



Jesuit
Social Services
Building a Just Society

Response to the inquiry into the relationship between domestic family and sexual violence and suicide

January 2026

Contents

Jesuit Social Services: Who we are and what we do	3
Submission overview	4
Summary of recommendations.....	5
Response to the Terms of Reference.....	8
Links between experiences of DFSV in childhood and suicide	8
Use of suicide and threats of suicide as a tactic of coercive control by people who use DFSV	10
The role of postvention services for people impacted by suicide in the context of DFSV	12
Opportunities to enhance data and research on the links between DFSV and suicide	16
Improving service system capacity to prevent DFSV-related suicides	18
Opportunities to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV victimisation and perpetration.....	20

We acknowledge the Traditional Custodians of all the lands on which Jesuit Social Services operates and pay respect to their Elders past and present. We express our gratitude for their love and care of people, community, land and all life.

For further information, contact:

Julie Edwards, CEO, Jesuit Social Services

T: 03 9421 7600

E: julie.edwards@jss.org.au

Jesuit Social Services: Who we are and what we do

Jesuit Social Services is a social change organisation. For almost 50 years we have been delivering support services and advocating for improved policies, legislation and resources to achieve a just society where all people can thrive. We are a national organisation with a significant footprint in Victoria, New South Wales and the Northern Territory, where we work with some of the most marginalised individuals and communities.

The Men's Project

Jesuit Social Services established The Men's Project in 2017 to provide leadership and develop new approaches to reducing violence and other harmful behaviours prevalent among boys and men, to keep families and communities safe and to improve the wellbeing of men and boys themselves.

Current priorities for The Men's Project include:

- building a greater understanding of men's violence and child sexual abuse, including opportunities for prevention and early intervention – drawing on our [Man Box](#) and [Adolescent Man Box](#) research and [child sexual abuse prevalence study](#);
- supporting people who work with men and boys every day (e.g. teachers, sports coaches, social workers) to prevent violence and improve the wellbeing of men and boys;
- developing new early intervention approaches with adolescents at risk of using violence;
- strengthening early intervention responses for adults and young people to prevent child sexual abuse; and
- advocating for systemic changes that seek to prevent violence and child sexual abuse – drawing on our grounded practice experience.

Suicide bereavement support services

Jesuit Social Services has over two decades' experience delivering support services for people bereaved by suicide:

- **Support After Suicide** has been supporting Victorians bereaved by suicide since 2004 and assists adults, children and young people. The program provides specialist bereavement and trauma counselling, support groups and online resources free of charge and for as long as they are needed. The service is delivered by qualified and experienced postvention clinicians and also delivers training to health, social services and education professionals.
- **StandBy Support after Suicide** (StandBy): StandBy is a national service established in 2002 that provides free, practical support to anyone who has been bereaved or impacted by suicide. Jesuit Social Services delivers this service in metropolitan Melbourne and Gippsland. StandBy offers one initial in-person session followed by phone sessions for up to two years. Peer support and counselling sessions are available in some jurisdictions.

Submission overview

Jesuit Social Services welcomes the opportunity to make a submission to the inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide.

Our submission focuses on those issues within the Terms of Reference where we have specific expertise to offer, and is structured according to the following themes:

- links between experiences of DFSV in childhood and suicide (ToR 1, 3, 5)
- use of suicide attempts and threats of suicide as a tactic of coercive control by people who use DFSV (ToR 4)
- the role of suicide postvention services in the context of DFSV (ToR 1, 3)
- opportunities to enhance data and research on the links between DFSV and suicide (ToR 2, 6)
- improving service system capacity to prevent DFSV-related suicides (ToR 3)
- opportunities to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV victimisation and perpetration (ToR 5)

Our submission is informed by the practice experience of our staff and participants, and draws on our experience delivering suicide postvention services, as well as prevention and early intervention programs to reduce men's violence.

Through our recommendations, we call on governments to:

- strengthen capacity across sectors to recognise, assess and respond to suicide risk in the context of DFSV, including among child and adult victim-survivors of DFSV (Recs 1, 4, 16)
- increase investment in healing and recovery support for children and young people who have experienced DFSV and mental health support for adult victim-survivors, recognising this is a suicide prevention measure (Recs 2, 3, 14)
- expand access to suicide postvention services, especially for children and young people and people in rural and regional services, recognising this is a suicide prevention measure (Recs 8, 9, 10)
- ensure suicide-related services (including crisis support and postvention services) are DFSV-informed and can assess and manage risk among people who use DFSV, including where they use suicide threats or attempts as a tactic of DFSV (Recs 5, 6, 7, 15)
- take a coordinated, whole-of-government approach to responding to suicide risk in the context of DFSV rather than treating health and social problems in isolation (Rec 17)
- invest in further research into the links between DFSV and suicidal behaviours to inform targeted prevention and early intervention initiatives (Recs 11, 12, 13)
- expand evidence-based prevention and early intervention initiatives across a range of settings, with a focus on addressing rigid gender norms and other drivers of DFSV and harmful behaviours such as suicide (Recs 18, 19, 20, 21).

Should this be of assistance, we would welcome the opportunity to meet with the Committee to discuss our submission and recommendations and/or give evidence at the inquiry.

Summary of recommendations

Recommendation 1: Governments should strengthen the capacity of the service system (including child and youth specialist services; child and family services; DFSV specialist services; and health, mental health and AOD services) to identify, assess and monitor children and young people who experience DFSV to prevent suicide and other harmful impacts, including through the forthcoming national Domestic and Family Violence Risk Assessment and Management Framework. (See also recommendation 16.)

Recommendation 2: Governments should make a substantial additional investment in holistic, child- and young person-centred, DFSV- and trauma-informed, culturally safe support services for children and young people who have experienced DFSV, with a focus on healing and recovery, as a form of suicide prevention.

Recommendation 3: The Federal Government should lead the development of a dedicated National Action Plan to address childhood victimisation, and adopt the recommendations in the report, *Missing Figures: The hidden role of domestic and family violence in youth suicide*, as part of this plan.

Recommendation 4: Governments should review and update risk assessment and management frameworks, tools and guidance to ensure they explicitly incorporate risk indicators for suicide by victims of DFSV to better take account of the multiple, intersecting and cumulative factors that may increase a woman's risk of suicide during and following DFSV victimisation, including suicide threats by the person using DFSV, coercion to suicide and other forms of coercive control.

Recommendation 5: Governments should ensure suicide postvention services, including bereavement support and counselling, are DFSV-informed, including by building staff understanding of and capability to respond to the dynamics and impacts of DFSV, including for children and young people and LGBTQIA+ people.

