

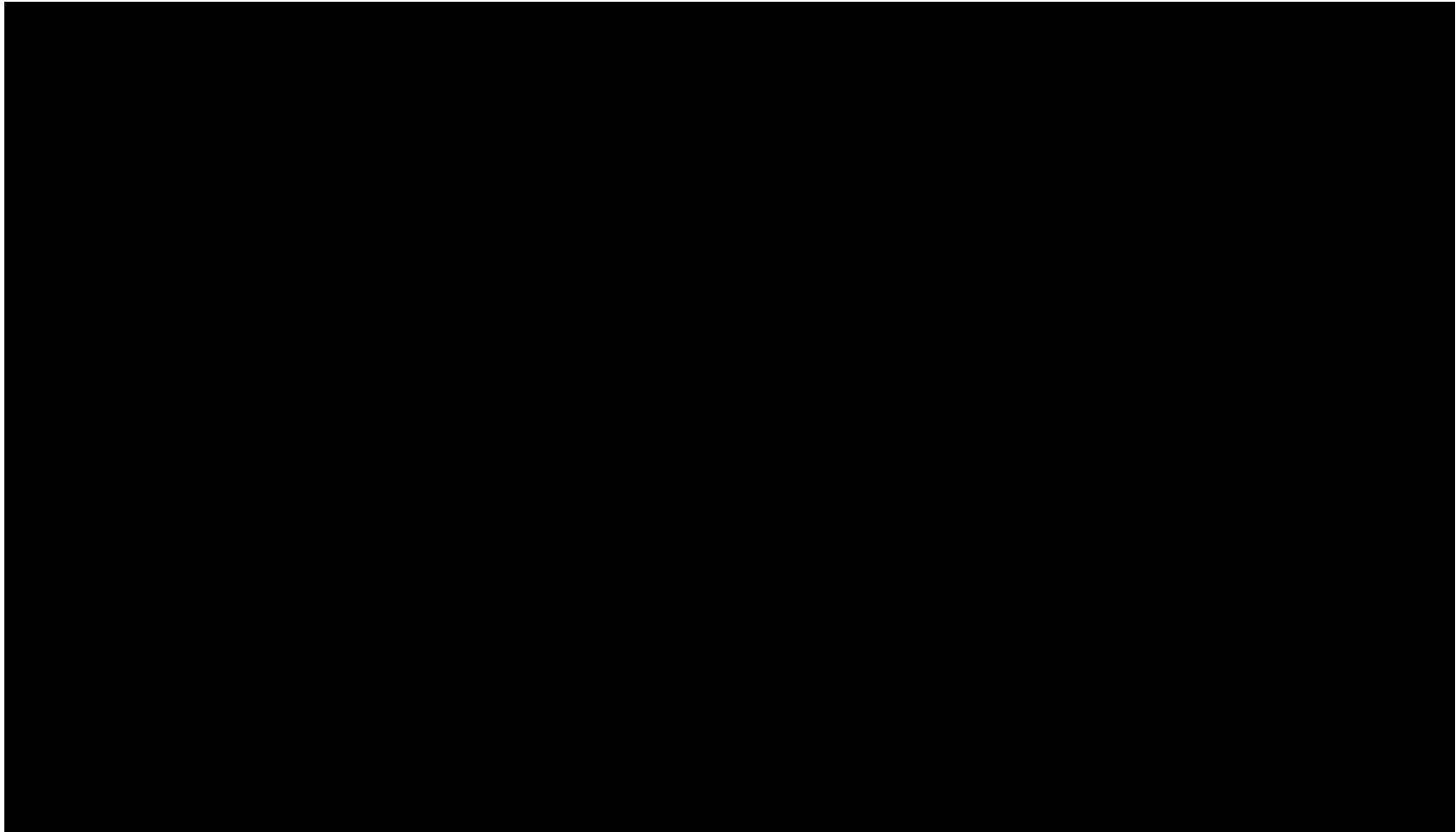
Highlighting the relationship between domestic abuse and suicide

“We don’t know a lot – but we know enough to
know that we should be seriously concerned”

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We would like to start by considering the perspective of domestic abuse (DA) victims – A conversation with Oasis DA Service (a local provider of support)



<https://youtu.be/mhK5qllXS7M>



2 years ago our Community Safety team asked us (what we thought would be) a simple question...

“How many suicide related Domestic Homicide Reviews should we be planning for over the next few years?”

It turned out to be impossible to answer. There is virtually no* academic, charity, national or local government evidence to look at.

