

# **Submission to the Consultation on the Second Action Plan (National Plan to End Violence against Women and Children 2022–2032)**

*August 2026*



**Australian Government**  
**National Mental Health Commission**



**Australian Government**



**National  
Suicide  
Prevention  
Office**

## Acknowledgement of Country

The National Suicide Prevention Office and the National Mental Health Commission acknowledge the traditional custodians of the lands throughout Australia. We pay our respects to their clans, and to the elders, past and present, and acknowledge their continuing connection to land, sea and community.

## Recognition of lived experience

The National Suicide Prevention Office and the National Mental Health Commission recognise the individual and collective contributions of those with a lived and living experience of mental ill-health and suicide, and those who love, have loved and care for them. Each person's journey is unique and a valued contribution to Australia's commitment to mental health and suicide prevention systems reform.

## Sources of support

Support is always available. Below are options for online and telephone information and support in Australia.

|                                                                                                               |                                                                                                                                                  |                                                                                                                                |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| <p>Lifeline</p> <p>☎ 13 11 14</p> <p>➤ <a href="http://lifeline.org.au">lifeline.org.au</a></p>               | <p>Suicide Call Back Service</p> <p>☎ 1300 659 467</p> <p>➤ <a href="http://suicidecallbackservice.org.au">suicidecallbackservice.org.au</a></p> | <p>Beyond Blue</p> <p>☎ 1300 224 636</p> <p>➤ <a href="http://beyondblue.org.au">beyondblue.org.au</a></p>                     |
| <p>MensLine Australia</p> <p>☎ 1300 789 978</p> <p>➤ <a href="http://mensline.org.au">mensline.org.au</a></p> | <p>Standby Support After Suicide</p> <p>☎ 1300 727 247</p> <p>➤ <a href="http://standbysupport.com.au">standbysupport.com.au</a></p>             | <p>headspace</p> <p>☎ 1800 650 890</p> <p>➤ <a href="http://headspace.org.au">headspace.org.au</a></p>                         |
| <p>ReachOut</p> <p>➤ <a href="http://au.reachout.com">au.reachout.com</a></p>                                 | <p>Kids Helpline</p> <p>☎ 1800 551 800</p> <p>➤ <a href="http://kidshelpline.com.au">kidshelpline.com.au</a></p>                                 | <p>13YARN</p> <p>☎ 13 YARN (13 92 76)</p> <p>➤ <a href="http://13yarn.org.au">13yarn.org.au</a></p>                            |
| <p>WellMob</p> <p>➤ <a href="http://wellmob.org.au">wellmob.org.au</a></p>                                    | <p>Open Arms</p> <p>☎ 1800 011 046</p> <p>➤ <a href="http://openarms.gov.au">openarms.gov.au</a></p>                                             | <p>Defence Member and Family Helpline</p> <p>☎ 1800 624 608</p>                                                                |
| <p>QLife</p> <p>☎ 1800 184 527</p> <p>➤ <a href="http://qlife.org.au">qlife.org.au</a></p>                    | <p>Medicare Mental Health</p> <p>➤ <a href="http://medicarementalhealth.gov.au">medicarementalhealth.gov.au</a></p>                              | <p>1800RESPECT</p> <p>☎ 1800 737 732</p> <p>➤ <a href="http://1800respect.org.au">1800respect.org.au</a></p>                   |
| <p>SANE</p> <p>☎ 1800 187 263</p> <p>➤ <a href="http://sane.org">sane.org</a></p>                             | <p>National Alcohol and Other Drug Hotline</p> <p>☎ 1800 250 015</p>                                                                             | <p>Embrace Multicultural Mental Health</p> <p>➤ <a href="http://embracementalhealth.org.au">embracementalhealth.org.au</a></p> |

## About the National Suicide Prevention Office

The National Suicide Prevention Office (NSPO) is a specialist office that sits alongside the National Mental Health Commission within the Department of Health, Disability and Ageing.

The NSPO is tasked with leading a coordinated, whole-of-governments approach to suicide prevention. It aims to provide robust, evidence-based insights and advice to guide and support all levels of government to take coordinated, comprehensive and consistent action to reduce suicide and suicidal distress.

The work of the NSPO is informed by people with lived and living experience of suicide and draws on the rich combined knowledge and expertise of individuals, communities, service providers, advocates, researchers and government agencies across portfolios and jurisdictions.

To reduce the rates of suicide deaths and attempts, the NSPO looks to address the factors associated with increased risk of suicidal distress, which includes the experience of domestic, family and sexual violence (DFSVM).

The NSPO developed the [National Suicide Prevention Strategy](#) (Suicide Prevention Strategy), which was formally endorsed by all relevant Commonwealth portfolios and all states and territories before being launched in February 2025. The Suicide Prevention Strategy outlines a comprehensive national approach to suicide prevention and includes specific reference to DFSVM as a key driver of suicidal distress. In 2026 the NSPO also released the [National Suicide Prevention Outcomes Framework](#) (Outcomes Framework) Outcomes Map, which enables the measurement of progress against the Suicide Prevention Strategy. The Suicide Prevention Strategy and Outcomes Framework highlight the importance of community safety and security in promoting wellbeing and preventing suicide.

## About the National Mental Health Commission

The National Mental Health Commission (the Commission) provides independent advice and evidence to support continuous improvement across Australia's mental health and suicide prevention systems and acts as a catalyst for change. Its strategic vision is for all people living in Australia to be enabled and supported to lead mentally healthy and fulfilling lives.

The Commission supports the Australian Government to lead and shape the mental health system through evidence-based advice and reporting. Its work is informed by data, evidence and lived experience, and shaped through engagement with governments, experts and Australia's diverse communities.

A core part of the Commission's remit is strengthening transparency and accountability across the mental health system. By monitoring and reporting on system performance, analysing trends and tracking progress against national priorities, the Commission identifies what is working, where improvement is needed and where investment can make the greatest difference.

Recognising that mental health outcomes are shaped by factors beyond healthcare alone, the Commission works across sectors and jurisdictions to promote coordinated action on the social, economic and environmental determinants of mental health and wellbeing. Through collaboration with consumers, carers, communities, service providers, governments and other partners, it helps build consensus around reform priorities and supports a more connected, responsive and sustainable system grounded in human rights and trust.

