

Policy submission

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

February 2026



Acknowledgments

About Neami National (Neami)

We're a values-based, national not-for-profit organisation and big believers in everyone having the opportunity to live a full life.

We support people to achieve the wellbeing and mental health outcomes that matter to them.

We provide services for mental health and wellbeing, housing and homelessness, and suicide prevention. Our team of over 1,100 people supports 34,000 people each year.

Acknowledgment of Country

We acknowledge Aboriginal and/or Torres Strait Islander peoples and communities as the Traditional Custodians of the land we work on and pay our respects to Elders past and present. We recognise that their sovereignty was never ceded.

A word on language

Throughout this submission, we use the term *mental health challenges* which is the preferred terminology for the majority of people with lived experience of mental ill-health surveyed by Neami.



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Executive summary

Neami welcomes the Inquiry into the relationship between domestic, family and sexual violence and suicide, and recognition of the need for greater national attention upon this critical issue. DFSV is a strong driver of distress and suicidality, yet this relationship is insufficiently understood and poorly addressed across service systems. Developing a methodology for accurate reporting, and improving our understanding of the relationship between DFSV and suicide more broadly, is vital.

The central contention of this submission is that, if we are to improve our understanding and reduce DFSV-related distress and suicide we must recognise the additional social determinants that often co-exist with and exacerbate this harm.

Neami staff's practice insights illustrate how conditions such as housing and financial insecurity, administrative harm from our social security system, inadequate policing responses, systems abuse by perpetrators, discrimination and social isolation compound DFSV-related harm. DFSV, suicide prevention and adjacent sectors are overstretched, fragmented, and inconsistently trauma-informed. DFSV and related services have not been well-equipped to recognise and appropriately respond to distress and suicidality.

Many victim-survivors experience repeated interactions with service systems that do not meet their needs over long periods of time, exacerbating distress. Systems can create barriers to safety and stability and may entail coercive and punitive practices that cause further trauma and deter victim-survivors from seeking help. Aboriginal and Torres Strait Islander people, LGBTIQ+SB individuals and culturally and linguistically diverse communities often encounter additional barriers to support and safety.

The requirements of various funding bodies do not support consistent data collection in relation to DFSV and suicidality, or the visibility of diversity, across Neami's programs. This is reflective of the Domestic, Family and Sexual Violence Commission's observation that Australian data is not sufficient to provide a comprehensive picture of DFSV-related distress and suicide across locations and cohorts.

Neami's practice experience underscores the need for a whole-of-government approach. Reformed structural and systemic conditions could have great potential to enable the safety, stability and agency necessary for victim-survivors to recover and rebuild their lives.

Summary of recommendations

Neami recommends that governments:

1. Adopt the Brotherhood of St Laurence's recommendations for urgent social security reform, including introducing equal access to income support for single and partnered adults, as one measure to combat the financial entrapment of victim-survivors.
2. Adopt ACOSS' recommendations around increasing income support payments and targets for social housing so that victim survivors can meet their basic needs and have the safety, security and stability necessary to rebuild their lives.
3. Explore the possibility of adjusting information sharing protocols between the Single Housing Register and social housing providers, to mitigate against 'cherry picking' practices, thereby improving access to stable housing for victim-survivors experiencing complex needs.

4. Address the significant service gap in longer-term, holistic and integrated support for victim-survivors experiencing multiple and complex needs, to overcome systemic barriers to safety and recovery. Ensure that provision is trauma informed, and has a strong focus on peer support, care coordination and advocacy.
5. Map service gaps of peer-led, drop-in safe spaces that provide alternatives to emergency departments for people in suicidal distress and expand provision accordingly. Ensure adequate provision of aftercare services, ideally co-located with safe spaces.
6. Promote and support in-reach initiatives such as health justice partnerships within safe spaces, as one measure to address fragmented service systems.
7. Amend commissioning practices within the mental health and suicide prevention sector to make five-year funding periods the norm, to promote workforce retention and development as per the Productivity Commission's recommendation.
8. Adopt the recent recommendations by the DFSV Commission about growing the DFSV workforce, and the Productivity Commission's recent recommendation to support the implementation of the National Suicide Prevention Workforce Strategy.
9. Ensure that specific mechanisms to expand and support the suicide prevention peer workforce are prioritised and explore how lived experience roles could be expanded within the DFSV sector.
10. Facilitate a comprehensive rollout of lived experience-informed suicide awareness response training for staff across the DFSV sector and about DFSV for the mental health and suicide prevention sector, to promote appropriate, skilled support. Consider how appropriate training could also be rolled out across adjacent sectors that interact with victim-survivors.
11. Acknowledge that DFSV-related distress in and of itself is a form of harm caused by DFSV. In developing improvements to the data landscape, consider indicators of rates of self-harm without suicidal intent, suicidal ideation and suicide attempts, in addition to deaths.
12. Design improvements to data collection that avoids inappropriate mandatory questions being asked of victim-survivors and additional administrative burden for staff. Consider ways to include experiences such as coercive control, emotional abuse, suicidal ideation and suicide attempts in data collection.
13. Develop improvements in data linkages to illustrate connections with social determinants and assist with monitoring the progress of whole-of-government approaches.
14. Fully fund the implementation of the National Suicide Prevention Strategy and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, to enable progress in reducing rates of suicidal distress.
15. Ensure that state and territory jurisdictional suicide prevention plans align with the national suicide prevention strategies in considering intersections with DFSV.
16. Amend legislation to establish both the National Suicide Prevention Office and the Domestic Family and Sexual Violence Commission as independent statutory bodies, and adequately resource them, to promote accountability through comprehensive, transparent reporting.
17. Embed cross-government coordination, robust governance, lived experience leadership and sector representation, as per the Productivity Commission's recommendations for the next iteration of the National Mental Health and Suicide Prevention Agreement.

Introduction

Neami welcomes the opportunity to provide a submission to the Inquiry into the relationship between domestic, family and sexual violence and suicide.

