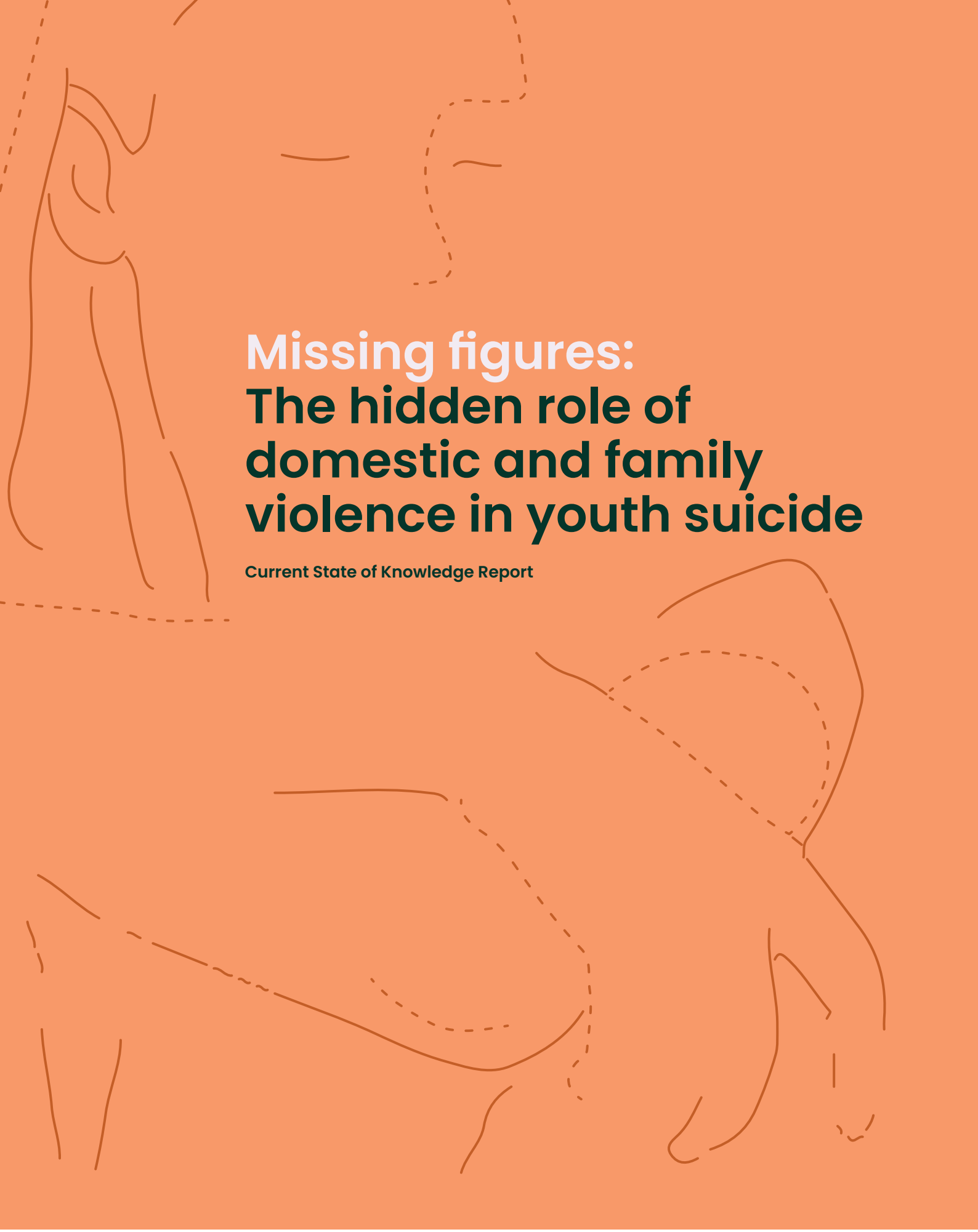

Missing figures:
The hidden role of domestic and family violence in youth suicide

Current State of Knowledge Report

Griffith UNIVERSITY
Centre for Mental Health

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Content warning and support services

This report contains details about violence and suicide among children and young people. If you or someone close to you is in distress or immediate danger, please call 000.

To access support, information and counselling services, you can contact:

1800 Respect
The national sexual assault, domestic and family violence counselling service. This service is free, confidential and available 24/7.
Contact: (p) 1800 737 732
www.1800respect.org.au

Full Stop Australia
The national trauma counselling and recovery service for people of all ages and genders experiencing sexual, domestic and family violence. This service is free, confidential and available 24/7.
Contact: (p) 1800 943 539
www.fullstop.org.au

13Yarn
A support line for mob who are feeling overwhelmed or having difficulty coping. Available 24/7.
Contact: (p) 13 92 76 www.13yarn.org.au

Thirrili Postvention Response Service
The Indigenous Suicide Postvention Response Service supports individuals, families and communities affected by suicide or other significant trauma. Available 24/7.
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eheadspace
National mental health counselling service.
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https://headspace.org.au/online-and-phone-support/

Kids Helpline
Free, confidential online and phone counselling service for young people aged 5 to 25 years old. Available 24/7.
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www.kidshelpline.com.au

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Switchboard provides peer-driven support services for lesbian, gay, bisexual, transgender and gender diverse, intersex, queer and asexual (LGBTIQA+) people.
Contact: (p) 1800 729 367
www.rainbowdoor.org.au/getsupport

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Acknowledgements

We would like to acknowledge the expert input from Tash Anderson and Morgan Cataldo in the conceptualisation of this project and publication of this report. This work is inspired by their leading advocacy in relation to the rights of children and young people and we thank them for their contribution to this project. In particular, we want to acknowledge Tash's ongoing efforts as a young advocate and the immense and significant load they have carried over the years to ensure this issue enters mainstream discourse.

This project received seed funding from the Griffith Centre for Mental Health and philanthropic funding. We would like to thank the philanthropic donor for their support of this critical piece of work.

Professor Kate Fitz-Gibbon contributed to this project in her capacity as Director of the Monash Gender and Family Violence Prevention Centre. This Current State of Knowledge Review is wholly independent of Kate Fitz-Gibbon's role as Chair of Respect Victoria.

Suggest citation:
Meyer, S., Atienzar-Prieto, M., Fitz-Gibbon, K., & Moore, S. (2023). Missing Figures: The Role of Domestic and Family Violence in Youth Suicide - Current State of Knowledge Report. Griffith University: Brisbane.

