withdrawal and transitions into or out of treatment. Risk is not evenly distributed**.** Women and gender diverse people, First Nations Peoples, people who are pregnant or newly parenting and people experiencing housing insecurity are disproportionately exposed to surveillance, service exclusion and loss of credibility, particularly where DFSV co-occurs with substance use or poverty. In these settings, suicide risk reflects the cumulative impact of DFSV, stigma and constrained access to safety[21].

People who are Pregnant and Parenting Who Use Substances

People who are pregnant or early-parenting who use substances experience compounding and mutually reinforcing risks. These factors frequently trigger heightened surveillance and conditional support rather than protections that enhance safety. Research demonstrates significantly higher rates of intimate partner violence among pregnant and postpartum people who die by suicide[22,23].

Practice experience across the Pregnancy and Homelessness Coalition, a network of specialist services, researchers and professionals working at the intersection of pregnancy, housing insecurity, substance use and DFSV, indicates that pregnancy and early parenting often coincide with increased scrutiny, reduced autonomy and restricted access to housing and parenting supports[24]. Where substance use is known or suspected, responses frequently shift away from safety and towards monitoring and compliance.

Practitioners described cases where accommodation offers were withdrawn or made conditional on abstinence, increased reporting, or engagement with multiple services simultaneously. For some, the cumulative impact of surveillance, housing insecurity and fear of child removal intensified suicidal distress. Overdose and suicide attempts were reported during these periods, not

[21] Gezinski, Lindsay. B., O'Connor, J., & Voth Schrag, R. (2025). The Effect of Intimate Partner Violence on Psychological Distress and Suicidal Ideation: An Investigation of Protective Factors Among University Students in the USA. *Journal of Interpersonal Violence*.
[22] Murray, S., Theobald, J., Haylett, F., & Watson, J. (2020). *Not Pregnant Enough? Pregnancy and Homelessness*. https://www.rmit.edu.au/sgsc
[23] Theobald, J., Watson, J., Haylett, F., & Murray, S. (2023). Supporting Pregnant Women Experiencing Homelessness. *Australian Social Work*, *76*(1), 34–46.
[24] Watson, Juliet., Theobald, J., Haylett, F., Hooker, L., & Murray, S. (2024). *You're in the Right Spot. Responding to Pregnancy and Homelessness: Evaluation of the Cornelia Program*. https://doi.org/10.25439/rmt.27859674

in the context of individual pathology, but following repeated experiences of being disbelieved, restricted, or excluded while actively seeking safety.

AOD services report holding suicide risk for extended periods in the absence of shared care, reinforcing abandonment and deepening distress:

"People weigh the risks of speaking about DFSV, suicidality, or substance use against losing housing, being surveilled, or having their children removed."

Evidence demonstrates that while DFSV is a primary driver of suicide risk, it is the interaction between DFSV, substance use stigma and system response that determines whether distress escalates or is alleviated. These dynamics are reflected not only in heightened suicide risk, but in recurring patterns of suicide and non-fatal self-harm observed during periods of instability and system transition[22,25].

While the literature has paid limited attention to stigma as a driver of suicide risk, practice experience suggests it is central. People who use substances and experience DFSV frequently internalise messages that they are undeserving of care or responsible for their own harm. These narratives are reinforced by system responses that prioritise compliance over safety and treat substance use as a barrier to support rather than a signal of need.

1.3 Separation, Retaliation and Escalation of Risk

Practice-informed evidence indicates that suicide risk frequently escalates following separation from a person using DFSV, rather than diminishing. Leaving does not automatically produce safety. Where protection, housing and continuity of support are inadequate, fear intensifies after separation.

The following accounts are drawn from practitioner engagement with people experiencing DFSV in AOD treatment settings. They reflect common and recurring patterns observed across services:

"After finally deciding to leave, no services would support them. They felt unable to return and unable to move forward. In that moment, having access to their anti-depressants became a contingency plan for escape"

"After being refused accommodation, they slept somewhere unsafe. As hopelessness intensified, they resumed using and began to view overdose as a possible way out, particularly as services did not believe or respond to disclosures of DFSV"

Workers consistently describe the post separation period as a tipping point, where multiple stressors converge. Housing instability, threats to contact with children, escalation of violence, withdrawal of practical support and physiological withdrawal often occur simultaneously, leaving people with no margin for error:

[25] Theobald, J., Haylett, F., Watson, J., & Murray, S. (2025). Pregnancy, early motherhood and homelessness: affective injustice. *Journal of Gender Studies*, *34*(7), 1068–1083.

"The risk spikes when everything changes at once. Housing falls over, contact with kids is threatened, family violence escalates, and suddenly the person is being asked to cope without any margin for error"

System responses can also replicate dynamics of control, particularly when separation is enforced without sustained safety planning or shared decision making[25].

