



Health and wellbeing for lesbian, gay, bisexual, trans, gender diverse, intersex, queer and other sexual orientation, gender and bodily diverse people (LGBTIQ+)

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## Submission to the inquiry into the relationship between domestic, family and sexual violence and suicide

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## About LGBTIQ+ Health Australia

LGBTIQ+ Health Australia (LHA) is the national peak organisation promoting the health and wellbeing of LGBTIQ+ people. With a diverse membership spanning LGBTIQ+ community-controlled health organisations, community groups, state and territory peak bodies, service providers, researchers and people with lived and living experience, LHA provides national leadership in policy, advocacy, research and capacity building.

LHA has a long-standing role in advancing evidence-informed responses to mental health, suicide prevention, and domestic, family and sexual violence (DFSV) affecting LGBTIQ+ people. This includes the development of Beyond Urgent, a national strategy focused on improving mental health and suicide prevention outcomes for LGBTIQ+ people through community-led, safe, inclusive, affirming and non-clinical approaches and the *Where to From Here: An Approach to Ending Gender-Based Violence in LGBTQ+SB Communities* report which outlines the outcomes of a national roundtable focused on addressing DFSV in LGBTQ+SB communities..

## A national focus on LGBTIQ+ health

LGBTIQ+ people are recognised as priority populations in key national policy frameworks, including the [National Mental Health and Suicide Prevention Agreement](#), the [National Suicide Prevention Strategy 2025–2035](#), and the [National Plan to End Violence against Women and Children 2022–2032](#). The [National Action Plan for the Health and Wellbeing of LGBTIQ+ People 2025–2035](#) further provides a whole-of-government framework to address systemic health inequities and improve mental health and wellbeing outcomes for LGBTIQ+ people across Australia.

National monitoring data from the [Australian Institute of Health and Welfare \(2025\)](#) demonstrate elevated rates of suicidal thoughts, self-harm and suicide attempts among LGBTIQ+ populations. Research such as *Rainbow Realities* (Amos et al. 2023) highlights the protective role of family acceptance, social connection and affirming environments in reducing risk of suicide, underscoring the importance of prevention approaches that extend beyond clinical intervention alone.

Broader Australian and international evidence consistently links exposure to violence, including domestic, family and sexual violence, with increased risk of suicide. Given the disproportionate exposure of LGBTIQ+ people to DFSV, these findings are directly relevant to understanding risk of suicide within LGBTIQ+ populations.

## Understanding experiences of LGBTIQ+ people

Despite national strategies to prevent violence and promote mental health, LGBTIQ+ people continue to experience elevated risk of both DFSV and suicide due to stigma, marginalisation, discrimination and abuse, as well as barriers to accessing safe, inclusive and affirming support. These risks are compounded for many people with intersecting experiences, including Aboriginal and Torres Strait Islander identity, cultural and racial diversity, disability, socioeconomic disadvantage, geographic isolation, and experiences of homelessness.

This submission draws on national data, peer-reviewed research, LHA-led policy work and lived and living experience to examine how DFSV contributes to risk of suicide among LGBTIQ+ people, and to identify opportunities for improved data, system responses, prevention and early intervention.

## Introduction

LGBTIQ+ Health Australia (LHA) welcomes this inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide. LHA is the national peak organisation working to improve the health and wellbeing of LGBTIQ+ people and represents community-controlled organisations, service providers, researchers and practitioners across health, mental health, suicide prevention and DFSV.

Australian evidence demonstrates that both DFSV and suicidal thoughts, behaviours and deaths by suicide occur at disproportionately high rates among LGBTIQ+ people (Amos et al. 2023; Hill et al. 2020; Mathews et al. 2025). These elevated risks reflect the cumulative impacts of stigma, discrimination, minority stress and systemic exclusion, and are strongly associated with exposure to family violence, intimate partner violence and sexual violence (Amos et al. 2023; Soldatic et al. 2024; Szalacha et al. 2017). The prevalence and severity of these harms mean that understanding the relationship between DFSV and suicide affecting LGBTIQ+ people is critical to the effectiveness of national suicide prevention and violence prevention efforts.

