

Domestic abuse and suicide

**Exploring the links with
Refuge's client base and work force**

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Executive Summary

This collaborative research between Refuge and the University of Warwick is the first of its kind in the UK and – involving a sample of more than 3500 clients – it is one of the largest internationally.

The suicide of Gurjit Dhaliwal, who took her own life after enduring years of physical and psychological abuse, was the impetus for this research. Dismayed at the apparent inability of the legal system to punish perpetrators who drive their victims to suicide, and by its failure to recognise the psychological injury which precedes it as a legitimate offence, we were moved to act.

We decided to investigate the links between domestic abuse and suicide in order to fill gaps in existing knowledge about the factors that might predict, contribute to or mitigate against the development of suicidality in victims. Our goal was to use this information to inform policy and practice in the field; including in relation to ‘liability for suicide’ in cases of domestic abuse.

This research provides detailed, substantial and original evidence on the prevalence of suicidal ideation and attempts amongst domestically abused clients in the UK. It supports existing research in suggesting a significant association between experiencing domestic abuse and suffering negative psychological effects. It highlights the importance of professionals that engage with domestically abused clients being more aware of and responsive to their risk of suicidality.

Key findings

Almost a quarter (24%) of Refuge’s clients had felt suicidal at one time or another

18% had made plans to end their life

3.1% had made at least one suicide attempt

There was strong evidence for psychological distress or injury across the whole sample:

86% scored above cut off for clinical concern (n11) on the CORE-10 measure of psychological distress

83% confirmed feeling despairing and hopeless - a key determinant for suicidality

96% of those in the suicidal group reported feeling despairing or hopeless

49% of the suicidal group scored within the severe range of psychological distress

86% of the suicidal group reported feeling depressed

Key findings

The chances of being suicidal were

- 3.5 times greater for those who were feeling depressed
- 1.87 times greater for those without children
- 1.69 times greater for who feel despairing or hopeless
- 1.68 times greater for those with alcohol difficulties
- 1.59 times greater for those with problem drug use

Key findings

- 97.5% (n3432) of the sample were women
- 84.1% (n2938) of abusers were described as male partners or ex-partners

Key findings

- Damaging gaps and delays were observed by staff who referred clients to community services
- Short term risk management approaches were often cited as inadequate to address suicidality, particularly when facilitating its disclosure
- Limitations of existing tools to assess risk of harm from the client to herself particularly over a broad timescale were highlighted
- The need for trauma informed approaches to practice, for clients and for the workforce were identified.

Recommendations

Gender, psychological injury and criminal liability

The gender split evident amongst Refuge's clients reflects broadly the international trend in domestic abuse perpetration and victimisation in that it is largely a phenomenon in which females are victims and males are perpetrators. We know from other research that females are more likely to be repeat and chronic victims of domestic abuse. The present study indicates that it is this chronicity of abuse, when embedded within a relationship that ought to be based on love and trust, that can be particularly injurious at the psychological level and apt to increase the risk of suicidality. It is not possible given the data available to comment on whether or not this sample of domestically abused victims might meet criteria for a psychiatric diagnosis: but we can assert, with some conviction, that the majority of them were psychologically distressed and that it would be appropriate to describe many, particularly those who fell within our suicidal group, as psychologically *injured*. It is vital, therefore, that all agencies recognise domestic abuse as a gendered issue and a gendered crime; and that the legal system in particular develop responses to prevent and punish perpetrators who cause *psychological injury*, including where this drives the victim to suicide or to attempt suicide.

Recording and monitoring suicide and suicidality

When domestically abused suicidal victims are in crisis, they often contact health or other services for help. It is important that there are agreed, clear and precise mechanisms for recording who these victims are, what happened to them (domestic abuse, for example, including the gender and relationship of the victim to the perpetrator) and the nature of their suicidality (attempt, thoughts, plans).

Domestic violence homicide reviews are already in place for victims who are killed by their perpetrator and there is some evidence that domestic violence suicides are starting to be reviewed. This is positive but long overdue, and needs to be developed on a more systematic basis. There is also much to learn from so called 'near misses' in which a suicide attempt is made but the victim lives - robust systems should be established so that agencies can monitor and respond to such cases accordingly.