** The evidence that does exist is many years old and most of it looks at “feelings of suicidality” rather than “deaths by suicide”.*



So our professional curiosity led us to examine the information sources we had access to...

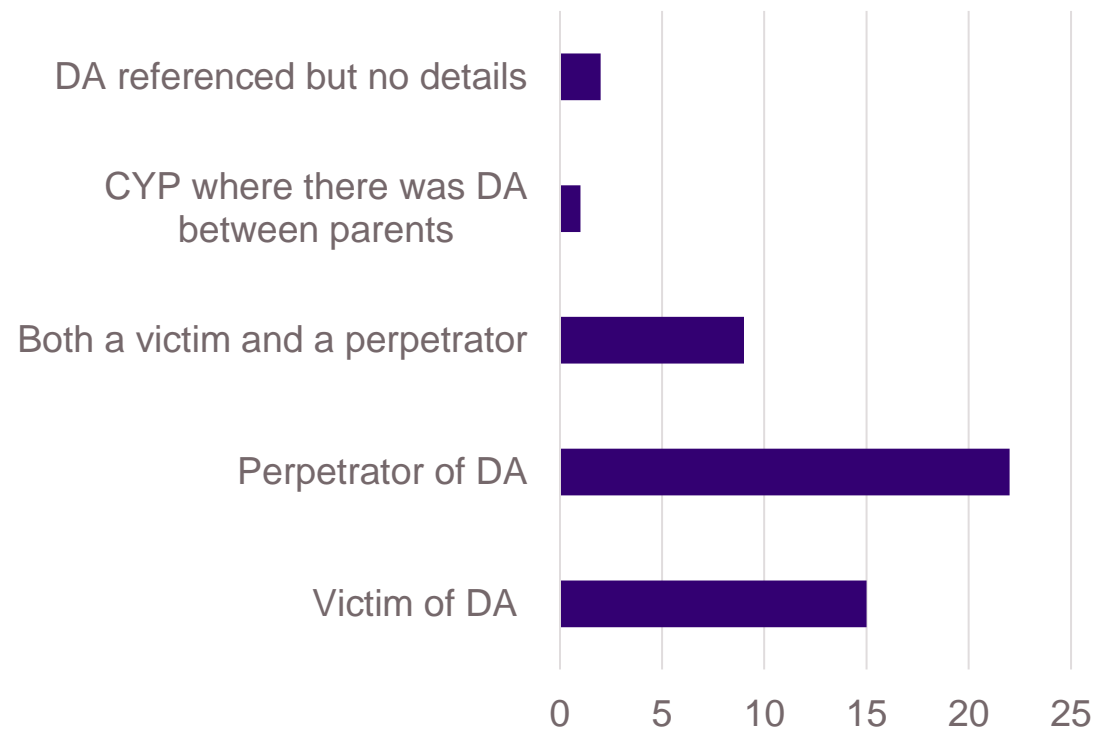
The Kent and Medway Suicide Prevention Team have undertaken a number of research projects over the last 18 months

1. Exploring the levels of suicidality amongst victims (63%) and perpetrators (61%) (based on 928 DASH risk assessments)
2. Reviewing 93 nationally published DHRs – 26% contained a suicide of either victim or perpetrator (NB most DA related suicides DON'T result in a DHR)
3. Undertook a Thematic Analysis of recent suicides amongst CYP in Kent which showed that some of the deaths were amongst CYP living in a household impacted by DA
4. Reviewed levels of suicidality amongst male victims of DA

These helped build a picture and convinced us to include a specific question on DA in our local Real Time Surveillance System which we introduced in 2020.



Over 20% of suspected suicides in Kent and Medway's RTSS in 2020 + Q1 of 2021 had been impacted by DA



Further analysis of these suicides show that there are five main cohorts:

1. **Victims** who are dying by suicide in the **middle of the abuse**
2. **Victims** who are dying by suicide **months or years after the abuse has ended.**
3. **Victims** who are also thought to have been perpetrators of DA at some point in their relationships or lives

