Submission in relation to

The relationship between DFSV victimisation and suicide

30 January 2026

Engender Equality is Tasmania's statewide specialist family violence organisation.

WARNING: This submission includes sensitive and distressing material.

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Term of Reference 1

The relationship between domestic, family and sexual violence (DFSV) victimisation and suicide, and the extent to which DFSV victimisation contributes to suicide risk and incidence in Australia, including prevalence, patterns, and any identifiable at-risk groups in order to improve understanding of the role of DFSV in suicides nationally.

1.1 Relationship between DFSV victimisation and suicide

Engender Equality is a specialist family violence service providing a range of services and programs across Lutruwita/Tasmania, including therapeutic services for victim-survivors of intimate partner violence.

The gendered nature and impacts of DFSV have been widely documented, including on the health and wellbeing of adult women who have experienced intimate partner violence (ANROWS 2016).

Practice-based insights from Engender Equality are consistent with this established evidence-base that DFSV causes psychological harm, and emerging evidence, such as the 2025 Victorian study by Vasil and colleagues (2025), which confirms a strong association between DFSV victimisation and risk of suicidal ideation, suicide attempts, and death by suicide.

Engender's observation is that for many victim-survivors their suicidality is not caused by their individual pathology, rather it is understood within the context of entrapment, fear and sustained dynamics of coercive control. Such dynamics can extend beyond separation from the person using violence (PUV) and be exacerbated by systemic responses that replicate or fail to stop the PUV's behaviour.

When suicidality, DFSV victimisation, and pre-existing mental health conditions co-occur, risks are further compounded, as the PUV may weaponise or deliberately target the victim-survivor's mental health vulnerabilities as part of their patterns of violence and control.

1.2 Extent to which DFSV victimisation may contribute to suicide risk and incidence

DFSV victimisation may act as a significant contributing factor to suicide risk and incidence, even when it is not explicitly identified in official records or datasets. In many cases, the role of violence may remain obscured due to limited disclosure, fragmented service responses, or the absence of consistent mechanisms for recording DFSV in suicide-related data.

Despite these limitations, available evidence and our practice-based insights show that DFSV is a contributing factor to suicide risk through:

- Cumulative trauma and chronic psychological distress including the stigma associated with sexual assault
- Entrapment and loss of autonomy

- Loss of housing, financial insecurity and other protective factors
- Social isolation
- System failures and institutional responses that inadequately address DFSV and suicide risk and fail to enhance victim-survivor safety
- Lack of access to specialist services, a particular issue for Tasmania where this are high rates of violence and low government investment in DFSV services.

1.3 Prevalence

Current publicly available data suggests that the prevalence of suicidal ideation, behaviours, and deaths associated with DFSV victimisation is significantly under-recognised.

From a Tasmanian perspective, recent Tasmanian Government reporting released in 2025 on suicide deaths from 2012–2020 shows that partner separation, relationship conflict, and experiences of abuse or violence are among the most common stressors preceding suicide, with nearly half of all people who died by suicide having experienced abuse or violence. However, these stressors are not routinely identified as family violence or sexual violence-related nor distinguish between experiences of victimisation and perpetration, limiting visibility of DFSV as a contributing factor.

Emerging research from Victoria (Vasil et al., 2025) similarly indicates that suicides linked to family violence are substantially underestimated, reinforcing the likelihood that DFSV-related suicidality is obscured within existing systems and datasets.

Engender Equality routinely supports clients presenting with suicidality, and although the true prevalence within our service remains unknown, it is a significant clinical risk that necessitates clear practice guidelines, ongoing supervision, and robust organisational safeguards.

