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Foundation for Alcohol Research & Education

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Committee Secretary
House of Representatives Standing Committee on Social Policy and Legal Affairs
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INQUIRY INTO THE RELATIONSHIP BETWEEN DOMESTIC, FAMILY AND SEXUAL VIOLENCE (DFSV) AND SUICIDE

Introduction

The Foundation for Alcohol Research and Education (FARE) thanks the Standing Committee on Social Policy and Legal Affairs for the opportunity to contribute a submission to this inquiry.

FARE is a not-for-profit organisation with a vision for an Australia free from alcohol harms – where communities are healthy and well, and where laws, policies and programs are fair, equitable and just. Working with local communities, people with lived experience of alcohol harm, values-aligned organisations, health professionals, researchers and governments across the nation, we are improving the health and wellbeing of everyone in Australia.

In conducting this inquiry, the Committee should consider the critical role that alcohol plays in domestic, family and sexual violence (DFSV), and in suicide. Alcohol is no ordinary commodity. It is a harmful product requiring regulatory controls, including licencing laws based on harm prevention, not on alcohol industry profits. Alcohol contributes to chronic diseases like cancer. It contributes to disability and homelessness. It also plays a key role in exacerbating DFSV and mental ill-health, including suicide. Reducing the severity of these public health issues, including DFSV and suicide, requires evidence-based policies that address alcohol availability and marketing, and that support people at higher risk of alcohol harms.

These policy approaches are well established in public health literature. FARE's *National Framework for Action to Prevent Alcohol-related Family Violence* explores these and other actions to reduce alcohol-related family violence in Australia.[1] However, the implementation of these policy measures by Governments in Australia has been limited. There has been insufficient action on reducing alcohol availability (particularly direct delivery into the home, which amplifies DFSV and suicide risks) and on liquor licensing regimes that fail to fully consider risks of harm. There is also lenient regulation of alcohol marketing and advertising which still allows, for example, the significant exposure of children to alcohol marketing.

Recommendation 1. Acknowledge, examine, and make recommendations about the role that alcohol plays in DFSV and suicide, referring to the evidence-based policies to reduce these harms.

Alcohol and DFSV

Alcohol is a significant contributor to gendered violence in Australia. Alcohol is implicated in 1 in 3 (34%) intimate partner violence incidents, over a quarter (29%) of family violence incidents,[2] and up to 54% of family violence incidents reported to police in Australia were classified as

alcohol related.[3] Alcohol increases the probability, frequency and severity of DFSV.[4] Over half (52%) of male intimate partner homicide offenders use alcohol at high-risk levels at the time of the homicide.[5]

Men's drinking results in direct, indirect and hidden harms to women that are cumulative, intersecting and entrench women's disempowerment.[6] Changes in their partners' drinking play a central role in women's journey to safety and can complicate their ability to leave.[7] Harms caused by men's alcohol use on women and children include intimate partner violence, reduced educational opportunities and financial deprivation.[8] When a perpetrator is intoxicated, craving, or in withdrawal from alcohol then controlling behaviours, financial abuse, conflict, and erratic behaviours escalate.

Women's use of alcohol is also weaponised against them in gendered violence. Victim-survivors are more likely to experience problematic alcohol and other drug use (AOD), as a coping mechanism.[9] Some victim survivors have been discouraged from pursuing criminal charges if they were drinking alcohol at the time of their assault. This is despite the laws in many Australian jurisdictions that say a person cannot be deemed to have consented to sexual acts if they are so affected by alcohol that they are incapable of consenting. Rape myths about intoxicated victims continue to influence police and court responses, undermining fair assessments of credibility and consent.[10,11]

Urgent reforms are needed to address the increased risk from the expansion of the availability and accessibility of alcohol. There has been unprecedented growth in the availability of alcohol in Australia, including late night and rapid delivery of alcohol. Increasing alcohol availability increases alcohol harms, including gendered violence.[12,13] Regulation of alcohol is an important prevention approach to domestic and family violence.

Rapid Review and National Cabinet

Following an initial National Cabinet meeting on gendered violence in May 2024, the Prime Minister announced an expert led '*Rapid Review of Prevention Approaches to End Gender-Based Violence'*. Recognising the role of alcohol in gendered violence, the *Rapid Review* report included recommendations for governments to adopt "primary objectives" in their Liquor Acts to prevent gendered violence; and recommendations to limit alcohol sales and delivery timeframes, and advertising.[14]

National Cabinet then met in September 2024, to again discuss gendered violence, with the Prime Minister stating that tackling the impacts of alcohol on violence was a priority. He acknowledged the role of systems and industries in exacerbating violence. State and Territory First Ministers agreed to review alcohol laws and their impact on family and domestic violence victims to identify and share best practice and reforms and to report back to National Cabinet on progress.[15]

There has been slow and limited progress on these recommendations, with only some jurisdictions advancing reviews of their Liquor Acts, and no jurisdictions implementing reforms. Several States and Territories have made changes to their Liquor Acts that are focused on supporting businesses and industry, which are inconsistent with the reforms proposed in the *Rapid Review*, and which in some instances would increase alcohol-related harm.