As the *Unlocking the Prevention Potential: Accelerating action to end domestic, family and sexual violence* report recently acknowledged, the relationship between domestic, family and sexual violence (DFSV) and suicide is a serious issue that warrants an urgent inquiry. The report explained that DFSV-related suicides are ‘not currently accounted for in conventional assessments of the ongoing national crisis’ of violence against women and children.¹ In her subsequent announcement of the current inquiry, the Standing Committee’s Chair stated that this data gap ‘may mean that the true death toll is much higher than previously thought.’² Developing a methodology for accurate reporting, and improving our understanding of the relationship between DFSV and suicide more broadly, is vital.

Victim-survivors experience a broad diversity of situations and needs. Contributors to DFSV-related distress and suicide are multiple, complex and compounding. Examining a wide range of structural conditions and systems and their interfaces is necessary. Neami also wishes to acknowledge the vital importance of having a strong policy focus upon perpetrators, such as with regards to accountability and behaviour change. Our submission, however, focuses predominantly on the aspects of most relevance to Neami’s experience as a provider of suicide prevention, mental health, and housing support to victim-survivors.

This submission has benefited from the direct involvement of staff from the following Neami programs:

- The [Safe and Secure Housing Program](#) (SSHP) in Adelaide, which supports women and their dependents who have been displaced by DFSV to secure safe and sustainable housing, and to address longer term barriers to safety and wellbeing. Around 30–40% of referrals to the program are for First Nations women, and 20% for women identifying as culturally and linguistically diverse.
- [The Way Back](#) program in Sydney, an aftercare service providing non-clinical care and practical support through an assertive model of care, for a period of up to three months.
- The [Urgent Mental Health Care Centre](#) (UMHCC) in Adelaide and the [Strathpine Safe Space](#) in Brisbane are drop-in services that provide alternatives to emergency department presentation for people experiencing distress. The UMHCC is open 24/7, 365 days a year, and has a 50/50 ratio of lived experience staff to clinical staff. The Safe Space is peer-led, facilitates access to a clinician where needed, and is open in the evenings when many other services are closed. Suicidal ideation is the most common reason people access these services.

The strong relationship between DFSV and distress and suicide

The Domestic, Family and Sexual Violence Commission (the Commission) describes ‘mental health and suicide deaths among people impacted by DFSV’ as ‘hidden impacts’. The Commission outlines Australian research findings, such as:

- ‘In 2019 intimate partner violence was the second highest contributor to years of healthy life lost due to suicide and self-inflicted injuries among women.’
- ‘In 24.5% of suicides recorded between 2009–2016 [in Victoria], there was evidence that the deceased had experienced family violence.’
- ‘Male survivors [of child sexual abuse] experience suicidality at 10 times the rate of community samples.’³

Extensive international research, including multiple meta-analyses and systematic reviews, demonstrates the strong link between family, domestic and sexual violence and suicide.⁴

It is important to highlight that Aboriginal women experience far higher rates of family violence than non-Aboriginal women.⁵ Further, suicide rates are almost three times higher among Aboriginal and Torres Strait Islander people than among the wider population.⁶

Research suggests that 76% of queer and gender-diverse Australians have experienced sexual victimisation, with trans men, trans women, and non-binary people heavily represented.⁷ Further, although domestic violence is experienced by trans and gender-diverse people at higher rates than cisgender heterosexual women, this can be ‘invisible’ in the national conversation about DFSV.⁸ Rates of attempted suicide are fifteen times higher among transgender people (aged 14–25) than in the general population.⁹

We also wish to acknowledge that men can experience family violence, and that ‘the highest risks to men and boys (including homicide)’ are from family members such as ‘parents, siblings, their adolescent or adult children’, rather than female partners. However, men are less likely to disclose and seek support for family violence.¹⁰

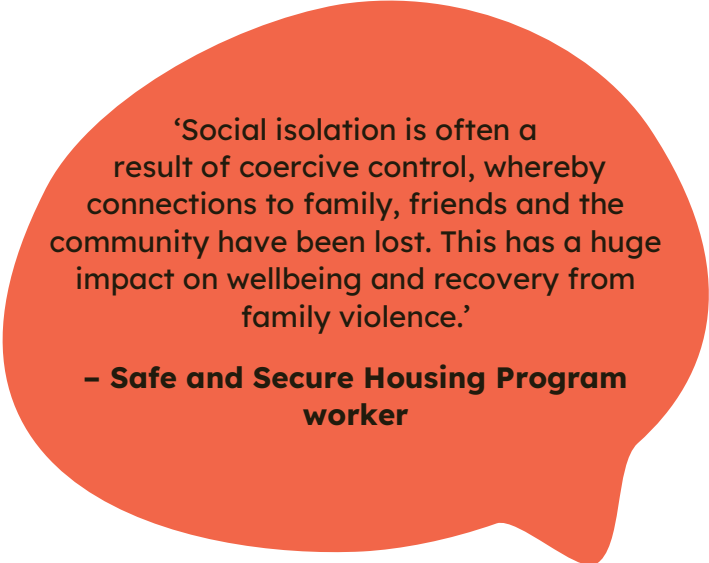
Neami’s programs illustrate the association between DFSV and suicidal crisis. For example:

- Family violence is ‘a common trigger for help seeking’ among women who present to Neami’s Urgent Mental Health Care Centre (UMHCC), and who progress to Aftercare (a program providing support following a suicidal crisis). In 2022 for example, 72% of Aftercare consumers were experiencing family violence, which included coercive control such as monitored communications and bank accounts.¹¹
- Family violence is a common contributor to suicidal distress among consumers within The Way Back aftercare service.
- the Safe and Secure Housing Program (SSHP) for women and their dependents who have been displaced by DFSV, often supports consumers experiencing chronic suicidality. SSHP consumers experience trauma from what has usually been prolonged and repeated exposure to DFSV, which is also often layered with childhood trauma.