Research indicates that the relationship between DFSV and suicide is rarely attributable to isolated incidents. Rather, risk of suicide often emerges from cumulative exposure to coercive control, chronic relational harm, identity-based abuse and prolonged system failures that erode protective factors over time (Amos et al. 2023; LGBTIQ+ Health Australia 2025; Gray et al. 2020). For some victim-survivors, suicidal ideation may function as a coping or survival response to entrapment and loss of agency, rather than reflecting individual pathology alone (LGBTIQ+ Health Australia 2025). Recognising these dynamics is essential to developing trauma-informed, survivor-centred responses that do not inadvertently silence disclosure or reinforce harm.

Despite growing policy attention to violence prevention and suicide prevention, the role of DFSV in deaths by suicide affecting LGBTIQ+ people remains under-recognised in data, policy and service systems. This invisibility is driven by inconsistent and non-inclusive data collection, under-reporting of violence, systemic and interpersonal bias, and fragmented responses across health, mental health, justice and DFSV systems (Lusby et al. 2024). These gaps are particularly pronounced for trans and gender-diverse people, Aboriginal and Torres Strait Islander LGBTIQ+ people, people with disability, and those living in regional, rural and remote areas (Soldatic et al. 2024; Salter et al. 2024).

This submission addresses the Committee's Terms of Reference by examining the relationship between DFSV and suicide risk among LGBTIQ+ populations, identifying limitations in current reporting and investigation practices, and highlighting opportunities to strengthen prevention, early intervention and system responses. It emphasises the importance of recognising DFSV as a key driver of suicidal distress, including the use of suicide threats and perpetrator suicide as potential tactics of coercive control, and of embedding inclusive data standards, lived and living experience, and sustained investment in LGBTIQ+ community-controlled responses.

## ToR 1: Relationship between DFSV victimisation and suicide risk, incidence and groups

Australian research demonstrates high levels of family-of-origin violence, intimate partner violence and sexual violence, with consistent associations with suicidal thoughts, behaviours and severe psychological distress (Hill et al. 2020; Mathews et al. 2025). Among LGBTIQ+ people, these risks are compounded by stigma, marginalisation and exclusion from safe, inclusive and affirming services (Amos et al. 2025).

Private Lives 3 (Hill et al. 2020), the largest national survey of the health and wellbeing of LGBTIQ+ people in Australia, provides robust evidence of the prevalence and impacts of domestic, family and sexual violence. The survey found high rates of family-of-origin violence and intimate partner violence among LGBTIQ+ respondents, with experiences of violence strongly associated with suicidal thoughts, behaviours and very high psychological distress.

Elevated risk was particularly evident among trans and gender-diverse people, people with disability, Aboriginal and Torres Strait Islander LGBTIQ+ people, those who had experienced homelessness, and people facing multiple forms of social and economic exclusion. These findings underscore the role of violence as a key contributor to poor mental health and suicidality among LGBTIQ+ populations and highlight the need for integrated violence prevention and suicide prevention responses (Hill et al. 2020).

Violence affecting LGBTIQ+ people frequently includes identity-based and status-based abuse, such as rejection linked to sexual orientation or gender, threats to disclose sexual orientation, intersex status or gender, invalidation of lived experience including deadnaming and misgendering, control over access to healthcare including gender-affirming care, and misuse of HIV status as a means of coercion. These forms of abuse intensify minority stress and compound risk of suicide (Amos et al. 2023; Bourne et al. 2023).