One professional described working with a parent engaged with multiple services whose partner, and the father of her child, was known across the system to be using family violence and substances. This assessment was not disputed:

"The client repeatedly stated that forced separation from her partner, without adequate and sustained alternative supports, would leave her unsafe and unable to parent alone. She explicitly identified suicide as a future way out if this occurred.

Despite these warnings, the system later required her to parent independently, removing shared decision-making and withdrawing relational and practical supports.

Following the loss of agency in decisions affecting her safety and parenting, and in the absence of the supports she had repeatedly sought, she died by suicide".

This case demonstrates how suicide risk can be produced by system response, particularly when fragmented risk frameworks override lived context, agency and safety in responses to DFSV and substance use. In these circumstances, separation becomes not a protective intervention, but a point of lethal escalation.

TOR2. 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

2.1 Suicide, Overdose and Misidentification in the Context of DFSV

Accurately determining cause and intent in deaths involving substance use presents well-recognised challenges within coronial and judicial systems. Where substances with lethal potential are involved, distinguishing between suicide, accidental overdose, and deaths occurring in contexts of DFSV requires careful consideration of clinical and systemic factors[8,13,15]. Coroners and investigators operate within legislative and evidentiary frameworks that rely on available documentation, witness accounts and observable indicators at the time of death.

Practice-informed evidence from AOD, DFSV and mental health and wellbeing sectors indicates that critical contextual information can be missed in post-death investigations, particularly where substance use is present[13,21]. In the context of DFSV, suicide and overdose should not be treated as separate events. Both often

arise through compounding patterns of harm, including entrapment, constrained choice, coercion and system responses shaped by stigma[5,26,27].

When overdose is framed as accidental and suicide as an individual mental health issue, the conditions that shape both outcomes can be obscured. This increases the risk of misidentification and limits opportunities for prevention, particularly where controlling behaviour, exploitation, or coercion are not recognised or documented[7].

2.1 Escalation of Suicide Risk Within Service Systems

Suicidality and overdose risk rarely appear as single or sudden events. Practice evidence shows that both often build over time, shaped by ongoing DFSV, limited control over safety, stigma attached to substance use and repeated experiences of unmet or conditional support[5,11].

Practitioners describe a gradual escalation, rather than an abrupt crisis. Each refusal, delay, or condition placed on help can increase distress, substance use and risk:

"It's not that people arrive suicidal. It's that after every experience, every door closing, every condition placed on help, something shifts. You can see the degradation of self, and the hope drains away."

In these circumstances, substance use often intensifies as a way to cope with fear, instability and loss of control. At the same time, overdose risk increases, particularly where use occurs in unsafe or constrained environments.

These cumulative pathways matter for how deaths are later understood. When suicidality and overdose risk escalate together and are shaped by system responses, they may not present as a clear or isolated suicide risk. This has direct implications for how this complexity is responded to, and how deaths are investigated, classified and recorded.

Where overdose deaths are not examined with the same depth as suspected suicides, particularly in contexts of known or suspected DFSV, patterns of harm and escalation can remain hidden[28,29].

2.2 Coercion to Overdose

Practice evidence shows that overdose risk can be deliberately constructed or escalated within DFSV. In these situations, substance use is not simply present but is actively manipulated and weaponised to increase danger and limit choice.

---

[26] Bagnall. Meg, & Clark, G. (2024). *Submission to the Legislative Assembly Legal and Social Issues Committee Inquiry into Capturing Data on Adults who use Domestic and Family Violence in Victoria*.
[27] Clark, G., & Bagnall, M. (2024). *Submission to Inquiry into Women's Pain*.
[28] Bohnert, Kipling. M., Ilgen, Mark. A., Louzon, S., McCarthy, John. F., & Katz, I. (2017). Substance use disorders and the risk of suicide mortality among men and women in the US Veterans Health Administration. *Addiction*, *112, 7*, 1193–0201. https://doi.org/10.1111/add.13774
[29] El-Bassel, N., Gilbert, L., Rajah, V., Foleno, A., & Frye, V. (2000). Fear and violence: Raising the HIV stakes. *AIDS Education and Prevention*, *12*(2), 154-170.

Professionals describe people being forced or pressured to use substances, often without control over what they are using, how much they are using, or the conditions in which use occurs. In these contexts, people experiencing violence may rely on harm-reduction strategies under extreme constraint to reduce the risk of death.

One professional shared the following account:

"He wouldn't teach her how to inject herself, and she never knew what he was putting in. So she always asked him go first, reducing the risk of a hot shot[30]"*

This decision was not reckless. It was a deliberate attempt to reduce overdose risk and preserve some agency where refusal would escalate violence. From a practice perspective, workers recognised that if death had occurred under these conditions, it would almost certainly have been recorded as a substance-related death, rather than recognised as DFSV-related harm[31].

This creates significant distress for the AOD workforce. Professionals describe knowing that coerced overdose, unsafe use environments and deliberate exposure to lethal risk can result in deaths being misidentified, rendering the violence that produced the risk effectively invisible[11,]20.