Consideration of gender is integral to understanding distress and suicide in Australia. Although females are less likely to die by suicide than males, they experience higher rates of suicidal

ideation and attempts. This is referred to as 'the gender paradox'. In 2023–24 for example, 64% of hospitalisations for intentional self-harm in Australia were among females,¹² yet in 2024, 76.5% of people who died by suicide in Australia were male.¹³ Australian data also suggests that females have a higher lifetime prevalence of suicidal thoughts and behaviours (18.3%) than males (15%).¹⁴

Powerful stigma and shame around DFSV as well as suicidal ideation can exacerbate suicide risk by discouraging disclosure and delaying or preventing access to support. SSHP staff report that these forms of stigma and shame can be particularly strong within culturally and linguistically diverse communities. Many consumers have lost all connection with their cultural community. Particularly for consumers who do not speak English, this situation has created profound social isolation.



'Social isolation is often a result of coercive control, whereby connections to family, friends and the community have been lost. This has a huge impact on wellbeing and recovery from family violence.'

**– Safe and Secure Housing Program
worker**

The effects of DFSV are compounded by additional structural and systemic contributors to distress and suicide

Social determinants of distress and suicide are often multiple and compounding. In addition to DFSV, extensive international evidence demonstrates that housing precarity, financial insecurity and discrimination are also strong contributors to suicidal distress.¹⁵ **In Australia, structural and socio-cultural conditions such as the housing crisis, administrative harm caused by the social security system, stigma, discrimination and social isolation are severely detrimental to the safety and wellbeing of many victim-survivors of DFSV.** Suicide prevention, DFSV services and adjacent health and social services are overstretched and often inaccessible.

Various forms of coercive or punitive practice can be experienced across many of these systems and services. As Australia's Domestic, Family and Sexual Violence Commissioner recently explained, '[t]oo many of our institutions – from hospitals to police stations to aged care facilities – operate from mindsets that replicate the very power dynamics that enable violence.'¹⁶

Housing and financial insecurity

The *Poverty in Australia 2025* report found that more than one in seven people currently live in poverty, which has been growing in recent years due to 'the removal of COVID income supports and large increases in rents.'¹⁷

Neami has seen a continuing increase in the number of consumers experiencing significant financial hardship.

Extensive evidence documents serious and ongoing risks of administrative harms caused by Australia's income support system.¹⁸ This includes the unintended consequences of Centrelink's 'couple rule', whereby individuals in relationships receive lower rates of income support than singles, or one partner receives no income support at all. A recent report explains how couples being considered 'a single economic unit' exposes 'women to economic abuse and traps women in violent and abusive relationships', such as where an abusive partner prevents them from accessing or jointly controlling finances.¹⁹ Further, Neami staff report that Centrelink can have a poor understanding of family violence.

'Suicidal crises relating to financial hardship and housing instability continue to rise – these issues appear to be more entrenched, and often dominate the support focus, making it difficult to prioritise emotional and psychological support.'

– The Way Back worker

Changes to the Leaving Violence Payment appear to have increased the risk of harm. SSHP staff explain that 'the LVF payment was much easier to access, but now it's very, very hard – it will only be paid for intimate family violence, rather than family violence more broadly, and so much evidence is needed. Also, women are on hold for a long time, and the application process is complex – if you don't speak English or if not able to read or write, it's out of the question. Caseworkers [who administer the LVP] often don't turn up for appointments.'

Further, domestic and family violence is ‘the homelessness driver that has increased most in the last two years; up 13% between June 2023 and June 2025.’ Domestic and family violence is the leading cause of homelessness. In the month of June 2025 alone, it led to 35,000 people across Australia needing to seek the assistance of a homelessness service.²⁰

The strong links between DFSV, housing precarity and suicidal distress are reflected within Neami’s services. For example, around three quarters of Aftercare consumers are experiencing family violence, and about half of consumers are experiencing, or at risk of, homelessness.²¹ The experience of SSHP is also illustrative. Staff have witnessed housing pathways shrink and financial stress increase in recent years.

For many victim-survivors who have left or are attempting to leave a violent relationship, the effects of Australia’s housing crisis, and more specifically, the severe lack of affordable rental housing, are often exacerbated by one or more of the following:

- ‘ongoing or escalating financial abuse’.²² Neami staff find that ‘financial abuse can lead to significant and life changing financial challenges – this often results in returning to the perpetrator, increasing risk’
- a single income, the gender income divide, and unequal expenses involved in leaving an abusive relationship (including costs associated with caring for dependents, temporary accommodation, etc.)
- not being in paid employment at the time of escaping family violence. This can include women being unable to maintain their job in the process of leaving violence or having to move beyond commuting distance. Fifty per cent of women escaping family violence must rely on social security as their main income source²³
- family violence having created a poor rental history such as through a lease being broken, property being damaged, and/or police attending. Women may be ‘blacklisted’ on the private rental market for a three-year period
- discrimination in the private rental market, particularly towards First Nations women, women from multicultural backgrounds, and new migrants and refugees.²⁴

‘We have people still in transitional accommodation after four years – there’s nowhere affordable to move on to. At some point, they’ll have to relocate, but they don’t know when or where. They already needed to move far away from the perpetrator. There’s too much uncertainty. How do you find a new job, make new connections, your kids get used to a new school – when you don’t know when you’ll lose all that again.’

– Safe and Secure Housing Program worker

The private housing market is often inaccessible for victim-survivors. Private rental subsidies for victim-survivors appear to “offer little benefit in improving affordability”, may “encourage higher asking rents from landlords” and are “time limited”.²⁵

Long waitlists and other barriers to social housing can mean that stable tenure is out of reach for many months or years. Victim-survivors are a priority population for social housing²⁶ yet are often at risk of having their application category downgraded. For example, their category can be downgraded when they enter short-term accommodation. Women escaping perpetrators who use stalking and intimidation may also move frequently for their safety and can have

difficulty continually updating their address to keep their application current. Those with a large family experience the additional barrier of social housing stock with sufficient bedrooms being scarce.