DOI: https://doi.org/10.25904/1912/4787
Publication date: March 2023

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Acronyms

ABS
Australian Bureau of Statistics

ACE
Adverse Childhood Experiences

AIHW
Australian Institute of Health and Welfare

CCYP
Commission for Children and Young People

DFV
Domestic and family violence

DSS
Department of Social Services

DV
Domestic violence

DFV
Domestic and family violence

NMD
National Mortality Database

NYSPS
National Youth Suicide Prevention Strategy

IPV
Intimate Partner Violence

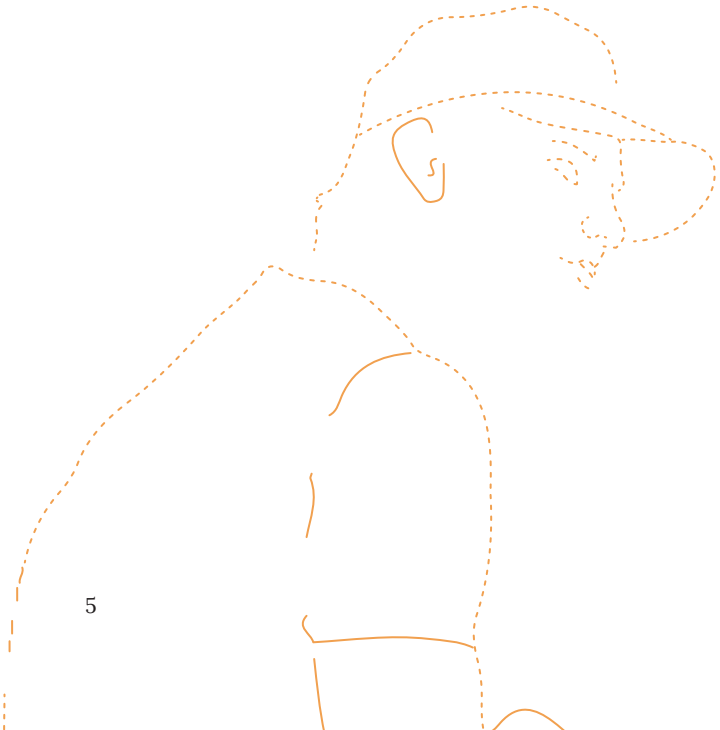
PTSD
Post-Traumatic Stress Disorder

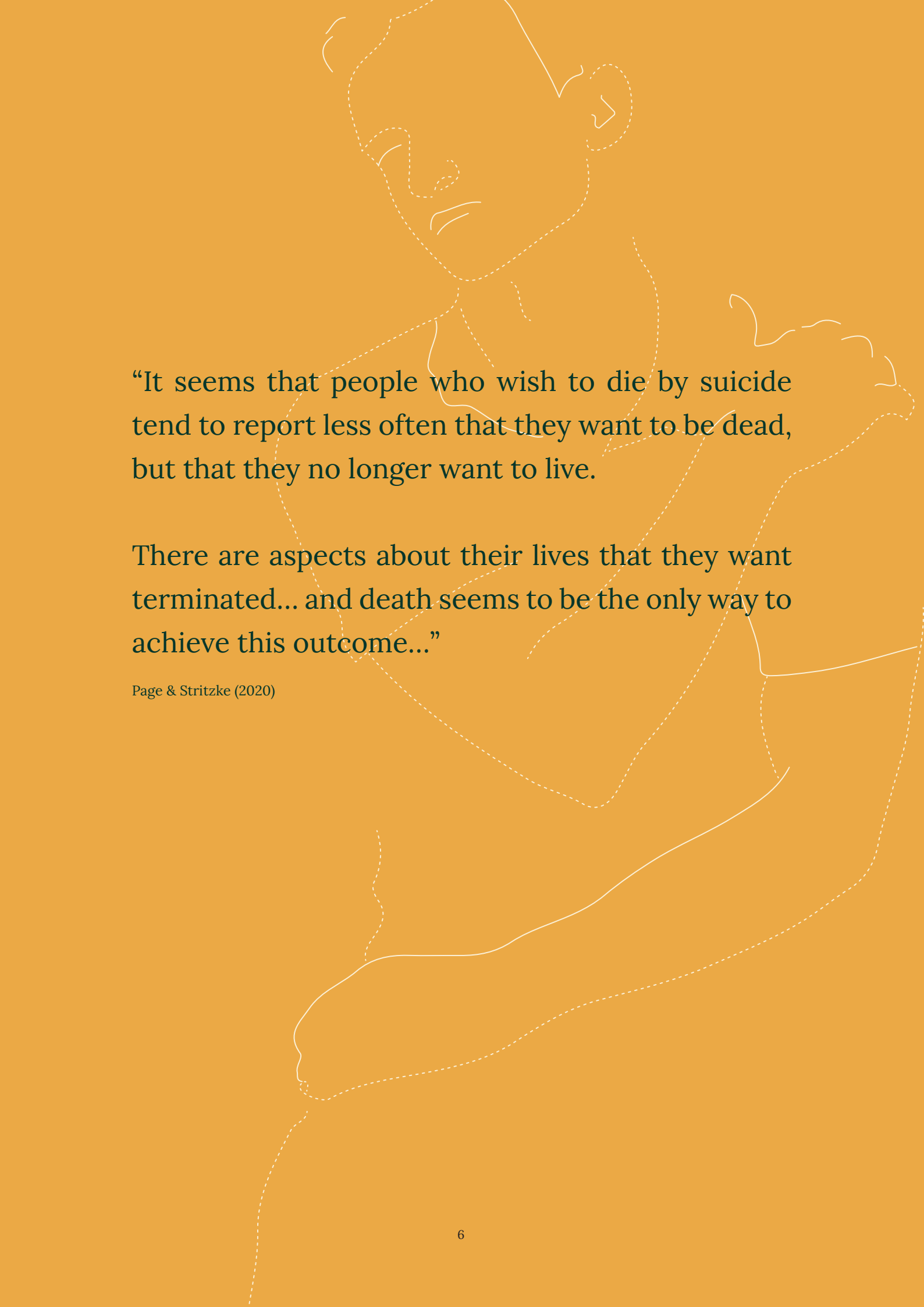
RCFV
Royal Commission into Family Violence

SES
Socio-Economic Status

WA
Western Australia

WHO
World Health Organisation





“It seems that people who wish to die by suicide tend to report less often that they want to be dead, but that they no longer want to live.

There are aspects about their lives that they want terminated… and death seems to be the only way to achieve this outcome…”

Page & Stritzke (2020)

Executive Summary

In Australia the national youth suicide statistics are alarming. Suicide accounts for 38 per cent of the deaths among young people aged 15-24 years old. Between 2018-2020 this made suicide the leading cause of death among young Australians (Australian Institute of Health and Welfare, 2022b). Within this, official statistics indicate that suicide is a serious problem among young Australians widely, with disproportionately high suicide rates among young First Nations people and young people with diverse gender and sexual identities. Evidence is now emerging that these, already alarmingly high rates, have further escalated since the beginning of the COVID-19 pandemic.

Understanding the factors that contribute to an increased risk of youth suicide is complex. Current evidence suggests that various factors, and their combination, may contribute to a young person's death by suicide. This evidence further suggests that contributing factors are often lumped together under the umbrella of adverse childhood experiences or childhood abuse, without examining the individual effects of different types of abuse and neglect. Further, childhood experiences are frequently examined together with the role of adverse outcomes in closer proximity to suicide (e.g. mental health problems, harmful substance use), often masking the initial and lasting impact of childhood trauma on the risk of youth suicide. In particular, examinations of the role of childhood experiences of (domestic and family violence) DFV as a lethality indicator remain scarce. Seeking to further current understandings of the role of DFV in youth suicide, this report presents the findings from a review of the current state of knowledge in Australia and internationally on the intersection between children and young people's experiences of DFV, and their risk of youth suicide.

This report examines current evidence on the association between growing up with experiences of violence in the home and youth suicide, child maltreatment and youth suicide, the role of the child protection system, and the impact of other adverse childhood events. It highlights the need for more research in Australia on the relationship between experiences of DFV during childhood and adolescence, and youth suicide. Building improved understandings is critical to ensuring that prevention, early intervention, response and recovery efforts are evidence-based. This must include building the evidence base through consistent screening for and data collection on DFV across service systems responding to children and families.

Australia's National Plan to end Violence against Women and Children 2022-2032 includes a critical acknowledgement of children as victim-survivors of domestic, family and sexual violence in their own right. Alongside the overarching goal to eliminate gender-based violence in one generation, the National Plan provides clear recognition of that children can experience a range of different forms of gender-based violence, including DFV, sexual harassment, technology facilitated abuse, and child sexual abuse. The Plan (2022: 44) states:

> "A child's worldview is shaped by the violence they see, hear and experience each day. These experiences affect their perception and understanding of the world, which can have long-term and ongoing impacts."

This recognition is long overdue. For too long system responses and services have been designed and delivered with only the adult victim-survivor in mind, rendering responses to children and young people as solely the extension of their primary carer parent. Australian children and young people who have experienced DFV during childhood and/ or adolescence cannot continue to encounter a system that is ill-equipped to identify their risk, to respond to their disclosures, and to provide effective child- and young person-centred supports. While there are innovative and good pockets of practice emerging nationally, this current state of knowledge review provides a stark reminder of another dimension of the fatal consequences of DFV for children and young people. Children and young people affected by DFV required a service system that will meet their needs for protection, security and recovery regardless of whether they are accompanied by a help-seeking adult or navigating the service system on their own.

Introduction: Suicide among young people in Australia

Every year approximately 703,000 people die by suicide globally, and countless more individuals try to take their own life (World Health Organisation [WHO], 2021). Although suicide can take place at any point in one's lifespan, global data indicate that suicide is the fourth leading cause of death among adolescents and young adults aged 15-29 years old (WHO, 2021). In Australia the national youth suicide statistics are alarming. Suicide accounts for 38 per cent of the deaths among young people aged 15-24 years old. Between 2018-2020 this made suicide the leading cause of death among young Australians (Australian Institute of Health and Welfare [AIHW], 2022b), and among young people (15-17 years old) in Queensland in 2021-2022 (Queensland Family & Child Commission [QFCC], 2022).

According to the most recent national suicide data from 2021, 322 Australian young people aged 18-24 died by suicide, and 112 deaths by suicide took place among young people aged 17 or under, with most of these deaths (71%) occurring in the15-17-year-old age group (AIHW, 2022b). Only in Queensland, data indicate that the rate of suicide among children and young people has increased by 2.6 percent per year on average over the 16-year period, from 1.7 per 100,000 in 2004-2008 to 2.1 per 100,000 in 2015-2019 (QFCC, 2020). An analysis of suicide trends in Australia between 2010 and 2021 shows that there has been an increase in suicides among young people aged 18-24 years old from 10.8 deaths per 100,000 population in 2010 to 14.6 in 2021, whereas suicide rates have remained relatively stable among individuals aged 15-17 years old (7.9 to 8.8.9 deaths per 100,000 population) (AIHW, 2022b). The official statistics indicate that suicide is a serious problem among young Australians widely, with disproportionately high suicide rates among young First Nations people and LGBTIQ+ youth. According to data from the National Mortality Database (NMD) and the Australian Bureau of Statistics (ABS), between 2016 and 2020 the suicide rates among First Nations people aged up to 24 years old were more than twice as high as those reported for non-First Nations young people (AIHW, 2022a). Likewise, a report released by the Coroners Court of Victoria (2022) examining deaths by suicide among Victorian LGBTIQ+ people for the period 2012 to 2021 indicates that 4.8 per cent and 20.2 per cent of suicides were among people under 18 years and aged 18-24 years old, respectively. Notably, these figures are approximately twice as high than the proportion of suicides in the same age groups among the general population (i.e., 2.8 per cent of suicide among people under 18 years and 10.6 per cent among people aged 18-24) (Coroners Court of Victoria, 2022).

While available data do not suggest an increase of death by suicide in 2020 and 2021 in Australia that can be associated to the COVID-19 pandemic (AIHW, 2023), research indicates that there were two rapid increases in demand for Kids Helpline, including suicide-related contact, during the pandemic (Batchelor et al., 2021). Specifically, after the pandemic was declared, there was an initial increase in demand, followed by a gradual decline (Batchelor et al., 2021). However, when parts of Australia experienced a second wave of infections and related stay at home orders, a second rise in demand occurred (Batchelor et al., 2021). Additionally, Sveticic et al. (2021) studied suicidal and self-harm presentations in emergency departments (EDs) in Queensland and found an increase in presentations by persons younger than 18 years old since the pandemic. Similarly, Sara et al. (2023) found that self-harm or suicidal ideation presentations by people aged 10-24 years old in New South Wales were increasing by 8.4 per cent per annum, and accelerated since the pandemic, growing at a rate of 19.2 per cent from March 2020 to June 2021. Additionally, there is extensive research evidence showing an increase in domestic and family violence (DFV)[1] cases affecting women and children during the COVID-19 pandemic (for a review of evidence, see Huang et al., 2023; Kourti et al., 2021; Piquero

1 We acknowledge that DFV can include any form of violence occurring in a domestic setting, such as sibling violence or child-to-parent violence. However, as most of the literature exploring young people's exposure to DFV primarily includes violence between adults, the term 'experiences of DFV' will be used in this report to refer to the DFV instances where DFV occurs between parents/carers involved in the young person's life.

et al., 2021). While research has currently not examined the increase in youth suicide in the context of increasing risk factors exacerbated by the pandemic (e.g., experiences of DFV, child abuse and neglect, mental health problems, lack of access to mental health support, invisibility of young people during stay at home orders, school closures and limited face to face child and family welfare service delivery), the raise of youth suicide-related presentations in EDs and use of helplines is alarming.