2.3 Child Protection System Responses and Escalation of Risk

In the context of DFSV, child protection involvement can mark a critical point where suicidality and overdose risk escalate, particularly for people who use substances. Practice evidence indicates that system responses intended to reduce risk can, in some circumstances, increase danger when they intensify surveillance, restrict autonomy, or remove access to safety[13]. This reflects deeply ingrained stigma, where substance use is routinely treated as a problem to control rather than a sign that someone may require support.

Practitioners consistently report suicide attempts and non-fatal self-harm following decisions to place children with the person using DFSV, or to increase contact despite known histories of violence. For many people experiencing DFSV, these decisions are not perceived as protective. Instead, they are experienced as confirmation that their children are unsafe and beyond their ability to protect, resulting in profound loss of safety, control and hope. In these contexts, people are often made to feel responsible for the harm they fear, particularly where substance use is treated as evidence of poor parenting or moral failure rather than as a response to DFSV.

Substance use plays a central role in how risk is assessed and interpreted in these situations. Practitioners describe cases where sustained efforts to reduce or

[30] A h*ot shot refers to the deliberate injection of lethal drug concoctions (usually fentanyl or analogues) with the intent to kill.* Canadian Paramedicine Research. (2025). Fentanyl-Driven "Hot Shot" Murders and Implications for Paramedic Practice.
[31] Nestadt, P. S., & Athey, A. (2022). Opioid agonist treatment for self-harm and suicide prevention. *The Lancet Psychiatry*, *9*(2), 100–101.

stabilise substance use are outweighed by ingrained stigma, while the perpetration of DFSV is deprioritised or insufficiently interrogated.

One practitioner described working with a parent who had completed residential rehabilitation and demonstrated sustained efforts toward safety and stability:

"Although her substance use reduced and she was working with AOD services, decisions continued to prioritise the person using DFSV as the safer parent. Suicidality escalated following each interaction with child protection, and led to multiple attempts".

Professionals understood these attempts as arising from system exhaustion. Repeated interactions reinforced the message that change would not result in safety or reunification, leading to loss of hope and escalating distress.

Across similar accounts, suicidality was understood as a response to fear, perceived irreversibility and the collapse of safety. Another professional reflected:

"After entering refuge, her children were taken and placed with the person using DFSV due to her substance use. She returned to him, because that is where her children were, but access to them was supervised by him. Despite completing multiple rehabilitation programs, reunification was repeatedly refused. Following each refusal, she attempted suicide.

Substance use is treated as evidence of risk or moral failing, while the perpetration of DFSV is deprioritised or insufficiently examined[32,33]. Responsibility for safety is shifted onto the person experiencing harm, while the person using DFSV is positioned as less risky. This misidentification directly escalates suicide risk.

2.4 Implications for Coronial Classification and Investigation

Deaths involving substance use are often difficult to classify. Where overdose occurs in the context of DFSV, coronial investigations must determine intent based on limited information available at the time of death, including toxicology, observable behaviour and witness accounts[15].

Practice evidence indicates that important context is frequently missing from these investigations. Where disclosures of DFSV, fear, coercion, or constrained agency are not documented, overdose deaths are more likely to be classified as accidental, even when systems may recognise ongoing patterns of violence or exploitation[28,29].

[32] Douglas, H., & Walsh, T. (2010). Mothers, domestic violence, and child protection: Toward collaboration and engagement. *Violence Against Women*, *16*(5), 537–542. https://doi.org/10.1177/1077801210366291
[33] Murray, Suellen., Theobald, Jacqui., & Watson, Juliet. (2018). *Pregnancy and homelessness : service responses*. Launch Housing.

This has consequences. When overdose deaths are not examined with the same depth as suspected suicides, patterns of control, coercion and escalation may remain invisible, limiting opportunities for learning and prevention.

This does not reflect a failure of coronial practice. Rather, it highlights the limits of existing legislative, evidentiary and data-sharing frameworks, which are not designed to consistently capture DFSV or forms of harm that fall outside traditional suicide indicators[9].

2.5 Data Visibility, Cross-Sector Knowledge and Prevention

The challenges described above are most acute where multiple systems intersect, including AOD treatment, housing instability, child protection involvement and judicial oversight. In these settings, people experiencing DFSV and substance use are often highly visible to services, yet poorly protected.

Information relevant to suicide and overdose risk is frequently held across multiple systems, but is not visibly connected, synthesised, authorised or considered for use in coronial investigation or national learning. As a result, patterns of escalation, coercion and system interaction are often missed.

As one practitioner described:

"Every time another service got involved, the stakes felt higher. Decisions were made quickly, and she felt like she was losing control over her own life at exactly the moment she needed stability."

The AOD sector holds a unique position within this landscape. AOD services often have sustained knowledge of substance use patterns, disclosures of DFSV, suicidality and controlling behaviour over time. SFVAs embedded within AOD services provide critical expertise in identifying DFSV, misidentification, and escalation of risk.