Coroners' courts have a key role to play in subjecting domestic abuse suicides to greater scrutiny, allowing more involvement of families and by operating with a greater degree of transparency than domestic violence homicide reviews allow. Collating, analysing and disseminating any findings and recommendations at a local and national level, is essential to bring about meaningful change.

The State has a positive obligation under the Human Rights Act to protect citizens from inhuman and degrading treatment (Article 3) or from threats to life (Article 2). This obligation extends to the need for agencies (including the police) to have systems that allow serious violent crime to be investigated effectively and to ensure that such systems are applied appropriately in all cases.

Timely and appropriate support

Given that 83% of Refuge's client group felt despairing or hopeless at intake (or shortly thereafter), and at least 24% felt suicidal either then or in the past, it seems crucial that services are in place (not only within the domestic abuse sector) to respond to these needs, *at the time* of need. This research found that long delays in obtaining support for victims of trauma and abuse had the potential to exacerbate any existing difficulties. Appropriate specialist services are designed to allow victims to take time to disclose the full impact of the abuse they have experienced, including any suicidality; they provide a suitable environment in which victims can 'tell

their story' at their own pace. Feeling safe, not just *being* safe, are pre-requisites for recovery from any trauma - providing a roof over someone's head or getting an injunction to keep a perpetrator away is only one part of the solution. Recovery from experiences of abuse, particularly those that lead someone to consider taking their own life, does not have a cost effective, scalable, short-term solution: it requires solid investment in a range of specialist services *and* in the individuals who run those services. A commitment to provide secure, protected funding for specialist domestic abuse services, as well as ensuring there are sufficient specialist refuges to meet demand, is essential.

Trauma focused approaches to work with victims of abuse

Specialist services, that take the suicidality of victims seriously, and respond with compassionate understanding to their 'cry of pain'² are essential in any strategy to prevent suicide or further acts of self harm. Trauma focused professionals who ask victims 'what happened to you?' rather than 'what is wrong with you?' and who recognise the relevance of the abuse within a victim's relationship *and* the broader social context in which they find themselves, are key. Any concurrent difficulties with drugs, alcohol or other complex needs should be met by a non-judgmental approach that seeks to understand the victim *from the perspective of her own experience*. Additional complexity in terms of cultural abuses, such as so-called 'honour' based violence, difficulties with immigration or the experiences that precede and follow being a refugee, must also be recognised and addressed, once again with understanding and compassion. This work can be complex, so it should progress at the client's own pace and not be driven by time limited programmes of a prescriptive nature. Survivors of abuse, and of suicidality, should be integral to the development of any programmes designed to meet their needs.

This study highlighted the emotional challenges that working with traumatised, suicidal clients can have on caseworkers and managers throughout an organisation such as Refuge. Addressing the impact that work with this population has on its workforce, in terms of a trauma focused organisational approach to Human Resources policy and practice, is as important as developing this kind of approach with clients.

The needs of children - redesigning the future, for them and for us all

Whilst this study found that having children was protective for victims of abuse, it is vital that we recognise and address the potentially devastating impact that having a suicidal parent can have on children, who may also be affected by domestic abuse in their own right. It was beyond the scope of this study to include the perspectives of children and young people and further work is needed to explore the implications for them in this extremely difficult context. For too long, children have been the 'silent witnesses' or 'invisible victims' of domestic abuse and despite decades of research into the harm it causes, their needs are often ignored, or viewed as secondary to those of their abused parent: this must change. Every area of the UK should provide specialist services for children to address the harms caused by living with domestic abuse, including those who have been bereaved through the suicide of a parent in this context.

We also need to engage in wide scale educational efforts to challenge and reform traditional perspectives of masculinity and femininity; preventative programmes of this type must be rolled out nationally if we are to have any hope of ever eradicating the gender inequality at the root of violence against women. As a society we must find the courage to articulate and accept that sexism and gender inequality lie at the root of violence against women and girls, we must find the will to develop strategy and programmes to overturn sexism and we must work together to ensure there are no more vulnerable women who feel so despairing and trapped by domestic abuse that they believe suicide is the only escape - it is not.