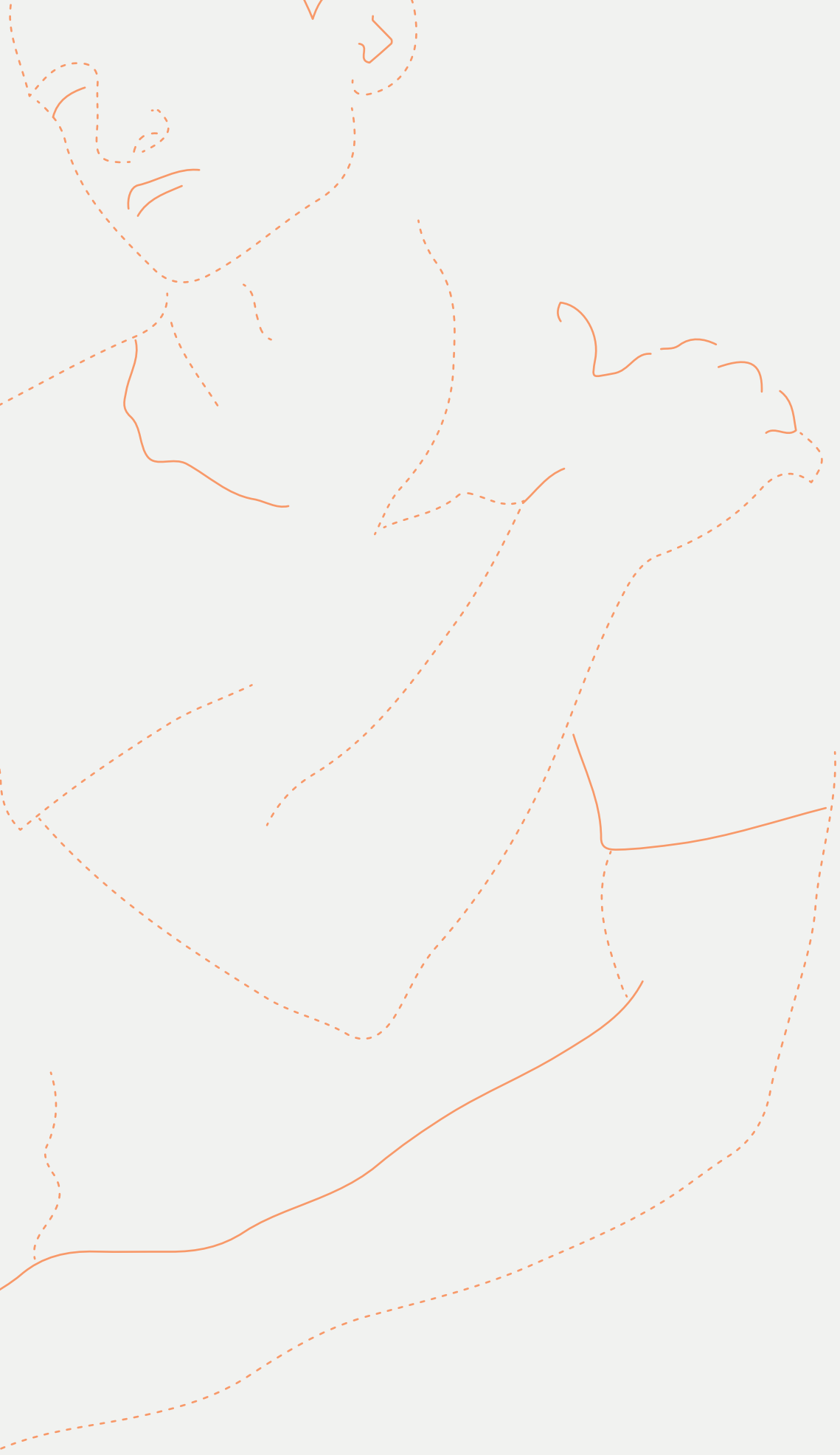
Risk factors associated with youth suicide are complex. Current evidence supports the idea that various factors, and their combination, may contribute to a young person's death by suicide (for a review of evidence, see Beautrais, 2000; Bilsen, 2018). It is well-established that suicide behaviours such as suicide ideation or previous suicide attempts are one of the strongest risk factors for completed suicide (Brown et al., 2000). In particular, a history of multiple suicide attempts has been identified as one of the strongest predictors of death by suicide in young individuals (Bridge et al., 2006; Kotila & Lönnqvist, 1987) as well as adults (Christiansen & Frank Jensen, 2007; Park et al., 2018; Suominen et al., 2004). Results from the 2020-21 cohort of the National Study of Mental Health and Wellbeing (ABS, 2022) indicate that, in the 12 months before the study, the highest prevalence of suicidal thoughts and behaviours were among people aged 16-34 years old (i.e., 5.2% of people aged 16-34). In Australia alone, 434 young people aged 24 or below died by suicide in 2021 (AIHW, 2022b). The numbers are significantly higher when you also include young people who attempted suicide without completion. Research has shown that for every completed suicide among young people there are approximately 200 suicide attempts (Goldsmith et al., 2002). Adopting trauma-informed risk and support needs assessments to successfully monitor and identify surviving suicide attempters is essential to prevent future suicide completions.

This report presents the findings from a review of the current state of knowledge on the intersection between children and young people's experiences of DFV, and their risk of youth suicide. Focusing our review on the experiences of children and young people growing up with experiences of violence as risk factors of youth suicide, our findings are presented thematically into four sections:

1. Child maltreatment[2] and youth suicide,
2. Experiences of parental / carer / adult domestic and family violence (DFV) and youth suicide,
3. International evidence,
4. Australian evidence

The report concludes by examining the implications of our review of the current evidence on policy and practice.

2 The term 'child maltreatment' is used in this report as this terminology is commonly used in the wider literature to refer to experiences of child abuse and/or neglect. We recognise that abuse and violence is used against children and young people in the context of 'child maltreatment'. Therefore, the term 'child maltreatment' is used interchangeably with 'child abuse' throughout this report and is not intended to minimise children's experiences.



Domestic and family violence related deaths among young people:

THE ASSOCIATION BETWEEN GROWING UP WITH EXPERIENCES OF VIOLENCE AT HOME AND YOUTH SUICIDE

In 2021, psychosocial risk factors were reported to be the most common factors associated with suicide in Australia (ABS, 2021). Some Australian and a large body of international studies have specifically identified child maltreatment and experiences of DFV as significant contributing factors to potentially avoidable deaths in early adulthood (Baldry & Winkel, 2003; Brockie et al., 2015; Dube et al., 2001; Gex et al., 1998; Gong et al., 2022; Hacker et al., 2006; Hill et al., 2021; Kim et al., 2021; Li et al., 2021; Oprescu et al., 2017; Raleva, 2018; Sharratt et al., 2022; Turner & Colburn, 2022). Given the high prevalence of childhood experiences of DFV and other forms of maltreatment among young people in Australia, it is critical to pay close attention to their role in young people's suicide attempts and completions. For example, a recent national study of 5,021 young Australians revealed that one in two young people in Australia grow up with some form of DFV (Fitz-Gibbon et al., 2022b). Understanding the link between experiences of DFV and other forms of maltreatment in young people's suicide and suicide attempts is therefore vital to inform future responses to DFV, including child-centred, trauma-informed responses and recovery support that mitigates the risk of adverse outcomes for young people.

In this report, adverse experiences during childhood and their link with youth suicide are discussed in two sections. First, literature in the field of child maltreatment, also referred to as family violence in some jurisdictions, including any form of physical, sexual, and emotional abuse and neglect directly targeted to a young person is reviewed. Although not always referred to as coercive control in the literature, we acknowledge the detrimental impacts of this form of abuse on young people's lives (Katz, 2022). Second, evidence including the study of young people's experiences of DFV between adults (e.g., parents or carers) is examined. This involves instances where a young person experiences one parent/caregiver being subjected to one or more forms of abuse as well as experiences of damage caused to property or the short- and long-term impacts on the adult victim-survivor caused by the other parent/caregiver's violent behaviour (Hamby et al., 2011; Jouriles et al., 2001; Wolak & Finkelhor, 1998). Most of the research exploring experiences of DFV and child abuse and neglect usually captures participants' experiences that took place prior to the age of 18 years old. Therefore, most of the literature included in this report explores the association between adverse experiences prior to the age of 18 years old and youth suicide, potentially missing adverse experiences of young people aged 18-25 years old. However, we acknowledge that young people over 18 years old also experience parental/carer DFV and abuse, along with its impacts. Thus, when we refer to children in this report, we refer to both children and young people, including adolescents and young adults up to the age of 25 years old, who may still reside in the family home, including living with parents and/or stepparents, or who have other living arrangements, including living with other adult family members or in foster care arrangements.

Language used to capture young people's experiences of DFV between adults is diverse. For example, the term 'witness' has been used extensively in prior research (e.g., Jaffe et al., 1985). However, scholars

have noted that this term does not adequately illustrate the pervasive impact that experiences of DFV between adults may have on young people (Goddard & Bedi, 2010). Children may experience the impacts of this abuse without necessarily being physically present at the time of the abusive behaviour and/or might be used as part of the adult perpetrator's abusive tactics (Kantor & Little, 2003). In an attempt to describe the complexity of this form of DFV young people experience, Goddard and Bedi (2010) propose the concept "children forced to live with intimate partner violence" (p.10). Although this term captures the different ways young people may experience violence between adults in an intimate partner relationship, this concept fails to recognise adverse DFV experiences that occur between adults in a domestic context who are not in an intimate relationship. Thus, in this report, the term DFV is used to include acts of violence between people who have, or have had, an intimate relationship characteristic in domestic violence (DV), at the same time recognising Australian First Nations people's experiences by acknowledging that violence can also occur in extended family and kinship relationships (Cripps & Davis, 2012).

Although individuals that are exposed to DFV are not necessarily the intended target of it, this form of vicarious victimisation can lead to similar negative outcomes as those experienced by individuals who are the primary object of abuse (Edleson, 1999). Thus, throughout this report, we expressly recognise experiences of growing up with DFV between adults as a form of violence experienced by children and young people. We acknowledge children and young people as victim-survivors in their own right (see further Meyer & Fitz-Gibbon, 2022; Meyer et al., 2022; Victorian Goverment, 2022) who have individualised risks and safety needs.