However, access to this expertise is inequitable across sectors. This limits the system's ability to consistently recognise DFSV-related risk where substance use and suicidality intersect and reduces opportunities for early intervention and prevention.

2.6 Legislative and System Opportunities

Strengthening investigative processes, data systems and national policy frameworks is essential to ensuring that every life lost in the context of DFSV is counted, examined and learned from. Risk does not escalate in isolation. It emerges where DFSV, substance use, distress and social conditions interact, particularly at points where control is tightened, and safety is reduced.

National frameworks already recognise these interactions and include actions across prevention, workforce capability and government coordination [8,9]. However, implementation remains uneven[34].

While suicide deaths linked to DFSV are routinely examined and captured in national datasets, **overdose deaths are not**. There is currently no consistent national approach to identifying, analysing, or reporting overdose deaths where DFSV is present, and no consolidated dataset that captures women's deaths linked to DFSV beyond homicide alone.

This gap has consequences. When overdose deaths linked to DFSV are not examined with the same rigour as suicide deaths, patterns of harm remain hidden, learning is lost, and prevention opportunities are missed. The exploitation of substance use and the role of constrained agency are rendered invisible, reinforcing inequities in whose deaths are scrutinised and whose are not.

Updating legislative and policy settings to ensure DFSV is consistently considered across both suicide and overdose deaths would strengthen investigations, improve data quality, and support shared learning across sectors. National approaches that count and examine all deaths linked to DFSV are essential to effective prevention.

TOR3. How legal and justice systems, DFSV specialist services, health, mental health and other services recognise and respond to suicide in the context of DFSV

3.1 Suicide, Distress and the Exploitation of Psychological Harm

Within DFSV, mental distress is not only a consequence of DFSV, but it is also frequently produced, sustained and exploited as part of the harm itself. Professionals working across AOD, mental health and wellbeing, and DFSV services describe people living for long periods under conditions of fear, surveillance, deprivation, isolation and uncertainty. Many live in states of ongoing hypervigilance, exhaustion and severely limited autonomy. Professionals often describe this as *living under constant threat* [5,13].

In this context, suicidality and overdose do not usually emerge from underlying mental illness alone. Instead, it often develops as a response to cumulative harm, prolonged entrapment and the gradual erosion of hope [7, 35].

Professionals report that suicide risk frequently escalates when controlling behaviour intensifies, or when contact, affection, or access to children is suddenly withdrawn by the person using DFSV. Risk can escalate further when systems replicate this withdrawal through exclusion, silence, or disengagement. Sudden loss of connection to children, family, services, or trusted professionals following

[34] Australian Government: National Suicide Prevention Office. (2025). *National Suicide Prevention Strategy 2025-2035*. www.mentalhealthcommission.gov.au/nspo/projects/national-suicide-prevention-strategy
[35] Canadian Paramedicine Research. (2025). *Fentanyl-Driven "Hot Shot" Murders and Implications for Paramedic Practice* .

disclosure, separation, or system intervention is repeatedly identified as a trigger for acute distress and suicidality.[5,36.]

Across Victoria, growing practice alignment authorised by legislation has strengthened understanding of how suicide and overdose intersect with DFSV, within the AOD sector. This work has supported more nuanced recognition of risk as shaped by violence, social conditions and system response, rather than framed as an isolated mental health presentation. Ongoing reform is needed to ensure this understanding is applied consistently, supported by shared accountability, cross-sector alignment and responses equipped to recognise and respond to compounded harm.

3.2 Suicide, Overdose and Substance Use as Tactics of DFSV

People use substances for many reasons, including relief, pleasure, connection, and to cope with distress linked to DFSV and other pressures[20,27]. In the context of DFSV, substance use can also be exploited as part of the harm. This can include pressure to use, forcing increased use, restricting access to safer use, and deliberately increasing overdose risk[12, 27].

Practice experience describes patterns where substance use, suicide risk, and overdose risk are used on purpose as tools of punishment, persuasion and control. In some cases, the person using DFSV escalates overdose risk in ways that make the harm more likely to be recorded as "accidental", rather than recognised as violence[28,29].

Professionals describe:

"instances where people using DFSV encourage unsafe substance use, force insecure injecting practices, or reinforce that overdose will be attributed to substance use rather than homicide"

"They were told their death would look like an overdose, and that no one cares enough to question it."

In these situations, overdose risk is not only a health issue, but it also becomes a control tactic and a way to hide accountability. Taken together, suicide risk and overdose risk need to be understood as part of how DFSV can be enacted, not only as individual outcomes.

3.3 System Responses That Escalate or Contain Risk

As previously detailed, system responses to suicide and overdose are often shaped by individual focused frameworks that miss DFSV and the way it restricts choice and safety. Where substance use is present, risk is more likely to be framed

[36] Munro, V. E., & Dangar, S. (2026). Strangulation, domestic abuse and suicide: Learning in and through domestic abuse–related death reviews in England and Wales. *International Review of Victimology*, *32*(1), 188–210. https://doi.org/10.1177/02697580251341915

as behavioural instability, which can reduce recognition of DFSV and narrow the response.

