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

Prepared by the Multicultural Centre for Women's Health
January 2026

Multicultural Centre for Women's Health is a feminist organisation led by migrant and refugee women to achieve equity in women's health and wellbeing.

Introduction

This submission has been developed by the Multicultural Centre for Women's Health (MCWH), a Victorian women's health service established in 1978. We work both nationally and across Victoria to promote the health and wellbeing of migrant and refugee[1] women and gender diverse people across Australia. We take a multifaceted approach to achieving health equity through multilingual health education, research and advocacy, as well as training, capacity building, and partnerships.

As the national voice for migrant and refugee women, our aim is to bring attention to migrants and refugees as a population that is highly diverse, yet commonly experiences preventable structural barriers to safety, health and wellbeing in Australia – matters that are frequently overlooked in research and national health policy. Our submission highlights the need for more intersectional research to address critical evidence gaps relating to the relationship between domestic, family and sexual violence (DFSV) and suicide, specifically for migrant and refugee women and gender diverse people. Addressing gaps in the evidence base is critical for ensuring current and future prevention and intervention efforts are responsive to the needs of migrant and refugee women and gender diverse people.

The submission is anchored by MCWH's substantial work in the field of family violence prevention, including partnerships with Our Watch and Safe and Equal to strengthen inclusive approaches to prevent family violence in migrant and refugee communities, and ANROWS-funded research on migrant and refugee women's experiences of family violence and help-seeking across Australia, and community led approaches to prevention. We have authored publications on primary prevention (Poljski, 2011), promoting community-led responses to violence against immigrant and refugee women (Vaughan, et al., 2016), and international students experiences of sexual violence (Tran, et al, 2023). Additionally, we have undertaken significant research into migrant and refugee women's

[1] The term 'migrant and refugee' refers to people who have migrated from overseas and their children. It includes people who are part of both newly emerging and longer established communities, and who arrive in Australia on either temporary or permanent visas.

experiences of mental health and wellbeing in Australia, including a 2023 research report that was funded to support the evidence for mental health reform in Victoria (Tran, et al., 2023). All of our work to prevent DFSV is grounded in our strong connections with migrant and refugee communities across Victoria and Australia.

Background: An urgent need for further evidence on suicidality in migrant and refugees living in Australia

Globally, domestic, family and sexual violence (DFSV) is significantly associated with increased odds of suicidal ideation and suicide attempts among women, and is a preventable risk factor associated with dying by suicide (Alimoradi, et al., 2025). In a recent synthesis of a global dataset taken from 34 studies published between 2008 and 2025, comprising 63,139 female participants from 17 countries including Australia, intimate partner violence (IPV) was strongly associated with suicide risk, particularly if it involved psychological abuse, or if people experienced multiple forms of IPV (Alimoradi, et al., 2025).

However, existing evidence on the association between DFSV and suicide risk among migrant and refugee populations is extremely limited. There is some research on migrant and refugee experiences of DFSV victimisation, but very little on the factors related to suicide risk among migrants and refugees, particularly in an Australian context. Forte, et al.'s (2018) literature overview of suicidal behaviour and specific risk factors in migrants and ethnic minorities concluded that the findings were inconsistent and inconclusive, noting that 'both migrant populations and ethnic minorities may have unique risk factors for suicidal behaviour; however, more studies are needed to clarify them' (p.17). Bowden McCoy & King's (2019) systematic review found that there were no relevant Australian studies of suicidality and suicide prevention in culturally and linguistically diverse (CALD) communities.

The limited existing Australian research into migrant and refugee people's suicide risk strongly points to the need for further research and tailored action. As the National Suicide Prevention Strategy 2025-2035 notes, there is an Australian study of coronial data from 2006 to 2019, which found that migrants from Oceania and African countries were disproportionately impacted by suicide compared with other migrant groups and the Australian-born population (Maheen & King, 2023, cited in National Suicide Prevention Office, 2025). However, little else is known about suicide and suicidality among and within different migrant communities in Australia, despite them being identified as a priority population for suicide prevention under the National Mental Health and Suicide Prevention Agreement (Cth of Australia, 2022). Migrants and refugees are also underrepresented in mental health research (Carbone, 2021; Minas, et al., 2025).