² Williams, J.M.G. (2014) Cry of Pain: Understanding Suicide and the Suicidal Mind; Piatkus



Nav Jaggal with a photo of his sister Gurjit Dhaliwal who was driven to suicide after enduring years of abuse.

SECTION 1

Background

It is difficult to believe that thirteen years have passed since Gurjit Dhaliwal took her own life after enduring years of physical and psychological abuse, and that it is more than a decade since the Crown Prosecution Service brought a pioneering case against her perpetrator, attempting to hold him liable for her suicide. The increased risk for suicide amongst abused women had been documented in the research literature from other jurisdictions³ at the time, with an estimated three UK women a week posited to escape domestic abuse by taking their own lives⁴. Nonetheless, the case against Harcharran Dhaliwal collapsed at the first hurdle⁵.

Much activity and attention followed Gurjit Dhaliwal's suicide and the case which brought her name into the public domain. Interest in the idea that psychological harm should be criminalised and that abusive partners should be criminally liable for the suicide of their victims entered the violence against women debate; Refuge took the lead via a broad based campaign that involved Government, its opposition (in the form of Iain Duncan Smith's⁶ Early Day Motion), the Law Society,⁷ academics⁸ and state agents such as the Association of Chief Police Officers⁹. Refuge, the national domestic violence charity, also challenged the courts' decision to view the impact of domestic abuse through 'an exclusively psychiatric lens' and asserted that the psychological impacts suffered by many victims were no less injurious for lack of a formal psychiatric label¹⁰. Refuge claimed that the chronic impacts of abuse can affect and change victims at their core and in ways that exceed the boundaries of psychiatric classifications, and that it was inappropriate to measure this distress against such narrow psychiatric criteria. Munro and Shah's subsequent 'feminist judgment' provided a reimagining of *R v Dhaliwal* in which a more flexible, victim-centred and trauma-informed approach was undertaken; one which the authors argued it would have been open to the Court of Appeal to have taken in the original judgment¹¹.

There was at the time, a real hope that the rigid psychiatric classification system relied upon by the legal system might be blurred to allow formal legal recognition of the severe nature of the psychological injury that can arise from domestic abuse: but it was not to be. And those of us who still work with and advocate for abused women today, find that little has changed. While an offence has now been created of coercive and controlling behaviour, which begins to capture some aspects of this psychological abuse within the criminal law, it is problematic as we discuss below. Abused women continue to take their own lives in numbers which are estimated¹² to exceed those killed by their partners or ex partners, and yet this ultimate 'cry of pain'¹³, and the psychological injury which precedes it, remains difficult for the legal system to address in a way that holds the perpetrator fully liable for the harm he has inflicted.

³ Stark E, Flitcraft A (1995) 'Killing the beast within: woman battering and female suicidality.' *Int J Health Serv.* 25(1):43-64.

⁴ Extrapolating from various statistics, Sylvia Walby has suggested that more than one-third of all female suicides in England and Wales may have been committed by women who had been subjected to domestic abuse. S. Walby (2004) 'The Cost of Domestic Violence', London: Women and Equality Unit

⁵ In *R v Dhaliwal*, the Crown Prosecution Service attempted to bring a charge of unlawful act manslaughter against an abusive partner, grounding the claim to a foundational criminal and dangerous act upon a long history of psychological abuse which had caused the victim to take her own life. The court took the view, however, that the case must fall at the first hurdle since there was no basis for arguing that the psychological injury alone constituted an offence under section 20 of the Offences Against the Person Act 1861, as had been suggested, since the extension of the meaning of 'bodily harm' had stopped short of including psychological (as opposed to psychiatric) injury.