Professionals report that when a person discloses both DFSV and substance use, they are more likely to be refused crisis accommodation, assessed as "not suitable", or redirected back into unsafe environments. In these circumstances, suicide risk is not abstract; it can be a predictable outcome of being denied safety and support at the point of greatest danger[26].

Where services respond in ways that recognise substance use within a DFSV context, rather than as a reason for exclusion, suicide risk can be reduced through safety, dignity, stable housing options and practical support[27],[37]. This shows that system response can increase risk or reduce it.

It is well established that risk escalates during separation from a person using DFSV. Professionals also observe increased substance related harm, suicidal distress and overdose risk during post separation instability. Where substance use is known to services, credibility is more likely to be undermined and access to protection restricted, with survival strategies punished or problematised rather than understood20,21,22. When substance use is treated as "the problem", rather than a risk factor and a safety issue in the context of DFSV, systems can increase monitoring and reduce autonomy in ways that deepen distress and increase lethality.

The replication of power and control is not limited to interpersonal relationships.

Professionals describe instances where mandatory or compliance-driven system responses replicate dynamics of control, removal of agency and a disregard for expressed safety needs.

An example shared involved a parent engaged with multiple services whose partner, and the father of her child, was known to be using family violence and substances. Despite her clearly articulated concerns that abrupt separation without sustained support would leave her unsafe and unable to parent alone, decisions proceeded that stripped her of shared decision-making and relational support.

Following this loss of agency and support, she died by suicide.

In these situations, consequences fall heavily on the person experiencing harm, while the use of DFSV remains insufficiently addressed.

3.4 Overdose, Suicide and Misidentification Across Systems

Evidence indicates that both frequently arise through shared pathways of harm, including entrapment, limiting agency and systemic abandonment[5,11,14]. Where overdose is framed as accidental and suicide as individual pathology, the

[37] Gilbert, L., Stoicescu, C., Goddard-Eckrich, D., Dasgupta, A., Richer, A., Benjamin, S. N., Wu, E., & El-Bassel, N. (2022). Intervening on the Intersecting Issues of Intimate Partner Violence, Substance Use, and HIV: A Review of Social Intervention Group's (SIG) Syndemic-Focused Interventions for Women. *Sage*, *33*(2).

conditions driving both outcomes are obscured. This limits prevention, enables misidentification and reinforces responses that prioritise surveillance and behavioural control over safety, autonomy and accountability [12,13].

While legislative and system reform continue to evolve, the consequences are immediate. Professionals across the AOD and DFSV sectors report losing clients to preventable overdose, suicide and lethal DFSV in the interim. In this context, judicial and coronial processes play a critical role in shaping which deaths are made visible and, therefore, which deaths inform systems change and prevention.

Practitioners describe the distress this creates, particularly in cases involving unsafe or coerced substance use. Workers understand that substance-related deaths are less likely to progress to an inquest or deeper investigation. This produces a strong sense of perceived injustice, where practitioners feel that the deaths of people who use substances and experience DFSV are afforded less scrutiny, context and consequence:

"I lost a client a couple of years ago. I still think about what happened. I heard that he was there when the police arrived and told them that she swallowed those pills herself. I know she wouldn't have."

Professionals report knowing that critical context about DFSV, controlling behaviour, substance use exploitation, coercion, fear and constrained agency is unlikely to be examined once a death is classified as substance-related, reinforcing this perceived injustice and limiting opportunities for learning and prevention.

3.5 The Essential Role of Specialist Family Violence Advisors (SFVAs)

The SFVA Capacity Building Program demonstrates how integrated, violence-informed practice can strengthen system responses where DFSV, substance use, suicidality and mental health intersect. Embedded across AOD and mental health and wellbeing services, SFVAs provide expert secondary consultation, lead workforce capability uplift, and drive systems alignment and reform, enabling earlier and more accurate response to DFSV, misidentification, and escalating intersectional risk.

Practice experience indicates that where SFVAs are active, disclosures of DFSV, suicidality and substance use are more likely to be contextualised within lived experience and system conditions rather than treated as isolated mental health or behavioural issues. This supports earlier intervention, improved intersectional risk response and more coordinated responses across sectors[12,38].

Coronial findings repeatedly identify the fragmentation of risk across systems, the absence of integrated violence-informed analysis and the failure to connect substance use, mental distress and DFSV context in the period preceding death[38].

[38] Judge Liberty Sanger, S. C. (2026). *COR 2021 005393 Form 38 - Coronial Findings into Death of Michelle Margaret Darragh*.

In cases where Specialist Family Violence expertise is not embedded within service responses, these dynamics are more likely to be misinterpreted, managed in isolation, or escalated through system responses rather than mitigated.