Recent Australian qualitative and mixed-methods research indicates that the relationship between DFSV and suicidality is rarely attributable to isolated incidents (Salter et al. 2024; Lim et al. 2025b). Rather, risk of suicide often emerges from cumulative exposure to coercive control, chronic relational harm and prolonged system failures that erode protective factors over time and contribute to entrapment, isolation and hopelessness. This evidence supports a causal interpretation in which suicide risk reflects sustained interpersonal and structural harm rather than individual vulnerability alone.

Victim-survivors of DFSV may experience suicidal thoughts for multiple, overlapping reasons, including entrapment and loss of agency; chronic psychological pain and exhaustion; shame, self-blame and internalised abuse; social isolation and disconnection; fear of ongoing or future violence; trauma-related mental distress or substance use; cumulative systems failures and institutional harm; efforts to protect others from violence; and attempts to regain control over one's own body or circumstances in situations perceived as inescapable. For some people living with DFSV, suicidal thoughts may create a sense of relief because they restore a feeling of agency, functioning as a coping or survival mechanism rather than an intention to die (Amos et al. 2023; Hill et al. 2020; Salter et al. 2024b).

It is therefore important not to conceptualise all suicidal thoughts solely as a mental ill-health. In contexts of coercive control and extreme threat, suicidal thoughts may reflect attempts to restore autonomy, resist ongoing harm or find safety where no other viable options are perceived. Treating all suicidal thoughts as evidence of imminent risk can silence victim-survivors, discourage disclosure and increase fear of coercive or punitive interventions. Effective responses require differentiation between drivers of suicidal distress rather than one-size-fits-all risk approaches.

Sexual violence experiences among LGBTIQ+ people are widespread, lifelong and associated with profound impacts on mental health, including anxiety, depression, shame, self-blame, suicidal thoughts and self-harm (Asquith et al. 2024; Wolbers et al. 2022). These impacts are exacerbated when sexual violence intersects with other forms of marginalisation, including racism, disability and geographic isolation (Ussher et al. 2020).

The National Survey of LGBTIQ+SB Experiences of Sexual Violence found that approximately three-quarters of participants reported experiencing sexual violence across their lifetime, with more than half experiencing both childhood and adult sexual violence. While the survey does not directly quantify suicide related experiences, it documents significant negative impacts on health, wellbeing, financial security and workforce participation, outcomes known to overlap with increased suicide risk in broader research literature (Salter et al. 2024a).

NSW research conducted by ACON in partnership with academic institutions found that just under 55 per cent of participants reported thoughts of self-harm or suicide following sexual violence, and 22 per cent reported acting on those thoughts (Asquith et al. 2024). Higher risk was associated with being younger, having a disability, and lifelong

exposure to sexual violence. For Aboriginal and Torres Strait Islander LGBTIQ+ people, DFSV and suicide must also be understood within the context of colonisation, racism, intergenerational trauma and disrupted kinship systems, all of which shape social and emotional wellbeing and compound risk of suicide (Soldatic et al. 2024).

## **ToR 2: Opportunities for improved reporting and investigation methodologies**

The inquiry's focus on reporting and investigation of DFSV-related deaths is particularly relevant for LGBTIQ+ populations, whose experiences are frequently invisible in administrative, service and coronial data (Latrobe University 2018). This invisibility reflects broader systemic data gaps across education, housing, homelessness, health and justice systems, and is particularly acute in relation to deaths by suicide.

Current data collection under the National Plan Outcomes Framework and Performance Measurement Plan (Commonwealth of Australia (Department of Social Services) 2023) does not adequately capture LGBTIQ+ populations, particularly those not included in major surveys such as the ABS Personal Safety Survey and the National Homicide Monitoring Program. In the context of suicide, invisibility is further compounded where individuals had not disclosed their sexual orientation, gender or intersex status prior to death, resulting in posthumous assumptions of cisgender, heterosexual and endosex status.