SSHP staff explain that some community housing providers (CHPs) as well as public housing offices ‘cherry pick’ tenants, creating a further barrier to stable housing for victim-survivors ‘who have too many barriers or complex needs.’ CHPs can have ‘a huge amount of personal information’ about applicants, which is taken from the Single Housing Register, whereby ‘engagement with multiple agencies is mapped in their file.’

‘Women are churned through the DV system quickly. But they often have to stay living with the perpetrator because there isn’t alternative housing. They feel trapped.’

– Safe and Secure Housing Program worker

Women must often choose between unsafe and insecure accommodation (such as emergency accommodation, boarding houses or caravans) or other forms of homelessness, or returning to the perpetrator.²⁷ Neami’s The Way Back aftercare service has noticed that ‘changes to Temporary Accommodation have made an already difficult system more restrictive and less accessible.’

The considerable complexity, time and stress involved in attempting to access stable housing, often unsuccessfully over a long period of time, can prolong and exacerbate the trauma of DFSV. Neami staff ‘see the distress and suicidality present in many families’ experiencing housing insecurity with ‘no end in sight’. In addition to ‘long wait times for safe and affordable housing’, staff observe that ‘overcrowding and unsafe temporary accommodation exacerbate trauma and stress.’ The Way Back reports that the ‘complexity and emotional toll’ of attempting to navigate the housing system has led to some consumers experiencing a recurrence of severe distress, whereby a number ‘disengaged entirely from seeking housing.’ This has particularly affected consumers with cognitive impairments and acute mental health concerns.

‘The lack of affordable housing means we see people losing hope about the future.’

– Safe and Secure Housing Program worker

Police engagement and lack of legal protection

Experiences among Neami consumers align with research findings that police can misidentify victim-survivors as the perpetrator and/or minimise the situation.²⁸ Many of the consumers the SSHP supports have been misidentified when police attended, including where the phone call to emergency services was made by the consumer. In one instance, a consumer who was physically attacked by her partner ‘got locked up instead of him’ because he was injured through the consumer trying to defend herself. Misidentification as the primary aggressor can have a significant impact upon a victim-survivor’s self-worth and mental health, as well as fostering mistrust of police and legal systems that can deter them from seeking help in future.

SSHP staff often find that police do not take threats to consumers seriously and can disbelieve them. For example, ‘the perpetrator might be waiting outside the house in the car and looking through the windows, and the police can say ‘well he hasn’t actually done anything so we can’t do anything.’ When staff have encouraged victim-survivors to call the police, some have explained they already tried but were disbelieved and not given a report number. Victim-survivors who ‘don’t have a report number can’t access temporary [DFSV crisis] accommodation.’

The women and children that SSHP support very often continue to be unsafe after they have left the perpetrator, including due to ‘an inconsistent response by police to breaches’ [of intervention orders (IVOs)] and ongoing coercive control. IVOs most often do not lead to safety for SSHP consumers: ‘it’s just a piece of paper, making a police report just aggravates offenders and makes it worse, it’s a cycle.’ The UMHCC also finds that ‘people [experiencing DFSV] are very nervous to go to the police.’ Stalking, threats and IVO breaches have ‘led to hypervigilance and a sense of hopelessness’ among victim-survivors that Neami supports.

Evidence demonstrates that the lack of police protection is particularly severe for Aboriginal women.²⁹ For example, a recent inquiry into the Queensland police service found a “culture where attitudes of misogyny, sexism and racism are allowed to be expressed, at times acted upon, largely unchecked” and that this impacts directly on the response of police to victim-survivors.³⁰

Child protection and the family law system

As the Domestic, Family and Sexual Violence Commission recently noted, the ‘family law system remains one of the clearest examples of how laws, policies and processes can be turned into tools of abuse’, such as through ‘[r]epeated applications, misuse of parenting orders, and delays in court proceedings’, which place ‘additional strain on individuals already experiencing violence and separation.’³¹

Neami’s Safe and Secure Housing Program (SSHP) often sees children used as ‘pawns’ by perpetrators, such as by threatening to withhold contact. If children are not currently attending school amongst the upheaval of moving and uncertainty about where they will live long-term, mothers can worry about a report being made to child protection. Many victim-survivors receiving support from SSHP have developed ‘survival adaptations – they have used substances to cope – but that is then used against them in family court, even if they are no longer using them.’ UMHCC staff explain that for women who have lost custody, ‘losing their identity as a mother is a huge risk factor [for suicidality]’.

‘Women experiencing suicidal ideation can be scared to tell anyone in case their kids are taken from them. They have lost trust in the system.’

– Safe and Secure Housing Program worker

The intersections between the family court system and the social housing system can prevent reunification for victim-survivors with their children, causing severe distress. In the experience of the SSHP for example, the family court may decide that children cannot return to live with their mother if she is living in temporary accommodation, as this is a form of unstable housing. If their children are no longer on the mother’s income statement, she may be unable to apply for social housing with more than one bedroom. Further, women who commence paid employment may have their category 1 social housing application downgraded, due to their

income being just above the threshold. As SSHP explains, women in this particular situation ‘might be able to just afford a one-bedroom unit [on the private market], but that would mean she would not gain custody of her children as there wouldn’t be room for them. These kinds of situations are a huge gap for women working towards reunification.’

It is common for victim-survivors within the SSHP who are going through the family court system to be afraid to disclose suicidal ideation to anyone, fearing they will lose their children. Staff explain: ‘we need to do a lot of work to build trust and address that level of fear about repercussions of disclosure. We need to reassure them that we won’t make a report to child protection if they seek mental health treatment.’

Reflecting the financial disparity that often exists, SSHP staff have seen instances of perpetrators but not victim-survivors being able to afford a private lawyer to represent them in court.

Suicide prevention, DFSV and adjacent services are significantly overstretched or inaccessible, and some can entail coercive or punitive practices

DFSV services primarily focus on short-term interventions aimed at immediate safety. Although these short-term services may assist with urgent needs, such as housing applications, safety planning, and legal support, they are often constrained by program guidelines and high demand. For example, the SSHP reports that ‘DV services often do not provide support if you have housing post separation.’