TOR 4 The use of suicide and threats of suicide as a tactic of coercive control by people using DFSV

Consistent with earlier analysis of DFSV-related suicide, overdose and lethal escalation, suicide and overdose are closely related and overlapping outcomes where DFSV and substance use are present. Evidence demonstrates strong convergence between suicidality and substance-related harm, with many deaths involving substances occurring amid fear, distress and constrained agency rather than clear or singular intent to die[19,20]. Despite this, overdose is commonly classified as accidental, while suicide is framed as an individual mental health outcome, obscuring the controlling conditions that shape both.

Homicide–suicide represents an extreme escalation within this same continuum of harm. Australian death review findings indicate that homicide–suicide most commonly occurs within intimate partner or family relationships, following prolonged patterns of DFSV, separation, retaliation and system failure[13,14]. It is not an isolated or spontaneous event, but the culmination of DFSV and escalating control. Australian domestic and family violence death review processes consistently identify substance use as present in the vast majority of homicide–suicide incidents, with toxicology findings indicating alcohol and/or other drugs were involved in approximately four in five cases reviewed[13]. This demonstrates how substance use frequently layers onto entrenched patterns of DFSV, amplifying lethality while obscuring accountability28.

Homicide–suicide must therefore be understood as part of the same spectrum of harm as suicidality, overdose and non-fatal self-harm. It also sits alongside DFSV tactics that exploit suicidality, mental health and substance use. Threats of suicide, encouragement to self-harm, coercion to suicide and/or overdose and deliberate creation of despair are commonly reported as mechanisms of control before lethal outcomes[12,39]. Excluding homicide–suicide from suicide prevention analysis artificially separates outcomes that emerge from shared pathways of harm, escalation and system failure.

People who use DFSV also frequently threaten suicide, self-harm, overdose, or unsafe injecting practices as mechanisms of power and control. Practitioners report these threats being used to:

“induce fear, enforce compliance, silence disclosure, or punish attempts to leave or seek help.”

[39] Munro, V. E., Bettinson, V., & Burton, M. (2024). Coercion, Control and Criminal Responsibility: Exploring Professional Responses to Offending and Suicidality in the Context of Domestically Abusive Relationships. *Social and Legal Studies*, *33*(3), 392–419. https://doi.org/10.1177/09646639231198342

In some cases:

"suicide threats or self-harm are positioned as the responsibility of the person experiencing violence, and shifting accountability away from the use of violence itself."

"People using DFSV threaten suicide or overdose, using the threat of suicide to induce fear, guilt, or continued compliance. These are interpreted as distress, rather than coercive tactics to establish control."

These behaviours sit on the same continuum as later lethal outcomes and must be recognised as tactics of DFSV[12,39].

Taken together, these findings demonstrate that suicide, overdose and homicide–suicide are foreseeable outcomes of escalating DFSV where threats, coercion, substance use exploitation and system gaps converge. These harms do not arise without warning. Practitioners consistently describe clear escalation markers, repeated disclosures and missed opportunities for intervention. Whether harm is interrupted depends on how systems interpret these warning signs, and whether they are recognised as tactics of DFSV rather than individual pathology.

Illustrative Coronial Findings: System Failure and System Correction

A recent coronial finding from the Coroners Court of Victoria illustrates these dynamics with stark clarity.

In January 2026, the State Coroner released findings into the homicide of Michelle Darragh, a 32-year-old woman killed by her former partner following separation. The Coroner identified multiple missed opportunities for intervention, including the failure to complete a MARAM risk assessment. The Coroner's findings illustrate how risk can be systematically underestimated even in the presence of clear, escalating indicators. Eleven evidence-based risk factors were present but not identified, including pregnancy, recent separation, prior threats and the partner's known substance use and mental health concerns.

The Coroner noted that reliance on self-assessment and the absence of secondary consultation contributed to this underestimation of risk, despite escalating warning signs. The findings also document a history of suicidality and acute risk indicators in the period preceding the homicide, which were not adequately assessed or responded to within existing mental health and family violence frameworks.

Importantly, the Coroner also recorded that systemic change followed this death, including strengthened DFSV responses and the involvement of Specialist Family Violence Advisors, noting that under current practice a MARAM assessment would now be expected in similar circumstances[38]. This underscores both the preventability of harm and the critical role of the Specialist Family Violence Advisor Capability Building Program in identifying escalation before lethal outcomes occur[12,26].

TOR 5. Opportunities to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV victimisation and perpetration

Practice-informed evidence demonstrates that suicide, overdose and other lethal harms in the context of DFSV do not arise from isolated episodes of distress, nor are they confined to specific stages such as separation or service involvement. Rather, risk is produced and escalated through ongoing exposure to controlling behaviour, threat, deprivation, surveillance and retaliation and through system responses that fail to recognise or interrupt these dynamics.

Across AOD, mental health and wellbeing, DFSV, housing and child protection services, professionals consistently describe suicidality and overdose risk emerging cumulatively over time. As outlined in Sections 2.2 and 2.3, coercion to suicide or overdose, encouragement of self-harm, unsafe or forced substance use and threats of lethal harm may occur at any point across the DFSV continuum, including during cohabitation, separation, reunification attempts, child protection involvement, or periods with no formal system contact. These harms are shaped by limiting agency and sustained fear, rather than discrete clinical crises.

