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

## Our holistic support to children, young people, and families

Parkerville Children and Youth Care is a For Purpose organisation that supports children, young people, and their families to build skills and capacity, address the impacts of trauma and adverse childhood experiences, and develop capabilities that will enable them to be the best versions of themselves.
We see a future where Western Australia is the safest place in the world and all children, young people, and their families feel safe to dream, to thrive, and to reach their fullest potential.
We have been working alongside vulnerable children, young people, and their families for over 120 years. Every year, we support more than 13,000 people across WA through our therapeutic, out-of-home care, and early intervention and prevention services. The future of those we serve depends on what we do in the present to support them to reach their potential.

### Our Purpose

Our purpose as an organisation is to support children, young people, and their families to build skills and capacity, address the impacts of trauma and adverse childhood experiences, and develop capabilities that will enable them to be the best versions of themselves.

### Our Vision

We see a future where Western Australia is the safest place in the world and all children, young people, and their families feel safe to dream, to thrive, and to reach their fullest potential.

### Our Values

As a strong, values-based organisation, we are dedicated to an ongoing journey of self-awareness, learning and improvement in everything we do because the children and young people with whom we work deserve nothing less.

**Bold and courageous:** We stand up for what is right and amplify the voices of the children, young people, families, and communities we support.

**Curious and humble:** We search out information and data that will help us remain at the forefront of all that we do.

**Caring and respectful:** We acknowledge and embrace the diversity and individuality of everyone we meet and those we serve.

**Hopeful:** We believe in the power of positivity and are optimistic about change, having faith that together we can overcome any challenge we may face.

**Truthful and accountable:** We are committed to being open, honest, and taking responsibility for our actions.



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## Parkerville CYC's services

### Therapeutic Services

- **Multi-agency Investigation and Support Team (MIST):** co-located, multi-disciplinary, trauma-informed model to reduce harmful impacts of trauma from abuse. It is WA's first truly integrated child sexual abuse (CSA) response, with Child Advocacy Centres in Armadale (2011), Midland (2019), and Rockingham (2024). MIST's core principle is to reduce instances of children having to tell and re-tell their story, and coordinate services (including Police) to wrap around the child and family, through collaboration and knowledge-sharing.
- **Therapeutic Services:**
  ***CSATS:*** We provide a Child Sexual Abuse Therapeutic Service (CSATS) in a regional area of WA.
  ***PACTS:*** We also provide a Parents and Children's Therapeutic Service (PACTS) in a northern Perth suburb.

### Out-of-Home Care

- Parkerville CYC have had children in our care for the entirety of our 123-year history. We are implementing an innovative, award-winning new model, Our Way Home: radically personalised shared care, that focuses on the needs and desires of each child, and deliberately seeking to establish, maintain and deepen connections between children and their families. We care for children through a mixed provision across family group homes, foster care, and temporary care homes.

### Early Intervention, Prevention and Youth Services

- **Child and Parent Centres (CPCs):** Parkerville runs two CPCs in Perth, servicing 12 primary schools in vulnerable communities. The centres work to create an entry point into the school system and help with school readiness, but importantly they focus on increasing family capacity and help them provide appropriate developmental experiences.
- **Kids' Hub:** multi-disciplinary approach to providing comprehensive mental health/wellbeing services for children aged 0-12 years, targeting mild to moderate emerging complexity. This service is a collaboration with Koya Aboriginal Corporation, Pregnancy to Parenthood, Lifespan Psychology Services, and MIFWA.
- **Family Support Network:** an early intervention program that connects families with coordinated services to strengthen child safety and prevent entry into out-of-home care.
- **Intensive Family Support Service:** in partnership with Koya Aboriginal Corporation, this service will provide practical, in-home support to families who are engaged with the Department of Communities (Child Protection), where children are either at significant risk of entering out-of-home care or are working towards reunification with their families.
- **Education Employment and Training Program (EET)**: For young people at extreme educational risk due to trauma, mental health, family issues.
- **Support and Community Services (SACS):** For families with children aged 4-14 that are experiencing homelessness, or at risk of homelessness and living in supported accommodation.
- **Moving Out, Moving On (MOMO):** service for young people aged 15-21 who are experiencing homelessness, or at significant risk of homelessness or transience.
- **Reconnect:** a diversion and early intervention service for families with young people (12-18) at risk of homelessness or family breakdown.
- **Young Women's Program:** medium-term accommodation and support for young women (including those with children) aged 16-25 experiencing or at risk of homelessness, or who need help to live independently.
- **Ruby's Reunification Program:** seeks to prevent youth homelessness through part-time accommodation, whilst engaging and supporting the family with counselling and practical support. It aims to foster hope for staying together or reunification, and keep young people out of the youth (and ultimately adult) homelessness sector.