⁶ Former leader of the Conservative party and MP for Chingford and Woodford Green

⁷ Horder, J, McGowan, L. (2006) 'Manslaughter by Causing Another's Suicide'. *Crim LR* 1035

⁸ Munro V. Shah, S. (2010) 'R v Dhaliwal: Reconstructing Manslaughter Cases in Domestic Violence Suicide' in C McGlynn, R Hunter & E Rackley (eds) *Feminist Judgments: From Theory to Practice* (Oxford, Hart), 261-272

⁹ ACPO review for the Home Secretary (2009) 'Tackling Perpetrators of Violence Against Women and Girls'

¹⁰ The Law Commission's tenth programme of law reform. 'Recognising the Psychological Impacts of Abuse': Project Proposal by Refuge. April 2007

¹¹ Munro V. Shah, S. (2010) 'R v Dhaliwal: Reconstructing Manslaughter Cases in Domestic Violence Suicide' in C McGlynn, R Hunter & E Rackley (eds) *Feminist Judgments: From Theory to Practice* (Oxford, Hart), 261-272

¹² Walby, S. (2004) 'The Cost of Domestic Violence', London

¹³ It has been suggested that suicidal behaviour (whether the outcome is life or death) should be seen as a "cry of pain" rather than the traditional "cry for help". According to the Cry of Pain model, rescue factors can moderate the relationship between entrapment and suicidality thereby reducing suicide risk. - Williams, M. (2001). *Suicide and attempted suicide: Understanding the cry of pain* (2nd ed.). London: Penguin in Rasmussen, S.A., Fraser, L., Gotz, M., MacHale, S., Mackie, R., Masteron, G., McConachie S., & O'Connor, R.C. (2010) 'Elaborating the cry of pain model of suicidality: Testing a psychological model in a sample of first-time and repeat self-harm patients'. *Br J Clin Psychol.* 49 (Pt 1):15-30

Complex Post Traumatic Stress disorder (PTSD) and the new offence of coercive control

Nevertheless, there are some signs towards positive change and the time appears to be right to bring the issue of domestic abuse and suicide to the forefront of debate once more. The first sign is the recognition of ‘complex post traumatic stress disorder’ as an independent condition within the psychiatric classification system, ICD-11¹⁴ - this construct is likely to include many of the adverse psychological impacts experienced by abused women. For many abused women, the psychological distress they experience is a consequence of the abuse they have endured and so pathologising expected, ‘normal’ reactions to abusive behaviour presents a dilemma¹⁵. Nevertheless, this development may make it more likely that these psychological impacts of domestic abuse will be recognised as indicators of a ‘psychiatric condition’ which would, in turn, fall within the already recognised boundaries of ‘bodily injury’ for the purposes of criminal liability. Where a victim of such abuse goes on to take her own life, this recognition potentially lays the foundation for a manslaughter charge, where it can be shown that the defendant’s unlawful act *caused* the death.

The second development is the new offence of coercive control, which includes a range of positive acts that cause psychological harm to victims of abuse. Unfortunately, by tying the legal recognition of injury to certain prohibited behaviours of the defendant, the offence of coercive control focuses on ‘acts’ rather than ‘impacts’ - the latter being central to psychological injury. However, it is not the nature of a particular act of abuse that makes it psychologically injurious, it is the *meaning* it holds for the victim. It is the slow drip, drip effect of ‘apparently minor’ acts of humiliation, control and subtle undermining that cause greatest harm, such that reality is distorted and the victim does not recognise the abuse for many years, nor hold the perpetrator responsible. It is the impact of such behaviour upon the victim, and the duration for which she has suffered this abuse, that should be considered in terms of psychological injury.

Furthermore, although the offence creates the possibility for unlawful act manslaughter to be grounded on criminally coercive and controlling behaviour, the legal foundations for this move are untested. In the recent case of Steven Gane, the perpetrator was charged and convicted of assault causing actual bodily harm and coercive control - but not manslaughter – when his victim took her own life. Significantly, this was despite the trial judge’s acknowledgment that Gane’s behaviour “drove [his partner] to hang herself that morning” because he “beat her and ground her down and broke her spirits,” which suggests support for the existence of a necessary causal link between the abuse and suicide [<http://www.bbc.co.uk/news/uk-england-beds-bucks-herts-4354153>].

¹⁴ The World Health Organisation (WHO) International Classification of Diseases, 11th version (ICD-11) has proposed two related diagnoses, post traumatic stress disorder (PTSD) and complex PTSD within the spectrum of trauma and stress related disorders.