## Introduction

The NSPO and Commission welcome this opportunity to contribute to the consultation on the *Second Action Plan (National Plan to End Violence against Women and Children 2022–2032)*.

This submission draws on the insights of all those who have contributed to the work of the NSPO and Commission, including people with lived experience of suicide, researchers, sector stakeholders, and governments. In particular, we thank members of the NSPO's Lived Experience Partnership Group and the NSPO Advisory Board who have provided input to this submission.

In line with the NSPO and Commission's respective roles in suicide prevention and mental health, this submission will focus on the intersection between suicide, mental health and domestic, family and sexual violence (DFSV).

## Summary of recommendations

**Recommendation 1** – Establish integrated, trauma-informed and culturally safe pathways across DFSV, mental health, suicide prevention and social support systems to provide timely, coordinated and appropriate support. This should include:

- Establishing clear guidance for enacting supported referrals and navigation processes across DFSV, mental health, suicide prevention, alcohol and other drugs, housing, legal, financial, child and family, and social support services.
- Defining clear roles, responsibilities and escalation processes, including guidance for mental health services on identifying DFSV, responding to trauma and suicidal distress, supporting safety planning, and linking people with specialist DFSV and social supports.

**Recommendation 2** – Implement and monitor integrated pathways through the Second Action Plan. This should include a dedicated action to map, test and evaluate pathways across DFSV, mental health, suicide prevention and social support systems, with a focus on:

- consent-based information sharing and active handover arrangements
- linked service directories and data-sharing mechanisms
- identification of service gaps and barriers at key transition points
- evaluation to monitor referral outcomes.

**Recommendation 3** – Align relevant Second Action Plan commitments with the *National Suicide Prevention Strategy 2025-2035* and *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025-2035* to support shared accountability across violence prevention, suicide prevention, mental health, justice, child and family services, and social policy portfolios by:

- explicitly recognising DFSV as a key social and structural determinant of mental health and wellbeing, and as a factor associated with increased risk of suicidal distress
- embedding suicide prevention in holistic trauma-informed wrap-around supports for victim-survivors and ensure supports for those impacted by DFSV and suicide, and those who care for them, are high quality and effective
- actively including the diverse experiences, voices, and insights of people with lived experience of suicidal behaviour and DFSV victimisation across all phases of system reform.

**Recommendation 4** – Develop wraparound supports for children and young people impacted by violence, abuse and neglect that are holistic, trauma-informed, culturally informed and are equipped to respond to suicidal distress. Supports should be developed in partnership with children, young people and their communities. This should include greater investment in culturally informed, community-controlled supports for First Nations children, young people and families that strengthen healing, connection to culture, family preservation and long-term wellbeing.

**Recommendation 5** – Review education-based programs aimed at identifying and providing support to children at risk of violence, abuse and neglect for early intervention to ensure effectiveness, and to inform design of nationally supported programs and curriculum that reflect best-practice and co-development with young people.

**Recommendation 6** – Resource a suitable national agency (or agencies) to define and implement nationally consistent data measures related to the intersection of DFSV, mental health and suicide, including DFSV-related suicide deaths and attempts. Nationally consistent DFSV-related data measures should complement those being used within the *National Suicide Prevention Outcomes Framework*.

**Recommendation 7** – Ensure workforces that are in a position to engage with people who have been impacted by DFSV are equipped to recognise and respond effectively to suicidal distress.

**Recommendation 8** – Identify the capability uplift gaps required for the mental health and suicide prevention workforces to effectively contribute to violence prevention and response needs and undertake a targeted review to identify and articulate the synergies and gaps between the Second Action Plan and the *National Mental Health Workforce Strategy* and the suicide prevention capability framework (in development) to maximise the impact of future investments.

**Recommendation 9** – Ensure the Second Action Plan clearly distinguishes between mental health as a consequence, correlate or co-occurring support need, and does not conflate experiences of mental health challenges as a cause of violence, to avoid stigma and ensure people are directed to appropriate supports.

**Recommendation 10** – Improve the integration of support pathways for harmful alcohol and other drug use, DFSV and suicide prevention, to ensure people receive appropriate and coordinated support. This should:

- Ensure service touchpoints are equipped to identify people whose substance use may be related to increased suicidal distress, violence, or victimisation.
- Upskill alcohol and other drugs and DFSV support services with suicide prevention capability to identify, and support people who are experiencing suicidal distress.
- Ensure support services are non-judgemental to promote accessibility and engagement.

**Recommendation 11** – Establish a nationally consistent evaluation framework for interventions and supports for people who use violence, to determine effectiveness, strengthen accountability and guide future investment and reform efforts.

**Recommendation 12** – Invest in programs that promote healthy expressions of masculinity that encourage help-seeking, emotional vulnerability, caring for others, and fosters respectful relationships for men and boys. This should:

- Ensure that messaging to challenge harmful societal attitudes is evidence-based, targeted and culturally appropriate to meet the needs of people seeking support.
- Develop programs in partnership with people with lived and living experience to increase awareness of the association of DFSV, mental health and suicide, promote healthy and safe relationships, and encourage reaching out for support.

**Recommendation 13** – Strengthen the evidence-base and act to address the impacts of gambling on DFSV and suicide through implementation of the House of Representatives Standing Committee on Social Policy and Legal Affairs' inquiry into online gambling and its impacts on those experiencing gambling harm.

## **An integrated approach to mental health, suicide prevention and domestic, family and sexual violence**

The use of violence, including DFSV, is influenced by complex and interconnected factors operating across individual, relationship, community and societal levels. This includes social, economic and structural determinants that can influence mental health and risk factors for suicide, such as personal safety, housing security, financial stability, social connection, education, employment, culture and gender norms. Framing DFSV within the context of these broader determinants highlights the need for approaches that strengthen protective factors, reduce risk, address the conditions that compound harm, improve pathways to safety, recovery and wellbeing for victim-survivors, children and families, and more effectively address the behaviours of perpetrators.

Responses must address the wider determinants that shape both exposure to violence and long-term mental health outcomes. The Commission and NSPO are working with the University of Queensland to better understand these determinants through a health equity lens and will share the findings with the Department of Social Services when available. The project will inform stronger evidence-based advice on upstream prevention, systems reform, and coordinated action across portfolios that influence on safety, mental health, wellbeing and recovery outcomes.