Child maltreatment and youth suicide

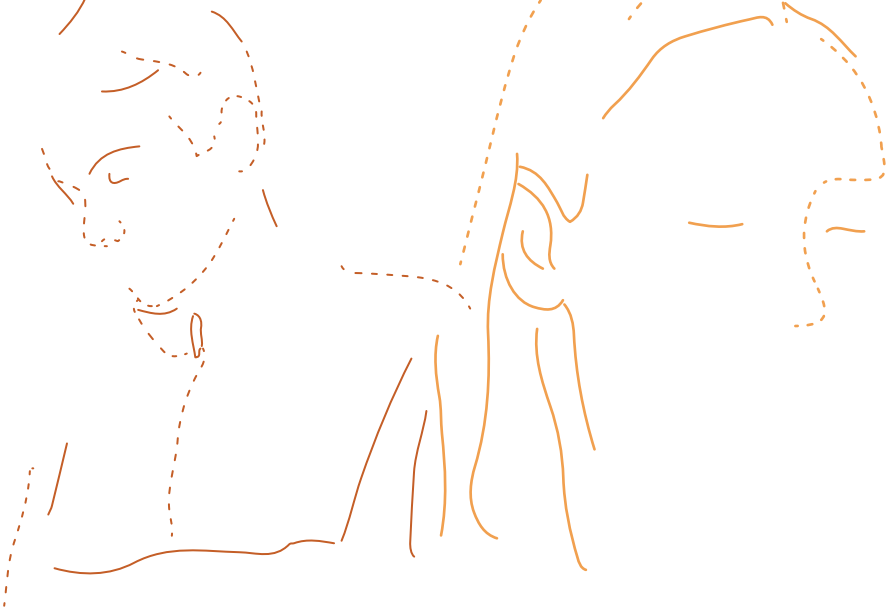
There is a considerable volume of research showing the association between child maltreatment and suicide behaviours. When looking at the role of different forms of child maltreatment in young people's suicide, Angelakis et al. (2020) found in their meta-analysis that individuals aged five to 24 years old with a history of sexual abuse were three times more likely to attempt suicide than the same age cohort without any experiences of childhood maltreatment. Additionally, experiences of physical abuse and emotional abuse double the chances of a young person attempting suicide (Angelakis et al., 2020). A similar increased risk of attempted suicide was found in a meta-analysis focusing on adult individuals with experiences of different types of child maltreatment (Angelakis et al., 2019). This indicates that the harmful impacts of experiencing abuse during childhood, including an increased risk of suicide, can persist into adulthood if left unaddressed during earlier developmental stages.

Other meta-analyses and reviews have also identified the association between diverse forms of child maltreatment and various types of suicide behaviours among young people. For example, in

a meta-analysis of longitudinal studies including individuals between 12 and 26 years old, Castellví et al. (2017) found that 14.3 per cent of the suicide attempts during adolescence and young adulthood could be attributed to childhood sexual abuse, followed by childhood physical abuse, and neglect, accounting for 8.6 per cent, 7.1 per cent, and 3.5 per cent of attempted suicides, respectively. In a review focusing on predictors of adolescent suicidality, King and Merchant (2008) also found a positive relationship between suicidal thoughts and behaviours and experiences of physical and sexual abuse, and/or emotional neglect. Further studies have focused on the distinct effects that adverse childhood experiences (ACEs) may have on different manifestations of suicide behaviours, such as suicidal thoughts and suicide attempts. For instance, in their study with adolescents, Liu and Tein (2005) found participants reporting being "beaten by their parents" were almost twice as likely to report suicidal ideation, and almost three times more likely to attempt suicide during adolescence. Similarly, Macalli et al. (2021) found a greater likelihood of suicidal behaviours among young adults with a history of physical or psychological maltreatment by parents. Specifically, experiences of these forms of child maltreatment predicted a higher risk for suicidal ideation followed by suicide attempt than for suicidal ideation alone (Macalli et al., 2021).

Other research has further examined differences in experiences of childhood maltreatment between adolescents that attempt suicide for the first time and those that have attempted suicide several times. For example, Makara-Studzińska and Koślak (2010) found that adolescents from the suicide attempters group, including both first time and consecutive suicide attempters, reported experiencing early childhood trauma, including physical, sexual, and emotional abuse more frequently compared to the non-attempters group. While this study revealed an increased risk of overall suicide attempts among young people with more frequent experiences of childhood maltreatment, the experience of various forms of childhood maltreatment suggested no increased risk of additional suicide attempts compared to the first suicide attempt. In other words, more frequent experiences of childhood maltreatment predicted more frequent suicide attempts during adolescence. Experiences of specific or diverse types of childhood maltreatment, however, did not predict whether young people had attempted suicide for the first or a consecutive time (Makara-Studzińska & Koślak, 2010).

Although many studies have relied on individuals' self-reported accounts of child abuse, other research has used administrative records to investigate the association between child maltreatment and suicide behaviours among young people. For example, Christoffersen et al. (2003) used population-based registers in their study and found young people (aged 14-27 years old) that had experienced maltreatment in their childhood were four times more likely to attempt suicide leading to hospitalisation. In another study, by comparing suicide cases to the matched population of children known to the child protection system, Palmer et al. (2021) found allegations of physical abuse and sexual abuse

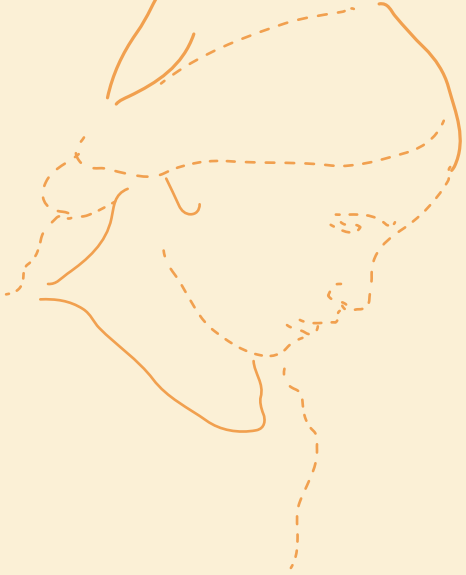


to be significant risk factors for suicide among adolescents aged 15-19 years old. The same risk was not observed for younger populations known to the child protection system (Palmer et al., 2021). Notably, in the same study, the authors found an association between recency of contact with child protection services and youth suicide (Palmer et al., 2021). This is, adolescents with more recent contacts with child protection services were at higher risk of dying by suicide. These results highlight the immediate intervention opportunities that child protection services and non-statutory child and family welfare services, which are often the initial point of contact in the lives of child protection involved children and families, may have. These include identifying risk of suicide and related support and recovery needs of children and young people when child maltreatment is reported to official agencies.

Some research has further alerted to the timing of experiences of childhood maltreatment. Research suggests an association between childhood abuse and higher odds for suicidal ideation during young adulthood when the abuse was experienced for the first time during early childhood (Dunn et al., 2013). This increased risk of suicidal ideation was particularly striking for those who experienced sexual abuse during early childhood. This cohort was found to have suicidal ideation odds that were 2.46 times greater than those who experienced maltreatment during adolescence (Dunn et al., 2013). Similarly, Salzinger et al. (2007) found that adolescents that had experienced abuse prior to adolescence, in this case physical abuse by parental figures, were more likely to display suicidal ideation and suicide attempts compared to adolescents without any maltreatment experiences. These findings emphasise the importance of recognising the extent to which young people experience different forms of maltreatment at different times during childhood and adolescence, and the increased risk of suicidal ideation depending on the timing and combination of ACEs. Further, these findings highlight the need to identify and respond to childhood experiences of abuse in a child-centred, trauma-informed, and recovery-focused way to mitigate the increased risk of suicide behaviours across different phases of the life course.

Experiences of DFV and youth suicide

International and Australian research examining the relationship between ACEs and youth suicide has focused primarily on the role of child maltreatment as a risk factor (see Angelakis et al., 2020 for a review and meta-analysis). However, when looking at adverse events that children and adolescents experience in the home context, experiences of DFV between adults (e.g., parents or carers) cannot be ignored. This is especially relevant given that research has found prevalence rates of childhood experiences of DFV to be considerably high. Despite this, prevalence rates vary depending on the definitions, awareness and understanding of what constitutes childhood experiences of DFV and the methods used for data collection.



According to the findings from a review conducted by Dodaj (2020), retrospective studies show prevalence rates of experiences of DFV between 20 to 40 per cent, whereas studies using self-reports by parents/caregivers yield higher prevalence rates, ranging from 59 to 80 per cent. In contrast, Meltzer et al. (2009) found a lower prevalence rate using parents and caregivers as proxies, with 4.3 per cent of children and young people experiencing DFV between other adult family members. This significant difference between prevalence rates could be due to disparities in the definitions adopted by researchers, as Meltzer et al. (2009) specifically measured 'witnessing severe forms of domestic violence'. Possibly, studies reporting higher prevalence rates of experiences of DFV might include a broader range of experiences, including non-physical forms of DFV. Overall, the lowest prevalence estimates are found in studies using police and clinical documentation, with rates between 9 and 24 per cent (Dodaj, 2020). This discrepancy between prevalence estimates from official data sources, such as child protection services, and self-reports has also been found in the child maltreatment literature (Moore et al., 2015). This is to be expected, given most maltreatment experiences are never reported to or detected by child protection or criminal justice agencies (Mathews et al., 2020). The low prevalence figures using official sources could reflect the underreporting of childhood experiences of DFV and/or a lack of adequate screening when individuals are finally in contact with official services. Research conducted in Australia over the last 25 years has shown prevalence figures between 6 to 51 per cent (Australian Bureau of Statistics [ABS], 1996, 2006; Cohen et al., 2006; Fitz-Gibbon et al., 2022b; Indermaur, 2001), which vary greatly depending on data source and study settings and are comparable to international prevalence estimates.