¹⁵ “The British Psychological Society (BPS) registered its concern about the application of psychiatric classifications to individuals who demonstrate appropriate reactions to distressing life experiences, warning against the negative impact of defining these individuals as ‘ill’ as well as the potential to miss important social and relational factors underpinning such distress”. Radford, L., Aitken, R., Miller, P., Ellis, J., Roberts J, Firkic, A. (2011) Meeting the needs of children living with domestic violence in London

Increased focus on suicide

In response to concern about the rate of suicide in general, national and international strategies have been developed to identify those at risk and prevent the occurrence of further, lethal harm¹⁶. Following this, the rate of completed suicides appears to be falling¹⁷. As yet, data on prevalence, risks and precursors, such as thoughts and plans about suicide and suicide attempts, is not always available¹⁸. An absence of agreed definitions for ‘suicidality’ and ‘attempts’, together with a lack of internationally agreed systems for data collection, appear to contribute to this gap in reliable knowledge¹⁹. Where data does exist, however, death rates from suicide appear to be consistently higher for men than for women, particularly in high income countries²⁰. But women are much more likely than men to make suicide attempts²¹. This tendency for females to attempt suicide more frequently than males seems to hold across all ethnic, racial and age groups²², with some studies suggesting that suicidality may be even more likely for minority ethnic women²³. A recent UK report acknowledged that many women who died through suicide ‘had multiple morbidities, as well as complex social factors, substance misuse and domestic abuse, illustrating the importance of a coherent whole public service approach to prevention’²⁴.

Although the role of traumatic experiences, such as domestic abuse and other forms of violence against women and girls is recognised as a precursor to suicide within national²⁵ and international²⁶ suicide strategies, this intersection remains under researched, particularly in the UK context. It is clearly of great concern that suicide is not recognised in the most recent violence against women and girls strategy²⁷. A cross cutting national strategy, which integrates what is known about the risk and protective factors for suicidality as it intersects with domestic abuse and other forms of gender based violence, is long overdue.

Against the background of this gap in knowledge, and motivated by acute concern regarding the failure of the criminal justice system to respond to the psychological injury experienced by abused women even when they are driven to take their own lives, this collaborative research was undertaken²⁸.

¹⁶ Department of Health (2017) ‘Preventing Suicide in England: Third Progress Report of the Cross-Government Outcomes Strategy to Save Lives’, London: Department of Health; The World Health Organisation (2014) ‘Preventing suicide: A global Imperative.’

¹⁷ “The recent decline in the suicide rate is likely to be due to the suicide prevention work in England by the government, the NHS, charities, the British Transport Police and others. The National Suicide Prevention Strategy for England has included work to reduce the risk of suicide in high-risk groups. These include young and middle-aged men, people in the care of mental health services, and those in the criminal justice system” - Office for National statistics (2017) ‘Who is Most at Risk of Suicide?’ available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/whomostatriskofsuicide/2017-09-07>

¹⁸ Nock, M.K., Borges, G. Bromet, E.J., Alonso, J., Angermeyer, M., Beautrais, A., Bruffaerts, R., Chiu, W., de Girolamo, G., Gluzman, S., de Graaf, R., Gureje, O., Haro, J., Huang, Y., Karam, E., Kessler, R.C., Lepine, J., Levinson, D., Medina-Mora, M., Ono, Y., Posada-Villa J & Williams, D. (2008) ‘Cross-national prevalence and risk factors for suicidal ideation, plans and attempts.’ The British Journal of Psychiatry 192, 98–105.

¹⁹ The World Health Organisation (2014) ‘Preventing suicide: A global Imperative’. In the UK, data about suicide attempts and self harm is collected in Derby, Manchester and Oxford about those presenting to hospital emergency departments - World Health Organisation (2016) Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm

²⁰ Suicide seems to afflict men and women more equally in low and middle income countries - The World Health Organisation (2014) ‘Preventing suicide: A global Imperative’.

²¹ Welch, S. (2001) ‘A Review of Literature of Epidemiology of Parasuicide in the General Population’ Psychiatric Services 52(3) 368-375; Freeman, A., Mergl, R., Kohls, E., Gusam, R., Arensman, E., Koburger, N., Hegerl, U. & Rummel-Kluge, C. (2017) ‘A Cross National Study on Gender Differences in Suicide Intent’ BMC Psychiatry. 17: 234

²² Kaslow, N., Sherry, A., Bethea, K., Wyckoff, S., Compton, M. Grall, M., Scholl, L., Webb Price, A., Kellermann, A., Thompson, N., Parker (2005) ‘Social Risk and Protective Factors for Suicide Attempts in Low Income African American Men and Women’ Suicide Life Threat Behav. 35(4):400-12.