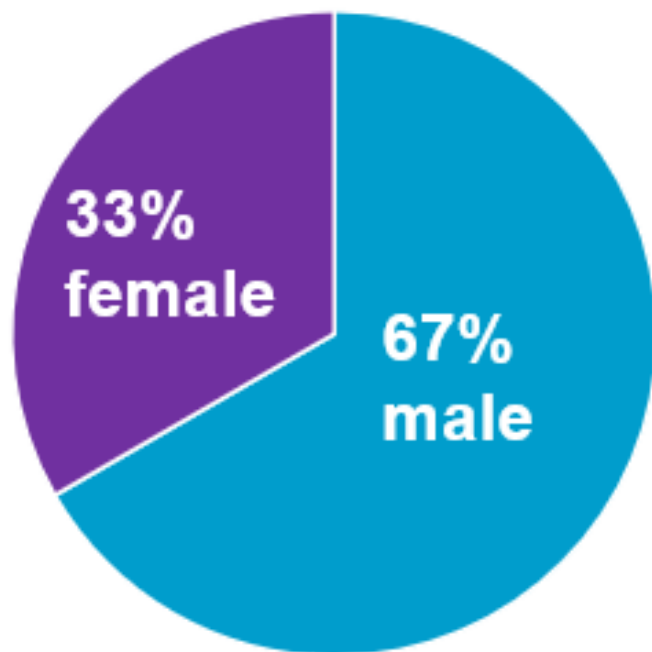
5. Children and young people living in households impacted by domestic abuse.

4. Perpetrators of domestic abuse. Including individuals who have been **convicted, accused** or who are **under investigation** for domestic abuse.

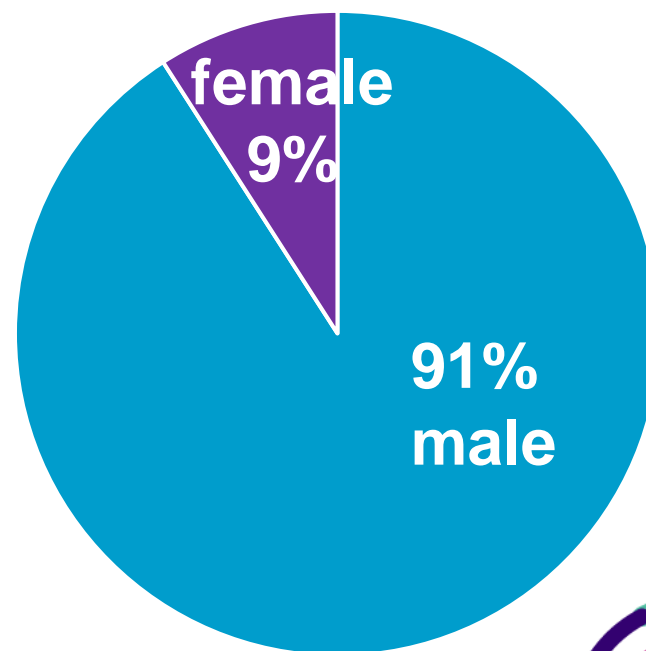


Gender of people who died of suspected suicide in Kent and Medway in 2020 and Q1 2021 after being impacted by DA

Individuals identified as victims of DA



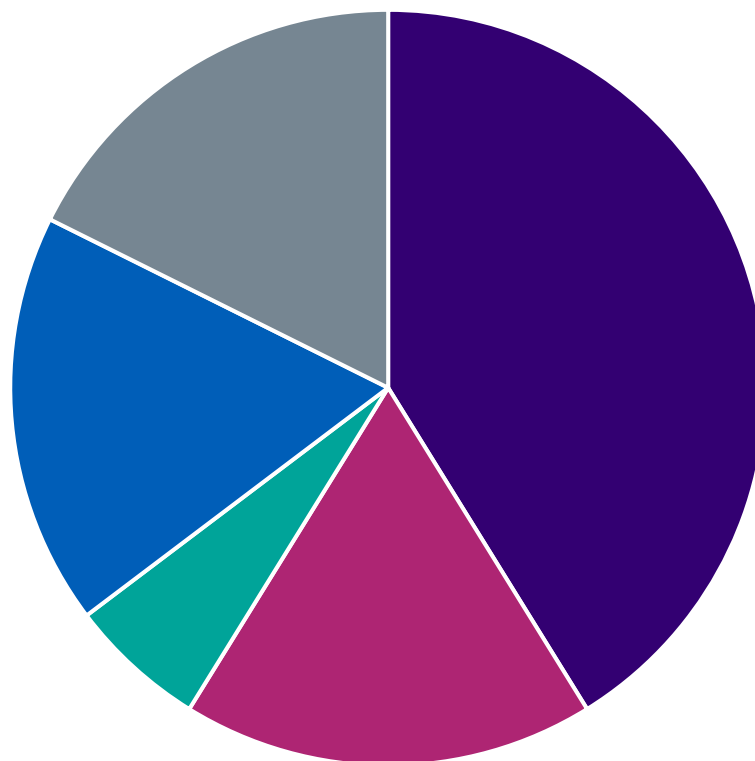
Individuals identified as perpetrators of DA



Please note – this a very small sample size.
It is based only on 15 months of data from one county in England.