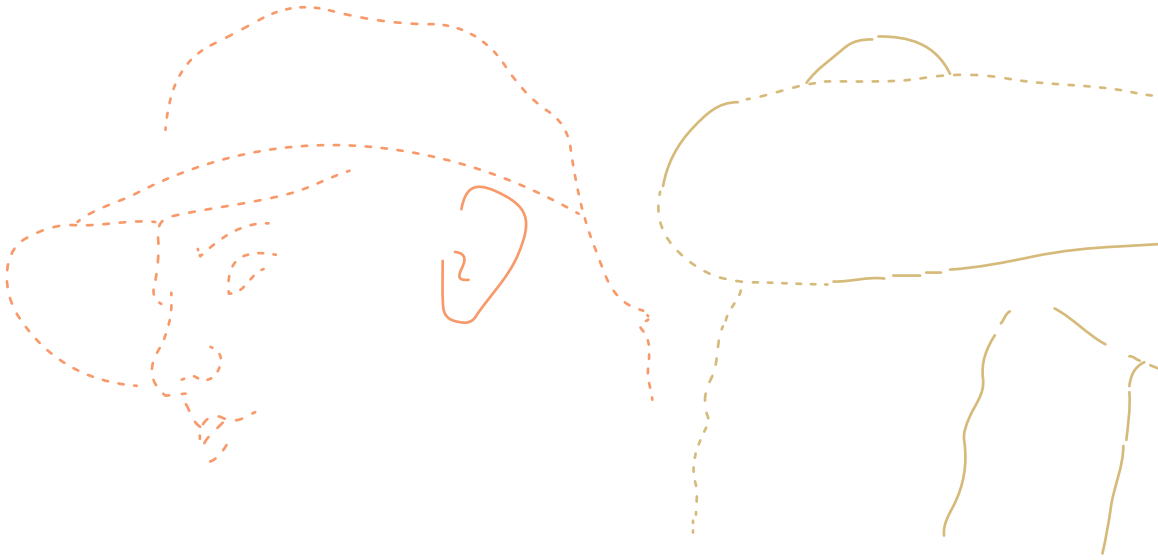
Similar to the child maltreatment literature, the different impacts of experiences of DFV on children and adolescents are well-established, as this form of vicarious abuse has been studied as one of the adverse experiences since the beginning of the ACE's research (see Felitti et al., 1998). For example, the available research and administrative data suggest a relationship between childhood experiences of DFV and various negative health outcomes during childhood, adolescence, and adulthood, at a physical, psychological, and behavioural level (see Campo, 2015; Holt et al., 2008; McDermott, 2021; Mueller & Tronick, 2019; Vu et al., 2016; Wolfe et al., 2003 for reviews and meta-analyses). Moreover, research indicates a strong association between childhood experiences of DFV and negative psycho-social impacts, such as poor educational outcomes, intergenerational transmission of violence, homelessness, and engagement in criminal activities (Campo, 2015; Holt et al., 2008; Schnurr & Lohman, 2013; Wolfe et al., 2003). Despite this evidence highlighting the negative impacts that growing up with DFV can have on a young person, the link between experiences of DFV during childhood and attempting or dying by suicide remains under-researched.

While the association between DFV and suicide has primarily been examined among adult victim-survivor and perpetrator populations (see McLaughlin et al., 2012 for a review), there is growing concern around the impact of childhood experiences of DFV on young people's mental health outcomes, including an increased risk of suicide. When an adult victim takes their life in the context or aftermath of DFV, suicide is deemed a consequence of intimate partner violence (IPV) experiences. However, when a child or young person dies by suicide during or following an experience of violence perpetrated by a parent, carer or family member in the home context, their death is more commonly interpreted as an outcome of poor mental health (Doemestic and Family Violence Death Review and Advisory Board, 2019). Consequently, concerns have been raised regarding young people being routinely pathologised, and the lack of attention paid to the impact of childhood experiences of DFV (Doemestic and Family Violence Death Review and Advisory Board, 2019).

Notwithstanding the prevalence rates of the different forms of abuse, the current evidence indicates that experiences of DFV and other forms of child maltreatment rarely occur in isolation, suggesting that poly-victimisation is common (e.g., Chan et al., 2011; Lacey et al., 2022), and increases the risk of adverse outcomes when compared to individual types of victimisation (Haahr-Pedersen et al., 2020; Herrenkohl et al., 2008). Considering that different forms of traumatic experiences during childhood, including experiences of DFV, tend to overlap, the following sections will focus on the role that experiences of DFV plays in youth suicide risk, either in isolation or in combination with other forms of child maltreatment.

International evidence

Results from a case analysis exploring the child protection system's response to cases of childhood experiences of DFV show that the impacts of this form of violence are sometimes minimised (Child Death Review Board, 2021). However, among the most detrimental consequences, research has identified growing up with DFV to play an important role in the manifestation of youth suicide behaviours. For example, in a sample of 14 to 19 years old adolescents, Baldry and Winkel (2003) found that adolescents who reported experiencing interparental violence were also those who reported suicidal cognition (i.e., a combination of thinking about suicide and engagement in self-harming behaviours). However, this effect was not significant after adjusting for direct abuse from parents, which was a stronger predictor for suicidal cognition (Baldry & Winkel, 2003). In other words, although childhood experiences of DFV between parents or carers increases the risk of suicidal cognition in adolescence, this risk is even greater for young people who had experiences of childhood maltreatment. These findings support the established need to provide safety and recovery support for children and young people who have experienced abuse and neglect. However, they also highlight the importance of child-centred interventions and recovery support for children

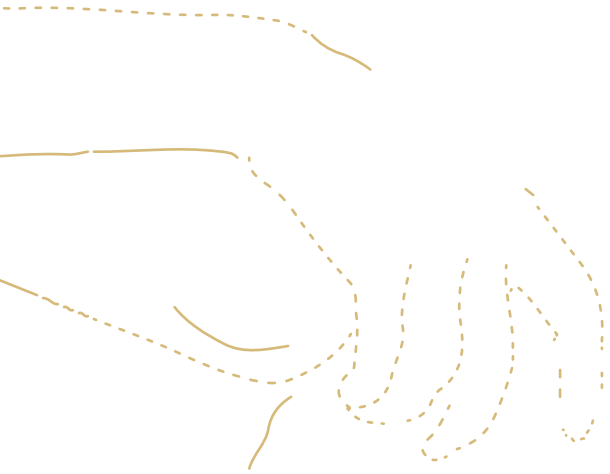


affected by parental/ carer DFV in the absence of other forms of childhood maltreatment to mitigate the risk of suicide behaviours for all adolescents, regardless of the nature and combination of their adverse experiences.

Some studies have explored the effect of different life events and the increased probability of suicide behaviours among adolescents. A study using a school-based survey among two groups of young people (ninth graders and eleventh graders) explored the relationship between reported suicide attempt and different risk variables (Hacker et al., 2006). Among these variables, the authors found an increased risk of suicide attempts among both grade nine and eleven students who reported childhood experiences of DFV, worrying about violence at home, being physically abused by a family member, and experiencing verbal or emotional abuse (Hacker et al., 2006). Similarly, Releva (2018) found that different types of ACEs, including childhood maltreatment, neglect, and childhood experiences of DFV, increased the risk of suicide attempts in adolescents.

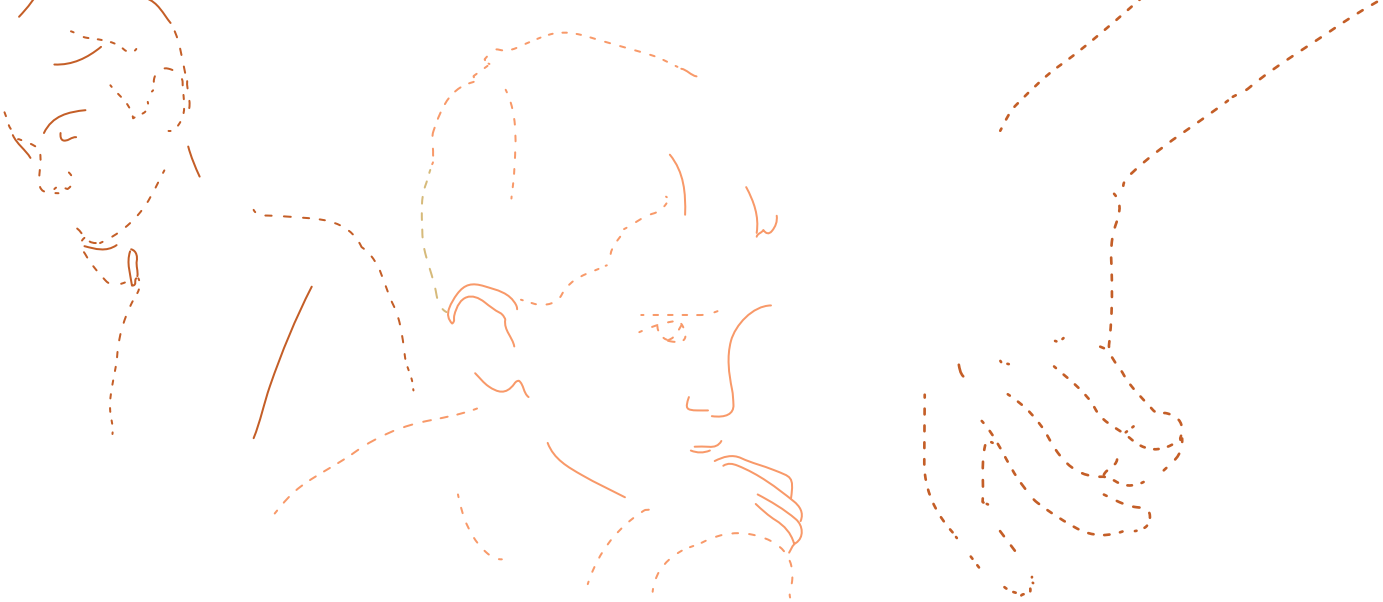
Experiences of DFV during childhood have not only been identified as a risk factor for suicide attempts but also for suicide ideation and planning. For example, a recent study conducted by Li et al. (2021) showed a significant association between different forms of child abuse and childhood experiences of DFV, and these three suicide behaviours among individuals aged 10-20 years old. Although sexual and emotional abuse were the strongest predictors of all types of suicide behaviours, those that reported childhood experiences of DFV were almost twice as likely to report suicide ideation, suicide plan, and suicide attempt (Li et al., 2021). Another recent study by Kim et al. (2021) explored the impacts of different forms of violence exposure in the home and school context. The results showed an association between physical and verbal child abuse and exposure to DFV, and suicidal ideation among middle school students. This is, higher levels of child abuse and exposure to DFV were associated with higher levels of suicidal ideation, and this association was not explained by other variables.

Using data from a nationally representative sample in the United States, Turner and Colburn (2022) also examined different forms of adverse experiences that children are exposed to, not only by looking at physical and emotional abuse and neglect, but also exploring the impact of childhood experiences of DFV. When examined individually, all types of adverse experiences were associated with an increased risk of suicidal ideation. However, when physical maltreatment, emotional maltreatment, neglect, and childhood experiences of DFV were explored together, only emotional abuse and childhood experiences of DFV showed significant individual effects on suicidal ideation (Turner & Colburn, 2022). This is, emotional abuse and childhood experiences of DFV were the strongest predictors of suicidal ideation, whereas physical abuse did not have an impact on suicidal ideation when other forms of maltreatment were also examined. Particularly, young individuals who experienced emotional abuse during the past year were four times more



likely to report past-month suicidal ideation, whereas those that had experienced DFV among other family members during the last year had nearly double the chances of reporting past-month suicidal ideation (Turner & Colburn, 2022). These results highlight the negative impacts of non-physical forms abuse and vicarious experiences of violence on young people's well-being, as opposed to traditional assumptions of these adverse experiences being less damaging than direct physical abuse.