²³ Gill, A. (2004) ‘A Lethal Code of Honour’ Journal of Community Care 38-40; Colucci, E. & Montesinos, A. (2013) ‘Violence Against Women and Suicide in the Context of Migration: A Review of the Literature and a Call for Action’ 4 Suicidology Online 81-91

²⁴ The ‘2015 Mother and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK’ (MBRRACE-UK) report in Department of Health (2017) ‘Preventing Suicide in England: Third Progress Report of the Cross-Government Outcomes Strategy to Save Lives’, London: Department of Health

²⁵ Department of Health (2012) ‘Preventing suicide in England: A cross-government outcomes strategy to save lives’. London: Department of Health.

²⁶ The World Health Organisation (2014) ‘Preventing suicide: A global Imperative’; World Health Organisation (2016) ‘Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm.’

²⁷ HM Government (March 2016) Ending Violence against Women and Girls Strategy 2016 – 2020.

²⁸ For further discussion of the background to, aims and key findings of this research, see Munro V. & Aitken R. ‘From Hoping to Help: Identifying and Responding to Suicidality Amongst Victims of Domestic Abuse in England and Wales’ (forthcoming), and Munro V. & Aitken R. ‘Adding Insult to Injury? Evaluating Current Criminal Justice Responses to Domestic Abuse-Related Suicide in England and Wales’ (forthcoming) and Aitken R. & Munro V. Examining the links between domestic abuse, psychological injury and suicidality amongst Refuge’s client base (in progress).



Structure of the report

The overwhelmingly gendered nature of domestic abuse is reflected in Refuge's clients who are largely female victims abused by male partners or ex-partners - as a result this report focuses primarily upon them. Refuge works with a smaller number of male and transgender clients, who are impacted by abuse and findings in respect of these clients are also discussed. In the first section of the report, we briefly review the relationship between domestic abuse and female suicidality. In the second section, we present the findings from our analysis of Refuge's national casework database ('IMPACT') which contains data from mainly domestically abused clients. This data gives an indication of the prevalence of suicidality (suicidal thoughts, plans and attempts) amongst this client group, as well as the factors that may be associated with an increase or decrease in this risk. The third section considers these findings alongside the themes arising from interviews with Refuge expert practitioners across a range of its services. These interviews explored interviewees' perceptions about suicidality amongst abuse victims, the processes involved in identifying and assessing suicidal risk and in enabling clients to access effective support. Finally we discuss the results, draw conclusions and make recommendations for policy, practice and the law.

Domestic abuse and suicidality

Experiences of domestic abuse, and other forms of gender based violence, are known to have long term adverse impacts on psychological well being, particularly when these harms are both traumatic and chronic in nature²⁹. Depression, post traumatic stress, anxiety and their behavioural consequences, such as social isolation, substance misuse and self harm (in its broadest sense), are common outcomes of such abuse. These negative consequences are recognised risks for suicide, and its precursor suicidality (suicidal thoughts, plans and attempts) amongst victims of domestic abuse, as well as the general population.

Whilst there is an extensive literature pertaining to suicide in general, it is beyond the scope of this study to review it comprehensively, and we have therefore focused mainly, though not exclusively, upon research that explores the relationship between suicidality and domestic abuse.

In brief, this research indicates that suicidality is more prevalent amongst domestically abused women than their non-abused counterparts³⁰ and that there may be associations between suicidality and the severity or types of harm experienced. Some studies found that the combination of physical and sexual abuse resulted in more suicidality than physical abuse alone³¹, whilst others indicate that cumulative harm involving psychological, physical and sexual abuse increased the risk of suicide³². Research has suggested that suicidality can be mediated by social isolation, depression, distress, hopelessness, PTSD and prior experiences of childhood abuse³³. Indeed, a meta review of thirty seven studies into domestic abuse and suicidality found that PTSD, psychological distress, hopelessness and substance abuse were consistently associated with suicidality, whilst the presence of coping skills and social support served to protect.³⁴ Whether the victim had children³⁵ has also

²⁹ Perkonig, A. Pfister, H., Stein, M.B., Höfler, M., Lieb, R., Maercker, A., Wittchen, H-U (2005) 'Longitudinal Course of Posttraumatic Stress Disorder and Posttraumatic Stress Disorder Symptoms in a Community Sample of Adolescents and Young Adults,' *Am J Psychiatry* 162:1320-1327; Grinage, B. (2003) 'Diagnosis and Management of Post-traumatic Stress Disorder.' *Am Fam Physician*. 68(12):2401-2409.