As many researchers suggest, the limited amount of available research in this area may be due to limitations in data collection (see for example Truong, et al., 2023; Maheen & King, 2023; Bowden, McCoy & Reavley, 2020). As this submission will discuss, inconsistency in data collection relating to the markers of migrant and refugee background certainly complicate the accuracy and analysis of suicide data. Moreover, research also suggests that migrant and refugee women are less likely to report family violence. (See, for example, Satyen, et al., 2020). This not only impacts our understanding of the connection between DFSV and suicide risk, but more importantly, means that

migrant women are more likely to experience violence more severely and for more prolonged periods of time than non-migrant women (Lum, et al., 2016), and are less likely to receive the services they need (Vaughan, et al., 2020). Consequently, and for multiple reasons, the intersection and relationship between DFSV victimisation and suicide risk among migrant and refugee women and gender diverse people remains a significant and addressable gap.

Despite the urgent need for further evidence, there are strong indications that the barriers that migrants and refugees face when seeking help for DFSV victimisation and interacting with Australian DFSV-related services are likely to compound and/or contribute to their risk of suicidal ideation and suicide. These barriers include social isolation, discrimination and bias, stigma, language difficulties and other issues related to acculturation, lack of knowledge about the services available and systemic shortcomings within legal and support frameworks (Vaughan, et al., 2016; Sullivan, et al., 2025; Watts, et al., 2025; Labra-Odde, et al., 2026). The literature strongly suggests that there are unique factors that must be considered to understand and appropriately address the relationship between DFSV and suicide in migrant and refugee communities. However, even in this area of research, significant gaps remain. In their recent systematic review of *Barriers to Family and Domestic Violence Support for Culturally and Linguistically Diverse Women in Australia* (2025), Watts, Rock, Gately, & Smith note:

> Research on Indigenous Australian populations and FDV has been growing, but studies focusing specifically on CALD populations or disaggregating findings by cultural groups remain limited, creating gaps in understanding the nuanced barriers these women face in accessing support. (Watts, et al., 2025)

Given this context, the central theme of this submission is the need for further evidence and quality data collection on suicidality and DFSV in migrant and refugees living in Australia. We need more evidence and quality data collection on suicidality and DFSV for migrant and refugee women and gender diverse people because, in the same way that there are unique factors that influence experiences of DFSV among this group, there may be unique factors that influence their risk of suicide. Moreover, we need this information to inform the development and implementation of evidence-based suicide prevention interventions. It is likely that migrant and refugee women and gender diverse people need tailored support that recognises and addresses the unique factors and barriers that exist for them. Without reliable evidence, policymakers, prevention organisations, mental health and family violence services are impeded in making informed decisions to reduce the risk of suicidality among victims of DFSV and to prevent DFSV from occurring.

In addition, we know that improving awareness of, and equitable access to, services, and continuing to invest in meaningful family violence prevention, will reduce suicide risk in migrant and refugee communities. Therefore, to strengthen our holistic response to this issue, we need to ensure community-led prevention measures are prioritised along with further research and intersectional data collection.

Response to the Terms of Reference

This submission responds to points one, two and five of the Terms of Reference.