1.4 Patterns

Practice observations and lived experience accounts indicate that certain patterns may be associated with DFSV victimisation and suicidality. These include:

- Periods of separation or attempted separation
- Ongoing post-separation abuse, including the use of technology-facilitated abuse and systems abuse
- Changes to the PUV's proximity to the victim-survivor, such as their release from custody
- System responses that are experienced as adversarial, dismissive, or insufficiently responsive to violence, including the misidentification of the victim-survivor as the predominant aggressor

- Removal of children from victim-survivor's care by either child protection orders, court-imposed parenting orders or by the PUV undermining the victim-survivor's relationships with children

These patterns may intersect with other factors experienced by victim-survivors such as:

- Childhood trauma
- Pre-existing mental health conditions
- Loss of family or friend by suicide
- Poverty, homelessness and housing insecurity
- Geographic location, specifically challenges around access to services in rural and remote settings

1.5 Identifiable at-risk groups

Engender Equality has observed the following groups who may have increased suicide risk within the context of DSFV victimisation:

- Women experiencing prolonged coercive control
- Aboriginal and Torres Strait Islander women and communities
- LGBTIQ+ people, in particular, transgender and gender diverse people
- Victim-survivors of childhood sexual abuse
- People with disability
- Women with co-occurring substance use or mental health conditions

For many of our clients, their experiences will often sit across these at-risk groups, which mirror broader structures of intersecting oppression, discrimination and marginalisation.

Term of Reference 2

Opportunities for improved reporting and investigation methodologies to accurately capture and report on deaths as a result of DFSV, including the adequacy of existing data, collection practices related to DFSV and suicide, and the availability, quality, and consistency of data across jurisdictions.

2.1 Role of specialist family violence services in improving identification

Specialist family violence services are well positioned to support more accurate identification of DFSV-related suicide deaths by contributing contextual, practice-informed insights to existing data collection processes. As outlined in Section 1.2, current reporting on suicide in Tasmania does not capture family or sexual violence–specific stressors, nor does it distinguish between victimisation and perpetration, limiting visibility of DFSV as a contributing factor. This gap means many DFSV-related suicides may remain unrecognised within official datasets.

Specialist services hold nuanced, often long-term knowledge of victim-survivors' experience. This knowledge is seldom captured in police, health, or mental health records and data. These insights can illuminate overlooked patterns of coercive control, systems abuse and cumulative trauma that may have shaped a person's distress prior to death.

Where it is appropriate, ethical and aligned with the wishes and privacy of victim-survivors and families, there may be opportunities for specialist services to inform post-death reviews, coronial processes and broader system-level learning. Their contributions can help identify whether DFSV dynamics were present but unrecorded, thereby strengthening the accuracy of data, improving understanding of prevalence and supporting more effective prevention strategies across jurisdictions.

2.2 Limitations of existing data collection from a practice perspective

Victim-survivor experiences of suicidality are complex. Traditional suicide risk assessment tools and practices may be inadequate when working with victim-survivors, as they do not account for the ways chronic suicidal ideation and persistent suicidal distress can emerge as enduring features of complex trauma.

From a practice standpoint, existing data collection processes may not consistently capture the complexity of DFSV victimisation, particularly in cases involving sexual violence and coercive control. These forms of violence are often under-disclosed, minimised and misunderstood. As a result, the recording of such information is fragmented across multiple systems.

Specialist services frequently observe that victim-survivors' interactions with health, justice, and social services are recorded in isolation, making it difficult to identify cumulative harm or escalating risk over time. This fragmentation limits the capacity of existing reporting mechanisms to accurately reflect the role of DFSV in suicide deaths.

In practice settings, a broader culture of risk management and accountability may contribute to hesitation among professionals when documenting explicit suicidal language or expressions of intent. This systemic dynamic can result in the use of softened or indirect documentation, which may affect the completeness and reliability of data used to understand suicidality in the context of DFSV.

2.3 Opportunities to improve reporting through contextual information

Improved reporting may be supported by incorporating contextual information alongside traditional data points. This could include, for example:

- Histories of coercive control or post-separation abuse
- Repeated system contact related to safety, housing, or child protection
- Patterns of perpetrator behaviour that continue beyond separation

Specialist family violence services may assist in identifying what contextual indicators are most relevant to understanding DFSV-related risk, without requiring those services to undertake investigative or statistical roles beyond their scope.

2.4 Consistency and information sharing across jurisdictions

Variation in definitions, recording practices, quality of service provision and information-sharing arrangements across jurisdictions limit the consistency and comparability of DFSV-related suicide data. From a service perspective, this can result in important information being lost when victim-survivors move between systems or geographic regions.

Consideration should be given to mechanisms that support safe, ethical information sharing and consistent recognition of DFSV indicators across jurisdictions, while maintaining strong privacy and consent safeguards.