Other authors have further examined the role of different types of child maltreatment and childhood experiences of specific forms of DFV. For example, Sharratt et al. (2022) explored the impact of experiences of witnessing physical and verbal DFV as a form of maltreatment in the home, together with different types of victimisation. In their cross-sectional study including almost 3,000 participants aged 10-17 years old, the authors distinguished between different profiles depending on the nature of the abusive experiences reported by the participants and their relationship with suicide behaviours. Notably, four latent classes or groups were identified, two of which included significant experiences of exposure to DFV (Sharratt et al., 2022). First, young people in the 'low victimisation' group (59.3% from the total sample) reported little to no experiences of all adverse experiences. Second, the 'emotional abuse and neglect' group accounted for 19 per cent of the sample and was characterised by a high likelihood of experiencing emotional abuse, a moderate likelihood of reporting emotional neglect experiences, and low to very low likelihoods of experiencing all other types of adverse experiences. Third, the 'maltreatment and domestic violence' group, characterised by moderate to very high probabilities of experiencing emotional and physical abuse and neglect, sibling abuse, and experiences of physical and verbal DFV among other family members, and a drug-related threat, accounted for 11.2 per cent of the sample, and had the largest number of individuals reporting a suicide-attempt history (Sharratt et al., 2022). In this group, abuse takes place in diverse forms, with individuals experiencing violence directly from parents, but also experiencing it between other family members in the home. Lastly, the 'high verbal domestic violence' group, characterised by a very high probability of reporting experiences of verbal DFV among other family members, moderate probabilities of reporting experiencing other forms of DFV and a drug-related threat, and low probabilities of experiencing all forms of child maltreatment, accounted for 10.5 per cent of the participants. When compared to young people in the 'low victimisation' group, individuals in the 'high verbal domestic violence' group were 4.63 and 5 times more likely to report suicide ideation and suicide attempt, respectively. Individuals in the 'emotional abuse and neglect' group were 4.29 and 4.5 times more likely to report suicide ideation and suicide attempt, respectively (Sharratt et al., 2022). Significantly, young people in the 'maltreatment and domestic violence' group were 14.37 times more likely to report suicide ideation and 12.36 times more likely to report suicide attempt than individuals in the 'low victimisation' group (Sharratt et al.,



2022). These results show that young people with combined experiences of direct child maltreatment along with childhood experiences of DFV have the highest risk of reporting suicide ideation and attempt. However, the findings indicate that young people who experience child maltreatment or solely experience DFV among other family members also have a higher risk of suicidal ideation and suicide attempt than those who are not victimised. This evidence stresses the need to acknowledge that children and adolescents' maltreatment experiences and childhood experiences of DFV among other family members are complex and diverse, and highlights the negative impacts that these experiences, either alone or in combination, can have on young people, including the risk of suicidal behaviours.

From a developmental perspective, both childhood and adolescence are considered critical periods, where individuals are especially sensitive to adverse events occurring in their environment, which can lead to negative consequences at a biological and emotional level (e.g., Andersen et al., 2008; Khan et al., 2015). To examine the specific impact that adversities may have depending on the timing of their occurrence, Thompson et al. (2012) distinguished between childhood (before the age of 12 years old) and adolescent (between age 12 and 16 years old) adversities. These included various forms of child maltreatment and experiences of DFV (referred as 'family violence' in the study). The results showed a strong association between cumulative adverse experiences and adolescent suicide ideation. Specifically, the relationship between adolescent adversities and suicide ideation was strongest among individuals with lower levels of childhood aversities (Thompson et al., 2012). However, this effect was reversed when the levels of childhood adversities were high. As such, the link between adolescent adversities and suicide ideation was weaker among adolescents that had been victimised also during childhood. Consistent with the child maltreatment literature discussed above (i.e., Dunn et al., 2013), these results highlight the significance of the timing of exposure, suggesting that the predictive utility of the cumulative effect of child maltreatment and experiences of DFV can be improved when also considering the developmental stage in which a young person is victimised.

Other studies have focused on the timing of suicidal behaviours, by exploring the link between ACEs, including childhood experiences of DFV, and lifetime suicide attempts. For instance, in their research, Dube et al. (2001) distinguished between childhood/adolescent (being younger than 18 years old) and adult (being 19 years old or older) suicide attempts. The results showed that, although adverse experiences, including experiences of partner-to-mother abuse, increased the probabilities of suicide attempt throughout the different life stages, this effect was especially strong among young people (Dube et al., 2001). The authors explain this outcome based on young people's limited coping mechanisms to face adversity and stressors, which would make them more prone to display suicidal behaviours as a response to experiences of trauma. Other studies have explored the role

of childhood adversities, including childhood experiences of DFV, in the onset and persistence of suicidal behaviours. For example, Bruffaerts et al. (2010) found that, although child maltreatment and exposure to physical DFV, referred to as 'family violence' in the study, increased the likelihood of suicide attempts across all life stages, adversities had a stronger association with the onset of suicide attempt during childhood (4 to 12 years old) and adolescence (13 to 19 years old), compared to older cohorts.

These results indicate that individuals who experience adversities while growing up, including parental DFV and child physical or sexual abuse, are at a higher risk of attempting suicide during childhood and adolescence. Improved risk-informed screening and intervention efforts are critically needed in early developmental stages to prevent fatal outcomes.

Australian evidence

Although the association between experiences of DFV during childhood and adolescence and youth suicide is well-established in the international literature, limited efforts have been made to systematically examine this relationship in the Australian context. For this reason, most of the evidence available is derived from anecdotal data from Coronial Inquests, Child Death Registers, and other state-based inquiries. Among the few studies that have been conducted in Australia, results show that from a sample of young Australians that died by suicide between 2006 and 2015, 7.4 per cent had a history of abuse and/or neglect and 2.5 per cent had a history of childhood experiences of DFV between adults/caregivers in their lives (Hill et al., 2021). However, as the data in this study relies on police and coroner reports, among others, these results are limited to cases where DFV was identified during service system contact (including police and other service system contact). Therefore, cases in which DFV was present but not reported or identified during the review process were likely to be overlooked.

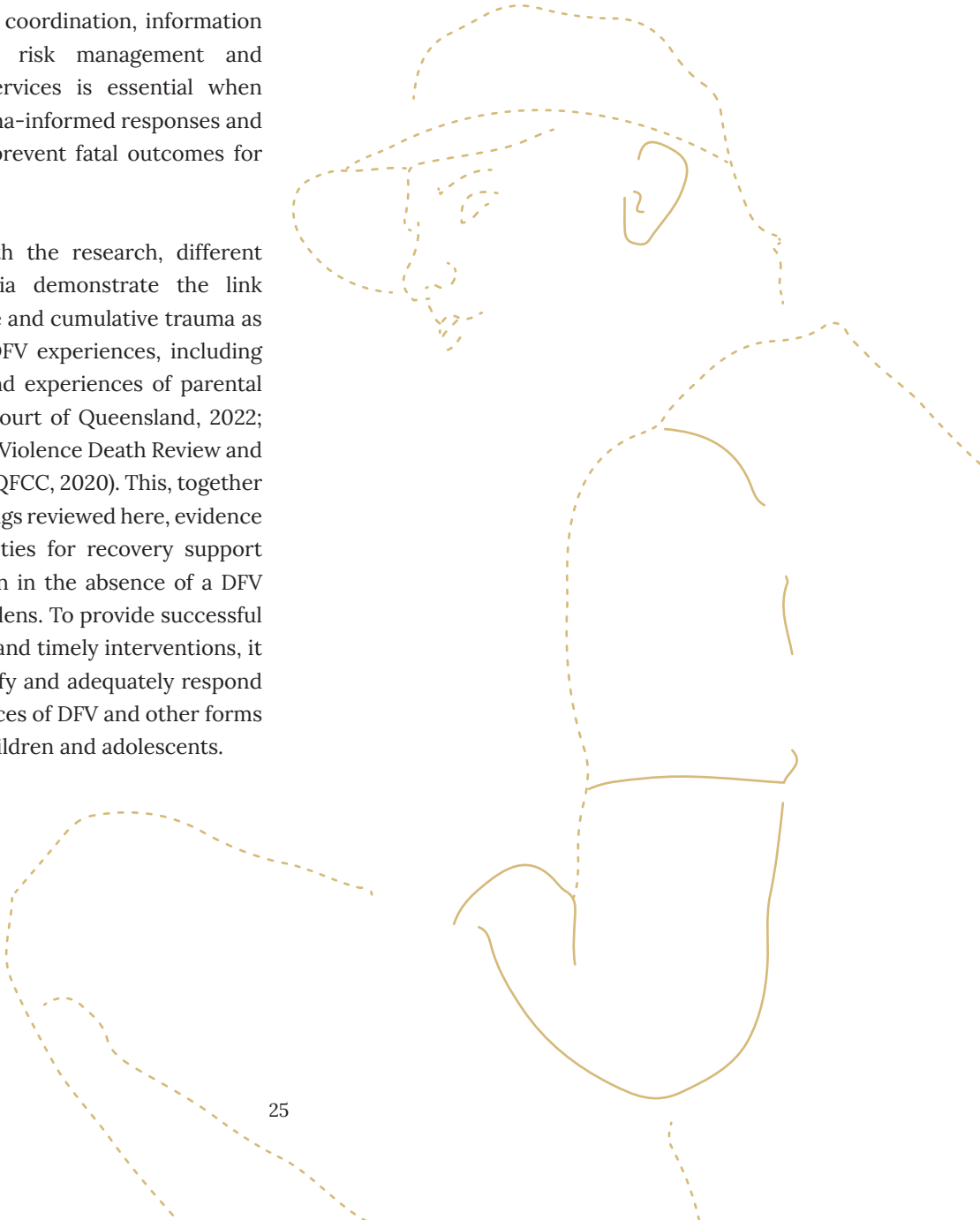
Despite the scant Australian research in this area, the link between experiences of childhood maltreatment, including experiences of DFV between parents or caregivers, and suicide among young people has increasingly received attention in governmental reports and inquiries over the last decade. Particularly, several recent Coronial Inquests and Reviews have emphasised the damaging effects that childhood experiences of DFV can have on children and adolescents. In a Coronial Inquest reviewing the deaths by suicide of 13 children and young people in the Kimberley Region in 2019, the findings showed that all young individuals had a history of childhood DFV (Coroner's Court of Western Australia, 2019). The Inquest report also stressed that the DFV these children and young people had been exposed to was at times chronic and severe. Furthermore, according to the Inquest's findings, some of the children's adverse circumstances were known to the police and the Department of Child Protection and Family Support (Coroner's Court of Western Australia, 2019). Formal service system contact and awareness of children's experiences of DFV

appear to be a common feature in these cases, as evidenced by similar findings outlined by the Coronial Inquest conducted to investigate the death by suicide of Child J (Coroner's Court of Western Australia, 2021). In this case, the Department of Communities had an extensive history of involvement with the child's family for matters regarding DFV and other child protection concerns (Coroner's Court of Western Australia, 2021).