Given the relationship between DFSV, mental health and suicidal distress, integrated responses across service systems are essential, including strategic alignment between mental health, suicide prevention and DFSV efforts. Underlying factors associated with DFSV that should be addressed include (but are not limited to) socio-economic disadvantage, discrimination, financial stress, alcohol and other drug harms, housing insecurity, childhood adversity, and relationship breakdown. However, there is no single victim-survivor archetype. People experiencing DFSV come from diverse backgrounds and circumstances, and service systems and policymakers must recognise that victimisation can be experienced by individuals not traditionally recognised as being at heightened risk.

Victim-survivors of DFSV often engage with multiple services both during points of crisis and throughout their recovery journey, including health, mental health, housing, justice, family support, education and social services. When these systems operate in isolation, opportunities to identify risk related to suicide, mental health challenges or DFSV, and provide coordinated support may be missed.

There is a need for a whole-of-service-system response that addresses multiple risk and protective factors rather than relying on any single intervention pathway, like mental health services. Oversimplifying the factors associated with violence use could create unintended consequences for both people who use violence and victim-survivors. There is, however, an important role for mental health and suicide prevention services as part of an integrated and holistic response. Embedding trauma- and DFSV-informed practice across the mental health and suicide prevention systems could significantly improve prevention, early intervention and recovery outcomes. Opportunities to support victim-survivors, including children, should be optimised to ensure a holistic focus not only on mental health symptoms and suicidal distress, but also on identifying and managing the risk of future violence and responding to the safety and support needs of the whole family. Mental health and suicide prevention services can also play an important role in early identification and intervention, and the evidence points to coordinated, relational and cross-sectoral models as most effective.

This can be achieved by ensuring services are equipped to recognise violence and coercive control, respond in ways that promote safety and dignity, and connect people with specialist DFSV, legal, housing, financial and social support services. This approach would help prevent escalation and repeat harm by treating violence as a safety, relational and social issue, rather than an individual, or isolated pathology. It would also strengthen the

conditions that more broadly support mental health and wellbeing, including access to safe and secure housing, financial autonomy, social connection, cultural safety, freedom from violence and specialist, trauma-informed support.

Seamless integration requires good data-sharing and communication practices to ensure timely access and service delivery. This requires consistent terminology, privacy considerations and system interoperability both within a service (i.e. between sessions or practitioners) and with other cross-sectoral service entities. This should be built into the Second Action Plan as it will underpin the success of interoperability and integration between systems. Specifically, utilising good data collection not only for monitoring purposes but also to support integration and care coordination across services.

Data sharing parameters should reference reporting, evaluation and a national minimum dataset, and specify how data will be shared between services and digital platforms, and how interoperability and information-sharing arrangements will operate in practice to support integrated care. This should be considered across sectors and governments (e.g. Commonwealth and state and territory governments, and the NGO sector).

Effective service navigation is critical to ensuring people experiencing violence can access the right support at the right time. The Second Action Plan should support the development of linked service directories and clear referral pathways that connect health, mental health, suicide prevention, alcohol and other drug, social, housing, legal and family violence services. This should include nationally consistent approaches to warm referrals, where consented information is shared and active handovers occur between services, reducing the burden on individuals to repeatedly navigate complex systems and retell their experiences.

Consideration should be given to service directories and digital navigation tools that enable practitioners and consumers to identify appropriate supports, understand eligibility requirements and access real-time referral information.

Initially, the Action Plan should commence further work to illustrate the interconnections and pathways between services that deliver across prevention, early intervention, response and recovery. It should demonstrate how people most commonly move through the systems, where transitions occur, and how referral mechanisms operate across jurisdictions and service types.

### **Recommendation 1**

Establish integrated, trauma-informed and culturally safe pathways across DFSV, mental health, suicide prevention and social support systems to provide timely, coordinated and appropriate support. This should include:

- Establishing clear guidance for enacting supported referrals and navigation processes across DFSV, mental health, suicide prevention, alcohol and other drugs, housing, legal, financial, child and family, and social support services.
- Defining clear roles, responsibilities, and escalation processes, including guidance for mental health services on identifying DFSV, responding to trauma and suicidal distress, supporting safety planning, and linking people with specialist DFSV and social supports.

### **Recommendation 2**

Implement and monitor integrated pathways through the Second Action Plan. This should include a dedicated action to map, test and evaluate pathways across DFSV, mental health, suicide prevention and social support systems, with a focus on:

- consent-based information sharing and active handover arrangements

- linked service directories and data-sharing mechanisms
- identification of service gaps and barriers at key transition points
- evaluation to monitor referral outcomes.

The *National Suicide Prevention Strategy 2025-2035* (Suicide Prevention Strategy) recognises exposure to DFSV as a key factor associated with increased risk of suicidal distress. Data from the Australian Institute of Health and Welfare (AIHW) found that between 2010 and 2018 people hospitalised due to family and domestic violence were twice as likely to die by suicide compared with people hospitalised for other reasons.<sup>1</sup> Problems in relationships with spouse or partner which include intimate partner violence were among the most common psychosocial risk factors for suicide deaths recorded in 2023.<sup>2</sup>

The Suicide Prevention Strategy recognises that victim-survivors often engage with multiple services (both crisis and long-term supports for a range of social and economic needs) throughout their recovery journey, and promotes holistic approaches that improve coordination between services and strengthens referral pathways to build integrated opportunities for people seeking support to access help across sectors. Embedding these principles within the Second Action Plan would support more connected and responsive services that can better meet the needs of victim-survivors experiencing both DFSV and suicidal distress.

The Suicide Prevention Strategy developed in concert with the [\*National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025-2035\*](#) highlights the importance of an integrated approach that considers both suicide prevention and DFSV outcomes. The Suicide Prevention Strategy incorporates recommendations from the First Action Plan in recognition that policy integration between both sectors can improve outcomes for people at risk of experiencing suicidal distress or DFSV victimisation. It charts a path for coordinated action to reduce suicide in a way that is connected to efforts to reduce exposure to DFSV. Recognising the importance of addressing the connected factors associated with DFSV and suicidal distress. As well as articulating what is required for support systems to be able to respond to intersecting needs whether they are related to suicidal distress, exposure to DFSV or associated factors.