The Personal Safety Survey includes sexual orientation but does not adequately capture the experiences of trans, gender-diverse or people with innate variations of sex characteristics (intersex). The National Homicide Monitoring Program similarly lacks systematic identifiers for these populations, relying on ad hoc references in police or coronial records. These limitations constrain understanding of DFSV-related deaths by suicide and hinder effective prevention and response.

Evidence indicates substantial under-reporting of DFSV by LGBTIQ+ people to police and other services (Amos et al. 2023). Barriers include fear of discrimination, concern about misidentification as perpetrators, previous negative experiences, and limited access to safe, inclusive and affirming care, particularly in regional, rural and remote areas. Gendered screening practices further compound invisibility, with DFSV assessments routinely applied to women but not to men, contributing to missed identification of violence affecting LGBTIQ+ men and those assumed to be male.

Under-reporting has direct implications for coronial investigations and suicide classification, as prior DFSV victimisation may not be documented or recognised. This is exacerbated by limited workforce training among frontline gatekeepers across health, education, justice and community services, many of whom receive disclosures of suicidal distress without training in LGBTIQ+ safe, inclusive and affirming practice. As a result, coronial determinations of suicide frequently fail to identify or record preceding DFSV exposure as a contributing factor, limiting understanding of the role of violence in deaths by suicide and constraining prevention efforts (Latrobe University 2018).

Historical and ongoing mistrust of police and justice systems, shaped by criminalisation, entrapment, over-policing of LGBTIQ+ events and well-documented historical harms, continues to influence reporting behaviours (Lim et al. 2025a; Fileborn et al. 2024). These dynamics further limit data quality and system accountability.

LHA supports national adoption of the Australian Bureau of Statistics' *Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020* (the 2020 Standard) across all relevant datasets (Australian Bureau of Statistics 2021). Without inclusive and standardised data collection and linkage across DFSV, health and coronial systems, accurate identification of DFSV-related deaths by suicide will remain limited.

### **ToR 3: How systems recognise and respond to suicide in the context of DFSV**

Legal, justice, DFSV, health and mental health systems frequently fail to recognise DFSV affecting LGBTIQ+ people, limiting effective suicide prevention (Amos et al. 2023; Lusby et al. 2024). Systemic stigma, discrimination and exclusion contribute to poor mental health outcomes and compound risk where responses focus narrowly on clinical intervention rather than social and structural determinants (Lim et al. 2025c).

Heterosexist, cisnormative and endosexist assumptions embedded in service models can lead to misidentification of primary aggressors, minimisation of harm or framing abuse as mutual relationship conflict (Lim et al. 2025a). Emotional abuse, coercive control and violence linked to sexual orientation, gender or variations of sex characteristics are particularly likely to be overlooked (Amos et al. 2023).

Research shows that LGBTIQ+ victim-survivors most commonly disclose first to informal supports and then to health or mental health professionals (Amos et al. 2024). Many rely on private, fee-for-service care, limiting access to specialist DFSV services with expertise in risk assessment and safety planning. While mental health services may be accessed during periods of suicidality, they are often not equipped to recognise or respond to underlying DFSV (Latrobe University 2018).

Fragmented service systems further compound risk. Where DFSV and suicide prevention operate in isolation, risk of suicide is addressed primarily as an individual mental health issue rather than as the outcome of sustained relational harm. Inadequate or unsafe responses can deepen isolation, reduce trust in institutions and exacerbate cumulative harm.

Systems must recognise that threats of suicide or self-harm may function as tactics of coercive control. At the same time, suicidal thoughts must not be used to exclude victim-survivors from supports such as crisis accommodation. Risk-averse exclusionary practices can replicate patterns of control and abandonment. Services require support to hold risk safely through integrated, trauma-informed responses (Lim et al. 2025).

Unlike many well-resourced generalist services, LGBTIQ+ not-for-profit, community-led organisations face precarious and insecure funding, which limits their capacity to build trust within communities, develop practice, deliver primary prevention and early intervention, and grow their intervention services. As a result, there is uneven availability of LGBTIQ+ DFSV and suicide prevention programs and support services, and many states and territories lack adequately resourced community-led organisations to meet the needs of their populations (LGBTIQ+ Health Australia 2025).