Periods of system interaction remain important escalation points, not because they initiate risk, but because they can amplify existing harm. Separation, housing loss, service exclusion, mandated service involvement and withdrawal or conditionality of support frequently coincide with ongoing DFSV from the person using violence (see Sections 2.4 and 3.5). Where substance use is present, these interactions are more likely to result in credibility discounting, exclusion from systemic risk reduction and punitive containment, further escalating suicide and overdose risk[13,32].

Evidence indicates that reducing substance use can meaningfully reduce the risk, frequency and severity of DFSV-related harm, even where violence has already occurred [12]. This is not because substance use causes DFSV, but because it frequently amplifies patterns of control, volatility and lethality. Where substance use is stabilised or reduced, practitioners consistently observe improved capacity for accountability, reduced escalation and greater opportunity to intervene before harm progresses to suicide, overdose, or homicide.

This creates a critical and time-sensitive prevention opportunity at the intersection of AOD and DFSV systems. Engaging people who use violence and substances during periods of escalation, rather than excluding them from services, enables systems to interrupt trajectories that would otherwise continue unchecked. In contrast, exclusionary responses often remove the very points of contact where risk can be identified, monitored and reduced.

Interventions that actively engage people who use DFSV and substances, therefore, represent a critical and underutilised prevention strategy. Programs such as Windana's U-TURN model demonstrate how integrated, behaviour

change responses delivered within AOD settings can directly address the interaction between substance use, coercive control and escalating violence. U-TURN does not treat substance use or violence in isolation. Instead, it explicitly recognises how substance use is embedded within patterns of DFSV, including controlling behaviour, coercive control, intimidation and threats of self-harm or suicide.

By combining substance use treatment, clear accountability for the use of violence and violence-informed practice, U-TURN intervenes at points where risk is actively escalating. This approach supports tangible reductions in harm and creates opportunities for earlier disruption of violence trajectories that would otherwise progress toward serious injury, suicide, overdose, or homicide. In doing so, it demonstrates the preventative potential of integrated AOD–DFSV responses that are currently absent from many parts of the service system.

TOR 6. Any other related matters

Systemic accountability for DFSV-related suicide is shaped by what systems can see, record and respond to. Across all systemic touchpoints, our systems are not consistently designed to identify and capture the harms associated with DFSV, and how these interrelate with points of lethality via suicide or overdose[7,9]. Where these elements are not visible in data and reporting, they are less likely to be recognised as prevention priorities.

Victoria's DFSV response provides an important exception (See TOR2.6), with legislated obligations across health and community services to identify and respond to DFSV. These systems themselves acknowledge that further work is required before the intersectional risk associated with suicide and overdose can be consistently identified, shared and acted upon across sectors. However, building upon the learnings from this initiative in the national landscape is essential to achieving change.

Pregnancy and early parenting expose particularly stark accountability gaps across DFSV, health, housing and child protection systems[38]. Despite clear evidence that pregnancy heightens the risk of intimate partner violence and suicide, there remains no consistent mechanism to ensure continuity of safe housing, violence-informed care and coordinated safety planning [25,40]. Where homelessness, mental distress, or substance use is present, responses frequently shift from protection to surveillance, prioritising risk management and compliance over safety, agency and prevention[33].

These dynamics result in an inequitable distribution of harm. Women and gender-diverse people, First Nations peoples, young people and those experiencing poverty, homelessness, pregnancy or early parenting and housing

[40] Walker, N., Mackean, T., Longbottom, M., Coombes, J., Bennett-Brook, K., Clapham, K., Ivers, R., Hackett, M., Redfern, J., & Cullen, P. (2021). Responses to the primary health care needs of Aboriginal and Torres Strait Islander women experiencing violence: A scoping review of policy and practice guidelines. *Health Promotion Journal of Australia*, *32*(S2), 40–53. https://doi.org/10.1002/hpja.417

insecurity are more likely to be subject to multiple intersecting systems that intensify monitoring without delivering safety[12,20,24]. Substance use stigma further shapes credibility and access to protection, reinforcing inequitable responses and deepening pathways to distress, suicidality and non-fatal self-harm[20].

Across systems, suicide and overdose in the context of DFSV are frequently foreseeable, yet they are rarely treated as preventable system failures. Risk is often identified, documented and discussed, particularly where substance use, mental distress, or prior DFSV disclosures are present. However, responsibility for outcomes frequently dissipates once harm occurs. Decisions to refuse or withdraw support, impose conditionality, or tolerate ongoing exposure to a person using DFSV are seldom examined as contributing factors, even where escalation was predictable.