With the Suicide Prevention Strategy having been released since the commencement of the First Action Plan, the development of the Second Action Plan provides an opportunity to strengthen integration by prominently acknowledging the relationship between DFSV victimisation and deaths by suicide, and by including the experiences and voices of people with lived experience of suicidal behaviour and DFSV victimisation in the development of government plans and priorities.

### Recommendation 3

Align relevant Second Action Plan commitments with the *National Suicide Prevention Strategy 2025-2035* and *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025-2035* to support shared accountability across violence prevention, suicide prevention, mental health, justice, child and family services, and social policy portfolios by:

- explicitly recognising DFSV as a key social and structural determinant of mental health and wellbeing, and as a factor associated with increased risk of suicidal distress
- embedding suicide prevention in holistic trauma-informed wrap-around supports for victim-survivors and ensure supports for those impacted by DFSV and suicide, and those who care for them, are high quality and effective

- actively including the diverse experiences, voices, and insights of people with lived experience of suicidal behaviour and DFSV victimisation across all phases of system reform.

## Support for child and youth victim-survivors

Childhood is a critical period for mental health and wellbeing. Adverse childhood experiences, including exposure to violence, sexual abuse and neglect, are strongly linked with the development of mental illness and suicide, and can have lifelong impacts on health, education, employment, substance use and involvement with the justice system. The Suicide Prevention Strategy recognises that childhood exposure to DFSV can influence developmental, social and emotional outcomes long after the violence has ended. These experiences can contribute to pathways of trauma, psychological distress, social disconnection and cumulative adversity that increase vulnerability to suicide and suicidal behaviours.

The Australian Child Maltreatment study found young people aged 16-24 who experienced any child maltreatment were 4.5 times more likely to have attempted suicide in the past 12 months and 3.5 times more likely to have self-harmed in the past 12 months.<sup>3</sup> Among Australians who experienced three to five types of child maltreatment, exposure to domestic violence was the most prevalent individual maltreatment type, and was present across the most frequent multi-type maltreatment patterns.<sup>4</sup>

A suicide prevention lens reinforces the importance of identifying and responding to childhood exposure to DFSV before harms compound over time. This includes recognising that children who experience violence, abuse and neglect may require coordinated supports that address safety, trauma, wellbeing and emerging suicide risk in a holistic manner with their families. Importantly, child protection systems need to actively recognise that for First Nations communities the historical and ongoing impacts of colonisation, racism, and child removal policies can perpetuate further harm. Interventions thus need to be grounded in the principles of cultural safety, self-determination, family preservation and community-controlled responses.

The Commission and the NSPO support the opportunities in the consultation paper to ensure the meaningful engagement of children and young people in the policies and programs that support them.

Addressing emerging forms of sexual violence prevalent among young people, including concerning or harmful behaviours on dating apps, deepfakes, non-fatal strangulation, exposure to violent pornography and online extortion, is necessary. The Commission has forthcoming research on the digital experiences of children and young people aged 5-25 years that speaks to young people's experiences of technology-facilitated sexual harms, including unwanted sexual content or contact, sexual coercion, non-consensual image sharing, pornography exposure and AI-enabled risks. The research also provides evidence of related experiences, including harmful or unwanted contact on digital platforms, exposure to sexual or violent content, and the ways these experiences may be associated with poorer mental health among children and young people. While the research provides adjacent evidence relevant to emerging forms of sexual violence, some issues, including deepfakes, online extortion, sextortion and non-fatal strangulation, are not examined as discrete research topics and require targeted future evidence. The Commission can share the final research findings and recommendations with the Department of Social Services when the report is available.

The [\*National Children's Mental Health and Wellbeing Strategy\*](#) highlights the importance of proactively supporting children's wellbeing and providing support as early as possible to minimise the long-term consequences of poor mental health. Investing in prevention and early intervention is one of the most powerful opportunities to improve mental health and suicide outcomes across the life course for victim-survivors. This includes child-centred, trauma-informed responses that recognise the impact of violence on development, behaviour and wellbeing; support trusted relationships with caregivers, family, community and services; and connect children and young people to timely mental health, DFSV, housing, education and social support.

Schools and educational settings play a particularly important role in promoting wellbeing, social connection and help-seeking, while providing opportunities to identify children and young people who may be experiencing violence, abuse or neglect. Initiatives that promote inclusive and affirming cultures, strengthen relationships with families and improve access to support services can contribute to both violence prevention and suicide prevention outcomes. Consistent with this, the Suicide Prevention Strategy calls for a review of existing school-based programs to ensure effectiveness and to then design a nationally consistent program co-designed with young people.

Consideration should be given to children and young people who experience multiple and intersecting vulnerabilities. Young people in out-of-home care are more likely to have experienced violence, abuse, neglect and other adverse childhood experiences associated with increased suicide risk.<sup>5</sup> Emerging research highlights the importance of improving understanding of the relationship between childhood sexual abuse and suicidality, particularly for boys and young men, who are overrepresented in suicide statistics.<sup>6</sup>

Children and young people exposed to or experiencing DFSV require holistic responses via wraparound supports that respond to the whole range of their unique needs, rather than addressing one issue in isolation or expecting them to navigate separate systems themselves. This means coordinated, holistic supports that address safety, trauma, mental health, suicidal distress and broader social needs, with active coordination and collaboration between services.

#### **Recommendation 4**

Develop wraparound supports for children and young people impacted by violence, abuse and neglect that are holistic, trauma-informed, culturally informed and are equipped to respond to suicidal distress. Supports should be developed in partnership with children, young people and their communities. This should include greater investment in culturally informed, community-controlled supports for First Nations children, young people and families that strengthen healing, connection to culture, family preservation and long-term wellbeing.

#### **Recommendation 5**

Review education-based programs aimed at identifying and providing support to children at risk of violence, abuse and neglect for early intervention to ensure effectiveness, and to inform design of nationally supported programs and curriculum that reflect best-practice and co-development with young people.

## **Addressing data gaps to strengthen understanding of DFSV related suicide**

While the connections between DFSV, mental health and suicide are significant, the extent of this complex relationship is not yet fully visible. This is in part due to the lack of granular and consistent data recording which makes it difficult to produce accurate or nationally representative figures. This is particularly the case when it comes to identifying DFSV as a contributing factor to suicide deaths. This reduces visibility of the importance of DFSV efforts in preventing suicide and obscures the true impact of DFSV in terms of lives lost. This can make the compounding nature of exposure to DFSV and suicidal distress invisible.