Recommendation 6: Governments should fund the development of dedicated resources to support people experiencing bereavement in the context of DFSV, similar to those developed by Jesuit Social Services (*Support After Suicide*) and Switchboard Victoria for LGBTQIA+ bereavement, complemented by resources for professionals working with people bereaved by suicide in the context of DFSV. These resources should be informed by the practice expertise of services like *Support After Suicide*, as well as people with lived expertise.

Recommendation 7: Governments should ensure suicide postvention services are in scope of the forthcoming national Domestic and Family Violence Risk Assessment and Management Framework including any guidance, training and capability-building initiatives developed to implement the Framework.

Recommendation 8: As part of the proposed dedicated National Action Plan to address childhood victimisation (see recommendation 3), the Federal Government should fund a dedicated response to children and young people bereaved by suicide, which:

- is informed by the evidence about what children need to heal from the relational trauma of losing a parent;

- takes account of the complexities associated with this grief where the parent they have lost has died by suicide and/or has perpetrated harm towards them and their surviving parent;
- is co-designed with children and young people.

Recommendation 9: The Federal Government should fund further research to test the application of evidence-informed approaches to healing after loss of a parent to circumstances where the parent dies by suicide, including in the context of DFSV, to better understand what children need to support them.

Recommendation 10: To ensure all people bereaved by suicide in the context of DFSV have access to appropriate support, governments should provide secure, increased and integrated funding for the delivery of comprehensive suicide postvention support, including for children and young people and in regional and remote communities.

Recommendation 11: Governments should identify and explore opportunities to further investigate suicidal ideation and suicide attempts in the context of DFSV, for example through the ABS National Study of Mental Health and Wellbeing and longitudinal research into women's health.

Recommendation 12: Governments should invest in research to enhance our understanding of the links between DFSV and suicide for cohorts at higher risk, including First Nations people, LGBTQIA+ people, and children and young people.

Recommendation 13: Governments should invest in research with suicide postvention services to enhance our understanding of the contexts in which DFSV-related suicides occur.

Recommendation 14: Governments should increase funding for mental health services to enhance system capacity to provide DFSV- and trauma-informed support to victim-survivors of DFSV with significant mental health concerns, including suicide risk.

Recommendation 15: Governments should ensure crisis response/support services are in scope of the national Domestic and Family Violence Risk Assessment and Management Framework including any guidance, training and capability-building initiatives developed to implement the Framework (see also recommendation 7).

Recommendation 16: Governments should build the capability of workforces across the health, social services and legal and justice sectors to better respond to the needs of victims of violence, including the specific needs of children and young people, for example through risk assessment and management workforce training packages across jurisdictions and wider government DFSV industry planning and workforce capability uplift efforts.

Recommendation 17: Governments should work together to enable a coordinated, collaborative and holistic response to suicide risk in the context of DFSV, including through information-sharing arrangements and multidisciplinary, cross-sector responses that provide long-term, integrated treatment and support, with by clear accountability for coordination.

Recommendation 18: Governments should invest in expansion of evidence-based prevention and early intervention initiatives across a range of settings, including schools, workplaces and sports clubs, that address rigid gender norms and other drivers of DFSV and harmful behaviours such as suicide, and equip

boys and young men with tools and resources to address concerns identified in the Adolescent Man Box research.

Recommendation 19: Governments should invest in initiatives to encourage formal and informal help-seeking among boys and men, underpinned by access to support services that are holistic, gender-responsive, DFSV- and trauma-informed, culturally safe and (where relevant) child- and young people-centred (see also recommendation 2).

Recommendation 20: Governments should build the evidence base for what

works to engage men and boys and decrease adherence to rigid gender norms, including through high quality program evaluations, to enable resources to be directed to the most effective interventions.

Recommendation 21: Governments should build the capability of workforces across relevant sectors to engage with men and boys and address harmful masculine norms including by embedding this as a priority into DFSV industry planning workforce strategies.

Response to the Terms of Reference

Links between experiences of DFSV in childhood and suicide

The deaths of women, children and young people by suicide in the context of domestic, family and sexual violence (DFSV) victimisation is an important but often overlooked dimension of gender-based violence. There is evidence that DFSV contributes significantly to the burden of mental health issues leading to self-harm and suicide among victims in Australia, and women, children and young people are disproportionately affected.¹

We urge the inquiry to pay particular attention to the links between experiences of DFSV and suicide (and suicidal behaviours) among children and young people. Research shows that experiencing DFSV or child maltreatment increases the risk of suicide among children and young people, especially adolescents.² Yet the role of DFSV in contributing to suicide deaths among children and young people is under-recognised and under-researched – and is often masked by other presenting issues such as mental health problems or substance use.³

Experiencing family violence and other forms of maltreatment in childhood also significantly increases the risk of self-harm and suicide attempts later in life.⁴ Through our suicide bereavement services, Jesuit Social Services witnesses the profound, long-term impacts of child maltreatment on individuals who later take their own lives. Our program experience also reflects the research showing that men who die by suicide in the context of using DFSV against a partner have often experienced DFSV victimisation in childhood.⁵

Further research is vitally important to better understand the interconnection between childhood experiences of DFSV and youth suicide risk in Australia and inform prevention, early intervention, response and recovery efforts.⁶ However, the current evidence already demonstrates that, if we are to prevent suicides and mitigate other harmful impacts of DFSV on children and young people, there is an urgent need to invest in healing and recovery for children and young people who experience DFSV.

¹ See Australian Institute of Health and Welfare (2025). *Family, domestic and sexual violence: Health outcomes*. [\[Weblink\]](#)

² Meyer S, Atienzar-Prieto M, Fitz-Gibbon K and Moore S. (2023). *Missing Figures: The hidden role of domestic and family violence in youth suicide – Current State of Knowledge Report*. Griffith University: Brisbane. [\[Weblink\]](#)

³ *Missing Figures*, op. cit.

⁴ Lawrence DM, Hunt A, Mathews B et al. (2023). The association between child maltreatment and health risk behaviours and conditions throughout life in the Australian Child Maltreatment Study. *Medical Journal of Australia*; 218:56. [\[Weblink\]](#)

⁵ See, for example, Maclsaac MB, Bugeja L, Weiland T, Dwyer J, Selvakumar K, Jelinek GA. (2018) Prevalence and Characteristics of Interpersonal Violence in People Dying From Suicide in Victoria, Australia. *Asia Pac J Public Health*. 2018 Jan;30(1):36-44. [\[Weblink\]](#)

⁶ *Missing Figures*, op. cit., p 9.