Terms 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

Prevalence of DFSV victimisation and its contribution to suicide risk and incidence among migrant and refugee women

While there is limited evidence exploring the relationship between DFSV victimisation and suicide in migrant and refugee communities in Australia, the research on DFSV and suicide across the general population is building (Vasil, Fitz-Gibbon, & Segrave, 2025). Nationally, the Australian Institute of Health and Welfare reported that intimate partner violence was the second greatest contributor to years of healthy life lost due to suicide among women over 15 years old (AIHW, 2025 cited in Vasil, Fitz-Gibbon, & Segrave, 2025, p.12). The Office of the Western Australian Ombudsman found that 56 percent of the women who died by suicide in 2017 in Western Australia, had been recorded as a victim of family and domestic violence prior to their death (Ombudsman Western Australia, 2022). In Victoria, a study of Coroner's Court Suicide Register data between 2009 and 2012 found 42 percent of women who had died by suicide had a history of exposure to interpersonal violence, most often as victims (68.9%) (MacIsaac, et al., 2018).

While these findings are likely to include people from migrant and refugee backgrounds, evidence on DFSV victimisation and suicide specific to migrant and refugee communities in Australia is extremely limited. One notable exception is O'Connor and Ibrahim's (2018) clinical audit of 84 psychiatric files of family violence victims born in South Asia and the Middle East, which found that the vast majority had experienced suicidal ideation (all those born in the Middle East, and three-quarters of those born in South Asia) while 43% of those born in the Middle East had attempted suicide and 17 percent of women born in South Asia had done the same. Despite being a small study, these limited findings strongly suggest the need for further inquiry.

Factors contributing to DFSV related suicide risk for migrant and refugee women

Although the existing evidence on the factors contributing to DFSV-related suicide risk for people from migrant and refugee backgrounds is extremely limited, there is emerging research indicating that suicide risk is compounded by other issues that are faced by migrant and refugee women and gender diverse people. Researchers exploring the connection between DFSV and suicide more broadly agree that suicide results from a complex mix of social, demographic and other factors, which can include DFSV, childhood abuse, social isolation and financial pressures, as well as co-

occurring conditions such as diagnosed mental illness, and substance misuse (Dhollande, et al., 2025; Vasil, Fitz-Gibbon, & Segrave, 2025). Many studies show that refugees in particular are more likely to experience poor mental health as a result of pre-migration and settlement trauma.(Sullivan, Vaughan & Wright, 2020) Therefore, a nuanced understanding of the connections between DFSV, migration-related stressors and suicide is needed.

State-enabled violence against migrant and refugee communities

As Sullivan, Vaughan, & Wright (2020) note, '[r]esearch has consistently demonstrated that people detained in immigration detention in Australia experience high rates of mental health conditions, including anxiety, depression, post-traumatic stress disorder, psychosis, self-harm and suicidal ideation' (p.18). More specifically, they write:

> A number of studies have highlighted the prevalence of suicidal ideation and self-harm among detainees…Hedrick et al. (2019) examined self-harm among offshore asylum seekers in detention on Nauru and Manus over 12 months and found that rates of self-harm were 200 times the rates of hospital treated self-harm in the general Australian population' (p.29)

Drawing upon interviews conducted with detained asylum seekers, Aitchison (2024) makes the argument that the psychological toll inflicted by Australia's offshore detention system is a clear instance of structural violence committed by systems, institutions and policies that reliably produces suicide and self-harm as a form of self-induced violence. The recent landmark ruling of the UN Human Rights Committee supports the view that Australia is responsible for the arbitrary detention of asylum seekers, even if they are offshore, and in that capacity, has 'failed to take effective measures to prevent torture and ill-treatment' (CAT/C/83/D/1079/2021, 2026).

It is well documented that the violence of detaining people in this country is based on the long and violent history of colonisation of Aboriginals and Torres Strait Islanders. Acknowledging and ending institutionally embedded racism and acts of state violence against Australia's First People, and against all people who experience forms of discrimination in Australia, is both important and necessary to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV victimisation and perpetration. It is the specific context in which DFSV victimisation occurs in Australia, and enables a culture of violence in which specific groups of individuals are treated as, and potentially made to feel, less deserving of life and care.