The effect of fragmented or absent data is more pronounced for First Nations communities where more data gaps exist compared to non-Indigenous peoples and experiences of suicide, suicidal distress, and DFSV are often under-reported or misidentified.<sup>7</sup> Focus should be placed on developing data measures that accurately represent the experiences of First Nations communities, supported by culturally safe approaches to data collection, interpretation and reporting consistent with the *National Indigenous Australians Agency's Framework for Governance of Indigenous Data*.

## Recommendation 6

Resource a suitable national agency (or agencies) to define and implement nationally consistent data measures related to the intersection of DFSV, mental health and suicide, including DFSV-related suicide deaths and attempts. Nationally consistent DFSV-related data measures should complement those being used within the *National Suicide Prevention Outcomes Framework*.

## Workforce capability uplifts

The NSPO and Commission welcome the Second Action Plan's focus on workforce uplift as a key consideration in enhancing the prevention of, and response to, violence against women and children. The Second Action Plan presents an opportunity to strengthen workforce capability across systems that routinely interact with people affected by DFSV. Many frontline workers are already responding to complex presentations involving trauma, housing instability, financial stress, mental ill-health, suicidal distress, substance use and legal challenges. Equipping these workforces with mental health, suicide prevention and DFSV knowledge and skills would support earlier identification of risk, more effective responses to disclosures and stronger referral pathways into appropriate support. This is particularly important in sectors not traditionally associated with mental health and suicide prevention, including DFSV services, courts, child and family services and community-based organisations, where workers may encounter people experiencing significant distress but lack the training or confidence to respond. By ensuring workforces that are in a position to engage with people who have been impacted by DFSV are equipped to recognise and respond effectively to suicidal distress, it would ensure that regardless of who provides support, the person encounters a workforce with shared fundamental skills and understanding of violence, trauma, safety and recovery.

The mental health workforce includes people who work exclusively in the mental health sector (for example, First Nations mental health workers, mental health nurses, psychologists and psychiatrists) and those that work in other health settings who frequently treat, interact with, care and support people experiencing suicidality, mental distress and/or ill-health (for example, allied health, general practitioners and nurses). People who work in settings who are likely to have regular contact with people experiencing mental distress and/or ill-health and suicidality as part of their role (for example, aged care workers, educators, drug and alcohol workers, and housing and justice services workers), and the Lived Experience (Peer) workforce are also considered part of the mental health workforce.<sup>8</sup>

The NSPO is currently developing a suicide prevention workforce capability framework, with a working definition of the suicide prevention workforce as including people who are employed in paid and volunteer roles who create conditions that reduce suicidality and who provide support to individuals experiencing suicidal distress. This workforce is defined by its focus and impact on suicide prevention outcomes rather than specific professions or disciplines.

Recognising the mental health and suicide prevention workforces are part of the broad group of workers who can play a role in the prevention of and response to violence against women and children, DFSV, and other forms of gender-based violence, it is recommended that a targeted review articulate the synergies and gaps between the Second Action Plan, the [National Mental Health Workforce Strategy 2022-2032](#) (MH Workforce Strategy), and the suicide prevention workforce capability framework currently in development by the NSPO. The review can signpost specific ways that investment across the Second Action Plan and the MH Workforce Strategy can be leveraged. The NSPO could work with the Department of Social Services to support the review using findings from the suicide prevention workforce capability framework.

### Recommendation 7

Ensure workforces that are in a position to engage with people who have been impacted by DFSV are equipped to recognise and respond effectively to suicidal distress.

### Recommendation 8

Identify the capability uplift gaps required for the mental health and suicide prevention workforces to effectively contribute to violence prevention and response needs and undertake a targeted review to identify and articulate the synergies and gaps between the Second Action Plan, the *National Mental Health Workforce Strategy* and the suicide prevention capability framework (in development) to maximise the impact of future investments.

## Supports for people who use violence

Evidence for the risk factors associated with the use of violence remains a key data limitation in Australia.<sup>9,10,11</sup> AIHW outline an inexhaustive list of potential risk factors, including experiences of or exposure to violence as a child, experiences of child maltreatment, alcohol and other drug use, mental health challenges, lower levels of educational attainment, financial or personal stress (including poverty), and lack of social support.<sup>12</sup>

Despite data limitations, the available research clearly demonstrates that the use of violence is likely influenced by complex and interconnected factors operating across individual, relationship, community and societal levels.<sup>13</sup> Supports to reform violent behaviour must reflect that these risk factors are not deterministic, and they should not be considered in isolation of each other.

There is some evidence to support interlinked protective factors that may reduce the likelihood of violence, such as a higher level of education, healthy parenting experiences as a child, having a supportive family, social support, and culture.<sup>14,15,16</sup> The likelihood of using violence is also shaped by societal gender norms, attitudes about respect and violence, and adherence to harmful forms of masculinity.<sup>17,18,19,20,21</sup>

Mental health challenges may be associated with, or arise because of, experiences of violence, but they should not be understood as a primary cause of violence.<sup>22</sup> Most people who experience mental health challenges do not use violence, and not everyone who uses violence experiences mental health issues.<sup>23</sup>

When people who experience mental health challenges are violent, there are usually other factors which inform their behaviour. Equating violence with people experiencing mental health challenges risks pathologising all perpetrators. Conversely, approaching the use of violence as a mental health issue risks inappropriately directing people to mental health services or diverting them from broader supports across other sectors. Care needs to be taken to not add to the stigma that people who experience mental health challenges face by linking poor mental health to violence in an overly simplistic way.

Additionally, utilising the mental health system as a primary point of response for people who use violence risks overburdening an already strained system, especially if enacted without corresponding workforce uplift. There is limited evidence to suggest that mainstream mental health services provide effective intervention and support for people who use violence. Consideration must be given to the potential effects of increasing stigma for people with mental health challenges if the association between mental health challenges and violence use is emphasised without appropriate acknowledgement of these research limitations.