## Introduction

Parkerville Children and Youth Care welcomes the opportunity to make a submission to the House Standing Committee on Social Policy and Legal Affairs Inquiry into the relationship between domestic, family and sexual violence (DFSV) and suicide, and how more accurate data and trends on DFSV deaths can be obtained. Our reflections are informed by direct practice experience across child sexual abuse (CSA) responses, family and domestic violence (FDV) impacts on children and young people, violence- and trauma-related homelessness and transience, and suicide prevention practice in trauma-affected cohorts.

## High-Level Reflections

Children and young people are frequently overlooked in DFSV-suicide data and adult-focused service responses, despite bearing significant and cumulative impacts of violence and trauma. In Parkerville's experience, children rarely present saying "I am experiencing FDV." Instead, the impacts of violence emerge through hypervigilance, anxiety, school refusal, behavioural distress, homelessness and family breakdown. Systemic responses that focus primarily on these presenting issues risk missing the underlying violence and trauma, leading to delayed or misdirected intervention and avoidable escalation of risk. This invisibility has material consequences for prevention, including missed early identification, fragmented supports, and poor continuity of care through transitions that are known to elevate risk for trauma-impacted children and young people.

Sexual violence, particularly child sexual abuse, is consistently under-named and under-examined in DFSV-suicide data and policy frameworks, despite being central to the lived experiences of many children being supported by services. While sexual violence frequently co-occurs with FDV, conflation obscures distinct dynamics such as delayed disclosure, secrecy and shame, developmental impacts, and the need for specialised therapeutic responses. Parkerville's practice evidence indicates that children who have experienced child sexual abuse commonly present with multiple, overlapping adversities rather than a single form of harm, resulting in complex patterns of distress that are not well captured in current data or service responses. When sexual violence is subsumed within broader FDV categories, these cumulative adversity profiles, and their implications for mental health vulnerability and suicidality, are diluted in policy and inconsistently addressed in practice.

Finally, DFSV victimisation is a well-established contributor to mental health harm, including suicide and self-harm, yet systems continue to respond as though risk is episodic rather than cumulative. For children and young people, suicide risk associated with DFSV can develop over time through the interaction of chronic fear, disrupted attachment, housing instability, repeated transitions, and fragmented service responses. Parkerville's experience suggests that it is particularly the accumulation and interaction of these adversities, rather than any single experience, that most strongly shapes vulnerability. This is compounded by the limits of current data in fully understanding how cumulative adversity translates into suicide risk. Event-based data and crisis-driven interventions are therefore misaligned with how risk develops. This reinforces the need for longitudinal, child-centred data and coordinated system responses capable of identifying and mitigating risk well before crisis points are reached.