Pre- and post-migration stressors

Findings of a study conducted by the Queensland Program of Assistance to Survivors of Torture and Trauma suggest that post-migration factors may play a larger role than many pre-migration factors in suicide risk. The study of 120 young people from refugee backgrounds who were originally from Africa, Middle East and Southeast Asia (51% women and 49% men) found some factors associated with the risk of self-harm related to pre-migration trauma (witnessing the murder of strangers, childhood physical abuse and destruction of family property). However, there were more post-migration factors significantly associated with deliberate self-harm. Post-migration factors included

serious problems with family, family violence, living with a mentally ill family member, suicide/death of a close friend or loved one, loneliness and boredom, isolation, and academic challenges (FASST, 2019).

Barriers to support services

While both pre- and post-migration factors may contribute to an individual person's suicide risk, their ability to seek and access support is an equally important consideration in examining the connection between DFSV and suicide in migrant and refugee communities. Through their survey of international studies, Forte, et al. (2018) identified lack of information on the health care system as a possible trigger for suicidal behaviour among migrants and ethnic minorities. Migrant and refugee people's access to health and support services in Australia is known to be limited by a range of systemic factors including migration related stress, visa precarity, visa exclusion from social support services and public healthcare, as well as social isolation, lack of local networks and experiences of discrimination, stigma, language and financial barriers when attempting to access family violence support services or mental health services. (Labra-Odde, et al., 2026) Many of these barriers have also been identified as contributors to migrant and refugee women's reluctance to seek help for DFSV, leading to more protracted and extreme experiences of abuse (Vaughan, et al., 2016). For example, recent research into the experiences of international students who experienced sexual violence showed that housing precarity was a key factor preventing students from help-seeking or leaving a partner (Tran, et al., 2024). These factors also exacerbate mental ill health and limit migrant and refugee individual's access to effective, timely and appropriate mental health interventions.

Social isolation

In the literature, social isolation has also been noted as a key factor contributing to suicide risk among migrant and refugee people, as well as common feature of migrant and refugee women's experiences of DFSV (Sullivan, et al., 2025; Tran, et al., 2024; Vasil, Fitz-Gibbon, & Seagrave, 2025). For example, a recent study into international students who experienced SV/IPV found that social isolation was a risk factor impacting international students' help-seeking behaviours and suicidal thoughts and that social isolation itself was a contributing factor to vulnerability to violence, along with lack of secure housing and financial security (Tran, et al., 2024). Similarly, Vasil, Fitz-Gibbon, & Seagrave (2025) highlighted how migration-related social isolation intersects with perpetrator-driven social isolation, particularly 'for migrant women who may not have high levels of English language proficiency and arrive with limited social connections and may be unaware of available supports' (Vasil, Fitz-Gibbon, & Seagrave, 2025, p.20).

For migrant and refugee women, who already experience greater barriers to help-seeking and higher levels of social isolation post-migration, the feeling of being trapped or having no options available to them, is worth further study in understanding the relationship between DFSV and suicide-risk. Moreover, these findings support existing research into the links between migration status and family violence (see Vaughan, et al. 2016; Seagrave, 2017; Vasil, 2023a, 2023b) and highlight the need to examine how migration status and visa conditions may impact migrant and refugee

individual's deaths by suicide.

Multi-perpetrator violence

Migrant and refugee women may be at greater risk of suicidality stemming from the impacts of multi-perpetrator domestic violence, about which relatively little is known. Salter (2014) defines multi-perpetrator violence as DFSV 'in which a person's intimate partner draws other people into participating in their physical and/0r sexual victimization' (p.102). Salter notes that there is an alarming lack of research into multi-perpetrator violence, which is 'frequently excluded from analysis or analyzed as though they were a single perpetrator incident' (p.103). Given the absence of data, it is difficult to know if multi-perpetrator violence is actually more prevalent in migrant and refugee communities, or if it is made more visible by racialized depictions of male honor in relation to violence against women, which some researchers argue is equally prevalent in Western cultures (See Salter, p.106). Nevertheless, Salter found that '[i]n some ethnic minority communities, extended kin networks, friends, and associates may collude in the collective victimization of a woman or girl' (p.104). In Australia, there is some evidence that multi-perpetrator domestic violence (MDV), is linked to negative mental and physical health outcomes including mental illness and suicidality (Salter, 2014; Watts, et al., 2025).