It is greatly concerning that ‘while Aboriginal women are at an elevated risk of violence and homicide, culturally safe family and domestic violence services are critically underfunded or non-existent.’³² Evidence shows that Aboriginal and Torres Strait Islander women are often reluctant to seek support from DFSV services and have significant concerns regarding child custody, particularly given Australia’s historical child removal policies as well as disproportionately high rates of removal currently.

‘There’s not a lot of early intervention. Some people have ideation but not intent for a long time. If there is nobody to help and they feel trapped, they can start to think of a way of dying.’

– Urgent Mental Health Care Centre worker

Further, the SSHP explains that ‘a lot of First Nations women are pigeonholed – the DV service arranges for them to be in a First Nations shelter, however sometimes they feel more unsafe in the shelter due to lack of anonymity, and would have preferred to be in a non-First Nations-specific shelter.’

LGBTIQ+ Health Australia (LHA) explain that a ‘lack of core funding and strategic action for LGBTIQ+SB DFSV services and programs has led to persistent gaps’ in prevention and inclusive, accessible service provision.³³

The complex interplay of experiences such as trauma, housing and financial precarity, systems abuse by perpetrators, discrimination and/or lack of supportive informal networks faced by many victim-survivors cannot be resolved within the limited engagement typical of DFSV programs. A critical gap is left for victim-survivors who require extended, holistic

support. Without long-term support, women risk returning to crisis situations, especially women experiencing severe mental health challenges or housing instability. This systemic gap also strains DFSV workers, who often experience burnout when unable to provide adequate ongoing care.

The recent Productivity Commission review of the National Mental Health and Suicide Prevention Agreement found that reforms thus far have not meaningfully addressed the significant gaps, shortages and fragmentation across the system. More specifically, findings included that support during suicide crisis is insufficient, that aftercare 'is sometimes only available to those who have presented to a hospital emergency department', and that '[m]any people attending emergency departments following suicide attempts do not receive any ongoing support.'³⁴

'Trying to progress through these different systems can be like being trapped in a big web. We have seen many women have to return to the perpetrator because of system barriers. Systems can cause harm.'

- Safe and Secure Housing Program worker

The experiences of Neami's programs strongly reflect the findings of the Productivity Commission review. For example, the Safe and Secure Housing Program (SSHP) in Adelaide reports:

- mental health deterioration in the absence of mental health service provision, 'we often see families presenting with depression, anxiety, PTSD symptoms but have no formal diagnosis due to historical lack of supports'
- 'you're either on a waitlist to see a psychologist for a long time and you can't afford it - or you're in crisis and you need to seek help immediately. There's a gap, particularly given many women experience suicidal ideation long-term. Services usually only act if a woman has a plan to suicide.'

Many victim-survivors accessing SSHP had ended up being 'part of the system for many years' due to going through 'referral after referral', 'telling their story over and over again,' without their needs being met.

The Way Back aftercare service in Sydney reports:

- An increase in consumers presenting with long-standing and complex mental health concerns, and multiple intersecting issues such as trauma, substance use, financial hardship and housing insecurity. In part, this likely reflects the lack of capacity and early intervention, as well as siloing, within mental health and adjacent systems.
- Access to longer-term or specialised services, including psychosocial support services for people with severe and enduring mental health challenges, is delayed by excessive waitlists or unaffordable costs.
- Access to affordable, long-term psychotherapy to address trauma, such as DBT, EMDR, or ongoing clinical psychology, is largely unavailable without out-of-pocket payment, which is often unaffordable.
- The limited duration of episodes of care within The Way Back means that addressing urgent needs (i.e. Centrelink, NDIS, housing) while also managing suicidal crises is a significant challenge.
- An increase in consumers reporting negative experiences when presenting to hospital with suicidal ideation, including due to long emergency department wait times and premature

discharges leading to inadequate care. This can lead to reduced willingness to re-present to hospital when needed.

- TIS (Translating and Interpreting Service) has proven unreliable at times, with last-minute cancellations or unavailability.
- Transgender consumers facing compounding barriers related to discrimination, lack of affirming and inclusive services, and social isolation.
- Recent changes to the NDIS have resulted in some consumers losing funding despite increasing needs. Delayed reviews, poor coordination of NDIS support and absent support coordinators have left some consumers with NDIS funding unsupported.
- A lack of community-based interest or activity groups across the lifespan to address loneliness, which are inclusive but do not require a clinical diagnosis to participate.

Narrow scope within, and lack of coordination between, services and systems

As the Domestic, Family and Sexual Violence Commission explains: ‘When child protection, family law, health services and justice systems operate separately, people fall through gaps that are too often exploited to cause harm. The segregation and siloing that characterises too many of our responses enables violence against the most vulnerable.’³⁵

Neami staff report:

- a lack of knowledge and skill about DSFV within the mental health and suicide prevention sector, and vice versa:
 - ‘the DV sector isn’t skilled in responding to suicidal ideation, particularly long-term passive suicidality. Many women experience suicidal ideation for years. DV services will act on suicidal ideation if it’s very active, however are really unequipped to deal with mental health in general’
 - ‘MH and DV experiences are seen as separate – you either have the mental health experience or the DV experience – that’s quite a big gap’
- challenges in coordinating with external services due to limited or unclear communication pathways. This delays referrals and reduces the effectiveness of collaborative care
- service gaps and narrow eligibility. Referral pathways are frequently limited for consumers requiring extended support, with many services unable to accept individuals experiencing suicidality or complex psychosocial needs. There are particularly large gaps in specialised support for those with co-occurring challenges, such as substance use and housing instability, for those who require case management and coordinated, multidisciplinary care, as well as youth-specific services. Some providers have exited consumers without warm referrals, particularly when suicidality remains elevated, resulting in repeated crisis presentations and reliance on emergency services and acute care teams.