Term of Reference 3

How legal and justice systems, DFSV specialist services, health, mental health and other services recognise and respond to suicide in the context of DFSV.

3.1 Recognition of suicide risk in the context of DFSV

Across legal, health, and service systems, suicide risk in the context of DFSV is not always be consistently recognised or interpreted within the broader pattern of violence experienced by victim-survivors. Responses often rely on individualised risk assessments that focus on generic mental health indicators, without sufficient consideration of gender, coercive control, ongoing abuse, or post-separation violence as contributing factors.

In some cases, suicidality may be treated as a discrete mental health issue rather than as a response to cumulative harm, entrapment, or fear. This can result in missed opportunities to address the underlying drivers of distress and risk.

3.2 Legal and justice system responses

There is an urgent need for legal and justice systems to develop a deeper and more nuanced understanding of the relationship between DFSV and suicide.

Engender clients frequently report experiences of having their suicidality disclosed in systems such as Family Court or child protection. This may be self-disclosure or disclosure without the victim-survivor's consent by the PUV as an abusive tactic to characterise them as mentally unwell or unstable. Victim-survivors are often met with system responses that overly focus on their mental health and parental capacity, ignoring or minimising their experiences of DFSV. Such responses leave victim-survivors feeling unsafe, disbelieved and fearful that accessing appropriate support for their suicidality will cause further harm to them and their children.

Engender clients also report inadequate emergency responses

Legal and justice systems may encounter suicidality in the context of DFSV through family law, criminal proceedings, child protection involvement, or coronial processes. From a practice perspective, these systems prioritise procedural requirements which limit recognition of the broader violence context shaping a victim-survivor's distress.

> *Victim-survivors may experience suicidality being viewed as a personal risk factor rather than as an indicator of harm caused by violence or systems interaction. In some instances, disclosures of suicidal distress are misinterpreted as instability, potentially affecting credibility assessments or parenting determinations.*

3.3 DFSV specialist service responses

DFSV specialist services are uniquely positioned to understand and respond to suicidality as arising within contexts of ongoing violence, coercive control, and entrenched power imbalances, including those reinforced through institutional and social responses. Specialist DFSV practice situates suicidal distress within experiences of powerlessness, and feelings of helplessness and hopelessness associated with DFSV and the cumulative impacts of trauma, including childhood sexual abuse and childhood experiences of family violence. Responses are client-centred and empowerment-focused, with explicit validation of lived experience, prioritisation of safety, and recognition of distress as shaped by relational, developmental, and structural conditions rather than individual pathology.

However, specialist services may face limitations in influencing broader system responses, particularly where their assessments are not fully integrated into legal, health, or mental health decision-making processes. Specialist services remain substantially underfunded, with resourcing levels that undermine service capacity and safety. For example, as of 31 December 2025 Engender has a waitlist of 186 victim-survivors who will wait 18 months to talk to a family violence practitioner.

3.4 Health and mental health service responses

Health and mental health services frequently play a central role in responding to suicidality yet may not always be equipped to identify DFSV as a primary contributor to risk. Clinical responses may focus on symptom management, diagnosis, or crisis intervention, without adequately addressing ongoing exposure to violence, compounding impacts or post-separation abuse.

As a specialist family violence service, Engender Equality often hears accounts from victim-survivors who have engaged with psychological services for varying periods prior to accessing specialist family violence support. In these accounts, distress is often understood and addressed primarily at an individual level, with the broader context of coercive and cyclical abuse not being recognised until engagement with a specialist family violence service.

Where DFSV is not recognised or is minimised, victim-survivors may cycle through services without the underlying causes of distress being addressed, potentially contributing to ongoing risk.

3.5 Considerations for strengthening recognition and response

Strengthening recognition and response to suicide in the context of DFSV must involve:

- Improved understanding of coercive control and cumulative harm across systems
- Gender representation in interpersonal violence
- Greater integration of DFSV expertise into mental health and legal decision-making
- Trauma-informed, violence-aware risk assessment frameworks
- Recognition of the potential impact of system interactions on suicidality

Term of Refence 4

The use of suicide and threats of suicide as a tactic of coercive control by perpetrators of DFSV.