Perpetrator misidentification

In addition, migrant and refugee women and gender diverse people have been found to be more likely to be misidentified as a perpetrator of violence, which has been directly linked to increased suicide risk. Spivak, et al. (2025) found that in Victoria, 'police-reported family violence is associated with increased mental health emergency department presentations', particularly for women who are identified as perpetrators. Women's Legal Service Victoria found that in a five-month period between January – May 2018 when police identified a female respondent as the primary aggressor, they were mistaken 58 percent of the time. Moreover, 53 percent of those women who were misidentified were culturally and linguistically diverse and came from non-English speaking backgrounds (Women's Legal Service Victoria, 2018). These findings are further supported by data from InTouch Multicultural Centre Against Family Violence, which estimated that at least one-third of their (mainly women) clients had experienced misidentification during interactions with law enforcement and the justice system (inTouch, 2022). While further research is needed, this raises serious questions about the role of discrimination and bias on migrant and refugee women's mental health and risk of suicide, as well as that of other groups that are frequently misidentified.

Perinatal mental health

Research shows that women are at increased risk of experiencing family violence from an intimate partner during pregnancy (AIFS, 2015). For example, Navodani, et al. (2019) found evidence to suggest that one in six Australian-born women (16.9%) and more than one in four migrant women (22.5%) experienced intimate partner abuse in the first 12 months postpartum. At the same time,

suicide was one of the leading causes of maternal death reported in Australia between 2014 and 2023 (20 deaths or 10%) (AIHW, 2025).

While both maternal health and the impacts of violence against women and girls are priorities in the National Women's Health Strategy 2020-2030, the potential association between perinatal mental health, DFSV and suicide risk is largely unexplored, although there is a strong commitment in the Strategy to further research more generally. Recent findings in New Zealand suggest that there is an urgent need for further inquiry. The Te Tāhū Hauora Health Quality & Safety Commission (2025) reported that suicide is the leading cause of maternal death in New Zealand, with 63 percent of those who died having experienced family violence. Moreover, the Commission found 40 perinatal deaths annually were linked to family violence (Te Tāhū Hauora Health Quality & Safety Commission, 2025).

During the perinatal period, migrant and refugee women experience similar risk factors for mental health issues, as the Australian-born population. However, low levels of social support, precarious immigration status, and DFSV victimisation add additional risk for migrant and refugee women.

> Pregnant women who experience family violence may have difficulty obtaining appropriate and sufficient social support, including support from family, friends, and professionals, which can result in severe perinatal depressive symptoms. There is evidence to suggest that migrant and refugee women may experience a higher burden of these symptoms and intimate partner violence (MCWH, 2022).

In addition, migrant and refugee women experience significant barriers to accessing perinatal mental health services, including complexity of navigating the health system, lack of culturally and linguistically responsive services, and high costs of services, particularly for women on temporary visas who are not eligible for Medicare. Though preliminary, we believe this issue warrants further consideration as a line of urgent research.

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

A number of studies have noted substantial gaps and inconsistencies in the availability, quality and consistency of data related to migrant and refugee individuals and suicide (Truong, et al., 2023) (Bowden, McCoy, & Reavley, 2020) (Pham, et al., 2024) (Vasil, Fitz-Gibbon, & Segrave, 2025).