As outlined in the 2023 report *Missing Figures: The hidden role of domestic and family violence in youth suicide*, led by Griffith University, this includes strengthening the capacity of the service system (including child and youth specialist services; child and family services; DFSV specialist services; and health, mental health and AOD services) to:

- identify, assess and monitor children and young people who experience DFSV; and
- deliver a coordinated and holistic, child- and young person-centred, DFSV- and trauma-informed and culturally safe response that meets their needs, including support for healing and recovery.⁷

Jesuit Social Services supports the recommendations made in the *Missing Figures* report, which elucidate the initial service system, policy and practice reforms necessary to begin to address the gaps in efforts to address the links between childhood experiences of DFSV and suicide.⁸

Further, Jesuit Social Services is calling on the Federal Government to lead the development of a dedicated National Action Plan to address childhood victimisation.⁹ The Australian Child Maltreatment Study found that child maltreatment is 'endemic' in Australia, with children experiencing high rates of physical, sexual and emotional abuse of children and childhood exposure to DFSV.¹⁰ The study findings show that, among Australian young people aged 16–24 years old, nearly 40% grew up in a household where there is domestic and family violence.

Research also shows that the impacts of DFSV in childhood can be long-term and profound, and can include (in addition to an increased risk of suicide) impacts on child development, mental health and substance use problems, impacts on engagement in education and school performance, homelessness, increased risk of future victimisation and perpetration of violence, and increased risk of contact with the criminal justice system.¹¹

We know from our own program data and experience that a high proportion of people involved with the criminal justice system are victims of DFSV and/or child abuse. In 2023–24, 74% of participants in Jesuit Social Services' adult justice programs and 53% of participants in our youth justice programs reported being a victim-survivor of family violence at some stage in their lives. The vast majority of the reported experience was in childhood.

⁷ *Missing Figures*, op. cit.

⁸ *Missing Figures*, op. cit.

⁹ See, for example, The Men's Project (2025). *The Adolescent Man Box: Findings from a survey with Australian adolescents aged 14–18 years*, Jesuit Social Services: Melbourne, Recommendation 3, p 111. [\[Weblink\]](#); Fitz-Gibbon K and Tyler M (2025). "Australia is failing children who experience violence", *Canberra Times*, November 7 2025. [\[Weblink\]](#)

¹⁰ Mathews, B. et al (2023). The Australian Child Maltreatment Study National prevalence and associated health outcomes of child abuse and neglect. *Medical Journal of Australia* 218:6. [\[Weblink\]](#)

¹¹ See, for example, Campo, M. (2015). *Children's exposure to domestic and family violence: Key issues and responses*, Australian Institute of Family Studies. [\[Weblink\]](#)

Identifying and adequately responding to childhood experiences of DFSV and other forms of child maltreatment is an essential suicide prevention strategy. A dedicated National Action Plan to address childhood victimisation would focus and coordinate national efforts to both prevent and respond to the devastating impacts of all forms of DFSV and abuse on children and young people, including suicide. It would seek to address the significant shortcomings of current system responses for children and young people impacted by violence and abuse, which are not designed to meet the help-seeking, recovery and healing needs of young victim-survivors.

It would also assist governments to deliver on action 4 in the *First Action Plan 2023–2027* under the *National Plan to End Violence against Women and Children 2022–2032*, as well as actions 1.2b and 1.2c in the *National Suicide Prevention Strategy 2025–2035* all of which relate to building system capacity to support children and young people impacted by DFSV and other forms of childhood adversity.

Recommendation 1: Governments should strengthen the capacity of the service system (including child and youth specialist services; child and family services; DFSV specialist services; and health, mental health and AOD services) to identify, assess and monitor children and young people who experience DFSV to prevent suicide and other harmful impacts, including through the forthcoming national Domestic and Family Violence Risk Assessment and Management Framework. (See also recommendation 16.)

Recommendation 2: Governments should make a substantial additional investment in holistic, child- and young person-centred, DFSV- and trauma-informed, culturally safe support services for children and young people who have experienced DFSV, with a focus on healing and recovery, as a form of suicide prevention.

Recommendation 3: The Federal Government should lead the development of a dedicated National Action Plan to address childhood victimisation, and adopt the recommendations in the report, *Missing Figures: The hidden role of domestic and family violence in youth suicide*, as part of this plan.

Use of suicide and threats of suicide as a tactic of coercive control by people who use DFSV

Suicide threats by an intimate partner are increasingly recognised as a *tactic of coercive control*, not just an expression of distress. In a national study, about 39% of women who experienced coercive control reported that their partner had threatened to hurt themselves.¹²

Suicide threats can be used by people who use DFSV to instil fear, guilt and responsibility in victim-survivors and to maintain dominance. They may be used to prevent separation, discourage reporting to police, discourage help-seeking, or compel compliance with the perpetrator's demands. Threats often occur during times of separation, divorce or custody battles, and appear to be a calculated response to

¹² Boxall H. and Morgan A. (2021), *Experiences of coercive control among Australian women*, Statistical Bulletin 30, Australian Institute of Criminology, p 8. [[Weblink](#)]

maintain influence when control is perceived to be lost.¹³ *Support After Suicide* staff are equipped to assess and manage concerns related to the suicide of a person who has used DFSV, with particular attention to identifying when suicide has been used as a form of coercive control, and emphasise to victim-survivors that they are not to blame.

Suicide threats and attempts by the person using DFSV are a significant indicator of heightened risk of lethal violence against the victim, including murder-suicide.¹⁴ Coercive control – which can include suicide threats and attempts, as well as coercion to suicide – has also been found to be more likely than other forms of intimate partner violence, such as physical assault, to lead to suicidal ideation and suicide by the victim.¹⁵ Anecdotally, our experience delivering *Support After Suicide* confirms this: that victims of DFSV who die by suicide are more likely to have been experiencing coercive control than other forms of DFSV.

Suicide threats and attempts are recognised as a risk factor for future serious violence by a person using DFSV in Victoria's Multi-Agency Risk Assessment and Management Framework (MARAM) and the national risk assessment principles for family and domestic violence. However, research suggests that risk assessment and management frameworks and tools could more explicitly incorporate risk indicators for suicide by the victim to better take account of the multiple, intersecting and cumulative factors that may increase a woman's risk of suicide during and following family violence victimisation. These factors include suicide threats by the person using DFSV, coercion to suicide and other forms of coercive control.¹⁶ This should be supported by further research into the different ways in which DFSV victimisation can contribute to suicide risk.¹⁷

Recommendation 4: Governments should review and update risk assessment and management frameworks, tools and guidance to ensure they explicitly incorporate risk indicators for suicide by victims of DFSV to better take account of the multiple, intersecting and cumulative factors that may increase a woman's risk of suicide during and following DFSV victimisation, including suicide threats by the person using DFSV, coercion to suicide and other forms of coercive control.