The following lived experience narrative has been shared with consent by Ann* and is intended to illustrate themes relevant to the fourth Term of Reference:

Even before we were married, he used coercively controlling behaviours marked by intense jealousy. When we were engaged, I tried to end the relationship, and it was through that experience that I realised his intention was never to let me go. It was at this point that I began self-harming and thinking about suicide. I did not stop self-harming or experiencing suicidal thoughts until 13 years later, when I left the relationship.

Like many victim-survivors, I was isolated from family and friends. My career was controlled, and I became hypervigilant, constantly trying to appease him, although it is impossible to anticipate everything. The relationship was both sexually and physically violent. From memory, he did not use suicide threats throughout the relationship, but they emerged just prior to my leaving.

In the lead-up to my departure, there were pressures related to his employment and a growing sense of economic insecurity. His control over me escalated. He became convinced I was having an affair and dedicated himself to finding evidence and 'catching me out'. His behaviour became increasingly unpredictable, and I was afraid of him. I believed he was going to kill me.

My first disclosure was to my work supervisor, who encouraged me to speak with my manager. Ultimately, it was my manager who was instrumental in helping me leave. Right up until that day, my suicide plan was complete. In the garage, there was a coiled hose, rags, and gaffer tape in the top drawer of a toolbox.

I was terrified to leave and did not know whether I had the courage to follow through. I did not want to leave before my stepson, who was 20 at the time, moved out, and this prolonged my stay. I was fearful my husband would discover I was planning to leave, and I even signed a contract to buy a house with him in order to maintain the façade. Weeks later, an incident occurred that finally prompted my departure.

My manager had arranged somewhere safe for me to stay. My husband could not contact me and did not know where I was.

The week I left, my stepson called me. He was crying. He told me his father had said he would kill himself if I did not meet with him. My stepson pleaded with me to "just have a coffee with him". I felt deep distress for my stepson, who became angry when I said I could not meet his father. I was too frightened to do so. While I understood the suicide threat as coercively controlling, I also feared he might follow through.

My experience of my husband in the final months of the relationship was confusing and terrifying. I could see he was fearful that I would leave, I would even say he was desperately fearful. He was intense, physically, sexually, and emotionally. He would hold me so tightly I could not breathe, as though gripping me might mean I would never go. He made constant accusations, interrogating me through long nights, demanding that I communicate my love for him in a way that he could finally believe. I tried.

I felt he had the capacity to end his life, but I did not believe he would die without taking me with him.

I still think about those last months and try to make sense of them. I remember his emotional desperation in his body language, in his eyes, in the curl of his lip as he accused me of having an affair. He loomed, paced, twitched, breathed heavily. His distress does not excuse his use of violence and intimidation, but I don't forget it because I can't make sense of it.

4.1 Use of suicide threats as a tactic of coercive control

In practice, Engender Equality practitioners hear accounts from victim-survivors in which threats of suicide are described as emotionally controlling. These accounts suggest that suicide threats form a tactic of coercive control, particularly when they arise in response to attempts to assert autonomy, resist abuse, or leave the relationship. Victim-survivors describe such threats occurring at different points within the cycle of abuse, often accompanied by language that emphasises dependency and emotional obligation, including statements that the perpetrating partner "would not know what to do" without them, that they are "the only person who truly understands them," or that separation would result in suicide. In these contexts, suicide threats may function to generate fear, guilt, and a sense of responsibility, shaping victim-survivors' decisions and constraining their capacity to leave safely.

Such threats may be used to prevent separation, compel compliance, or maintain emotional surveillance and control. The impact on victim-survivors is often profound, with many

describing remaining in violent or unsafe situations out of fear that leaving would result in the perpetrator's death. Regardless of the perpetrator's intent or internal state, the effect of suicide threats within abusive dynamics is to reinforce power imbalance, entrapment, and ongoing harm.

4.2 Silence around men's distress at separation

There appears to be limited public and professional discourse regarding the distress some men experience at the point of relationship separation, particularly in the context of prior use of violence or coercive control. This silence may reflect understandable concern about centring perpetrators' experiences or inadvertently legitimising violence against women. However, the absence of careful discussion about this distress may also limit opportunities to identify and respond to heightened risk. Separation is widely recognised in practice as a period of increased danger for women, yet the emotional and psychological states of perpetrators during this time are often left unexamined due to the sensitivity and complexity of the issue.