Service responses can undermine agency and may create further trauma

Service responses to suicidal distress across mental health, DFSV and related sectors can insufficiently recognise and support a person's agency. Persuasion or referral to emergency services may occur without proportional consideration of the person's wishes, context, or capacity to participate in decision-making. For victim-survivors, these responses can be distressing, stigmatising, undermine feelings of safety, and further erode their sense of agency. Such practices are often driven by a lack of training in agency-affirming approaches to distress, alongside organisational and workforce concerns about legal and professional liability.

Treatment in emergency departments and mental health services may exacerbate distress for victim survivors. Research demonstrates that approaches to care that are not patient-centred and trauma informed can lead to victim survivors feeling 'disrespected, dismissed, silenced, and more afraid.' Particularly where coercive or restrictive practices in inpatient settings are used, replicating abusive power dynamics, victim-survivors can be retraumatized.³⁶

Furthermore, SSHP staff explain that some family violence services place certain requirements upon women, and that women may be exited if they are unable to meet them. This can function like a form of 'mutual obligations.' For example, women in emergency accommodation may be required to apply for a certain number of rental properties each month.



'... women can internalise it- they can think that being overwhelmed trying to navigate all these different services is a reflection on them.'

- Safe and Securing Housing Program worker

An insufficient data landscape

Although the Australian evidence thus far is indicative of the gravity and urgency of the issue, it is not sufficient to provide a comprehensive picture of DFSV-related distress and suicide across locations and cohorts. The Domestic, Family and Sexual Violence Commission (the Commission) have identified problems such as: underrepresentation of populations including ‘Aboriginal and Torres Strait Islander peoples, children, people with disability, LGBTIQ+SB communities, migrant and refugee groups, and those living in rural or remote areas’, limited longitudinal evidence on the offending of perpetrators, ‘an over reliance on 4-year national surveys’, and data that is ‘often unable to be compared or linked across jurisdictions and sectors.’ The Commission explains that it is therefore not possible to accurately monitor progress under the *National Plan to End Violence Against Women and Children 2022–2032*.³⁷

The requirements of various funding bodies do not support consistent data collection in relation to DFSV and suicidality across Neami’s programs. For example:

- The Minimum Data Set (MDS) for Neami’s Commonwealth funded programs does not include DFSV. While income status and risk of homelessness is captured, how that might relate to family violence is not reflected. It also does not delineate between sex at birth, gender and sexual orientation, nor refugee and migrant status, so these groups are invisible in this data set.
- Neami’s Universal Aftercare programs have a data set additional to the MDS that includes identification of culturally and linguistically diverse background and LGBTIQ+SB identity. These programs also collect data on where ‘referrals out’ are sent to. Referrals are often sent out to DFSV services. Neami also collects data on ‘protective factors’ and ‘precipitating factors’ for a suicidal event. DFSV is one of the ‘precipitating factors’ that can be selected. Neami initiated this additional data collection due to the importance of capturing this information.
- Neami’s Urgent Mental Health Care Centre (UMHCC) is required to collect data about ‘presenting issues’ that guests disclose when first arriving at the centre, however not on issues that may be shared later during their visit. While some guests experiencing DFSV inform staff upon arrival, others do not until later in the visit, and some may not feel able to disclose at all.

It is important to note that data collection requirements can be a barrier to access. Some people avoid attending a mental health or suicide prevention service when in crisis as they may not feel safe disclosing certain information.

Pathways to safety and security: detailed recommendations

As the Domestic, Family and Sexual Violence Commission explains, improving our understanding of the relationship between suicidality and DFSV is critical to addressing the harm caused by DFSV.³⁸ **To understand this relationship, we must recognise the additional structural and systemic determinants of suicidal distress that often co-exist with and compound DFSV-related harm.**

Neami echoes Suicide Prevention Australia's call for a whole-of-government approach to reducing suicide, whereby a broader range of portfolios have a clear responsibility to address social determinants. Structural and systemic reforms could meaningfully reduce distress and suicide, and enable recovery from DFSV.

Housing and financial security

Addressing Australia's housing crisis and poverty is vital to reducing rates of suicidal distress.

People being 'safe and having a sense of security and stability in their lives' is central to the *National Suicide Prevention Outcomes Framework*. Indicators include 'Increase in economic security' and 'Increase in stable, secure, safe and affordable housing.'³⁹

Suicide Prevention Australia call for an increase to income support payments 'in line with the Australian Council of Social Service's Raise the Rate policy platform', and for the development of 'a national strategy to end homelessness.'⁴⁰

Further, as the *National Plan to End Violence Against Women and Children 2022-2032* explains, '[h]ousing is essential to ending gender-based violence', and 'its role in policy responses must be considered across the continuum, from prevention to recovery and healing.'⁴¹

Progress towards increasing social housing stock through the Housing Accord is welcome, yet current goals will fall well short of meeting the scale of need. The Australian Council of Social Service (ACOSS) calls for 'firm targets to increase the supply of quality, accessible social housing to at least its historic level of 6% of dwellings by 2035, and to 10% by 2045.'⁴²

'Women need a pathway to actually have hope.'

– **Safe and Secure Housing Program worker**

Neami recommends that governments:

1. Adopt the Brotherhood of St Laurence's recommendations for urgent social security reform, including introducing equal access to income support for single and partnered adults, as one measure to combat the financial entrapment of victim-survivors.
2. Adopt ACOSS' recommendations around increasing income support payments and targets for social housing so that victim survivors can meet their basic needs, and have the safety, security and stability necessary to rebuild their lives.
3. Explore the possibility of adjusting information sharing protocols between the Single Housing Register and social housing providers, to mitigate against 'cherry picking' practices, thereby improving access to stable housing for victim-survivors experiencing complex needs.

Accessible DFSV services, including holistic, specialised longer-term support

The Domestic, Family and Sexual Violence Commission has highlighted the ‘urgent need for targeted prevention, early intervention, and robust support systems for those affected by DFSV.’⁴³

While immediate crisis intervention services are critical, many victim-survivors also require extended, wraparound support, particularly those displaced by DFSV and experiencing complex and enduring support needs.