¹³ Fitzpatrick, S. J., Brew, B. K., Handley, T., & Perkins, D. (2022). Men, suicide, and family and interpersonal violence: A mixed methods exploratory study. *Sociology of Health & Illness*, 44(6), 991–1008. [\[Weblink\]](#)

¹⁴ See, for example, Woolley, J. (2024). Policing perpetrator suicide threats in family violence cases: competing priorities and contemporary challenges. *Policing and Society*, 34(10), 997–1010. [\[Weblink\]](#)

¹⁵ For example, Wolford-Clevenger C, et al (2017). Associations of Emotional Abuse Types with Suicide Ideation among Dating Couples. *Journal of Aggression, Maltreatment & Trauma*, 26(9), 1042–1054. [\[Weblink\]](#); Vasil, S, Fitz-Gibbon K and Segrave, M. (2025). *Family violence and women's deaths by suicide: A Victorian study*, Australian Catholic University; Sequire Consulting; University of Melbourne. [\[Weblink\]](#)

¹⁶ *Family violence and women's deaths by suicide*, op. cit.

¹⁷ *Family violence and women's deaths by suicide*, op. cit.

The role of postvention services for people impacted by suicide in the context of DFSV

Through our *Support After Suicide* service, Jesuit Social Services works with people bereaved by suicide in the context of DFSV, including in cases where the victim of intimate partner violence has died by suicide, where the person using DFSV has died by suicide, and where the victim experienced DFSV in childhood and later died by suicide. The intersection of suicide and DFSV can lead to highly complex grief, involving ongoing trauma, isolation, stigma, and a range of emotions (grief, anger, guilt, and sometimes relief).

Impact of suicides by people using DFSV on victim-survivors

The bereavement experience of a victim-survivor of intimate partner violence (IPV) whose partner/ex-partner has died by suicide can be highly complex. Alongside the sudden and often traumatic loss associated with suicide, some victim-survivors may experience feelings of relief, as the abuse has ended with the death of the person using violence, and may at the same time feel guilty about experiencing relief.

The suicide may also be experienced as an extension or continuation of the violence, the impacts of which continue after they have died. For example:

- The suicide of the person using violence may have involved an element of malice towards the victim-survivor, for example, in terms of where and how they died.
- The person using violence may have misrepresented the relationship to family and friends before their death leading to blame and exclusion of the victim-survivor, further compounding the isolation they may have experienced during the relationship. In some cases, victim-survivors are held responsible for the death who was using violence or they and their children are excluded from funeral or memorial services.
- We have worked with women whose abusive partners/ex-partners have deliberately manipulated their children to damage the mother-child bond before taking their life. This can have an ongoing negative impact on the relationship, including the children blaming their mother for the suicide.

Other factors that can add to the complexity of an adult victim-survivor's bereavement experience include:

- The victim-survivor may need support to deal with disclosures made by the person using violence prior to death – for example, we have responded to suicides where the person using DFSV has disclosed perpetration of child sexual abuse before taking their life.
- People who have used violence may be idealised after death by friends and family who, due to the shame and secrecy surrounding DFSV, may be unaware of the harm perpetrated, which is isolating for the victim-survivors of their violence.
- Adult victim-survivors may be supporting children with grief experiences which differ from their own, for example where the person using violence appeared caring and loving to their children.

- Victim-survivors may be experiencing the ongoing impacts of abuse, including physical and mental health challenges, trauma responses, stress, low self-esteem, substance use, financial insecurity, housing insecurity, legal issues and social isolation.

This combination of factors means that providing suicide bereavement support for victim-survivors of DFSV is highly complex, and requires skilled practitioners with an understanding of the dynamics and impact of DFSV, including on children and young people. Governments should ensure suicide postvention services, including bereavement support and counselling, are DFSV-informed, including by building staff understanding of and capability to respond to the dynamics and impacts of DFSV, including on children and young people.

We recommend that governments also fund the development of dedicated resources to support people experiencing bereavement in the context of DFSV, similar to the resources developed by Jesuit Social Services (*Support After Suicide*) and Switchboard Victoria for LGBTQIA+ communities at the [Support After Suicide Hub \(SASH\)](#), as well as resources for professionals working with people bereaved by suicide in the context of DFSV. These resources should build on the practice expertise of services like *Support After Suicide*, as well as the expertise of people with lived experience.

Suicide deaths of victims of DFSV

Support After Suicide has also responded to deaths by suicide of people who were victims or suspected victims of DFSV, including both recent and historical violence. In our experience, coercive control is a common form of abuse experienced by victims of IPV before their death.

Responding to the suicide of a victim of DFSV may involve working with the partner/ex-partner (and suspected user of DFSV), the parents, children or other family members of an adult victim who experienced IPV, or the parents or family members of a victim who experienced DFSV in childhood. For example, we might work with the mother of a person who experienced DFSV in childhood and died by suicide, who may herself be a victim-survivor of the perpetrator's violence; it is likely that she will feel guilt and self-blame for a perceived failure to protect the child.

In cases where we work with someone suspected of using DFSV, we apply organisational risk assessment and management tools, and – as a child-safe organisation – the safety and wellbeing of any children is our highest priority. We recognise the risk associated with fathers who use DFSV continuing to have relationships with their children due to the proximity and opportunity to continue to use violence against children in their care.

Currently, there is no formal, nationally implemented risk assessment and management framework – equivalent to state-based frameworks such as Victoria's Multi-Agency Risk Assessment and Management Framework or MARAM – applicable to Commonwealth-funded programs, including suicide postvention services. The Federal Government, in collaboration with states and territories, is developing a national best-practice risk assessment framework as part of the *National Plan to End Violence against Women and Children 2022-2032*, building on ANROWS' National Risk Assessment Principles for

family and domestic violence. Completion is anticipated in early 2026. Suicide postvention services should be in scope of any obligations arising from the forthcoming national framework and supported by guidance on assessing and managing risk and making appropriate referrals, particularly in situations where use of DFSV is suspected but not confirmed.

The availability of bereavement support for children and young people impacted by suicide is limited. *Support After Suicide*, for example, offers a school holiday program for children impacted by suicide, which runs four times a year for three hours and aims to provide a safe, supportive environment for children to process loss and connect with others who have had similar experiences. The service also works with parents and carers to equip them to support their children through their experience of bereavement. Wait lists for existing services mean that children and young people are not routinely offered the necessary and timely therapeutic support to process their grief around losing a parent, though the service has limited capacity to work with young people in complex cases, including where there is a history of DFSV and/or child abuse.

Given that bereavement by suicide is itself a risk factor for suicide,¹⁸ increasing access to postvention support for children and young people is critical for suicide prevention. Children and young people's grief following suicide of a parent (whether that parent is a person who uses DFSV or a victim) is complex and requires a dedicated, funded response that takes account of the complexities associated with this grief where the parent they have lost has died by suicide in the context of using or experiencing DFSV. In our experience, it is important for children and young people to have their experience and its impact acknowledged by adults; to feel safe, secure and stable; and to connect with other children and young people with similar experiences.