Additionally, building sustainable capacity in specialist LGBTIQ+ Community Legal Centres is essential. These centres provide safe, inclusive, affirming and trauma-informed legal assistance, alongside community education and sector-wide capacity building that strengthens inclusive legal responses (Lim et al. 2025b).

Legal stressors associated with DFSV, including court proceedings, child protection involvement, policing interactions and unresolved legal matters, can significantly exacerbate distress and risk of suicide for LGBTIQ+ victim-survivors. Access to trusted, specialist legal support can mitigate these harms by reducing uncertainty, restoring agency and supporting safer navigation of complex systems (Lim et al. 2025b).

### **ToR 4: Suicide and threats of suicide as a tactic of coercive control**

When a perpetrator of domestic or family violence dies by suicide, the impact on the victim-survivor can be profound and enduring. Perpetrator suicide may occur for a range of reasons, including the perpetrator's own shame or guilt, a

recognition that the violence has escalated beyond what they can tolerate, or as a deliberate act intended to maintain control and inflict further harm (LGBTIQ+ Health Australia 2025).

In these cases, the person's death by suicide may operate as a continuation of coercive control, extending harm beyond the perpetrator's death. Victim-survivors may experience intense guilt, shame and self-blame following the person's death by suicide. Additionally, an abuser may deliberately end their life, so the victim continues to be punished through external consequences such as inheriting debt, managing unresolved legal matters, or navigating stigma and blame from the perpetrator's family or community (LGBTIQ+ Health Australia 2025).

In some situations, perpetrators explicitly threaten suicide or use suicidal behaviour as a tactic of abuse, intending to punish, manipulate or silence their victim. Death by suicide or threats of suicide may be used to avoid accountability, evade legal consequences, or ensure that responsibility for harm is redirected onto the victim after death, including through family narratives that blame the victim for the perpetrator's actions.

It is therefore critical that DFSV-related deaths by suicide is examined not only in relation to victim-survivors' risk of suicide, but also in relation to perpetrator death by suicide as a mechanism of ongoing harm. Victim-survivors affected by this form of violence often require long-term, trauma-informed support due to continued psychological, social, legal and financial impacts, as well as ongoing safety risks. Recognising this dynamic is essential to developing effective responses that address the full scope of harm associated with DFSV.

Many services, including behaviour change programs and justice system responses, screen for risk of suicide and self-harm and may subsequently prioritise mental health intervention or exclude individuals from programs due to identified risk. However, insufficient guidance exists to support practitioners to distinguish between genuine risk of suicide and the use of deaths by suicide or threats of self-harm as a mechanism to avoid accountability or to exert further harm. Additional training and practice guidance are required to enable services to respond effectively to concurrent risks, managing a person's risk to themselves while also addressing their risk to others, without deferring accountability or compromising the safety of partners, children and families (Gray et al. 2020).

Additionally, many behaviour-change programs and practitioners do not receive training specific to LGBTIQ+ people who use violence. Dedicated LGBTIQ+ behaviour change programs are rare, under-resourced, and there is currently no specialised workforce to deliver them (Gray et al. 2020). To address this gap, investment is needed in targeted training for community behaviour change practitioners, as well as sustainable funding to develop, expand and consistently implement these programs across jurisdictions.

## **ToR 5: Opportunities to enhance prevention and early intervention**

The evidence base strongly supports prevention and early intervention approaches that address DFSV as a driver of risk of suicide and are inclusive of LGBTIQ+ populations.