³⁰ Reviere, S., Farber, E., Tworney, H., Okun, A., Jackson, E. & Zanzville, H. (2017) 'Intimate Partner Violence and Suicidality in Low-Income African American Women: A Multimethod Assessment of Coping Factors.' *Violence Against Women* 13: 1113-1129; Pico-Alfonso, M., Garcia-Linares, I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E. & Martinez, M. (2006) 'The Impact of Physical, Psychological, and Sexual Intimate Male Partner Violence on Women's Mental Health: Depressive Symptoms, Posttraumatic Stress Disorder, State Anxiety and Suicide.' *Journal of Women's Health* 15(5): 599-611.

³¹ Wingood, G. M., DiClemente, R. J., & Raj, A. (2000). 'Adverse consequences of intimate partner abuse among women in non-urban domestic violence shelters.' *American Journal of Preventive Medicine* 19: 270-275.

³² Pico-Alfonso, M. A., Garcia-Linares, M. I., Celda-Navarro, N., Blasco-Ros, C., Echeburua, E., & Martinez, M. (2006) 'The impact of physical, psychological, and sexual intimate male partner violence on women's mental health: Depressive symptoms, posttraumatic stress disorder, state anxiety, and suicide.' *Journal of Women's Health* 15: 599-611.

³³ Kaslow, N. J., Thompson, M. P., Meadows, L. A., Jacobs, D., Gibb, B., & Bornstein, H. (1998) 'Factors that mediate and moderate the link between partner abuse and suicidal behaviour in African American women.' *Journal of Consulting and Clinical Psychology*

66: 533-540; Thompson, M. P., Kaslow, N. J., Kingree, J. B., Puett, R., Thompson, N. J., & Meadows, L. A. (1999). 'Partner abuse and posttraumatic stress disorder as risk factors for suicide attempts in a sample of low-income, inner-city women.' *Journal of Traumatic Stress* 12: 59-72; Houry, D., Kaslow, N. J., & Thompson, M. P. (2005). 'Depressive symptoms in women experiencing intimate partner violence.' *Journal of Interpersonal Violence* 20: 1467-1477.

³⁴ McLaughlin, J., O'Carroll, R. & O'Connor, R. (2012) 'Intimate Partner Abuse and Suicidality: A Systematic Review'. *Clinical Psychology Review* 32: 677-689

³⁵ Welch, S. (2001) 'A Review of Literature of Epidemiology of Parasuicide in the General Population' *Psychiatric Services* 52(3) 368-375.

been identified as protective against suicide, whereas other research highlights the risks for suicidality in women with young babies in particular³⁶.

Most of the existing research into suicidality and domestic abuse has been undertaken outside the UK. The applicability of its findings to our current context, given our diverse communities and particular national health and welfare systems, is uncertain. Some of this research suggests that suicide risk is greater for abused women from ethnic minorities, or amongst abused immigrants and / or refugees, largely as a consequence of cultural practices, concepts of so-called 'honour' and 'shame', and language or community barriers that act to frustrate help seeking behaviours³⁷. It has been suggested that as many as half of all Asian women living in the UK who have attempted suicide or self-harm, have also suffered domestic violence³⁸.

Whilst studies suggest that more than 90% of all suicides in western countries are associated with mental ill health³⁹, this compares with less than half of those in China⁴⁰ where suicide is also understood to be an act of protest or form of escape. This speaks to the importance of social, cultural and political contexts in framing not only understandings of, but also responses to, suicidality. In India, where suicide has replaced maternal disorders as the leading cause of death amongst women aged 15 to 49,⁴¹ with married women reported to be at greater risk of suicide than any other group⁴², it has been acknowledged that *"the main social determinants for suicide in women are interpersonal violence (for example, marital violence) and economic difficulties"*⁴³.