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## Core Position Statements

1. **Children and young people must be explicitly centred as victim-survivors in DFSV-suicide analysis and action:**
   Children and young people are an identifiable at-risk group whose DFSV experience materially contribute to suicide risk and incidence, but whose experiences are not consistently visible in data, investigations, or service responses. This invisibility limits early identification, weakens prevention efforts, and undermines continuity of care. Addressing this gap must be a priority in understanding prevalence, patterns and identifiable at-risk groups, and in designing reforms that strengthen national understanding of the relationship between DFSV and suicide.
2. **FDV is a direct and indirect driver of suicide risk for children and young people:**
   FDV contributes to suicide risk for children and young people both directly (through fear, trauma and coercive family environments) and indirectly (through destabilising impacts on housing, schooling, caregiving capacity and safety). Children impacted by FDV are often 'hiding in plain sight' in service systems, presenting through 'symptoms' rather than disclosure; meaning that risk is frequently addressed once distress has escalated, rather than prevented upstream through early, coordinated and child-centred intervention.
3. **Accurate naming matters: FDV, sexual violence and child sexual abuse must be distinguished, while allowing for co-occurrence:**
   Sexual violence, particularly child sexual abuse, frequently intersects with FDV but is not interchangeable with it. Conflation obscures distinct risk pathways, disclosure dynamics and therapeutic needs, and weakens both data integrity and specialist responses relevant to suicide prevention. Effective policy and practice require analytic frameworks and service systems that can capture intersection without erasing distinction, ensuring that sexual violence, and especially child sexual abuse, remains visible and appropriately responded to in DFSV-suicide analysis and response.
4. **Fragmented and adult-centred responses compound risk; coordinated, child-centred system responses are essential:**
   Where a parent or primary caregiver is experiencing FDV and severe mental distress, the implications for children and young people are profound and cumulative. Caregiver distress and violence alter the relational and practical conditions of children's lives, often eroding safety, predictability and emotional availability; conditions that are fundamental to development and recovery. When systems respond to adult risk in isolation, without a child-centred and family-centred lens, children's own mental health trajectories and suicide risk remain unaddressed over time. Effective prevention therefore requires coordinated, trauma-informed system responses that prioritise continuity of care for children, particularly at periods of transition and heightened vulnerability.
5. **Improved data is necessary but insufficient unless it drives integrated, child-centred prevention and practice reform:**
   Strengthening data and reporting on DFSV-related suicide is essential, but data reform alone will not reduce risk. Improved information must translate into longitudinal, child-centred analysis and coordinated system responses that track and respond to cumulative risk over time, not only at points of acute crisis. Without this translation into practice, systems will continue to detect harm late, intervene episodically, and miss critical opportunities to prevent escalation and support recovery for children and young people.

## Recommendations

Across these recommendations, Parkerville emphasises that effective suicide prevention for children and young people depends on recognising, measuring and responding to cumulative adversity over time, rather than treating risk as episodic or event-based. Parkerville's data shows that both FDV and sexual abuse are rarely experienced by children in isolation; it most often sits within a broader ecology of adversity that includes emotional abuse and neglect, housing and financial insecurity, sexual abuse, caregiver mental ill-health, and repeated system disruption. Children typically enter services through issues such as school disengagement, homelessness, mental health distress or child sexual abuse disclosures, yet the underlying pattern is one of clustered and compounding harm. These realities demand prevention and response approaches that can see, track and respond to cumulative adversity across systems and over time.

### Making cumulative, multitype adversity visible: what Parkerville's data shows

To better understand the realities shaping children's safety, wellbeing and suicide risk, Parkerville has been deliberately tracking adverse childhood experiences (ACEs) across our services.

Our data shows that:

- A substantial proportion of children supported by Parkerville are experiencing FDV, with rates varying significantly across service contexts (including particularly high prevalence in out-of-home care and youth homelessness services).
- Among children experiencing FDV, exposure to **multiple, overlapping adversities is the norm rather than the exception**, including emotional abuse and neglect, housing and financial insecurity, sexual abuse, food insecurity, and caregiver mental ill-health.
- These adversities cluster and interact, creating **complex, cumulative patterns of distress** that cannot be understood or responded to through single-issue or threshold-based approaches.

This data reinforces that children's experiences of harm are relational, cumulative and ongoing. When systems are organised around discrete issues, isolated events or adult disclosure, they are structurally misaligned with how risk develops in children's lives. Making cumulative adversity visible is therefore a prerequisite for effective suicide prevention, early intervention and coordinated care.

Of the 1,096 clients for whom we have an ACE recorded:

- **51%** are impacted by mental health in the household
- 501 (**46%**) have an experience of sexual abuse
  - Of these 501, 199 (**40%**) have co-occurring FDV experiences
- 412 (**38%**) have experienced emotional abuse
- Parental separation/divorce impacts **46%**
- 455 have experienced FDV (**42%**)
- 402 (**37%**) are living in financial insecurity

## A. Making children and young people visible in DFSV-suicide analysis and reporting (Visibility)

Effective prevention depends on whether children and young people are visible in the data and analytic frameworks that inform policy, investment and system design. At present, children's experiences of DFSV and related suicide risk are not consistently captured, despite clear evidence of cumulative and long-term harm.