Type of abuse noted in Police records in relation to individuals who die by suicide after being impacted by DA (taken from Kent and Medway RTSS 2020 and Q1 2021)



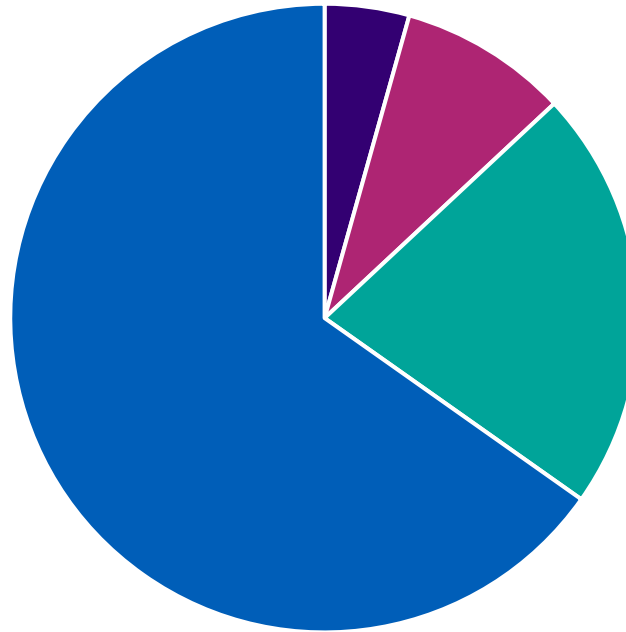
Please note – this a very small sample size. Only 30% of cases noted the type of abuse, the remaining 70% was unknown.

This chart therefore only shows the type of abuse for 30% of the cases, from 15 months in one county in England.

- Physical abuse
- Sexual abuse
- Verbal abuse
- Stalking/harrassment
- Multiple types of abuse noted



There were a total of 23 perpetrators within the Kent and Medway RTSS 2020 and Q1 2021. Of these 23 their contact with the Criminal Justice System was as follows:



Please note – this a very small sample size.

Based on only 23 individuals.

- Conviction of domestic abuse
- Under police investigation
- On bail
- Accused of DA but no known police contact



Some examples... (all taken from Kent & Medway 2020 RTSS)

Female, mid 30s. Victim of DA.
Perpetrator's court case ongoing.

Male, mid 20s. Victim of DA in 2019.
Split from mother of child.

Male, mid 40s. Suspected perpetrator of DA. On bail, awaiting trial.

Male, late 40s. Perpetrator of DA.
Convicted in 2014.

Male, early 50s. Suspected perpetrator of DA. Died two days after alleged incident with wife.

It is important to note that in some of these deaths, the DA appears to be the only **recent** risk factor; in others it is just one in a number of **historical** risk factors (*eg substance misuse, homelessness, debt*)



It's only 15 months of data. From one county in England. Based on limited data & initial Police reports which haven't been tested by coroners.

“We don't know a lot – but we know enough to know that we should be seriously concerned”



**So many unanswered questions remain... “was 2020 an outlier for us?”
“Are we an outlier compared to the rest of the country?”**

1. How many victims of domestic abuse die by suicide nationally and locally (both during the abuse, or in the months and years that follow)?
 - Are any groups at higher risk (gender? LGBTQ+? Age?)
 - Do any types of abuse (financial, stalking, coercive control etc) pose a higher risk?
 - Are there any high risk points within the abuse cycle?
 - Eg when a victim is informed the perp is being released from custody?
 - Or by suicide after the abuse has stopped and services may have drifted away
2. How many perpetrators of domestic abuse die by suicide nationally?
3. How many children living in households impacted by domestic abuse are dying by suicide nationally?
4. How strong is the link between DA and suicide?
 - Correlation or causation?
 - Does this differ between groups?
5. What (strategic or tactical) interventions could reduce the risk of deaths by suicide?



How have we responded in Kent and Medway?