Ann's testimony highlights a broader and often under-examined issue: the limited public and professional conversation about the distress some men experience at the point of relationship separation, particularly in the context of prior use of violence or coercive control. This silence may reflect understandable concern about centring perpetrators' experiences or inadvertently legitimising violence against women. However, as illustrated in Ann's account, the absence of careful and bounded discussion about this distress may also limit opportunities to recognise elevated suicide risk and associated escalation of harm. The emotional and psychological states of perpetrators at the point of separation, including expressions or threats of suicide, warrant closer examination as part of suicide prevention, homicide prevention and risk management, without diminishing accountability for violence.

4.3 Distress, control, and risk escalation

It is important to distinguish between recognising distress and excusing violence. Acknowledging that some perpetrators experience acute distress at separation does not justify harmful behaviour, nor does it diminish perpetrator responsibility. Rather, it provides critical context for understanding risk escalation at moments when control is perceived to be lost.

For some perpetrators, separation may coincide with a collapse of identity, entitlement, or perceived authority, particularly where control over a partner or family has been central to their sense of self. In these circumstances, distress may escalate alongside increased risk of severe violence, including homicide, filicide, or homicide-suicide. Understanding these dynamics is essential for prevention, appropriate intervention and risk management.

4.4 Implications for prevention and system response

Recognising suicide threats as a tactic of coercive control has important implications for prevention and system response. Suicide threats within DFSV contexts should be treated as indicators of risk to victim-survivors, not solely as individual mental health concerns. Responses that focus only on crisis management for the person making the threat may inadvertently reinforce control and increase danger for those being coerced.

At the same time, improved understanding of distress and risk escalation at separation may support earlier, more targeted interventions aimed at preventing serious harm. This requires systems to hold complexity: to centre victim-survivor safety, maintain clear accountability for violence, and develop responses that address risk without excusing abuse. Silence or avoidance in this area may obscure warning signs and limit opportunities for effective prevention.

Ann's testimony also underscores the importance of recognising both domestic, family and sexual violence and suicide as gendered phenomena shaped by unequal power relations. Violence against women is overwhelmingly perpetrated by men, and this gendered pattern of harm intersects with suicide risk in complex ways, including the use of suicide threats as a tactic of coercive control and the escalation of risk at separation. Understanding suicidality within DFSV contexts therefore requires attention to how gendered norms around power, entitlement, emotional expression, and control may shape both the perpetration of violence and the responses of systems to distress. Recognising gender as a structural factor is essential for prevention, without conflating distress with justification or diminishing accountability for harm.

Please see Appendix A for an interpretive tool, The Coercive Control Escalation Risk Lens, designed to support recognition of escalation in the thoughts, attitudes, and behaviours of the person using violence. This tool is developed from the lived expertise of thousands of victim-survivors who have shared their experiences with Engender's therapeutic team over the past 40 years.

Term of Reference 5

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

Reducing deaths by suicide in the context of DFSV requires a layered approach that spans primary prevention, early intervention, and system accountability. Prevention efforts are most effective when they address not only individual harm, but also the relational, structural, and cultural conditions that give rise to domestic, family and sexual violence.

5.1 Primary prevention: addressing gender, power, and violence

Opportunities to reduce deaths by suicide in the context of DFSV align with primary prevention approaches that seek to address the gendered drivers of violence, including gender inequality, rigid norms of masculinity, and entitlement. Prevention initiatives that promote gender equality and challenge harmful constructions of identity and power may contribute to reducing the conditions in which violence, coercive control, and associated suicidality occur.

Central to this work is the promotion of informed and reflective conversations about power, how it is exercised, justified, and challenged within intimate relationships, communities, institutions and systems. Supporting greater awareness of responsibility and the impacts of power misuse may assist in disrupting patterns of control that underpin both violence and suicide risk.

5.2 Early intervention: recognising coercive control and cumulative harm

Early intervention efforts can be strengthened by improving recognition of coercive control and its cumulative, often non-physical, impacts. Education and training across health, mental health, justice, and community services can support earlier identification of patterns of abuse, entrapment, and escalating risk that may otherwise be misunderstood or individualised.