Parkerville's practice data indicates that many children and young people affected by DFSV present with multiple, overlapping adversities rather than a single identifiable issue, underscoring the importance of data and analytic frameworks that can capture cumulative exposure and complexity rather than isolated incidents.

1. **Explicitly identify children and young people as a priority at-risk group** in DFSV-suicide analysis, including in national datasets and reporting, to improve understanding of DFSV's role in suicides nationally. Children remain inconsistently visible in data, investigations, and service responses. This must be addressed as a priority in understanding prevalence, patterns, and identifiable at-risk groups, and in designing reforms that improve national understanding of DFSV's role in suicide.

## B. Naming violence accurately: distinguishing FDV, sexual violence and child sexual abuse

What is named determines what is seen. Accurate identification of different forms of violence is essential to understanding suicide risk pathways and ensuring appropriate specialist responses.

Parkerville's service data shows that child sexual abuse frequently occurs alongside other forms of adversity, and that failure to clearly distinguish sexual violence from FDV obscures cumulative harm patterns that are critical to understanding mental health vulnerability and suicide risk for children and young people.

2. **Ensure that analytic frameworks distinguish FDV experience, sexual violence and child sexual abuse, and co-occurrence**, so that intersection is captured without conflation, and specialist pathways remain visible. Sexual violence frequently co-occurs with FDV but is not interchangeable with it. Conflation risks mischaracterising risk pathways, weakening specialist CSA capability, and obscuring the distinct dynamics associated with sexual violence, including delayed disclosure and specific therapeutic needs.

## C. Recognising cumulative and developmental suicide risk for children and young people:

- ***Moving beyond event-based data to capture longitudinal harm, instability and system fragmentation***

Parkerville's experience demonstrates that suicide risk for children and young people is shaped by the accumulation and interaction of multiple adversities over time, rather than by single events, yet current data systems struggle to capture this cumulative risk.

For children and young people, suicide risk associated with DFSV develops cumulatively and developmentally, shaped by chronic fear, disrupted attachment, instability and repeated transitions. Analytic frameworks must reflect this reality.

3. **Include transition-related risk markers relevant to children and young people**, such as relocation due to FDV or homelessness, out-of-home care placement moves or transition from care, and school disengagement, in DFSV-suicide analysis, reflecting known high-risk junctures.

4. **Strengthen routine capture (where known) of DFSV history in suicide and self-harm data collections, with structured fields that reflect co-occurrence.** There is a need for consistent fields that distinguish: (a) FDV; (b) sexual violence/CSA; (c) coercive control indicators; and (d) key child-specific destabilising factors such as placement instability, homelessness or transience, and school disengagement, noting current gaps including the absence of comparable figures for youth suicides in the context of FDV.

   Without structured ways to record multiple and overlapping adversities across a child's history, Parkerville's experience suggests that suicide risk is often underestimated or mischaracterised, limiting opportunities for earlier, preventative intervention.

5. **Strengthen cross-system data linkage so children are not lost between service siloes.** Enable ethical linkage across coronial, police, health and mental health, child protection, education, and specialist DFSV/CSA services, so that children's experiences/cumulative adversity as recorded in service interactions are visible in aggregate trends, and can inform prevention investment. Children do not live in service siloes, and neither can data.

## D. Coordinated, child-centred system responses to DFSV-related suicide risk

Where suicide risk and DFSV intersect within families, fragmented and adult-centred responses leave children exposed to unmanaged and cumulative harm. Caregiver distress and violence fundamentally reshape the relational and practical environments in which children live, often undermining safety, predictability and the conditions required for development and recovery. Coordinated, child-centred system responses are therefore essential, particularly at points of transition and heightened vulnerability. Parkerville's practice evidence indicates that children experiencing multiple adversities are particularly vulnerable to system fragmentation, with each uncoordinated response or disrupted transition compounding distress and undermining recovery.

6. **Embed child-centred, family-centred safety planning** whenever FDV and suicide risk are identified in a household, ensuring that children and young people are not treated as incidental to adult service responses.

7. **Invest in and expand multi-disciplinary, trauma-informed models** that reduce retelling and improve coordination for children and families affected by abuse and violence, consistent with integrated practice approaches that make it easier for children and families to access coordinated support in one safe place.