A recent report investigating the death by suicide of 68 women and children found that, despite most DFV not being reported to government services, two-thirds of these women and children had DFV-related contact with Western Australia (WA) Police between 2003 and their deaths in 2017 (Ombudsman Western Australia, 2022). Notably, from the women and children that had been in contact with WA Police, 84 per cent had multiple recorded incidents of DFV related contact with the police, and nearly half of them had more than 10 contacts (Ombudsman Western Australia, 2022). When looking at the contact between these women and children and police services, the proximity of DFV to suicide is particularly important. From the 43 women and children known to WA Police, 58 per cent had their most recent DFV related contact with the police withing the 12 months prior their suicide (Ombudsman Western Australia, 2022). This association between the proximity of contact with official services and suicide is supported by the available research, that indicates that young people with more recent contact with official services, such as child protection services, are more likely to die by suicide (e.g., Palmer et al., 2021). Finally, contact regarding DFV incidences was not limited to police services, but it was also common with health services (i.e., emergency department attendances), court counselling and support services and the Department of Communities (i.e., child protection interactions) (Ombudsman Western Australia, 2022). Similarly, in the inquiry into 35 children (aged 12-17 years old) who died by suicide and were known to child protection, the Commission found that these children presented multiple chronic risk indicators that brought them into repeated contact with different service systems (Commission of Children and Young People [CCYP], 2019). Among these complex risks, experiences of DFV were a common feature in children's daily lives. Specifically, 94 per cent of the children were reported to have experiences DFV, 97 percent of the children's mother had been victim of DFV, 89 per cent of the children were reported to have experienced one or more elements of child neglect and 51 per cent were reported to have been sexually abused by a family member or person known to the family (CCYP, 2019). Notably, most children had contact with child protection services early on in their lives, with 66 per cent of the children having their first contact before they turned eight years old and 65 per cent having their first contact in the first three years of life (CCYP, 2019). As reported in other inquiries and reviews, contact with multiple formal services was also common among the 35 children reviewed. Specifically, 89 per cent had a recorded contact with a mental health service, and this contact typically occurred before or at the same time as contact with child protection.

Additionally, 51 per cent of the 35 children had contact with police in the 12 months preceding their death and 43 per cent within six weeks of death (CCYP, 2019). Given that reported DFV cases are often known to different statutory and non-statutory services and considering the proximity between services involvement and youth suicide, service coordination, information sharing and shared risk management and monitoring across services is essential when providing timely trauma-informed responses and recovery support to prevent fatal outcomes for young people.

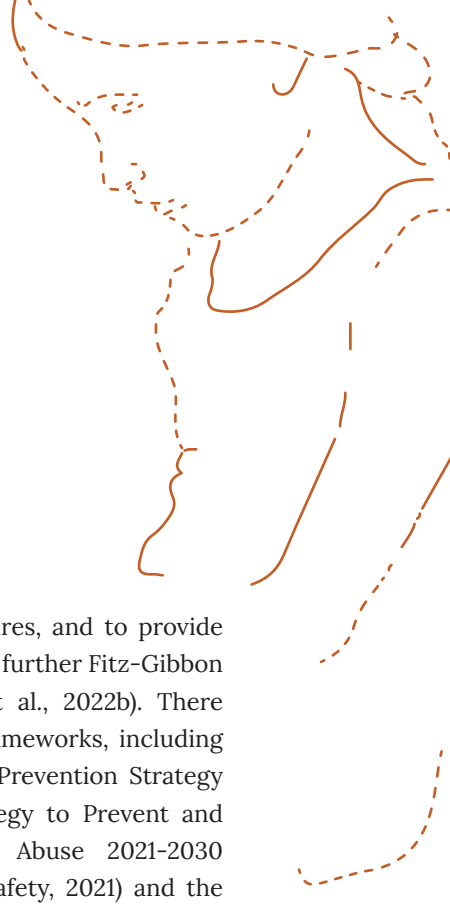
Lastly, consistent with the research, different cases across Australia demonstrate the link between youth suicide and cumulative trauma as a result of complex DFV experiences, including child maltreatment and experiences of parental DFV (e.g., Coroner's Court of Queensland, 2022; Doemestic and Family Violence Death Review and Advisory Board, 2019; QFCC, 2020). This, together with the reports' findings reviewed here, evidence the missed opportunities for recovery support and suicide prevention in the absence of a DFV and trauma-informed lens. To provide successful prevention strategies and timely interventions, it is imperative to identify and adequately respond to childhood experiences of DFV and other forms of maltreatment by children and adolescents.



Implications for policy, practice and research

The available literature and the anecdotal data from Inquiries and Reviews raise pressing concerns around the risks associated with the exposure to DFV during childhood and adolescence. Examining this closely, research suggests that the interconnections between experiences of DFV and youth suicide are complex. For example, in the child maltreatment literature, evidence suggests that abuse and neglect have a direct effect on suicidality, while mental health and interpersonal factors, such as parental relationships, mediate the relationship between ACEs and youth suicide behaviours (McRae et al., 2022; Miller et al., 2014; Wanner et al., 2012). Specific to young people's experiences of DFV among other family members, the individual associations with mental disorder symptoms (e.g., depressive symptoms, Post-Traumatic Stress Disorder (PTSD) symptoms), and suicidality during adolescence and adulthood are well established (Afifi et al., 2009; Brockie et al., 2015). Nevertheless, this relationship might be more complex than a direct one. To better understand the role of mental health, some researchers have explored the link between experiences of DFV during childhood, suicide behaviours, and poor mental health conditions. For example, Cluver et al. (2015) found a significant indirect effect of ACEs, including exposure to DFV between adults, on youth suicide behaviours via mental health. A similar mediating effect of mental health was noted by Dube et al. (2001), who found a partial mediation of the relationship between different ACEs, including experiences of DFV, and suicide attempts by depressive disorders and harmful substance use. Although screening for the development or manifestation of mental health problems among young people is valuable in the prevention of youth suicide, early risk identification and trauma-informed intervention in cases of childhood experiences of DFV and other forms of child maltreatment, including child-centred recovery support, provides unique opportunities to reduce the risk of both adverse mental health outcomes and suicide behaviours.

When considering the impact of experiences of DFV among young people, it is important to consider the high degree of co-occurrence of adverse experiences during childhood and adolescence (Finkelhor et al., 2007; Hamby et al., 2011). This is especially important given that young people who have experienced child maltreatment and/or have experienced DFV are more likely to be subsequently victimised (Finkelhor et al., 2007; Holt et al., 2008). Although there exists individual heterogeneity of exposure to different childhood adversities among adolescents, abusive experiences rarely take place in isolation. Indeed, young people who grow up in home environments where DFV occurs are also more likely to be victim-survivors of other forms of child abuse (see Goddard & Bedi, 2010 for a review) and adolescent family violence (see (see Fitz-Gibbon et al., 2022a). It is necessary to consider the increased risk of poly-victimisation. There is a consensus in the scholarly literature regarding the cumulative effects of being exposed to multiple forms of child abuse on young and adult individuals' well-being (e.g., Finkelhor et al., 2007; Hoertel et al., 2015; Hughes et al., 2017; Moylan et al., 2010). When considering suicide behaviours as an outcome, research indicates that as the number of ACEs increases, the risk of displaying suicidal behaviours during childhood or adolescence also rises drastically (Bruffaerts et al.,



2010; Cluver et al., 2015; Dube et al., 2001; Raleva, 2018; Turner & Colburn, 2022). The evidence included in the above sections highlight the high prevalence rates of exposure to DFV, other forms of maltreatment, and the combination of these experiences. Given that experiences of DFV and/ or child maltreatment are associated with an increased risk of suicide behaviours, successful suicide prevention efforts must acknowledge both the individual and cumulative effects of diverse forms of child maltreatment and childhood experiences of DFV. There is a need to advance integrated understandings of these adverse experiences along with their impact and to develop collaborative working practices across services.

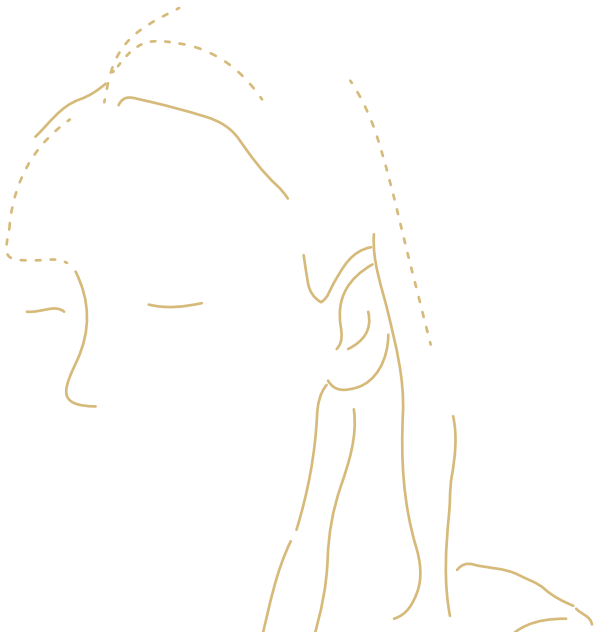
The release of the National Plan to end Violence against Women and Children 2022-2032 (Department of Social Services [DSS], 2022) and within it the stated acknowledgement of the need to respond to children and young people as victim-survivors of domestic, family and sexual violence in their own right, is a significant opportunity (on this, see also Meyer & Fitz-Gibbon, 2022; Meyer et al., 2022). The National Plan organises its commitments across four domains – prevention, early intervention, response, and recovery and healing. Delivering upon the Plan's overarching goal to end gender-based violence in one generation will necessitate a focus on young victim-survivors within each of these domains. Critically, children and young people who have experienced DFV during childhood and/ or adolescence cannot continue to encounter a system that is ill-equipped to identify their risk, to respond to their disclosures, and to provide support services (on this, see further Fitz-Gibbon et al., 2023; Fitz-Gibbon et al., 2022b). There are other relevant policy frameworks, including the National Youth Suicide Prevention Strategy (NYSPS), the National Strategy to Prevent and Respond to Child Sexual Abuse 2021-2030 (National Office for Child Safety, 2021) and the National Housing and Homelessness Plan that is currently being developed (DSS, 2023).