Several researchers note that limitations in the available data on suicide greatly impede research and understanding of the issue. Pham, et al. (2024), who used linked hospital and mortality data in Victoria, argue that there is a need to:

> strengthen self-harm and suicide data quality and coverage. This could include the development (or improvement) of self-harm databases to collect more detailed data on

> CALD people, capturing information on how people entered Australia and under what circumstances (as refugees or as planned migrants), the main language spoken at home, race, as well as other factors that might be relevant to self-harm, such as family violence and substance use. (p.16)

Similarly, reflecting on the limitations of their study, which used data from the National Coronial Information System, Maheen and King (2023) conclude:

> At present, coroners do not regularly collect migration-related data, such as ethnicity, language skills proficiency, visa status, and length of residence. These variables are known to be linked to poor mental health, acculturation stress, and, in turn, suicidal behaviour. To better understand suicide risk factors in migrant communities, we argue that national data collection should capture ethnicity and migration-related information. We support calls for police and coronial data collection to report ethnicity and migration-related data to enhance our knowledge of high-risk groups for suicide in migrant communities across Australia. (p.10)

Beyond the limited data collected that could help researchers to identify people from migrant and refugee backgrounds, inconsistency in data sets and definitions of CALD across institutions and states was also found to significantly compromise the quality of the data. In a pilot study into the availability and quality of data related to cultural and linguistic diversity in the Victorian Suicide Register, Truong, et al. (2023) found that substantial gaps existed in the availability and quality of data related to cultural and linguistic diversity, which they noted was indicative of many local, state and federal registry-based databases in Australia. Moreover, the study highlighted:

> National and state definitions of CALD used in policy, government documents and research are highly variable, creating challenges with data collection and assessment of CALD-specific population health, social and economic needs. It is critical that any definition of cultural and linguistic diversity is operationalised to enable accurate and consistent identification of those from CALD backgrounds to enable the collection of data that can be used to assess community needs to ensure equitable access to services (p.6).

For example, the researchers noted that country of birth was the most frequent CALD indicator recorded for decedents in the Victorian Suicide Register, with less information about citizenship, residency or visa status, preferred language, English language proficiency, religious affiliation or mother and father's country of birth. Birthplace can be a good indicator, but is only one small part of a person's cultural identity, and may not necessarily give a full or reliable picture of an individual's background or their experiences as a migrant or refugee. Maheen & King (2023) also emphasise the importance of keeping up-to-date data, arguing that '[g]iven the substantial changes in Australia's population demographics due to migration over the years, and the likelihood of further changes, evaluating suicide mortality over time is crucial' (Maheen & King, 2023).

While decisions about the specific types of data that can and should be collected is a complex issue, which would need to be balanced against the impact of data collection on migrant and refugee communities' trust in services, it seems clear that greater national coordination in data collection is needed. Truong et al. (2023) suggest one solution would be to:

> Implement a formal coding framework, with reference to relevant standards from organisations that routinely collect CALD-identity-related information, to ensure that the necessary information is collected to generate insights into how CALD identity and suicidality and/or family violence may intersect.

Improving the consistency of data collection and research around suicidality and family violence would require national co-ordination and co-operation across multiple sectors, but would lead to better informed and evidence-based policymaking.

Reducing stigma around DFSV and increasing migrant and refugee women and gender diverse people's trust in services is also essential to reduce underreporting and improve our understanding of the connections between DFSV and suicide risk. As mentioned, there is evidence that migrant and refugee women are less likely to report DFSV than non-migrant women (Satyen, et al., 2020). As Vaughan, et al. (2016) note:

> Researchers reported many reasons as to why immigrant and refugee women may be reluctant to seek help for family violence, including limited knowledge of available services, fears of retribution from multiple perpetrators, concerns for the perpetrators themselves or the consequences of using legal systems, previous negative experiences from contact with services including racism and anti-immigration sentiment, and wanting to maintain a positive reputation for their communities (Vaughan, et al. 2016, p.11).

Further participatory and intersectional, qualitative research is needed to provide essential context, explanation and community-responses to the data. Understanding the ways in which factors like disability, housing insecurity, perinatal mental health, and gender diversity might impact on the association between DFSV and suicidality are all areas of research that may shed urgently needed light on the issue and suggest new policy directions and solutions.