Mental health services could play a major role in the prevention of violence, more so than providing mainstream supports to people who use violence. For example, research has shown that experiences of childhood maltreatment and experiences of violence in childhood is an established risk factor for violence perpetration.<sup>24</sup>

It is very well established that these experiences also predispose individuals to later mental health challenges.<sup>25</sup> To reduce the use of violence, efforts need to be focused on broader prevention and early intervention through increased social supports, healthy parental relationships, and healthy masculinity programs.

#### **Recommendation 9**

Ensure the Second Action Plan clearly distinguishes between mental health as a consequence, correlate or co-occurring support need, and does not conflate experiences of mental health challenges as a cause of violence, to avoid stigma and ensure people are directed to appropriate supports.

## **Alcohol and other drug use**

Harmful alcohol or other drug use can be a key contributor to both DFSV perpetration and suicide. In 2023, about 1 in 6 people who died by suicide were intoxicated from acute alcohol use, and 1 in 7 had lived with a chronic alcohol dependence disorder.<sup>26</sup> In relation to other drugs, in 2023, about 1 in 6 people who died by suicide were intoxicated from acute psychoactive substance use or had lived with a psychoactive substance use disorder.<sup>27</sup> Similarly, for a variety of reasons including as a coping mechanism, victim-survivors of DFSV are more likely to engage in high-risk alcohol and illicit drugs consumption, than people who had not experienced DFSV.<sup>28</sup> Intimate partner violence incidents involving alcohol or drug use were more likely to result in physical injury than incidents that did not involve alcohol or drug use.<sup>29</sup> Research has also found that dependence on illicit drugs may be more likely than drug use itself to contribute to the risk of domestic violence perpetration.<sup>30</sup>

DFSV is ultimately a choice by the perpetrator and cannot be solely explained as caused by harmful alcohol or other drug use. But appropriate action on alcohol and other drug use can operate as one method among others to reduce the intensity and frequency of harms associated with DFSV perpetration. Collectively this data points to the criticality of ensuring a robust, integrated, and coordinated alcohol and other drugs system to support people with lived experience of DFSV, perpetrators of DFSV, and people experiencing suicidal distress across touchpoints. The alcohol and other drugs workforce can be instrumental in early intervention responses and addressing the underlying factors that contribute to substance misuse, violence and victimisation, and suicidal distress. The Suicide Prevention Strategy recognises that addressing harmful alcohol and other drug use is an important avenue to improving suicide prevention outcomes. Consideration should also be given to broader prevention opportunities in relation to harmful alcohol and other drug use that endeavour to address the role of alcohol and other drug use in DFSV.<sup>31</sup> The Second Action Plan presents an opportunity to similarly recognise and seek to address the challenges posed by harmful alcohol and other drug use by improving the integration of supports for alcohol and other drug use and DFSV.

#### **Recommendation 10**

Improve the integration of support pathways for harmful alcohol and other drug use, DFSV and suicide prevention, to ensure people receive appropriate and coordinated support. This should:

- Ensure service touchpoints are equipped to identify people whose substance use may be related to increased suicidal distress, violence, or victimisation.
- Upskill alcohol and other drugs and DFSV support services with suicide prevention capability to identify, and support people who are experiencing suicidal distress.
- Ensure support services are non-judgemental to promote accessibility and engagement.

## Existing interventions and supports for people who use violence require better evaluation

Identifying and implementing appropriate methods to work with people who use violence, to hold them to account and support behaviour change, has been hampered by the fact that existing supports and interventions have not been consistently and effectively evaluated.<sup>32,33,34</sup>

Existing supports for people who use violence include police and legal responses, behaviour change programs, and specialist perpetrator services.<sup>35</sup> However, these responses lack standardisation, are fragmented across jurisdictions, and national monitoring and evaluation of their outcomes remains limited and inconsistent. For example, evaluating the effectiveness of behaviour change interventions is limited by a reliance on participant self-reporting or simply reviewing program completion rates.<sup>36</sup> Existing interventions should be routinely, consistently and effectively evaluated to determine their effectiveness and identify if adjusted or alternative supports need to be pursued.

Consistent evaluation of supports may in part be held back by the fact that definitions of violence vary substantially across academic, policy, and practice settings.<sup>37</sup>

The Second Action Plan is an opportunity to set the standard for evaluating interventions and supports for people who use violence, to ensure any existing or future programs and practices are effective and evidence based. This could include new perpetrator intervention models that are individualised, including for people with mental health challenges. There are calls for innovation in behaviour change programs. For interventions to be effective, research suggests they need to be tailored to perpetrators' individual and intersecting needs, including trauma, adverse childhood experiences, substance misuse, mental health, housing, employment, and history of incarceration.<sup>38</sup>

### Recommendation 11

Establish a nationally consistent evaluation framework for interventions and supports for people who use violence, to determine effectiveness, strengthen accountability and guide future investment and reform efforts.

The Suicide Prevention Strategy recognises the need to challenge attitudes which may contribute to perpetration of DFSV and can also act as barriers for help-seeking for people experiencing suicidal distress, particularly among men and boys. Initiatives that promote positive attitudes and behaviours that foster respectful relationships, meaningful connection, and caring for others not only reduce risk of DFSV perpetration but are also likely to promote increased help-seeking which can protect against mental health challenges and suicidal distress. Broader mental health campaigns aimed at promoting men and boys' mental health and help seeking may also complement efforts to address harmful gender norms and attitudes that contribute to violence. Improving men and boys' wellbeing and challenging harmful attitudes and behaviour norms can be mutually reinforcing goals that benefit all genders. Ensuring that messaging is appropriate and evidence based to support the intended effect for the population is critical and should include voices of people with lived and living experience of mental ill-health and suicide.

### Recommendation 12

Invest in programs that promote healthy expressions of masculinity that encourage help-seeking, emotional vulnerability, caring for others, and foster respectful relationships for men and boys. This should:

- Ensure that messaging to challenge harmful societal attitudes is evidence-based, targeted and culturally appropriate to meet the needs of people seeking support.
- Develop programs in partnership with people with lived and living experience to increase awareness of the association of DFSV, mental health and suicide, promote healthy and safe relationships, and encourage reaching out for support.