However, despite the authorising policy environment, as others have indicated, policy responses to young people's experiences of DFV are typically hindered by the "intersecting policy jurisdictions of child protection, family law and domestic violence sectors" (Campo, 2015, p.18). To better ensure young people's safety and to prevent further harm, a collaborative model across systems is crucial (Zannettino & McLaren, 2014). Child and young personcentred, risk-sensitive and DFV-informed responses are needed to ensure that no young person is invisible to and excluded from support and service system access. For this, a cooperative and information sharing approach needs to be adopted by relevant sectors, including adult DFV specialist services and youth homelessness and mental health services. Moreover, child-aware approaches that acknowledge that parental or carers' problems can negatively affect young people have been recommended (Hunter & Price-Robertson, 2014; Meyer et al., 2021), as opposed to the traditional adult-centred approaches found in adult DFV services (Fitz-Gibbon et al., 2023; Humphreys et al., 2008). Thus, a holistic, child-

inclusive, and trauma-informed approach to service delivery and recovery needs provision is necessary to offer coordinated responses where children and young people experience DFV, alone or in combination with other child maltreatment experiences. This is crucial for the design of effective and timely strategies aimed at the prevention of young people's suicide behaviours, as well as the implementation of the National Plan's (DSS, 2022) ambitions to acknowledge children as victim-survivors in their own right and to deliver the service responses required to realise that acknowledgement.

Shifting to acknowledge children and young people as victim-survivors of DFV in their own right is crucial to identify and respond to experiences of growing up with DFV as a contributing risk factor of youth suicide. Children and young people that experience DFV face ongoing challenges, including further child abuse at home and the risk of using violence in their own familial relationships (Fitz-Gibbon et al., 2022a; Meyer et al., 2021; Morris et al., 2015) which prevents them from living a safe and healthy life. To better prevent the wide-reaching impacts that DFV has on youth, which includes suicide behaviours, children and young people's adverse experiences significantly require attention in research, policy, and practice.

As noted throughout this report, the link between childhood experiences of DFV and youth suicide is well-established. This is a global issue, however, the Australian evidence remains scarce, and mostly limited to individual Coronial Reviews rather than population-based or large-scale empirical studies. Future research is critically needed to build the evidence-based needed to better understand the interconnection between childhood experiences of DFV and youth suicide risk in Australia. Such research should explore the opportunities for points of intervention, the development of improved child-centred risk identification, assessment and management practices, as well as the need to develop DFV-informed response services specific to children and young people at risk of suicide.



Recommendations

THIS CURRENT STATE OF KNOWLEDGE REPORT MAKES EIGHT KEY RECOMMENDATIONS:

1. A trauma-informed service system

There is a need to build a trauma-informed service system that meets the protective and recovery needs of children and young people affected by DFV and other forms of child abuse and acknowledges the high degree of poly-victimisation and the individual and cumulative effects of various forms of ACEs on children and young people's short- and long-term wellbeing.

2. Victim-survivors in their own right

This service system (including DFV specialist services, child and family welfare services, youth services, mental health, AOD and crisis accommodation services) must recognise children and young people as victim-survivors and help-seekers in their own right, regardless of whether they are accompanied by an adult victim-survivor, fall under the statutory obligations of the child protection services or are navigating the service system on their own. This will require the review of organisational policies to ensure children and young people can access support services independently regardless of age, gender, and nature of DFV experienced.

3. Recognise the role of DFV and child abuse

Policy and practice reforms must recognise the role of DFV and other forms of child abuse in youth suicide to avoid histories of childhood trauma being masked by other presenting issues (e.g., poor mental health outcomes, family, peer and intimate relationships, harmful substance use) at the time of suicide, suicide attempts and suicidal ideation. This may mediate the relationship between youth suicide behaviours and experiences of DFV and other forms of child abuse but might not necessarily be its primary driver.

4. Routine screening practices for data collection

All service systems (statutory and non-statutory) encountering children, young people and/or families should use routine screening practices to identify the potential presence of DFV to ensure accurate service data collection and inform and facilitate referral pathways for child- and young person-centred trauma recovery support along with relevant support referrals for other family members.

5. A national holistic service system model

There is a need to develop and implement a holistic service system model across all Australian states and territories that allows collaborative practices across services that are risk-sensitive and DFV-informed to provide timely, initial and where necessary long-term responses from support and service agencies.

6. Child and young person-centric service responses

State and territory service systems must be resourced and upskilled to ensure DFV-informed, victim- and child- and young person-centric responses are delivered across service systems, including child and youth specialist services, child and family welfare services, DFV specialist services and other general service areas (e.g. health, mental health, AOD services) that may neither specialise in DFV or child- and young people-centric practice, to ensure children and young people can navigate a service system that will meet their needs when affected by DFV and other forms of child abuse. This should be connected to activities stemming from Action Plans stemming from the National Plan to End Violence Against Women and Children 2022-32.

7. Address current research and data gap

Future research should address the current data gap in identifying the role of DFV and other forms of child abuse in youth suicide in Australia through the application of consistent coding schemes of police, coroners, child protection, child and youth mental health and other service system data that may not explicitly state DFV but where a DFV-informed coding scheme will allow researchers to identify the presence of DFV based on other key words and descriptions used in service records.

8. Ethically embed voices of lived experience

Future research and policy making processes should explore opportunities to ensure the voices, insights and recommendations of children and young people with lived experience of DFV are ethically embedded into and directly inform research, policy and practice reforms.

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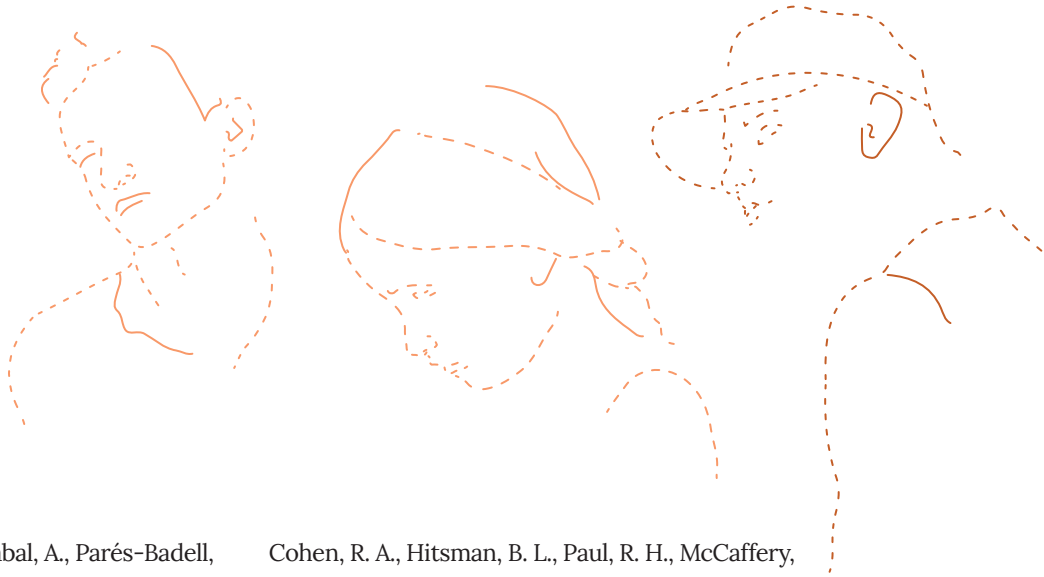

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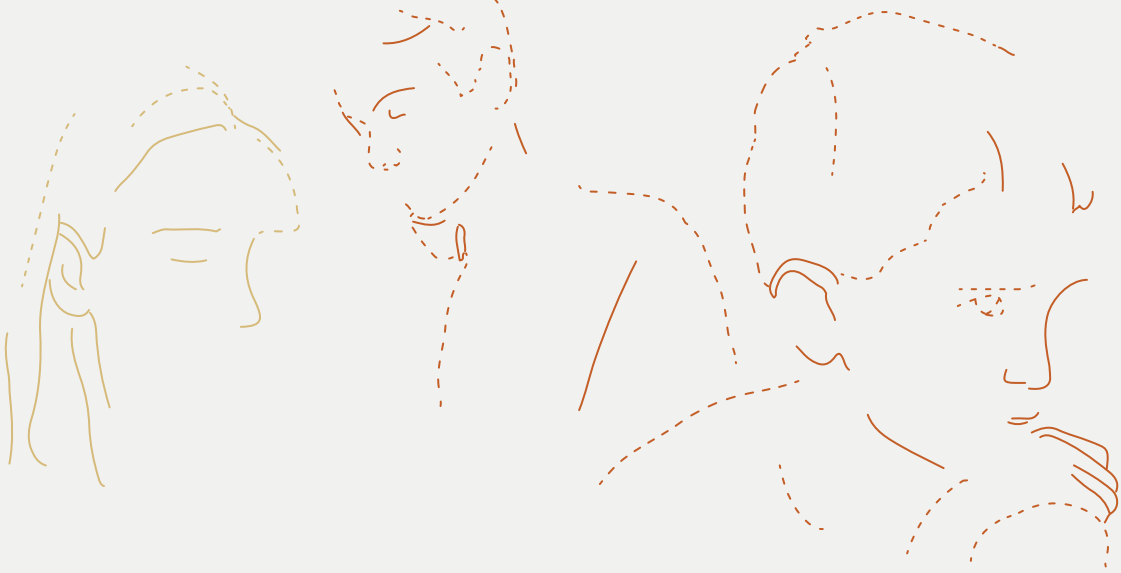

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