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

Many opportunities exist to enhance prevention and early intervention efforts to reduce deaths by suicide in the context of DFSV for migrant and refugee communities.

Remove structural inequalities and discrimination that can impact migrant and refugee people's access to primary prevention, early intervention and mental health and other DFSV-related support services

Migrants and refugees face systemic barriers and discrimination, which can have wide-ranging and long-lasting negative impacts on their mental health, their capacity to participate in the community and their access to and use of services. For example, migrants on temporary visas are often excluded

from access to Medicare, Centrelink, housing services and publicly funded family violence services, which can exclude them for access to primary prevention initiatives, limit their ability to form social networks and in cases where they are experiencing DFSV victimization, can exacerbate their mental distress, increase their dependance on a perpetrator of violence and delay or prevent them from seeking help (Tran, et al., 2023; Labra-Odde, et al., 2026).

Furthermore, services that do not take into account the cultural, linguistic and religious needs of their clients can also impede access to primary prevention, early intervention, health and DFSV support services. Labra-Odde, et al. (2025) conducted in-language focus group interviews with 139 women across Australia and found that participants experiences in relation to mental health 'indicated a lack of training among practitioners to deliver culturally responsive care' (Labra-Odde, et al., 2025, p.39). Addressing bias and discrimination of all forms is key to both preventing violence and improving mental wellbeing for migrant and refugee women and gender diverse people across Australia.

There are many ways to do this work, but effective initiatives are often cross-sectoral and community-driven. An example of this is the Crossroads to Community Wellbeing Group, which was established in response to an increase in suicides of South Asian women living in the City of Whittlesea in Victoria in late 2018. A Coroner's Court investigation into four of the deaths confirmed that this 'was a cluster of suicides of women of South Asian background and that some of the women had experienced family violence, social isolation and unmet mental health needs' (EMPHN, 2023). Engaging with local community leaders, and comprising a wide range of community services, the working group developed an Action Plan. Opportunities identified included:

> …expansion of mental health, family violence, perinatal and other support services in the City of Whittlesea; the establishment of additional South Asian women's support groups, including increased use of religious leaders and survivors of abuse as mentors; increased education for South Asian women regarding women's rights, Australian law and accessing services; increased education regarding cultural sensitisation and appropriateness of service providers; and improved processes for information sharing and data collection across organisations. (Coroner's Court of Victoria, 2020)

Promote migrant and refugee women's independence and decision making in private and public life to prevent family violence and improve mental health

A key action to prevent violence against women and to improve mental health is to promote women's independence and decision making. Migrant and refugee women are strong leaders and active contributors to public, community and private life. However, they face additional barriers to employment, participation and financial independence. For example, migrant and refugee women tend to be concentrated in low-wage industries with high rates of casualisation, reducing their opportunities for financial independence to leave a perpetrator and increase feelings of being trapped (Hach & Aryal-Lees, 2019). Additionally, migrants and refugees often experience racial discrimination in the housing market or disadvantage due to lack of local rental history or

employment history leading to their concentration in poorer quality, more crowded housing (MCWH, 2025).

Reducing barriers to education and employment will create opportunities for migrant and refugee women to engage meaningfully in public life. Equally, programs that foster social connections and advocate for gender equality and women's autonomy, can support women to establish social networks and build confidence. Community groups that are accessible to migrant women and responsive to their needs have also been shown to reduce the risk of developing mental disorders (Fellmeth, 2018).