Children need an active response in their own right – separate from and in addition to equipping their surviving parent to provide support. Bereavement support for children and young people could take the form of individual child-centred therapies and/or group-based support. It should be informed by the evidence about what children need to heal from the relational trauma of losing a parent and co-designed with children and young people.

Further research should be undertaken to test the application of these evidence-informed approaches to healing after loss of a parent through suicide, to better understand what children need to support them, noting the loss occurring in the context of DFSV further complicates (and at times disenfranchises) the grief for children and the adults around them.

Suicide in the context of identity-based violence

We have responded to several deaths of young transgender people where a commonly reported factor (though not in all cases) was familial denial of the young person's

¹⁸ Research shows people bereaved by suicide are 65 per cent more likely to attempt suicide than people bereaved by sudden natural causes: Pitman, A, Osborn, D, Rantell, K, & King, M. (2016). Bereavement by suicide as a risk factor for suicide attempt: A cross-sectional national UK-wide study of 3432 young bereaved adults. *BMJ Open*. 2016;6. [\[Weblink\]](#)

identity. This included intentional misuse of pronouns, deadnaming, withdrawal of emotional support and, in some cases, being excluded from the family home at a young age.¹⁹

Postvention services can find themselves navigating a complex and sensitive tension: seeking to honour and respect the young person's identity while supporting family members who continue to deny that identity.

It is essential that the recommended capability-building (including training and resources) for postvention services to ensure they are DFSV-informed includes the dynamics and impacts of DFSV perpetrated against LGBTQIA+ people (see recommendation 5).

Access to suicide postvention services

Action 5.2f in the *National Suicide Prevention Strategy 2025–2035* calls on governments to provide universal access to postvention services to support people bereaved by suicide, including dedicated tailored supports for groups disproportionately impacted by suicide.

Current funding arrangements for suicide postvention services are disjointed and complex, characterised by short-term funding arrangements and multiple funding sources. This creates a patchwork of support across different regions, with reduced service access for people in regional areas, who are up to twice as likely to die by suicide as people living in major cities.²⁰ Our waitlist for *Support After Suicide* is growing, with funding insufficient to meet demand.

Recognising these challenges, the Productivity Commission's recent review of *National Mental Health and Suicide Prevention Agreement* (the Agreement) recommended that the level of funding for suicide prevention services remain at or above the existing level for the next Agreement, separate funding streams be integrated, and services be locally commissioned and flexibly funded to meet community needs.

To ensure all people bereaved by suicide in the context of DFSV have access to appropriate support, governments should – through the next Agreement and the proposed National Action Plan to address childhood victimisation – provide secure, increased and integrated funding for the delivery of comprehensive suicide postvention support, including for children and young people and in regional and remote communities.

Recommendation 5: Governments should ensure suicide postvention services, including bereavement support and counselling, are DFSV-informed, including by building staff understanding of and capability to respond to the dynamics and impacts of DFSV, including for children and young people and LGBTQIA+ people.

¹⁹ See also Fitz-Gibbon, K., Stewart, R. & McGowan, J. (2023) *Young people's experiences of identity abuse in the context of family violence: A Victorian study*. Monash University. [\[Weblink\]](#)

²⁰ See Australian Institute of Health and Welfare, *Suicide and intentional self-harm hospitalisations among regional and remote communities*. [\[Weblink\]](#)

Recommendation 6: Governments should fund the development of dedicated resources to support people experiencing bereavement in the context of DFSV, similar to those developed by Jesuit Social Services (*Support After Suicide*) and Switchboard Victoria for LGBTQIA+ bereavement, complemented by resources for professionals working with people bereaved by suicide in the context of DFSV. These resources should be informed by the practice expertise of services like *Support After Suicide*, as well as people with lived expertise.

Recommendation 7: Governments should ensure suicide postvention services are in scope of the forthcoming national Domestic and Family Violence Risk Assessment and Management Framework including any guidance, training and capability-building initiatives developed to implement the Framework.

Recommendation 8: As part of the proposed National Action Plan to address childhood victimisation (see recommendation 3), the Federal Government should fund a dedicated response to children and young people bereaved by suicide, which:

- is informed by the evidence about what children need to heal from the relational trauma of losing a parent;
- takes account of the complexities associated with this grief where the parent they have lost has died by suicide in the context of using or experiencing DFSV;
- is co-designed with children and young people.

Recommendation 9: The Federal Government should fund further research to test the application of evidence-informed approaches to healing after loss of a parent to circumstances where the parent dies by suicide, including in the context of DFSV, to better understand what children need to support them.

Recommendation 10: To ensure all people bereaved by suicide in the context of DFSV have access to appropriate support, governments should provide secure, increased and integrated funding for the delivery of comprehensive suicide postvention support, including for children and young people and in regional and remote communities.

Opportunities to enhance data and research on the links between DFSV and suicide

There is no nationally consistent collection of data for DFSV-related deaths by suicide.²¹ The lack of consistent data – together with under-reporting of DFSV and under-identification of DFSV-related suicides (for example, due to the presence of other factors such as mental health or substance use issues) – means that DFSV-related deaths are likely to be underestimated, and the particular circumstances, dynamics and pathways leading to suicide following DFSV victimisation or perpetration are not well understood, limiting the potential for targeted prevention and early intervention.²²

²¹ Australian Institute of Health and Welfare (2025). *Family, domestic and sexual violence: Health outcomes*. [Weblink]

²² *Family violence and women's deaths by suicide*, op. cit.

Recent research has identified a wide range of issues related to suicide in the context of DFSV that warrant further investigation, as well as opportunities to improve data collection and analysis, that would improve our understanding of the circumstances in which victims of DFSV, including children and young people, die by suicide,²³ as well as the relationship between men's suicidality and use of DFSV.²⁴ These represent important opportunities to assist in improving risk identification, assessment and management practices, and building system capacity to deliver DFSV-informed responses to women and children at risk of suicide following experiences of DFSV.

We wish to highlight, in particular, the need to further explore the relationship between DFSV and suicidal ideation and suicide attempts by victim-survivors, in addition to suicide deaths. Measuring and analysing non-fatal outcomes, including suicidal ideation and attempts, better recognises the lived experience and ongoing distress and suffering of victim-survivors. For example, research has shown that for every completed suicide among young people there are approximately 200 suicide attempts.²⁵ Measuring non-fatal outcomes also focuses attention on gendered patterns in suicide. While males die by suicide at much higher rates, research consistently finds a higher prevalence of suicidal thoughts and behaviours (including suicide attempts) among females.²⁶ For example, ambulance attendances for suicide attempts and self-harm are significantly higher for females across most age groups, especially young people.²⁷ Suicidal ideation and attempts are also strong predictors of future harm, including repeated attempts and long-term mental health concerns.²⁸

A better understanding of suicide ideation and attempts in the context of DFSV would inform the development of DFSV- and trauma-informed, gender-responsive and culturally safe prevention and early intervention initiatives, including screening and risk assessment tools, as well as offering insights into victim-survivors' support and safety needs to inform service improvement (see also recommendation 4). Existing surveys and studies such as the ABS National Study of Mental Health and Wellbeing and the Australian Longitudinal Study on Women's Health may offer a vehicle to support for further research in this area.