This gap between foreseeability and accountability limits learning, obscures the role of system action or inaction, and constrains prevention. Where substance use is present, the gap widens further, with deaths more readily attributed to individual behaviour rather than recognised as the culmination of known risk, unmet safety needs and unaddressed DFSV. Addressing these systemic blind spots is essential to ensuring that DFSV-related suicide and overdose are treated not only as tragic outcomes, but as preventable harms requiring collective responsibility and reform.

Recommendations

1. **Expand Specialist Family Violence Advisor (SFVA) models nationally**
   Expand and embed Specialist Family Violence Advisor models across AOD and mental health and wellbeing services nationally to strengthen violence-informed practice, secondary consultation, system navigation and organisational accountability where suicide risk intersects with DFSV, substance use and mental health distress.
   Outcome: Earlier identification of DFSV-related suicide and overdose risk, reduced misidentification and stronger accountability across service systems.

2. **Prioritise the fourth Critical Enabler of the National Suicide Prevention Strategy: Capable and integrated workforces**
   Fund the AOD sector to produce and facilitate workforce development activities for housing, child protection and DFSV services on risk relevance of substance use, substance use and coercive control and the relationship between substance use, DFSV and suicidality
   Outcome: Improved workforce capability, reduced stigma-driven decision-making and more effective cross-sector prevention.

3. **Formally recognise DFSV as a primary driver of suicide and non-fatal self-harm**
   National suicide prevention frameworks must explicitly recognise Domestic,

Family and Sexual Violence as a primary driver of suicide risk, including suicide threats, encouragement to self-harm, coercion to suicide, coerced overdose and homicide–suicide.
Outcome: Suicide prevention approaches that address violence, power and control and substance use as intersectional risk considerations.

4. **Embed violence-informed suicide risk assessment across allied systems**
   Health, mental health, AOD, housing, child protection and judicial systems should be required to routinely identify and respond to DFSV within suicide and self-harm risk assessments, including where mental health distress or substance use is present.
   Outcome: Fewer missed escalation points and safer, more consistent responses to compounded risk.

5. **Invest in partnership initiatives to address substance use stigma and misidentification**
   Invest in partnership initiatives that enable capability uplift and attitudinal change related to substance use in the context of DFSV and management of risk related to substance use within DFSV services, System guidance and workforce frameworks must explicitly recognise substance use and mental health distress as both survival responses to violence and sites of exploitation within DFSV, reducing misidentification of people experiencing family violence and minimising the opportunities for them to be excluded from crisis accommodation and specialist responses within service systems.
   Outcome: Improved access to safety, reduced punitive responses and more equitable DFSV service provision.

6. **Invest in mechanisms that support shared care initiatives between mental health, family violence, housing and AOD systems to limit gaps in service provision post-separation.**
   Suicide prevention, family violence, housing and AOD systems must explicitly recognise post-separation periods as high-risk phases characterised by escalation and increased lethality, ensuring continuity of protection and support rather than withdrawal or de-escalation of service system responses.
   Outcome: Reduced suicide, overdose and homicide risk during one of the most lethal periods of DFSV.

7. **a) Enable national counting of DFSV-related overdose deaths**
   Fund and support targeted research to identify and define DFSV indicators in overdose deaths, aligned with existing national suicide data frameworks. This research should establish consistent criteria for identifying DFSV context, controlling behaviour, substance use exploitation and constraints on agency in overdose deaths, enabling overdose fatalities to be counted and analysed alongside suicide data at a national level.
   Outcome: Overdose deaths linked to DFSV are systematically identified, counted and reported, enabling national monitoring, trend analysis and prevention planning equivalent to suicide data.

b)Strengthen coronial and investigative responses to overdose deaths
Require coronial and investigative processes to explicitly examine DFSV context in all overdose deaths, including assessment of controlling behaviour, coercion, substance use exploitation and limitations on agency. This should align with existing Victorian approaches to suicide investigation, where DFSV context is routinely considered and extends equivalent scrutiny to overdose deaths.
Outcome: Reduced misclassification of overdose deaths, improved accountability across systems and stronger learning to inform prevention and early intervention responses.

8. **Create National legislation for information sharing and cross-sector data collaboration nationally, with an ability for cross-jurisdiction information sharing.**
   Invest in information-sharing mechanisms and cross-sector data collaboration so that risk-relevant information held across AOD, family violence, health, housing, child protection and judicial systems is connected, visible and usable for prevention, investigation and accountability.
   Outcome: Connected systems that can see, act on and prevent escalating risk.

9. **Invest in initiatives that are co-designed and delivered by ' at-risk' populations to address DFSV and suicide.**
   Women, gender diverse, First Nations, CALD, young people, homeless, people with substance use and mental health needs must be engaged to co-design appropriate preventative responses for their communities.
   Implement reforms to reduce stigma-driven surveillance, credibility discounting and punitive responses, particularly for women and gender diverse people, First Nations peoples, young people and those experiencing pregnancy, homelessness, substance use, or mental health distress and prioritise access to safety, stability and timely support.
   Outcome: Prevention initiatives that are culturally safe, trusted and effective in reducing DFSV-related suicide and harm.