Mental Health and Suicide Prevention Agreement Review
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

RE: Mental Health and Suicide Prevention Agreement Review

Women's Health NSW (WHNSW) is the peak body for 21 non-government community-based women's health centres (WHCs) in New South Wales. All our members are funded by NSW Ministry of Health under a Ministerial Approved Grant called the *Women's Health Program*. We work from a model that incorporates the social determinants of health. This sees our members actively counter sex role stereotyping and gender bias in medicine, systemic sexism, and violence against women. The women's health sector provides gender-sensitive and trauma-informed care that values women's own knowledge, skills, and their right to make informed decisions about their own health and wellbeing.

WHNSW appreciates the opportunity to provide the Productivity Commission with this submission relating to their review of the National Mental Health and Suicide Prevention Agreement (National Agreement).

Mental health, suicide, and domestic, family and sexual violence are interconnected

Mental health is core business for our members. Mental health was the most common presenting issue for our members in 2024–25, comprising 35 per cent of all presenting issues (n=66,646 of 191,373; data from 14 WHCs). Violence was also a significant presenting issue for women in 2024–25, comprising 13 per cent of all presenting issues (n=25,563 of 191,373; data from 13 WHCs). Suicide and self-harm have remained at a steady level across the last three years. From a data sample from 11 women's health centres, we see on average 1,378 suicide and self-harm presentations per year (2022–23: n=1,422; 2023–24, n=1,327; 2024–25, n=1,385). These presenting issues are not mutually exclusive.

In a position paper entitled, *Violence against women and mental health* (2020), ANROWS outlined a significant body of evidence connecting experiencing violence with poorer mental health. The paper argued that meeting the needs of women who sit at the intersection of gender-based violence and mental health impacts requires improved collaboration and coordination across the mental health, domestic, family and sexual violence, justice and child protection sectors (ANROWS, 2020). To achieve an improvement in collaboration across sectors, it is essential that our national strategies speak to each other.

WHNSW welcomes the Productivity Commission's call for new policy architecture, in particularly draft recommendation 4.3 that suggests the next National Agreement needs stronger links with the broader policy context. Our work at the intersection of mental health, suicide and domestic, family and sexual violence (DFSV) shows it is important that this policy context includes *The National Plan to End Violence against Women and Children 2022–2032* (Commonwealth of Australia, 2022).

Recommendation 1:
The next National Agreement integrates with *The National Plan to End Violence against Women and Children 2022–2032.*

Staged suicides, including via strangulation, are an under-recognised result of domestic, family and sexual violence

For the last two years, WHNSW has undertaken work under the Pathways Project to reform the way our workforce recognises and responds to strangulation and sexual choking (WHNSW, 2024). Evidence gathering for this project included data from the most recent Australian Domestic and Family Violence Death Review Network (ADFVDRN) report, which indicated that suffocation or strangulation was the cause of death in 12.9 per cent of IPV homicides where a male homicide offender killed a female intimate partner in Australia between 2010 and 2018 (ADFVDRN & ANROWS, 2022, p. 30). Evidence gathering drew our attention to grey literature about intimate partner violence homicides being misrepresented as suicides in global jurisdictions (See, for example, Kippert, 2024; Alliance for Hope International, 2025) and, more recently, as published research here in Australia (Mullin & Hardiman, 2025a).

Emerging Australian research suggests a way to differentiate homicidal intent from suicidal and accidental neck compression scenarios, with homicidal intent "often presenting a higher prevalence of injury as well as increased odds of injury" (Mullin & Hardiman, 2025b, p. 1). However, as Mullin and Hardiman (2025a, p. 3) point out, in Australia only 12 per cent of deaths are examined in coronial inquests. It is only by examining suicides through a domestic and family violence-informed lens that the full breadth of staged suicides will become visible, and justice for these hidden intimate partner violence victims will be achieved. To facilitate this, the next National Agreement needs to articulate the complexity of suicides in the context of domestic and family violence, including staged suicides.

Mental health, suicide and domestic, family and sexual violence intersect in complex ways

WHNSW would like to draw attention to the important work of our sector colleagues at ShantiWorks. In their submission to this review, ShantiWorks provided evidence about tactical and coerced suicides in the context of DFSV (ShantiWorks, 2025). Tactical suicide refers to the way perpetrators use threats of suicide as a tool to maintain control over the victim and survivor, and prevent them from leaving the abusive relationship. Tactical suicide is not primarily motivated by a desire to end one's own life, but as a method of manipulation to further entrap the victim and survivor. When systems do not view suicide, suicidal ideation, and self-harm through a DFSV-informed lens, mental health services can inadvertently enhance perpetrator control, putting victims and survivors and children at greater risk.

Mental health, suicide and DFSV intersect in the work our members undertake with women across NSW in complex ways, at every level of the ecological model of health.

Individual level:

- Women are anxious, constantly on 'high alert' with the activities of daily living impacted, particularly sleep. Presenting issues at women's health centres frequently include anxiety, depression, diminished self-worth resulting from coercive control, including coercive control that seems intended to foster suicidal ideation.
- Women experience poorer health following perpetrator threats of or completed suicide.
- Women experiencing entrapment due to perpetrator threats of suicide.
- 'Walking on eggshells': women report being fearful and modifying behaviour to prevent perpetrator suicide. This sees the primary victim of DFSV take on full responsibility for the mental health and wellbeing of the perpetrator.
- Secrecy – stigma and shame associated with mental health – so the perpetrator hides or presents differently to services, refuses to seek help, or seeks help but weaponises systems, positioning themselves as the victim.