## Harms of gambling as a risk factor for suicidal behaviour

There is growing evidence of a link between gambling and suicidal distress. The harms of gambling are strongly associated with other suicide risk factors, such as financial distress, the functioning of family and intimate relationships, and intimate partner violence.<sup>39</sup> The National Gambling Prevalence Study Pilot conducted in 2024 found among high-risk gamblers, 16% reported experiencing suicidal thoughts, compared to 4% of low-risk gamblers, and 19% of people whose partner gambled weekly or more reported experiences of intimate partner violence, compared to 7% of people whose partners did not gamble.<sup>40</sup> As access to gambling activities increases rapidly due to the rise in online gambling platforms and the normalisation of gambling culture in Australia, it is important to recognise the significant public health impacts and respond accordingly. This can include developing strong community messaging on gambling harms and increased guidance for services on supporting people experiencing the harms of gambling. The Suicide Prevention Strategy calls for the implementation of the House of Representatives Standing Committee on Social Policy and Legal Affairs' inquiry into online gambling and its impacts on those experiencing gambling harm (Action 2.2j).<sup>41</sup> Appropriately regulating gambling use and promotion is likely to reduce the harms associated with gambling and its downstream outcomes including both suicidal distress and DFSV victimisation.

### Recommendation 13

Strengthen the evidence-base and act to address the impacts of gambling on DFSV and suicide through implementation of the House of Representatives Standing Committee on Social Policy and Legal Affairs' inquiry into online gambling and its impacts on those experiencing gambling harm.

## References

- <sup>1</sup> AIHW (Australian Institute of Health and Welfare) (2021) [Examination of hospital stays due to family and domestic violence 2010–11 to 2018–19](#), Australian Institute of Health and Welfare.
- <sup>2</sup> Family and personal hardship: Psychosocial risk factors and deaths by suicide, (2023). Suicide & self-harm monitoring. Australian Institute of Health and Welfare.
- <sup>3</sup> Matthews, B. (2023). The Australian Child Maltreatment Study: National prevalence and associated health outcomes of child abuse and neglect, *The Medical Journal of Australia*. Available from: [Main Findings | Australian Child Maltreatment Study](#)
- <sup>4</sup> Scott, JG. & Matthews, B. (2023). Introducing the Australian Child Maltreatment Study: baseline evidence for a national public health challenge, Editorial, *The Medical Journal of Australia*. Available from: [mja2\\_v218\\_s6\\_cover.indd](#)
- <sup>5</sup> AIHW (Australian Institute of Health and Welfare), (2021). [Young people in out-of-home care](#), AIHW.
- <sup>6</sup> Intersections of Child Sexual Abuse, Suicidality & Violence, (2025). CEVAW & SAMSN
- <sup>7</sup> Aboriginal and Torres Strait Islander Peoples, Family, Domestic and Sexual Violence, (2026). Australian Institute of Health and Welfare.
- <sup>8</sup> National Mental Health Workforce Strategy 2022-2032, (2022). Department of Health, Disability and Ageing.
- <sup>9</sup> Lloyd, J., Dembele, L., Dawes, C., Jane, S., & Macmillan, L. (2023). *The Australian National Research Agenda to End Violence against Women and Children (ANRA) 2023–2028*. Australia's National Research Organisation for Women's Safety (ANROWS). [https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2023/11/08085134/ANROWS\\_ANRA\\_2023-2028\\_WEB\\_FINAL.pdf](https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2023/11/08085134/ANROWS_ANRA_2023-2028_WEB_FINAL.pdf)
- <sup>10</sup> House of Representatives Standing Committee on Social Policy and Legal Affairs. (2021). *Inquiry into family, domestic and sexual violence*. Commonwealth of Australia. [https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024577/toc\\_pdf/Inquiryintofamily,domesticandsexualviolence.pdf](https://parlinfo.aph.gov.au/parlInfo/download/committees/reportrep/024577/toc_pdf/Inquiryintofamily,domesticandsexualviolence.pdf)
- <sup>11</sup> Australian Institute of Health and Welfare. *Factors associated with FDSV*. <https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/factors-associated-with-fdsv>
- <sup>12</sup> Australian Institute of Health and Welfare. *Factors associated with FDSV*. <https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/factors-associated-with-fdsv>
- <sup>13</sup> Flood, M., Brown, C., Dembele, L., & Mills, K. (2023). *Who uses domestic, family, and sexual violence, how, and why? The state of knowledge report on violence perpetration*. Queensland University of Technology. <https://research.qut.edu.au/centre-for-justice/wp-content/uploads/sites/304/2023/01/Who-uses-domestic-family-and-sexual-violence-how-and-why-The-State-of-Knowledge-Report-on-Violence-Perpetration-2023.pdf>
- <sup>14</sup> Australian Institute of Health and Welfare. *Factors associated with FDSV*. <https://www.aihw.gov.au/family-domestic-and-sexual-violence/understanding-fdsv/factors-associated-with-fdsv>
- <sup>15</sup> O'Donnell, K., Woldegiorgis, M., Gasser, C., Scurrah, K., Andersson, C., McKay, H., Hegarty, K., Seidler, Z., & Martin, S. (2025). *The use of intimate partner violence among Australian men* (Ten to Men Insights #3 Report, Chapter 1). Australian Institute of Family Studies. <https://aifs.gov.au/tentomen/insights-report/use-intimate-partner-violence-among-australian-men>
- <sup>16</sup> Campbell, E., Fernando, T., Gassner, L., Hill, J., Seidler, Z., & Summers, A. (2024). *Unlocking the prevention potential: Accelerating action to end domestic, family and sexual violence: Report of the Rapid Review of Prevention Approaches*. Commonwealth Government, Office for Women. <https://www.pmc.gov.au/sites/default/files/resource/download/unlocking-the-prevention-potential-4.pdf>
- <sup>17</sup> National Mental Health Commission. (2020). *National Mental Health Commission submission to the House of Representatives Standing Committee on Social Policy and Legal Affairs inquiry into family, domestic and sexual violence*. [https://www.mentalhealthcommission.gov.au/sites/default/files/2024-04/national-mental-health-commission-submission-to-the-house-of-representatives-standing-committee-on-social-policy-and-legal-affairs-inquiry-into-family-domestic-and-sexual-violence\\_0.pdf](https://www.mentalhealthcommission.gov.au/sites/default/files/2024-04/national-mental-health-commission-submission-to-the-house-of-representatives-standing-committee-on-social-policy-and-legal-affairs-inquiry-into-family-domestic-and-sexual-violence_0.pdf)
- <sup>18</sup> Flood, M., Brown, C., Dembele, L., & Mills, K. (2023). *Who uses domestic, family, and sexual violence, how, and why? The state of knowledge report on violence perpetration*. Queensland University of Technology. <https://research.qut.edu.au/centre-for-justice/wp-content/uploads/sites/304/2023/01/Who-uses-domestic-family-and-sexual-violence-how-and-why-The-State-of-Knowledge-Report-on-Violence-Perpetration-2023.pdf>