Enhanced understanding of these dynamics may enable earlier, more contextually informed responses to both victim-survivors and behaviours associated with increased risk, including suicidality and threats of suicide.

5.3 Centring children's safety and rights

Children's experiences of domestic and family violence are a critical focus for prevention and early intervention. Exposure to violence, coercive control, and chronic fear can have significant impacts on children's emotional, psychological, and developmental wellbeing, with potential long-term consequences.

Childhood sexual assault is one of the most stigmatising experiences a person can endure. And while fear of social stigmatisation prevents many sexual assault survivors from accessing support or reporting their experience, the coinciding internalised stigma is a burden that results in childhood sexual assault survivors taking on average 24 years to disclose the crime, if they disclose at all.

Opportunities exist to strengthen prevention by consistently centring children's rights to safety across policy, practice, and decision-making. This includes recognising children as victim-survivors in their own right and ensuring that their safety is prioritised within all system responses.

5.4 Strengthening system capability and responsibility

Health, mental health, legal, and justice systems play a central role in shaping prevention outcomes. Strengthening system capability through education, reflective practice, and violence-informed approaches may improve recognition of DFSV dynamics and the ways in which institutional responses can either mitigate or compound harm.

Prevention efforts may be enhanced where systems actively recognise their own power, influence, and responsibility in responding to violence and suicidality, and where responses are guided by safety, accountability, and dignity rather than risk aversion alone.

Term of reference 6

Any other related matters.

In Tasmania, geographic dispersion, rurality, and remoteness present distinct challenges in responding to domestic, family and sexual violence and suicide. Many regional and remote communities experience higher exposure to suicide and DFSV, alongside reduced access to specialist services, mental health supports, and early intervention initiatives. Limited service availability (due to underfunding), workforce shortages, and long travel distances can delay support, increase isolation, and constrain opportunities for timely, coordinated responses.

These conditions may be further compounded by reduced access to education, prevention initiatives, and specialist training across health, justice, and community services. In smaller communities, concerns about privacy, visibility, and social interconnectedness may also inhibit disclosure and help-seeking. Addressing suicide in the context of DFSV in Tasmania therefore requires targeted, place-based responses that recognise the cumulative impacts of isolation, limited service reach, and systemic gaps, alongside sustained investment in prevention, early intervention, and specialist family violence capability across rural and regional settings.

References

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Vasil, S., Fitz-Gibbon, K., & Segrave, M. (2025). Family violence and women's deaths by suicide: A Victorian study. Australian Catholic University, Sequre Consulting and University of Melbourne. DOI: 10.24268/acu.914zx

Webster, K. (2016). A preventable burden: Measuring and addressing the prevalence and health impacts of intimate partner violence in Australian women (ANROWS Compass, 07/2016). Sydney: ANROWS

Appendix A (see Term of Reference 4)

Coercive Control Escalation Risk Lens

The Coercive Control Escalation Risk Lens is an interpretive tool designed to support recognition of escalation in the thoughts, attitudes, and behaviours of the person using violence.

Context for the Coercive Control Escalation Risk Lens

Existing risk assessment tools play an essential role in identifying factors associated with increased danger in the context of domestic, family and sexual violence. These tools commonly assess increased risk such as social and economic stressors, substance use, pregnancy, the presence of children, and the frequency and severity of jealousy, control and threats of harm or suicide through in intersectional lens. While these indicators are critical, they are often recorded as discrete factors rather than interpreted as expressions of the thinking, feeling, and attitudinal positioning of the person using violence.

The Coercive Control Escalation Risk Lens outlines 6 domains that reflect patterns of escalation that highlight how suicidality, loss of control, and escalating coercive behaviours may intersect to significantly increase danger to victim-survivors. It builds on existing approaches by placing greater emphasis on how such indicators may reflect internal states, shifts in control, and escalating fixation, particularly at points of threatened separation.

This assessment is designed to support earlier recognition of escalating danger within intimate partner relationships, especially in contexts of prolonged coercive control. It recognises that many women engage with risk assessment processes while experiencing significant constraints on perception, language, and choice, where violence may be normalised, minimised, or reframed as relational difficulty, and the recognition of harm as criminal or life-threatening may not be immediately accessible.