Interpersonal level:

- Even if children are unaware of the details of the threat, they experience fear/tension.
- This behaviour "normalises" self-harm/suicide as a coping strategy or reaction to boundaries in the family. Our members report women, and their children, engaging in self-harm following perpetrators using tactical suicide.
- Children may be parentified, taking on responsibility for wellbeing and care of the perpetrator
- Children's needs are secondary, including financially, as perpetrator gains control. Family resources are diverted to care and appeasement of perpetrator.
- Perpetrators often use being unwell or suicidal as an excuse to accumulate debt, which further entraps women. High levels of debt resulting from DFSV can be catastrophic for clients. As one member, whose service helps women with DFSV-related debt put it: "So often we hear the client say, 'you have given me my life back'."
- Children may witness suicide attempts, with one member pointing out multiple victims and survivors at their service report the perpetrator chose location or timing to inflict maximum harm by ensuring children would be the ones to find the body. This can lead to the child developing post-traumatic stress disorder (PTSD). Mental health impacts on children can cause significant impairment if the children are not identified for support.
- Children may also be given therapy without any requirement for the environment they are in to change.
- In Family Court matters, decision to end life blamed on lack of access to children, which creates guilt and grief for children who have been coerced into contact with perpetrator but have conflicting emotions regarding this.

Organisational level:

- Mental health services generally have poor understanding of DFSV and impact on mental health generally. This knowledge gap is amplified for the complexity of suicidality in context

of DFSV. This can lead to the suicidal person being dismissed as manipulative without receiving adequate assessment or treatment, which may put the primary victim and survivor of DFSV and children at greater risk.
- Mental health services can collude with the perpetrator of DFSV.
- Referring workers' concerns can be dismissed, with safety planning for the whole family not being integrated with suicide risk planning.
- DFSV perpetrators threatening suicide can be discharged for not meeting the mental health schedule, sometimes with medication that could result in harm to self or others.
- Worker psychological safety or support is not always considered. For example, mental health nurses have no requirement for clinical supervision; Employee Assistance Programs are located within the servicer and may not be trusted by the worker.

Community level:
- Difficulty accessing mental health services to address needs related to suicidal ideation, self-harm and its impact on the individual and family network.
- Community siding with primary DFSV perpetrator after completed suicide can further impact the victim and survivor and children.
- Media reporting can drive community support in favour of deceased perpetrator and further isolate primary DFSV victim and family.

Public policy level:
- Legal issues regarding involuntary care complex to navigate and place the rights of individuals above rights of family members/carers.

To illustrate the complexity of the intersection of mental health, suicide, and domestic, family and sexual violence, we have provided this deidentified case study from one of our members.

Case study: the intersection of mental health, suicide, and domestic and family violence

Sarah had completed her studies and was working as a health professional when she met James in the workplace. After they married, James began to enforce strict gendered roles at home, including by positioning himself as the earner, blocking Sarah's attempts to work outside the home. They have a daughter and two sons together. James is a respected and well-known professional in their rural community.

As time went on, Sarah reports James took complete control of finances, controlled how she dressed, and limited her contact with neighbours/friends/family. James used gaslighting and undermined Sarah's parenting, which impacted her mental health. Sarah has a history of social anxiety, and an episode of significant depression/PTSD, which saw her hospitalised. Sarah received a mental health diagnosis of borderline personality disorder and was heavily medicated during admission.

Medications, depression and impact of gaslighting saw Sarah struggle to function and make decisions. Sarah reported a high level of conflict between herself and James, particularly after he had an issue at work, and became a client of the same rural mental health service.

Sarah reported James parentified their daughter – screening revealed some indicators but no evidence of sexual assault of daughter. James completed suicide in the family home at a time and location chosen to be found by the daughter. After this, daughter engaged in problematic use of alcohol and other drugs and became estranged from Sarah and the family. Sarah is very isolated and feels the community blames her for James' suicide. Sarah's health has deteriorated because she feels triggered when attending health services either alone or with her other children.

Sarah contacted our service because she no longer feels comfortable attending the mental health service they both attended. Staff at that mental service report feeling divided by casework with this family, and some team members reported experiencing vicarious trauma and poor psychological safety in the workplace.

This was the first service contact where DFSV screening identified James as a DFSV-perpetrator.

We hope this case study demonstrates the complexity of suicide in the context of domestic and family violence, particularly the impact of siloed service systems where service providers and organisations do not address suicide through a DFSV-informed lens. This points to the necessity of the next National Agreement articulating suicide in a way that reflects this complexity.

WHNSW lends our support to Shantiworks' insights on tactical/threatened and coerced suicides by adopting their recommendation with the expansion of staged suicides discussed above.

Recommendation 2:
The next National Agreement articulates the complexity of suicides in the context of domestic and family violence, including threatened, coerced, and staged suicides.

Data collection is critical to prevention work at the intersection of mental health, suicide and domestic and family violence

The National Plan to End Violence against Women and Children 2022–2032 (Commonwealth of Australia, 2022) sets out to end DFSV in a single generation. Eliminating DFSV-related suicides is a key part of achieving this goal. To measure success, the National Agreement needs to include a nationally consistent approach to data collection for domestic and family violence related suicide, self-harm and suicidal ideation. While the Australian Domestic and Family Violence Death Review Network does publish data on perpetrator suicide following intimate partner violence homicide, more information is needed to form a complete picture of DFSV-related suicide, particularly victim and survivor suicide, self-harm and suicidal ideation.

Recommendation 3:
The next National Agreement includes a nationally consistent approach to data collection and information sharing about domestic, family and sexual violence-related suicidal ideation, self-harm and suicide.

WHNSW again thanks the Productivity Commission for the opportunity to make this submission.

I would be happy to speak further on any of these issues. I can be reached by phone on 0414 780 417 or by email at ceo@whnsw.asn.au.

Regards,

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Women's Health NSW
20 August 2025

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