In December 2024, the SA Government released a draft Liquor Licensing Amendment Bill that included the introduction of a 2-hour safety pause between the order and delivery of alcohol. In October 2025, the ACT Government tabled the Liquor Amendment Bill 2025 that included the 2-hour safety pause. In November 2025, the Tasmanian Government launched a *Liquor Licensing Reforms* consultation, that included "*considering and responding to the role that alcohol may*

play in contributing to family and domestic violence, by strengthening controls on alcohol availability and better regulation of online sales and delivery."[16]

Recommendation 2. Complete the National Cabinet commitment by ensuring that all States and Territories enact changes to alcohol laws in line with the *Rapid Review* to prevent DFSV. This includes adopting primary objectives to prevent gendered violence, limiting alcohol sales and delivery timeframes (2-hour safety pause and 10pm cutoff), and restricting advertising.

Alcohol and suicide

Suicide is complex, with multiple, inter-related contributing risk factors, including the use of alcohol and other substances. Alcohol has a clear association with the risk of suicidality,[17,18] and the role of alcohol in suicidality interacts with other risk factors.[19] Between 2010 and 2015, more than 26% of suicide deaths in Australia had a blood alcohol concentration (BAC) above 0.05 g/100 mL.[20] Alcohol use is associated with 65% increased risk of suicidality.[21]

In Australia, **alcohol is the second leading risk factor among adult males for suicide**, responsible for 17% of the burden of suicide and self-inflicted injuries among males aged 15 years and over in 2019.[22] **The second leading suicide risk factor for adult females is intimate family violence, of which alcohol increases the frequency and severity.**[23] These priority groups will not always be contactable through formal service delivery pathways, (only half of those who die by suicide in Australia each year have previously accessed mental health services).[24]

There are also strong associations between high-risk or dependent alcohol use and other mental ill-health, such as depression and anxiety.[25] Stress can lead to the onset and maintenance of high-risk alcohol use, and alcohol can also be used to attempt to manage anxiety. People are more likely to have increased alcohol use if they had more severe symptoms of depression or anxiety.[26] There is also evidence of associations between depressive and anxiety symptoms and increased alcohol use during the COVID-19 pandemic in Australia.[27]

The same alcohol harm reduction policies targeting DFSV above, also contribute to suicide prevention, and to a reduction of alcohol involvement among suicide deaths. As part of a comprehensive approach to suicide prevention, alcohol policies (such as regulating availability and marketing) should be adopted.[28]

A study of unmet demand for AOD services showed that between 26.8% and 56.4% of those in need of treatment accessed it. This translates to a demand gap of 43.6 to 73.2%, or 180,000 to 553,000 people nationally.[29] Research also demonstrates that for every dollar invested in treatment services, more than $7 is returned to the community through health and social benefits.[30,31]

Recommendation 3. Increase funding investment in mental health and AOD treatment services.

Intersections and integrated responses

There is a strong and complex three-way connection between high-risk alcohol use, DFSV and suicide. The same underlying vulnerabilities (eg. trauma, impulsivity, mental ill-health) can predispose people to all three issues. Depression, anxiety, attempted suicide and post-traumatic stress disorder are among the frequently reported effects of DFSV on victims.[32] A DFSV victim may engage in high-risk AOD use to medicate the physical and emotional pain caused by the violence and to cope with the ongoing violence.

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Yet the presence of all three issues may sometimes be missed in screening assessments because one or two of the factors are foregrounded as the primary issues. Health and social service providers need to screen for problematic alcohol use, mental health issues, DFSV, and suicide risk concurrently, as addressing these issues in isolation can be less effective.

The intertwining connections of these issues require integrated responses. A coordinated and integrated service system would include AOD, DFSV, child protection, justice, and mental health sectors collaborating seamlessly to provide holistic support for people with complex needs. In this system, people encounter a 'no wrong door' approach, where no matter which service they access, they receive appropriate care, early identification of issues, and timely referrals.

Currently, sectors that address AOD, DFSV, child protection, justice, and mental health often operate in silos with differing approaches. This can lead to fragmented care, gaps in knowledge, lack of cross-sector training, and inconsistent responses to overlapping issues such as alcohol as a risk factor for violence. Siloed funding mechanisms exacerbate these challenges. Additionally, clients, particularly women, may fear stigma or repercussions such as losing custody of children, which deters them from seeking help.

Recommendation 4. Invest in integrated models of care (eg. common risk assessment frameworks), and cross-sector professional development to build shared expertise and improve support for people with intersecting AOD, mental health, and family violence needs, (eg. a shared understanding of alcohol and violence against women and children).

Data collection

A robust, consistent, and comprehensive data collection system would capture the full scope and complexity of alcohol-related violence against women and children across each jurisdiction. This system would support better understanding of the intersections between alcohol use and DFSV, enabling informed policy decisions and targeted interventions. Enhanced data sharing and communication between state and federal jurisdictions will ensure coordinated responses and effective resource allocation to protect populations at risk of harm.

Currently, data on alcohol's role in DFSV incidents is inconsistent and incomplete across different services and jurisdictions.[33] Police records, ambulance callouts, emergency hospital presentations, and child protection reports often lack standardised collection of alcohol involvement, making it difficult to accurately measure prevalence and patterns. These gaps hinder the development of evidence-based responses and cross-jurisdictional collaboration.

Recommendation 5. Improve and standardise data collection on the role of alcohol in DFSV across police, emergency, and child protection systems and invest in qualitative research to inform more effective prevention and intervention strategies.

Thank you for your consideration. We would be pleased to meet to discuss this submission further.

Kind regards,

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CHIEF EXECUTIVE OFFICER

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