Women are frequently socialised to prioritise care, empathy, and responsibility within intimate relationships, and may seek to understand or protect their partner even in the presence of fear or harm. Concerns about being a burden, disrupting family or social relationships, or making the situation “real” by naming it may further inhibit disclosure. Positive aspects of the relationship may coexist with abuse, contributing to confusion and self-doubt rather than clarity. This risk assessment is therefore designed to work with these gendered realities, rather than against them.

The assessment places particular emphasis on recognising escalation in the thoughts, attitudes, and behaviours of the person using violence, especially where separation or loss of control is perceived. It intentionally shifts focus away from what is happening *to* the perpetrator, such as external stressors or situational pressures, and towards what may be

occurring *within* them, including entitlement, desperation, obsession, suicidal ideation, and threats of extreme harm. This distinction is critical, as external stress alone does not reliably predict lethal risk, whereas shifts in control dynamics and internal states may signal heightened danger.

By making these patterns explicit, the assessment supports women and practitioners to recognise escalation even when fear is unformed, language is limited, or danger has become familiar. It is intended as a tool for interpretation and prevention, not diagnosis, and seeks to restore clarity in contexts where coercion has narrowed perception and constrained choice.

This risk assessment is gendered and situated within a heteronormative lens. This reflects the well-established pattern that violence against women, including intimate partner homicide, is overwhelmingly perpetrated by men, with national data consistently indicating that approximately one woman per week is killed by a current or former intimate partner. The use of a gendered framework is therefore a response to disproportionate risk, rather than an assumption about the nature of all intimate partner relationships. This approach is not intended to minimise or obscure the serious incidence of suicide, homicide, or coercive control used against LGBTIQA+ people, where violence and harm also occur and warrant dedicated, inclusive responses. Rather, it reflects a deliberate focus on the population-level patterns of harm most strongly associated with lethal risk, while recognising that different relational contexts may require distinct analytical lenses.

1. Intersection between Suicide Risk and Separation-Related Escalation (Relational)
- He uses suicidal and/or self-harming language, or is practicing self-harming behaviours - During a time of planning to leave, her desire and plan to leave may become stronger than her experience of suicidal ideation. However, self-harming behaviours may increase *(Note: This item also interacts strongly with coercive control. Additionally, it shows a shift in the victim-survivor's internal calculus and the narrowing window for intervention.)*
2. Escalation of Obsession and Surveillance
- His increased attunement to her behaviours, feelings, and attitudes (e.g. "he always knows when I am lying," "he has a sixth sense," "he reads me like a book") - Interrogation-style questioning about where she has been and what she has been doing, including searching for inconsistencies to discredit her reality - Constant preoccupation with her, with conversations consistently orientated around her - Accusations that she is having an affair and actively seeking to "find proof" to support an evolving narrative - Increased isolation and monitoring, including spying to "catch her out" - New suspicions - One of his presentations being "smug," associated with a perceived superiority of knowing something she does not
3. Escalation of Possession and Entitlement

- The use of language expressing ownership, such as "You're mine, all mine, and no one else is going to have you"
- Telling her who she is, what she thinks, and how she feels
- New rules
- Holding her tightly or suffocatingly
- Drawing children into his narrative and seeking their support

4. Escalation of Control and Coercive Behaviours

- Increased sexual abuse
- Increased cycles of violence occurring over shorter periods of time, including multiple cycles within a single day (this can feel chaotic and hard to identify)
- Sharing his narrative with a "confidante" of perceived authority or status, resulting in validation through collusion
- Death threats or suggestions of death or murder (e.g. "the only way this relationship is going to end is in murder")

5. Behavioural Intensity, Volatility, and Affective Shift

- His energy feeling anxious and anxiety-provoking
- Carrying a sense of loss of control
- Carrying a sense of desperation
- Presenting with emotional desperation where nothing she says or does can reassure him that she loves him or will not leave
- Carrying a sense of despise toward her, including snarling

(This cluster signals qualitative change, not just "more of the same.")

6. Risk Signals Identified by the Victim-Survivor and Others

- She experiences people expressing concern, sharing worried looks, or asking "is everything okay?"
- She experiences increased fear and vigilance around physical safety, including placing physical obstacles between them, remaining hyper-alert, watching his eyes, and being prepared to move quickly if needed