Neami recommends that governments:

4. Address the significant service gap in longer-term, holistic and integrated support for victim-survivors experiencing multiple and complex needs, to overcome systemic barriers to safety and recovery. Ensure that provision is trauma informed, and has a strong focus on peer support, care coordination and advocacy.

Creating the conditions for long-term stability and recovery: the Safe and Secure Housing Program

Neami’s Safe and Secure Housing Program (SSHP) is one of the few post-crisis services for victim-survivors displaced by DFSV who require specialist, holistic and extended support. Recognising that women experiencing complex and enduring barriers to wellbeing require more than temporary assistance, SSHP builds on initial DFSV interventions and provides longer-term support to address homelessness and promote healing. SSHP aims to avoid repeated crisis accommodation stays and a return to the abusive relationship by supporting access to ongoing, safe housing. SSHP can remain engaged until stable housing is secured, and also provide post-tenancy support for a few months. Support can include:

- advocating to housing providers or property managers
- addressing outstanding legal issues
- exploring employment, training or study pathways
- accessing financial assistance, such as through the Leaving Violence Program (LVP)
- ensuring that income support payments are correct and underpayment isn’t occurring
- improving mental health and wellbeing
- identifying and addressing physical health needs
- family and parenting needs
- building community connections that act as protective networks
- skill development, including to sustain a tenancy
- linking to ongoing or longer-term supports as required.

A core challenge SSHP addresses is navigating fragmented housing and support systems and overcoming barriers to access. Examples include SSHP staff using their expertise to:

- mitigate against social housing applications being downgraded, advocate for clients, prevent tenancy loss, and assist with practical solutions such as payment plans or brokerage
- support women to apply for the NDIS, particularly those with psychosocial disabilities. Many women displaced by DFSV lack documentation, making NDIS access difficult. SSHP helps prepare applications and advocates for approval, a service rarely offered by other DFSV providers.

Central to SSHP's approach is building trust and safety through consistent and collaborative relationships, enabling experiences to be shared and unmet needs identified. Staff employ trauma-informed, transdisciplinary methods to understand how intersecting barriers affect recovery. Together, consumers and staff address obstacles to housing stability and set goals across life domains. Continuity and flexibility in support is vital, particularly during periods of mental health decline.

SSHP has established strong partnerships with diverse agencies to ensure comprehensive resources for women and children. The program works closely with DFSV referring partners to maintain care continuity during transitions from short-term services.

Importantly, staff take the initiative to ask women about suicidal ideation, in the context of having built rapport and trust, as part of the program's 'safety narrative'.

Safe spaces and aftercare for people in distress

People experiencing suicidal distress often seek relational support, not medical intervention.

Neami believes that every person in suicidal distress deserves:

- timely support, and agency in how and where they access support
- compassionate, non-judgmental, person-led care grounded in trauma-informed principles and culturally safe practice
- a safe, calm and welcoming environment that prioritises connection over assessment
- the option of skilled peer support, which is particularly effective at reducing shame and fear, and fostering hope
- support beyond the crisis moment through options for longer-term psychosocial, clinical and/or community linkages, including aftercare
- experiences of care that engender agency and dignity. This includes collaborative decision-making and co-creation of safety plans.



These principles build trust and enable people to feel safe to tell their story. They are particularly vital for victim-survivors of DFSV, to avoid environments and responses that can compound trauma.

Expanding drop-in, lived experience-led safe spaces that have a strong peer worker focus could meaningfully contribute to reducing rates of acute suicidal crises, and enabling safety.

An evaluation of Neami's Urgent Mental Health Care Centre (UMHCC)⁴⁴ aligns with broader research findings⁴⁵ that safe spaces fill a critical gap in the suicide prevention and mental health system. In a survey, 42% of UMHCC guests reported that they would have otherwise attended an emergency department, and 50% of guests were unsure where else they would have sought help. 27% indicated that they would not have sought support at all if there service didn't exist.⁴⁶ Further, many guests benefit from the in-reach service provided fortnightly at the UMHCC by the Women's Legal Service South Australia.



Neami recommends that governments:

5. Map service gaps of peer-led, drop-in safe spaces that provide alternatives to emergency departments for people in suicidal distress, and expand provision accordingly. Ensure adequate provision of aftercare services, ideally co-located with safe spaces.
6. Promote and support in-reach initiatives such as health justice partnerships within safe spaces, as one measure to address fragmented service systems.

Grow and upskill the DFSV and suicide prevention workforces

In addition to the need to resource expanded service provision to meet demand across the country, addressing the critical issue of widespread, significant workforce shortages in both the DFSV⁴⁷ and suicide prevention sectors requires urgent attention.

Short-term funding periods for services and uncertainty about whether these will be extended can significantly undermine service providers' efforts to build and sustain a high-quality workforce. Insufficient job security can lead to reliance upon casual staff, which is detrimental to consumers as well as corrosive to a positive team culture and staff wellbeing. Providers are disincentivised from training and investing in staff where services may be shortly decommissioned.

Funding uncertainty and the casualisation of the workforce is particularly problematic for the vital work of building strong lived experience cultures within services, and the growth and development of peer workforces.

At Neami, funding periods for services can be as short as a year. For the UMHCC for example, funding periods have never been longer than two or three years.

Neami recommends that governments:

7. Amend commissioning practices within the mental health and suicide prevention sector to make five-year funding periods the norm, to promote workforce retention and development as per the Productivity Commission's recommendation.
8. Adopt the recent recommendations by the DFSV Commission about growing the DFSV workforce, and the Productivity Commission's recent recommendation to support the implementation of the National Suicide Prevention Workforce Strategy.
9. Ensure that specific mechanisms to expand and support the suicide prevention peer workforce are prioritised, and explore how lived experience roles could be expanded within the DFSV sector.

Lived experience-informed suicide awareness and response training for DFSV workers would be integral to shifting the sector away from reactive practice and towards person-centred responses that remove stigma and shame, and collaboratively build safety.