Protective factors include family acceptance, affirming services, peer connection and early access to safe, inclusive and affirming support. Conversely, prolonged exposure to DFSV-related harms, including identity-based abuse, family rejection, economic stressors, housing insecurity and system failure, significantly increases risk of suicide (Gray et al. 2020). Understanding the drivers of violence experienced by LGBTIQ+ people is critical to effective primary prevention. Entrenched gender-based norms, cisnormativity, heteronormativity and endosexism contribute to harm, while mainstream prevention initiatives rarely integrate LGBTIQ+ perspectives. A coordinated approach is required that addresses structural drivers and strengthens community capacity.

The Department of Social Services has funded development of a National LGBTIQ+ Primary Prevention Framework. Sufficient resourcing for implementation is essential to avoid undermining its effectiveness and to realise its potential not only to prevent violence against LGBTIQ+ people, but to inform and transform primary prevention approaches across all communities.

LHA's LGBTIQ+SB DFSV Roundtable identified chronic under-resourcing of LGBTIQ+ community-controlled organisations, limited early intervention programs and inadequate workforce training as key structural gaps (LGBTIQ+ Health Australia 2025).

These findings underscore the need for prevention and early intervention strategies that are community-led, adequately resourced and embedded across policy, service and workforce systems.

Violence exposure is not consistently identified or incorporated into routine mental health and suicide risk assessments, particularly in primary care and mental health services, resulting in DFSV histories being overlooked when screening for risk of suicide. At the same time, risk of suicide is often insufficiently addressed within DFSV risk assessment frameworks and safety planning processes, creating critical gaps in identification, and inhibiting early intervention responses (Gray et al. 2020).

## **ToR 6: Any other related matters**

Understanding pathways from DFSV to suicidal thoughts remains critical to effective prevention. While elevated risk is well established, limited evidence exists on why some people go on to attempt suicide or die by suicide. Positioning LGBTIQ+ inclusion as contingent on further research delays action while harms persist.

This inquiry provides an opportunity to embed inclusive data standards, strengthen accountability and centre LGBTIQ+ community-led organisations in policy development and implementation.

## **Conclusion**

Australian evidence demonstrates that DFSV is a significant contributor to increased risk suicide among LGBTIQ+ populations yet remains under-recognised in national data and service systems. Improving visibility, strengthening system responses and investing in prevention grounded in lived experience and inclusive data are essential to reducing deaths by suicide in the context of DFSV. LHA welcomes the opportunity to support this reform work.

## Recommendations

LGBTIQ+ Health Australia recommends that governments take the following actions.

### Data, reporting and accountability

1. Adopt the ABS 2020 Standard across coronial, police, DFSV, health and mental health systems, including in relation to deaths by suicide, to enable consistent identification, monitoring and accountability.
2. Strengthen system-wide data collection, reporting and linkage on DFSV-related suicides to support cross-sector coordination, measurable accountability, and ongoing monitoring and evaluation of suicide prevention initiatives affecting LGBTIQ+ populations.
3. Further implement the ABS 2020 Standard across core datasets within the National Plan Outcomes Framework and Performance Measurement Plan and ensure LGBTIQ+ expertise is represented on the Personal Safety Survey Advisory Group.
4. Enhance data gathering and analysis to better understand trajectories from DFSV to suicidal thoughts, behaviours and death by suicide, including differentiating between types of suicidal distress, to support more targeted and effective prevention efforts.
5. Require DFSV, including coercive control and abuse linked to sexual orientation, gender or variations of sex characteristics, to be explicitly considered in all relevant death by suicide investigations, recognising the elevated risk of suicidal distress among LGBTIQ+ victim-survivors.