- Included DA as a priority within our local Suicide Prevention Strategy
- Ensured we added a specific question on Domestic Abuse into our Real Time Suicide Surveillance System with Kent Police
- Funded Oasis to pilot *Trauma Impact Workshops* for survivors of DA where the abuse has stopped (A psychoeducational programme which helps participants understand how brains react to trauma, and how to manage their feelings)
- Targeted our MH campaigns to DA audiences
- Continued promotion of suicide prevention training to DA teams and DA training to mental health teams (but needs to be more specific)
- Presented to local Domestic Abuse Forums in each District
- Recommended local DA risk assessments are changed to capture more relevant information



Anxious?

Stressed?

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for free and confidential support

shout
85258
here for you 24/7

Shout 85258 won't appear on a phone bill and does **not** require data, an app, registration or password. For more information, visit [giveusashout.org](https://www.giveusashout.org).



What are we planning to do next?

- We have agreed to fund Kent Police to retrospectively complete RTSS with 2019 data
- We have added additional data fields (including “*type of abuse*”, “*current or former relationship*”, “*dependent children?*”) into our 2021 RTSS data capture
- Deep dive with Kent Police on DA related suicides in 2020 and 21
- Statistical analysis (in partnership with Liverpool John Moore University) of our local Real Time Surveillance System DA related suicides
- Qualitative research with victims and perpetrators (funding dependent)
- We have secured funding for County-wide roll out of Trauma Impact workshops for victims of DA – Including an academic evaluation
- Action research how to provide bereavement support to families of DA perpetrators who die by suicide
- **We will continue to advocate for national scale action and research**
 - NSPSAG (22nd April)
 - Partnering with NSPA (12th May) to host national roundtable discussion
 - The inclusion of DA as an explicit priority within the sixth annual progress report of the national suicide prevention strategy?



One idea to move forward - A national working group?

We believe the way forward could be a national working group made up of

- Policy leads (Govt and independent)
- Academics
- Charities
- People with lived experience
- Local providers and commissioners

Neither the domestic abuse sector, or the suicide prevention sector can solve this on their own. Any working group must have representation from both the suicide prevention AND domestic abuse sectors in all the categories listed

Can the working group identify;

- 1) What are the key questions that need answering?
- 2) What data is available now and can we collate it?
- 3) What data could be available with methodology changes or new guidance?
- 4) Existing best practice
- 5) Policy and practice recommendations for agencies including - Dept Health, Home Office, PHE, Local Authorities, Police, Coroners, Domestic abuse service providers, Mental health service providers, Suicide bereavement services, Academics

National DA Strategy consultation later in the summer provides an opportunity?



Appendix A - What can local areas do?

Tim Woodhouse

- 1 Include Domestic Abuse as an explicit priority within your local multi-agency Suicide Prevention Strategy
- 2 Ensure your local Real Time Suicide Surveillance system asks specific questions about DA (Victim, perpetrator, CYP? Type of abuse? Current or former relationship?)
- 3 Domestic abuse training completed by all mental health staff. (Consider making this a commissioning condition).
- 4 Mental health and suicide prevention training completed by all domestic abuse staff. (Consider making this a commissioning condition).
- 5 Ensure provision of recovery (including trauma aware elements) programmes for female and male victims of domestic abuse in the months and years after the abuse has stopped
- 6 Ensure provision of perpetrator programmes for both men and women
- 7 Undertake further research
 - Qualitative research with victims
 - Detailed analysis of RTSS
 - Detailed analysis of data held by secondary MH trust



Appendix A (cont) - What can local areas do?

Tim Woodhouse

- 8 Consider revising risk assessments to ask the following questions of both the victim and the perpetrator

	At any point in your life?	During your current relationship?	Within the last 3 months?
Have you self-harmed?			
Have you felt suicidal?			
Have you made a suicide attempt?			

- 9 Specialist domestic abuse counsellors to be made available for all MARAC victims

- 10 Ensure that local suicide bereavement services are trained / experienced in supporting families after the suicide of a DA victim or perpetrator



Appendix B - Important data quality caveats about the Kent and Medway RTSS data....

- ❑ Deaths within the RTSS are those which (after post-mortem) Kent Police are treating as suspected suicides. They are pre-coroner inquest.
- ❑ Some deaths included in the RTSS may get ruled as something other than suicide once the coroner inquest is concluded.
- ❑ It is also possible that there are also some deaths which are not initially treated as suspected suicides (and therefore are not in the RTSS) but are later recorded as a suicide by the coroner
- ❑ Data in the RTSS is based on information included in the investigating officer / Detective reports. If information is not included in the Detective records it is not included in the RTSS.
- ❑ The analysis is based on the RTSS between January 1st 2020 – 31st March 2021 in Kent and Medway. This provides us with a reasonably sized data set but not a huge one.