Neami recommends that governments:

10. Facilitate a comprehensive rollout of lived experience-informed suicide awareness response training for staff across the DFSV sector and about DFSV for the mental health and suicide prevention sector, to promote appropriate, skilled support. Consider how appropriate training could also be rolled out across adjacent sectors that interact with victim-survivors.

A comprehensive data landscape

A focus on distress, in addition to lives lost

Particularly due to the gender paradox, it is important that a focus on DFSV-related suicide does not occlude recognition of DFSV-related distress more broadly. Understanding DFSV-related harm, including with respect to population trends over time, requires consideration of a broader range of experiences and expressions of distress in addition to deaths.

Neami recommends that governments:

11. Acknowledge that DFSV-related distress in and of itself is a form of harm caused by DFSV. In developing improvements to the data landscape, consider indicators of rates of self-harm without suicidal intent, suicidal ideation and suicide attempts, in addition to deaths.

Improving data collection by frontline services

Improvements to the consistency of data collection around DFSV and suicidal distress across health and social services would be welcome. **Neami staff have emphasised that data collection requirements must avoid routine, mandatory questions about DFSV or suicidal ideation being asked of consumers.** Many people do not feel safe or comfortable disclosing to service providers,

particularly early in engagement. It is imperative that data collection does not disrupt the building of rapport and trust that is often necessary for disclosure.

Neami recommends that governments:

12. Design improvements to data collection that avoids inappropriate mandatory questions being asked of victim-survivors and additional administrative burden for staff. Consider ways to include experiences such as coercive control, emotional abuse, suicidal ideation and suicide attempts in data collection.
13. Develop improvements in data linkages to illustrate connections with social determinants and assist with monitoring the progress of whole-of-government approaches.

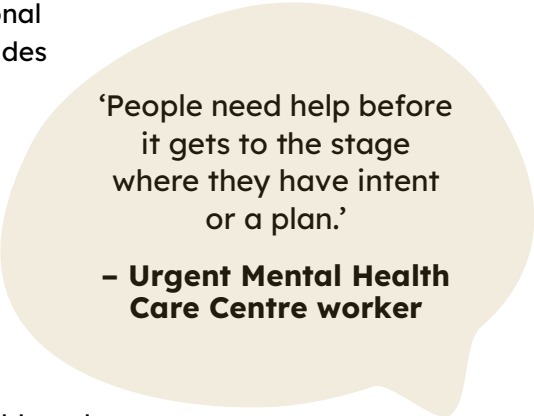
Neami would also like to echo the recent Rapid Review of Prevention Approach's acknowledgement of the 'crucial role of data sovereignty' for Aboriginal and Torres Strait Islander communities.⁴⁸

Progress implementation of formalised whole-of-government approaches, with robust governance and accountability

The federal budget has not yet allocated funding to implement Australia's National Suicide Prevention Strategy 2025–2035, despite calls from the sector.

As Suicide Prevention Australia explains, the strategy is a comprehensive, whole-of-government, long-term framework, which is vital to reduce rates of suicide. It encompasses the prevention of suicidal distress, support for those experiencing suicidal distress, and 'critical enablers' such as 'strong governance, lived experience leadership, research translation, and workforce development.'⁴⁹

The strategy is designed to work 'in concert' with other national strategies that tackle social determinants. The strategy includes Actions for governments around implementation of the *National Plan to End Violence against Women and Children 2022–2032 (the National Plan)*, the *National Strategy to Prevent and Respond to Child Sexual Abuse 2021–2030*, and *Safe and Supported: the National Framework for Protecting Australia's Children 2021–2031*. This includes an Action within the National Plan's Action to: 'Build the capacity of services and systems that support victim-survivors to provide trauma-informed, connected and coordinated responses that support long-term recovery, health and wellbeing.'



'People need help before it gets to the stage where they have intent or a plan.'

– Urgent Mental Health Care Centre worker

Further, although progress has been made in implementing the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, Gayaa Dhuwi Australia expressed disappointment that the 2025–2026 Federal Budget 'didn't include a sustained commitment to social and emotional wellbeing, mental health, and suicide prevention across Aboriginal and Torres Strait Islander communities.'⁵⁰

The recent review of the National Mental Health and Suicide Prevention Agreement by the Productivity Commission highlighted a lack of funded, tangible mechanisms to progress a whole-of-government approach. Insufficient transparency and accountability was also identified.⁵¹ **The Productivity Commission recommends '[s]etting mental health and suicide prevention as a national priority and reorienting agreement governance to support cross-portfolio collaboration'⁵², to create more holistic, person-centred and integrated systems that enable prevention and early intervention, and address social determinants.**

Neami recommends that governments:

14. Fully fund the implementation of the National Suicide Prevention Strategy and the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, to enable progress in reducing rates of suicidal distress.
15. Ensure that state and territory jurisdictional suicide prevention plans align with the national suicide prevention strategies in considering intersections with DFSV.
16. Amend legislation to establish both the National Suicide Prevention Office and the Domestic Family and Sexual Violence Commission as independent statutory bodies, and adequately resource them, to promote accountability through comprehensive, transparent reporting.
17. Embed cross-government coordination, robust governance, lived experience leadership and sector representation, as per the Productivity Commission's recommendations for the next iteration of the National Mental Health and Suicide Prevention Agreement.

More information

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Endnotes

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⁹ [Factsheet: Understanding Suicide Among Trans and Gender Diverse People - LGBTIQ+ Health Australia](#)

¹⁰ [Family violence against men | Respect Victoria](#)

¹¹ [*Assessing legal needs and capability for HJP](#) p. 17

¹² [Self-harm hospitalisations - Suicide & self-harm monitoring - AIHW](#)

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- ²⁰ [Scale of domestic and family violence's role in homelessness revealed: World Homeless Day – Homelessness Australia](#)
- ²¹ [*Assessing legal needs and capability for HJP](#), p. 19
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