### System integration and workforce capability

6. Integrate DFSV services with suicide prevention systems, ensuring coordinated, trauma-informed responses across health, mental health, justice and community sectors to better identify and support LGBTIQ+ populations at elevated risk.
7. Strengthen workforce capability across health, mental health, coronial, police and DFSV systems to recognise DFSV affecting LGBTIQ+ populations and provide safe, inclusive and affirming suicide prevention support for both victim-survivors and people who use harm.
8. Review the National Mental Health Workforce Strategy to strengthen capacity to identify and respond to DFSV across a range of roles and practice settings, including the development of dedicated DFSV specialist roles within acute, community and primary care mental health services, and ensure workforce competencies include responding to suicidal distress in the context of DFSV.
9. Integrate violence exposure into routine mental health and suicide risk assessments, particularly in primary care and mental health services, so that DFSV histories are consistently considered when screening for risk of suicide. Risk of suicide also needs to be explicitly incorporated into DFSV risk assessment frameworks and safety planning processes.

### Community-controlled services and legal support

10. Provide sustained funding for LGBTIQ+ community-led organisations to deliver safe, inclusive and affirming suicide prevention, early intervention and DFSV support services for victim-survivors and people who use harm, ensuring diverse community needs are met.
11. Fund specialist LGBTIQ+ legal services in every state and territory to provide safe, inclusive, and affirming legal assistance for LGBTIQ+ people navigating the justice system, recognising the role of legal stressors in exacerbating distress, entrapment and risk of suicide.
12. Embed lived and living experience across policy development, program design and service delivery, ensuring responses are informed by the realities of LGBTIQ+ victim-survivors and people who use harm.

13. Fund a National LGBTIQ+ Safety Alliance to bring together lived and living-experience leaders, practitioners, researchers and policy experts to provide coordinated national policy advice, develop a shared agenda, and strengthen DFSV responses for LGBTIQ+ populations.

#### **Prevention and early intervention**

14. Implement culturally and contextually tailored suicide prevention and early intervention approaches that explicitly address DFSV and prioritise intersectionally vulnerable LGBTIQ+ populations, including Aboriginal and Torres Strait Islander people, trans and gender-diverse people, and people living in regional, rural and remote areas.
15. Adopt and fund a whole-of-system, trauma-informed approach to suicide prevention that explicitly recognises DFSV as a key driver of risk of suicide and moves beyond individualised mental health frameworks to address entrapment, coercive control, cumulative trauma, social isolation, fear of ongoing violence, systemic failures and loss of agency.
16. Provide sufficient funding to fully implement the national LGBTIQ+ Primary Prevention Framework, recognising that development without resourcing for implementation will undermine its effectiveness in reducing violence and risk of suicide.
17. Empower Aboriginal and Torres Strait Islander peoples to design and deliver culturally relevant DFSV and suicide prevention responses, with particular attention to the needs of Aboriginal and Torres Strait Islander LGBTIQ+ people.

#### **Perpetrator behaviour, coercive control and accountability**

18. Investigate suicide among perpetrators of domestic and family violence, including the role of coercive control, as well as other drivers of violence and suicide such as socioeconomic factors, mental health and substance use, to inform prevention, risk management and accountability strategies.
19. Formally recognise perpetrator deaths by suicide and threats of death by suicide as potential tactics of coercive control within DFSV frameworks and embed this recognition across prevention, risk assessment, service responses and post-incident support.

This includes:

- training for frontline services, behaviour change practitioners, mental health services, police, courts, prisons and child protection to identify and respond to deaths by suicide or threats of death by suicide by perpetrators as forms of ongoing abuse rather than isolated mental health events
  - dedicated, trauma-informed supports for victim-survivors impacted by perpetrator suicide, including psychological, legal and financial assistance
  - Frameworks that guide how organisations and professionals respond after a perpetrator's suicide, so that responsibility is not shifted onto the victim-survivor
  - Integrated victim-survivor responses that address ongoing safety risks, grief, stigma and material harms, including debt, legal matters and family retaliation, because of perpetrator suicide and self-harm.
20. Fund and establish a national LGBTIQ+ behaviour change workforce and intervention program to deliver culturally relevant, evidence-informed perpetrator interventions tailored to LGBTIQ+ populations and the specific dynamics of DFSV within LGBTIQ+ relationships

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