²³ See for example, *Family violence and women's deaths by suicide*, op. cit.; *Missing Figures*, op. cit., especially recommendations 4 and 7.

²⁴ See, for example, O'Donnell K. et al (2025), *The use of intimate partner violence among Australian men: Ten to Men Insights #3 Report*. Australian Institute of Family Studies, p x. [\[Weblink\]](#)

²⁵ *Missing Figures*, op. cit., p 12, citing Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney W. E. (eds) (2002). *Reducing suicide: A national imperative*. Washington, DC: National Academy Press.

²⁶ See, for example, Australian Institute of Health and Welfare, *Suicide & self-harm, monitoring: Thoughts, ideation and suicide attempts*. [\[Weblink\]](#)

²⁷ Australian Institute of Health and Welfare, *Ambulance attendances: Suicidal ideation, and suicidal and self-harm behaviours*. [\[Weblink\]](#)

²⁸ See, for example, Brown, G. K., Beck, A. T., Steer, R. A., & Grisham, J. R. (2000). Risk factors for suicide in psychiatric outpatients: A 20-year prospective study. *Journal of Consulting and Clinical Psychology*, 68(3), 371. [\[Weblink\]](#); see also Australian Institute of Health and Welfare, *Suicide & self-harm, monitoring: Thoughts, ideation and suicide attempts*. [\[Weblink\]](#)

Future research should also further explore the relationship between DFSV and suicide for cohorts at higher risk of family violence and/or suicide, including First Nations people, LGBTQIA+ people, and children and young people, to inform targeted prevention, early intervention, response and recovery efforts.

Suicide postvention services such as *Support After Suicide* often work with people impacted by suicide over several years and have the opportunity to gather qualitative data about the context and circumstances in which DFSV-related suicides occur.²⁹ This data could be more systematically captured and analysed to enhance our understanding of suicide in the context of DFSV.

Recommendation 11: Governments should identify and explore opportunities to further investigate suicidal ideation and suicide attempts in the context of DFSV, for example through the ABS National Study of Mental Health and Wellbeing and longitudinal research into women's health.

Recommendation 12: Governments should invest research to enhance our understanding of the links between DFSV and suicide for cohorts at higher risk, including First Nations people, LGBTQIA+ people, and children and young people.

Recommendation 13: Governments should invest in research with suicide postvention services to enhance our understanding of the contexts in which DFSV-related suicides occur.

Improving service system capacity to prevent DFSV-related suicides

Research indicates that people who die by suicide in the context of DFSV – both victims and those who use violence – are often known to DFSV and other service systems, including police, mental health, substance use, and child and family services.³⁰

Practitioners from *Support After Suicide* report that in many cases of suicide deaths by victims of DFSV, these individuals – particularly young people – had long histories of mental health or alcohol and other drug (AOD) service contact before their deaths. The violence they had experienced was often disclosed during this service contact related to mental health or AOD support, rather than within DFSV-specific service systems.

This suggests critical missed opportunities to recognise untreated trauma from DFSV as a risk factor for suicide, to recognise suicide threats as a serious risk factor for both self-harm and homicide, and to respond in a DFSV- and trauma-informed way – with potentially life-threatening consequences for victims. As highlighted on page 11 of this

²⁹ See, for example, Flynn, L. (2020). "We were fighting the system as well as the illness": Family perceptions of how Victoria responds to people at risk of suicide and their loved ones. Melbourne: Jesuit Social Services. [\[Weblink\]](#)

³⁰ See, for example, *Missing Figures*, op. cit., pp 23–24; Woolley, J. (2024). Policing perpetrator suicide threats in family violence cases: competing priorities and contemporary challenges. *Policing and Society*, 34(10), 997–1010. [\[Weblink\]](#); Suicide Prevention Australia (2024). Submission to South Australian Royal Commission into Domestic, Family and Sexual Violence, pp 2–3. [\[Weblink\]](#)

submission, there is a vital need to strengthen DFSV risk assessment and management practices across relevant services, including by explicitly incorporating (victim) suicide risk into risk assessment frameworks, practice guides and training (see recommendation 4).³¹ Even where significant mental health concerns, including suicide risk, are identified by good risk assessment and case management practice, inadequate mental health system capacity can constrain access to the type of mental health support required, indicating a critical need to increase funding for (DFSV- and trauma-informed) mental health services.

Suicide-related services also need a stronger DFSV lens. For example, the *National Suicide Prevention Strategy 2025–2035* recognises DFSV and child abuse as social determinants of suicide and recommends actions to prevent and reduce DFSV as a means of preventing suicide. However, the Strategy does not contain any actions designed to ensure crisis support/response services are DFSV-informed and able to recognise and respond to suicide risk in the context of DFSV (among both victims and people using violence). In addition to suicide postvention services (recommendation 7), we recommend that crisis support/response services also be in scope of any obligations arising from the forthcoming national risk assessment and management framework.

This common history of service contact – often frequent and recent – among both victims and people using DFSV who die by suicide not only indicates potential missed opportunities for intervention but also suggests an ongoing failure to provide adequate support for healing and recovery from DFSV, especially for children and young people. As per recommendation 2 in this submission, there is an urgent need for investment to expand access to DFSV- and trauma-informed healing and recovery supports for victim-survivors of DFSV, especially children and young people, to mitigate its harmful impacts, including the risk of suicide.

More broadly, there is a need to build the capability of workforces across the health, social services and legal and justice sectors to better respond to the needs of victims of violence, including the specific needs of children and young people. This could be incorporated into risk assessment and management workforce training packages across jurisdictions and into wider government DFSV industry planning and workforce capability uplift efforts.

Health service and criminal justice responses offer important opportunities to intervene to prevent further violence, including suicide. However, research indicates that health and justice system responses to suicidal behaviours in the context of DFSV are often siloed and short-term, and involve limited exchange of information between services. Threats of suicide or self-harm tend to receive a health system response, in which the DFSV context often goes unrecognised and unaddressed.³² A whole-of-government

³¹ *Family violence and women's deaths by suicide*, op. cit.