- <sup>19</sup> Doherty, L., Dowling, C., & Dickens, M. (2026). *Disengagement from online misogynistic incel communities and its implications for attitudes to gendered violence* (Trends & Issues in Crime and Criminal Justice No. 727). Australian Institute of Criminology. <https://doi.org/10.52922/ti78168>
- <sup>20</sup> Campbell, E., Fernando, T., Gassner, L., Hill, J., Seidler, Z., & Summers, A. (2024). *Unlocking the prevention potential: Accelerating action to end domestic, family and sexual violence: Report of the Rapid Review of Prevention Approaches*. Commonwealth Government, Office for Women. <https://www.pmc.gov.au/sites/default/files/resource/download/unlocking-the-prevention-potential-4.pdf>
- <sup>21</sup> Kelleher, A. (2022). *Reducing relationship and sexual violence: Findings from reviews about the effectiveness of respectful relationships and bystander programs in school and tertiary education settings* (Research Report WW.22.01/1). Australia's National Research Organisation for Women's Safety (ANROWS). <https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2021/12/14074123/ANROWS-OofR-Education.pdf>
- <sup>22</sup> [The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy - The Lancet Psychiatry](#)
- <sup>23</sup> [The Lancet Psychiatry Commission on intimate partner violence and mental health: advancing mental health services, research, and policy - The Lancet Psychiatry](#)
- <sup>24</sup> Flood, M., Brown, C., Dembele, L., & Mills, K. (2023). *Who uses domestic, family, and sexual violence, how, and why? The state of knowledge report on violence perpetration*. Queensland University of Technology. <https://research.qut.edu.au/centre-for-justice/wp-content/uploads/sites/304/2023/01/Who-uses-domestic-family-and-sexual-violence-how-and-why-The-State-of-Knowledge-Report-on-Violence-Perpetration-2023.pdf>
- <sup>25</sup> Australian Bureau of Statistics. (2025, September 15). *Childhood experience of abuse*. Measuring What Matters. <https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/secure/childhood-experience-abuse>
- <sup>26</sup> Australian Bureau of Statistics. Causes of Death, Australia, 2023 [Internet]. ABS, Australian Government; 2023. Available from: <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#intentional-self-harm-deaths-in-Australia>
- <sup>27</sup> Australian Bureau of Statistics (2024), *Causes of Death, Australia, 2023* (Intentional self-harm deaths and associated risk factors)
- <sup>28</sup> Australian Institute of Health and Welfare (AIHW) 2025, *Behavioural outcomes*, Family, Domestic and Sexual Violence, AIHW, Canberra.
- <sup>29</sup> Australian Institute of Family Studies (2026) Factors associated with FDSV. Available from: [Factors associated with FDSV - Australian Institute of Health and Welfare](#)
- <sup>30</sup> Factors associated with FDSV, Family, Domestic and Sexual Violence, (2026). Australian Institute of Health and Welfare.
- <sup>31</sup> Opportunities to address alcohol policy as part of a holistic approach to preventing violence against women, (2025). Our Watch.
- <sup>32</sup> Australian Institute of Health and Welfare. (2021). *Monitoring perpetrator interventions in Australia*. <https://www.aihw.gov.au/reports/family-domestic-and-sexual-violence/monitoring-perpetrator-interventions-in-australia/contents/summary>
- <sup>33</sup> Bell, C., & Coates, D. (2022). *The effectiveness of interventions for perpetrators of domestic and family violence: An overview of findings from reviews*. Australia's National Research Organisation for Women's Safety (ANROWS). <https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2021/12/08091000/ANROWS-OofR-Perpetrator-Interventions.pdf>
- <sup>34</sup> Australia's National Research Organisation for Women's Safety. (2021). *Interventions for perpetrators of domestic, family and sexual violence in Australia*. <https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2021/06/09135019/Intervenions-for-perpetrators-od-DFS-Synthesis-Insights.pdf>
- <sup>35</sup> Australian Institute of Health and Welfare. *Specialist perpetrator interventions*. <https://www.aihw.gov.au/family-domestic-and-sexual-violence/responses-and-outcomes/specialist-perpetrator-interventions>
- <sup>36</sup> Australia's National Research Organisation for Women's Safety. (2021). *Interventions for perpetrators of domestic, family and sexual violence in Australia*. <https://anrows-2019.s3.ap-southeast-2.amazonaws.com/wp-content/uploads/2021/06/09135019/Intervenions-for-perpetrators-od-DFS-Synthesis-Insights.pdf>
- <sup>37</sup> Australia's National Research Organisation for Women's Safety. (2026, May). *Evidence to action: Informing direction for the Second Action Plan: Consultation paper in support of the National Plan to End Violence against Women and Children 2022–2032*. <https://engage.dss.gov.au/wp-content/uploads/2026/05/second-action-plan-consultation-paper.pdf>

---

<sup>38</sup> McLachlan, F., Swart, T., Desmond, K., & O’Leary, P. (2026). Male perpetrator interventions for domestic and family violence in the Indo-Pacific: A scoping review. *Trauma, Violence, & Abuse*, 1–17.

<https://doi.org/10.1177/15248380261451797>

<sup>39</sup> Suicide Prevention Australia. Gambling and Suicide Prevention: A Roadmap for Change [Internet]. SPA; 2022. Available from: [https://www.suicidepreventionaust.org/wp-content/uploads/2022/02/Gambling-Report\\_2022.pdf](https://www.suicidepreventionaust.org/wp-content/uploads/2022/02/Gambling-Report_2022.pdf)

<sup>40</sup> Australian Gambling Research Centre (2025) National Gambling Prevalence Study Pilot 2024. Available from: [National Gambling Prevalence Study Pilot 2024 | Australian Institute of Family Studies](#)

<sup>41</sup> Inquiry into online gambling and its impacts on those experiencing gambling harm, (2022). Parliament of Australia