8. **Require continuity-of-care protocols at high-risk transition points, with explicit cross-agency accountability for the child's plan.** Where children and young people are impacted by DFSV and suicide risk is present within the family system, services must implement continuity-of-care arrangements at high-risk junctures such as relocation due to FDV or homelessness, placement changes, and discharge from crisis or inpatient settings. These

protocols should include a lead professional, proactive information sharing with safeguards, warm referrals with follow-up, and review of safety plans as circumstances change.

9. **Build workforce capability across first-contact systems to recognise child presentations as potential DFSV-related distress and respond early.** Strengthen training and practice guidance across schools, emergency departments, housing and youth services to support safe inquiry, appropriate referral, and child-centred support when children present through symptoms rather than disclosure.

## E. Prevention and early intervention that address upstream and cumulative risk: Prevention as system design, not crisis response

Preventing suicide in the context of DFSV requires addressing the upstream conditions that compound risk over time for children and young people.

10. **Adopt a tiered public health approach that explicitly treats FDV and sexual violence/CSA as upstream determinants of child and youth suicide risk, with proportionate universalism.** This approach should incorporate universal, selective and indicated responses, and scaling intensity according to risk.

11. **Fund low-barrier, outreach-enabled responses for children and young people affected by FDV and sexual violence; meeting them where they are:** Invest in models that reduce access barriers through outreach into schools, youth centres, accommodation services and safe home settings, alongside no-wrong-door pathways, waitlist safety check-ins and proactive linkage to interim supports.

12. **Treat housing instability and system barriers as suicide prevention issues for children and young people impacted by DFSV, with clear policy levers.** Parkerville's experience shows that housing instability rarely occurs alone, and is often one element within broader patterns of cumulative adversity that disrupt continuity of care and exacerbate mental health vulnerability for children and young people. Prevention strategies should explicitly address housing instability, service barriers and long waitlists that disrupt continuity of care and increase distress, including resourcing for service navigation, advocacy and coordinated pathways that keep children connected to stable therapeutic relationships during periods of instability.

## F. Enablers for effective reform: sector collaboration and trauma-informed data practices

13. **Support sector-led collaboration that raises the visibility of sexual violence and child sexual abuse alongside FDV without conflation**, enabling coordinated advocacy and shared messages while respecting distinct specialist disciplines and mandates.

14. **Embed trauma-informed principles into any new data and reporting reforms**, consistent with the Inquiry's emphasis on systemic issues and safe handling of sensitive information.

## Concluding Remarks

Parkerville Children and Youth Care strongly supports the intent of this Inquiry to improve understanding of the relationship between domestic, family and sexual violence and suicide, and to strengthen the evidence base that underpins prevention and response.

Our experience, supported by growing body of practice data across more than 1,000 children and young people for whom we have adverse childhood experiences recorded, demonstrates that violence and trauma rarely occur in isolation. FDV is common within this cohort, but it is rarely the issue through which children first enter our services. More often, children present through support pathways for child sexual abuse disclosures, mental health distress, school disengagement, homelessness or family breakdown, and it is only through sustained and trusted engagement that the underlying presence of FDV becomes visible. This pattern reinforces that children and young people's experience of violence is frequently hidden within broader, cumulative adversity, rather than disclosed as a single presenting concern.

Without explicitly naming sexual violence, centring children as victim-survivors in their own right, and recognising FDV-related instability and trauma as core suicide-risk pathways, prevention efforts will continue to miss those most at risk. When violence and significant caregiver distress coexist, the everyday conditions of children's lives are fundamentally altered, eroding safety, predictability and emotional availability, and shaping developmental and mental health trajectories in ways that are not captured when responses focus narrowly on adult risk or isolated events.

We urge the Committee to adopt a child-centred, trauma-informed lens in its findings and recommendations; one that ensures improved data is used to illuminate cumulative adversity and translate into coordinated, specialist and developmentally appropriate responses. Such an approach is essential to enable earlier identification of risk, stronger continuity of care, and more effective prevention for children and young people living with the impacts of violence, instability and trauma.

Yours sincerely,

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Chief Executive Officer

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### Contact details

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