³² Fitzpatrick, S. J., Brew, B. K., Handley, T., & Perkins, D. (2022). Men, suicide, and family and interpersonal violence: A mixed methods exploratory study. *Sociology of Health & Illness*, 44(6), 991–1008. [[Weblink](#)]; Woolley, J. (2024). Policing perpetrator suicide threats in family violence cases: competing priorities and contemporary challenges. *Policing and Society*, 34(10), 997–1010. [[Weblink](#)]

approach is needed to enable a coordinated, collaborative and holistic response to suicide risk in the context of DFSV that does not treat social and health problems in isolation and enables long-term, integrated treatment and support.³³ This should include information-sharing and multidisciplinary responses across the health, social and legal and justice sectors, supported by clear accountability for coordination.

Recommendation 14: Governments should increase funding for mental health services to enhance system capacity to provide DFSV- and trauma-informed support to victim-survivors of DFSV with significant mental health concerns, including suicide risk.

Recommendation 15: Governments should ensure crisis response/support services are in scope of the national Domestic and Family Violence Risk Assessment and Management Framework including any guidance, training and capability-building initiatives developed to implement the Framework (see also recommendation 7).

Recommendation 16: Governments should build the capability of workforces across the health, social services and legal and justice sectors to better respond to the needs of victims of violence, including the specific needs of children and young people, for example through risk assessment and management workforce training packages across jurisdictions and wider government DFSV industry planning and workforce capability uplift efforts.

Recommendation 17: Governments should work together to enable a coordinated, collaborative and holistic response to suicide risk in the context of DFSV, including through information-sharing arrangements and multidisciplinary, cross-sector responses that provide long-term, integrated treatment and support, with clear accountability for coordination.

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

Addressing rigid masculine norms through prevention and early intervention

Jesuit Social Services' Man Box (2024) and Adolescent Man Box (2025) studies have made a critical contribution to the evidence on the association between adherence to masculine stereotypes (the 'Man Box rules') and the behaviours of men and boys.

Our Man Box research shows that adherence to rigid masculine norms is associated with both increased risk of perpetration of DFSV and increased risk of suicidal thoughts and behaviours. For example, the men who most strongly agreed with the Man Box rules were 17 times more likely to have hit their partner and eight times more likely to have thoughts of suicide nearly every day.³⁴

³³ Fitzpatrick S. (2022). Perpetrators of family violence sometimes use threats of suicide to control their partner, *The Conversation*, 5 May 2022. [[Weblink](#)]

³⁴ The Men's Project & Flood, M. (2024). *The Man Box 2024: Re-examining what it means to be a man in Australia*. Melbourne: Jesuit Social Services. [[Weblink](#)]

Our Adolescent Man Box research has also found an association between personal agreement with the need to be manly, poor mental health outcomes and a range of harmful behaviours, including coercive and controlling behaviours. Of boys who most strongly agreed with the need to conform to rigid masculine norms:

- 39% had engaged in bullying, physical violence or sexual harassment in the past month;
- 35% agreed that if a teenage boy has a girlfriend, he should know where she is all the time;
- 35% would probably retaliate if rejected;
- 52% believe it's okay to send multiple messages or calls when their partner isn't responding immediately or when they are frustrated with them;
- 42% believe it's normal to continually check who their partner is communicating with;
- 22% believe it's okay to call their partner mean names when they disagree with them or their beliefs;
- 85% reported a experiencing a poor mental health symptom in the past two weeks, including little interest or pleasure in doing things (78%); feeling down, depressed or hopeless (70%); or having thoughts of self-harm (23%).³⁵

These research findings highlight the need to focus on decreasing adherence to harmful masculine norms as part of prevention and early intervention efforts that seek to address DFSV and suicide, and suggest that programs that seek to challenge rigid gender norms are likely to have a dual benefit.

Importantly, the Adolescent Man Box research also found that most adolescents who had used aggression in the past month (83%) reported that they had been victimised in the same time period,³⁶ suggesting that it is not only boys' attitudes that increase the likelihood of using violence, but also their own experience of violence. This is explored further below.

Work with men and boys to address the drivers of DFSV and suicide and intervene earlier with men and boys at higher risk has increased in recent years but is still far from sufficient to match the scale of the problem. Further investment is needed to scale up high quality prevention and early intervention programs with a focus on engaging men and boys. This work should be informed by:

- data on the extent, dynamics and drivers of perpetration of DFSV;

³⁵ The longitudinal study into men's health has also found that men who experience suicidal thoughts, plans or attempts are also significantly more likely to use intimate partner violence: O'Donnell K. et al (2025), *The use of intimate partner violence among Australian men: Ten to Men Insights #3 Report*. Australian Institute of Family Studies [[Weblink](#)]

³⁶ *The Adolescent Man Box*, op. cit., p 23.

- research into attitudes and behaviours linked to rigid gender norms, such as the Man Box and Adolescent Man Box; and
- practice evidence of what works to engage men and boys.

As recommended in the *Adolescent Man Box* report, prevention and early intervention programs should also respond to young people's concerns and the social pressures they face and give them the tools and support they need to deal with issues emerging from the research such as coping with rejection, safely navigating digital environments and mitigating the impacts of harmful pornography.³⁷ These programs should also be trauma-informed, recognising that those who use or are at risk of using violence are likely to have experienced it themselves, and be culturally safe for First Nations and Culturally and Racially Marginalised communities.

Priority levers for change include:

- working across a range of settings with those who can positively influence men and boys, such as teachers, sports coaches, community leaders and social workers
- working with adolescent boys (particularly those at greater risk of using violence) and adult men to promote healthier relationships with themselves and others.

Jesuit Social Services delivers a range of programs in different settings (such as schools, workplaces and sports clubs) that seek to build the capability of those who work with men and boys (such as teachers and coaches) to challenge harmful gender norms that drive DFSV and contribute to poor mental health and wellbeing. These include [Modelling Respect and Equality \(MoRE\)](#), [Active Respect](#) and work with the construction industry.

Case study: Modelling Respect and Equality (MoRE)

Our practice expertise and research suggest that engaging role models to demonstrate healthy and positive alternatives to rigid and outdated masculine norms is a crucial strategy to reduce violence, improve outcomes for men and boys and promote cultural and attitudinal change.

Modelling Respect and Equality (MoRE) supports role models who regularly interact with boys and men to challenge limiting and harmful stereotypes and promote respect and equality towards women. The program supports participants to develop greater awareness of masculine norms and their impact, learn how to model and promote positive change, and recognise and challenge problematic attitudes and behaviours. Participants include teachers, social workers, sports coaches, leaders in workplaces, and leaders in faith communities. An [evaluation of MoRE](#) found significant change in participants' knowledge, confidence and motivation to bring about change among the men and boys they worked with.