Increase bilingual health education and tailored/community-led prevention

MCWH leads a national bilingual health education program that has proved itself to be an effective early intervention tool to increase understanding of family violence and available support services in multicultural communities. For example, the Safety and Support in My Language Project delivered bilingual health education sessions in Arabic, Chinese and Hindi to 35 women on the topics of Gender Equality, Healthy Relationships and Family Violence between June 2020 and February 2022. Project findings showed that bilingual health education is an effective tool in multicultural communities to prevent family violence and promote help-seeking. Receiving information in languages other than English strengthened migrant and refugee women's understanding of family violence and healthy relationships in a culturally safe and empowering way. Migrant and refugee women were better able to make the links between gender inequality and family violence as well as recognise the early signs of violent or abusive behaviour (Huggins, 2022). The project also found:

- 100% of Arabic and Hindi-speaking participants preferred education in their language rather than in English.
- 69% of all participants said the lack of bicultural workers in the family violence system is a major barrier to accessing support and information.
- 55% of all participants said that health information delivered in English or with interpreters was difficult to follow.

Support multicultural and settlement services

Multicultural and settlement services are one of the primary points of contact migrant and refugee communities have with services after arrival. They work across prevention and early intervention and are well-positioned to support migrant and refugee women to navigate family violence response systems, as well as other interconnected services to ensure continued safety (Vaughan, et al., 2020). However, many services continue to do this work mostly unfunded, relying on short-term project funding rather than system-level investment (MCWH, Whittlesea Community Connections, & inTouch, 2022). Without sustained and adequate resourcing, gaps in DFSV prevention and response will only persist and contribute to preventable harm, including suicide.

We refer the Committee to consider the suite of evidence-based recommendations based on the

findings of the MuSeS Research Project, which examined settlement and multicultural services in three states supporting migrant and refugee women who have experienced violence (Vaughan, et al., 2020).

Recommendations

The National Prevention Suicide Strategy includes many excellent actions to reduce suicide stigma and build suicide prevention capability, such as Action 6.2b., to build the capacity of services that are frequently in contact with people negatively impacted by social determinants to recognise and respond compassionately to signs of suicidal distress. This excellent work must include capacity building to recognise and reduce intersecting forms of discrimination and bias and barriers to access commonly experienced by migrant and refugee women and gender diverse people.

1. Invest in further research with migrant and refugee communities

a) Fund and support population-based research, to understand suicide prevalence and incidence among migrant and refugee women and gender diverse people, and longitudinal data to track change over time.

b) Fund and support community-driven, participatory research to better understand migrant and refugee women and gender diverse people's experiences of violence, mental health and suicidality.

Both of these recommendations could align with the National Women's Health Strategy 2020-2030 action to 'Support research into the short and long-term impacts of family and intimate partner violence and/or sexual violence and develop targeted strategies to support those affected'

2. Standardise data collection relating to migrant and refugee communities

Work with multicultural (or migrant and refugee) organisations and researchers to establish and implement clear and effective cross-sectoral national standards to ensure that accurate and appropriate information is collected to learn more how migrant and refugee identity, suicidality and DFSV intersect.

3. Improve access to health, mental health and DFSV services that are trauma informed, inclusive and culturally and linguistically responsive

a) Address intersecting structural, institutional and interpersonal forms of bias and discrimination in mental health and DFSV support services, through policy review and workplace training.

b) Build the capacity of family violence and mental health services to

provide an appropriate, effective and culturally safe response to migrant and refugees, including removing visa-related eligibility barriers to access services.

4. Ensure that existing strategies and initiatives to prevent suicide risk, prevent DFSV and increase awareness of services centre the needs of migrant and refugee women and communities

Primary prevention of gendered violence initiatives are an essential piece in reducing suicide risk. Building on the National Suicide Prevention Strategy 2025–2035 Recommendation 7.3c, to increase the availability of tailored, culturally appropriate suicide prevention support services for migrants at higher risk of suicide.

a) Support MCWH's HIML in-language, community led, culturally appropriate health education to expand on topics delivered to include suicide prevention, perinatal mental health and family violence

b) Allocate funding to programs that strengthen migrant and refugee communities' social connections and networks; foster women's leadership; and build their capacity to navigate the family violence, health, legal and welfare service systems

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