Case study: Improving safety and wellbeing in the construction industry

³⁷ *The Adolescent Man Box*, op. cit., recommendation 1, p 109.

Rigid adherence to stereotypical ideas about what it means to be a man is prevalent amongst male-dominated industries. The construction sector has been identified as one of the highest occupational risk sectors in Australia,³⁸ where women are at particular risk of experiencing gendered violence in the workplace. This often drives women to resign from their jobs, with women leaving the construction industry 38% faster than men.³⁹ Data also show that young construction workers more than twice as likely to die by suicide than other young Australian men.⁴⁰

The Men's Project delivers evidence-based programs for the construction sector that challenge harmful gender norms in order to improve wellbeing, behaviour and safety. We engage with organisations to identify and address beliefs and behaviours which may lead to poor mental health and suicidality, alcohol and drug abuse, workplace bullying, sexual harassment, low female workforce participation, risk taking behaviour, and absenteeism.

For example, in Victoria, The Men's Project has partnered with ICON Construction to deliver a whole-of-organisation approach to Inclusion, Equality and Safety through tiered training and support for leaders, project managers, site managers, other key influencers, contractors, and onsite staff. The partnership aims to generate positive cultural change, towards inclusion, gender equality and safety (including violence and harm reduction). The partnership project incorporates: intensive training for leadership; establishment of a network of "site champions" who receive training in bystander intervention to influence their peers; regular toolbox talks to reinforce key messaging; and a video series that introduces key concepts.

As noted on pages 8 and 21 of this submission, a significant proportion of both people who use violence and who die by suicide have histories of victimisation, often in childhood. This points to the importance of early intervention with young people – especially men and boys – who may have experienced DFSV and be at higher risk of using violence or other harmful behaviours to disrupt intergenerational cycles of violence, prevent poor mental health outcomes including suicidal behaviours, and set young people on a path to living safer, healthier and happier lives.

Jesuit Social Services delivers evidence-based early intervention programs for young people who have used or are at higher risk of using violence or other harmful behaviours, such as *Change Makers*, that seek to increase protective factors for healthy relationships and reduce risk factors for harmful behaviours, including adherence to rigid gender norms.

Case study: Change Makers

³⁸ Ross, V, Caton, N, Gullestrup, J and Kloves, K. (2020). A Longitudinal Assessment of Two Suicide Prevention Training Programs for the Construction Industry. *International Journal of Environmental Research and Public Health*. [[Weblink](#)]

³⁹ Victoria Government (2019). *Victoria's Women in Construction Strategy*. [[Weblink](#)]

⁴⁰ SafeWork NSW (2022). *Findings Report: Mental Health in Construction 2022*. [[Weblink](#)]

Funded by the Victorian Government, Jesuit Social Services is piloting an early intervention program, 'Change Makers', which aims to empower at-risk boys and young men with the knowledge, skills and confidence to live safer, fuller lives, free from violence and other harmful behaviours.

Change Makers focuses on increasing protective factors like attendance at school, healthy relationships, association with pro-social peers, connection to a caring adult (including help-seeking), and non-violent problem-solving skills. It also aims to decrease risk factors for violence like antisocial beliefs and attitudes, with a focus on harmful gendered beliefs and involvement in gangs.

The program includes group work with young people aged 12–25, as well as capacity-building for partner organisation staff, who are already engaged with the young people and will continue to work with them after the program ends.

We co-deliver Change Makers in collaboration with community partners, including specialist schools, secondary schools, and community organisations – often with cultural brokers who can support the relationship between facilitators and the young people in their cultural context.

Interim evaluation findings show improvements in participants' emotional literacy, empathy for others, non-violent problem-solving skills, help seeking behaviours, and understanding of gender norms and societal pressures related to masculinities. Program impacts also include stronger social connections and behavioural changes for participants, such as improved attendance and behaviour at school.

Promoting help-seeking among boys and men

While women and girls experience poorer mental health and wellbeing overall, they are more likely than boys and men to seek help. Over one-third of adolescent boys (36%) surveyed in the Adolescent Man Box study reported they had not sought any support for an emotional or personal issue in the past six months, compared with one in five girls who had not sought support (20%).⁴¹ Adolescent boys' adherence to the Adolescent Man Box pillars of 'constant effort to be manly', 'emotional restriction', 'self-sufficiency' and 'acting tough' may discourage or stigmatise help-seeking and displays of vulnerability among men and boys.

In order to both prevent DFSV and improve the health and wellbeing of boys and men, there is a need to increase boys' and men's access to supports and services. This should include encouraging both formal and informal help-seeking – particularly among adolescent boys – including for mental health concerns, among those who have experienced and/or who are at risk of using violence, and for other troubling behaviours including suicidal thoughts and behaviours. Initiatives to promote help-seeking must be underpinned by access to appropriate services, which must be holistic, gender-responsive, DFSV- and trauma-informed, culturally safe and (where relevant) child- and young people-centred.

⁴¹ *The Adolescent Man Box*, op. cit., p 29.

Building the evidence base and workforce capability to engage men and boys

Both DFSV and suicide remain endemic in our community. If we are to make meaningful progress towards reducing violence and suicidal behaviours, further work is needed to build the evidence base for what works to engage men and boys and decrease adherence to rigid gender norms, translate evidence into practice, and scale up promising initiatives. This includes investing in high quality program evaluations so we can build the evidence base on effective practice and target resources to interventions and approaches that achieve meaningful change.

Scaling up promising practice also requires a skilled workforce. There is a need to build the capability of workforces across sectors (including child and family services, health promotion, DFSV prevention, mental health, AOD and justice services) to ensure people who work with men and boys – especially men and boys at higher risk of using violence or other harmful behaviours – adopt evidence-based strategies for engagement and addressing rigid gender norms.

Recommendation 18: Governments should invest in expansion of evidence-based prevention and early intervention initiatives across a range of settings, including schools, workplaces and sports clubs, that address rigid gender norms and other drivers of DFSV and harmful behaviours such as suicide, and equip boys and young men with tools and resources to address concerns identified in the Adolescent Man Box research.⁴²

Recommendation 19: Governments should invest in initiatives to encourage formal and informal help-seeking among boys and men, underpinned by access to support services that are holistic, gender-responsive, DFSV- and trauma-informed, culturally safe and (where relevant) child- and young people-centred (see also recommendation 2).

Recommendation 20: Governments should build the evidence base for what works to engage men and boys and decrease adherence to rigid gender norms, including through high quality program evaluations, to enable resources to be directed to the most effective interventions.

Recommendation 21: Governments should build the capability of workforces across relevant sectors to engage with men and boys and address harmful masculine norms including by embedding this as a priority into DFSV industry planning workforce strategies.

⁴² See also Recommendations 1 and 2 in *The Adolescent Man Box* report.