The idea of suicide as an escape from intolerable pain has also been articulated in other contexts - in respect of domestically abused women by Weaver et-al⁴⁴ and by Williams,⁴⁵ who developed understanding about suicidality with his 'cry of pain' hypothesis more generally. According to this theory, suicidal acts (completed or not) are understood as a cry of pain, rather than a cry for help, with suicide more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue nor escape are possible.⁴⁶ It is suggested further that this constellation of feelings and beliefs can lead anyone⁴⁷, irrespective of psychiatric diagnosis, to consider and even enact, suicide. A key finding, observed across a number of studies is that previous suicidal behaviour, regardless of cause, is one of the most robust predictors of future suicide,⁴⁸ with some research indicating that a completed attempt often follows an uncompleted attempt within an average of one year.⁴⁹ Therefore, to dismiss suicidality and attempts as 'merely a cry for help' risks ignoring those who are in the greatest psychological pain and more likely to take their own lives in the future.

³⁶ Knight, M., Tuffnell, D., Kenyon, S., Shakespeare, J., Gray, R., Kurinczuk, J. (2015) Saving Lives, Improving Mothers' Care. Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13

³⁷ Colucci, E. & Montesinos, A. (2013) 'Violence Against Women and Suicide in the Context of Migration: A Review of the Literature and a Call for Action' 4 *Suicidology Online* 81-91; Gill, A. (2004) 'A Lethal Code of Honour' *Journal of Community Care* 38-40; Southall Black Sisters (2011) 'Safe and Sane: A Model of Intervention on Domestic Violence and Mental Health, Suicide and Self-Harm Amongst Black and Minority Ethnic Women', Middlesex: SBS

³⁸ Chantler, K., Burman, E., Batsleer, J. and Bashir, C. (2001) 'Attempted suicide and self-harm: South Asian women' (Manchester: Women's Studies Research Centre, Manchester Metropolitan University); Newham Asian Women's Project and the Newham Inner-City Multi-Fund (1998) 'Growing Up Young, Asian and Female in Britain: A Report on Self-Harm and Suicide'

³⁹ Hong Y and Li, X (2007) 'Correlates of Suicidal Ideation and Attempt Among Female Sex Workers in China.' *Health Care Women Int.* 28(5): 490-505; Phillips MR, Li X, Zhang Y. (2002) 'Suicide rates in China, 1995-99.' *Lancet* 359:835-840.

⁴⁰ Pearson V (2002) 'Liu M. Ling's death: An ethnography of a Chinese woman's suicide.' *Suicide & Life-Threatening Behavior.* 32: 347-358.

⁴¹ Clark L (2013) 'Suicide is number one cause of death among young women in India' available at <http://www.wired.co.uk/article/suicide-women-india>

⁴² Sareen, H. & Trivedi, J.K. (2009) Legal Implications of Suicide Problems Specific to South Asia. *Delhi psychiatry journal* vol. 12 no.1

⁴³ Clark L (2013) 'Suicide is number one cause of death among young women in India' available at <http://www.wired.co.uk/article/suicide-women-india>

⁴⁴ That 'suicidal ideation may represent a desire to escape the intolerable psychological pain' arising from rape related intimate partner violence is posited by Weaver T.L, Allen JA, Hopper E, Maglione M.L, McLaughlin D, McCullough M.A, Jackson M.K, Brewer T. (2007) 'Mediators of suicidal ideation within a sheltered sample of raped and battered women.' *Health Care For Women International* 28(5):478-89.

⁴⁵ Williams, J. M. G. (1997). *The Cry of Pain*. London: Penguin

⁴⁶ Rasmussen, S.A., Fraser, L., Gotz, M., MacHale, S., Mackie, R., Masterton, G., McConachie, S & O'Connor, R.C. (2010) 'Elabo-rating the Cry of Pain model of suicidality: Testing a psychological model in a sample of first-time and repeat self-harm patients.' *British Journal of Clinical Psychology* 49: 15-30.

⁴⁷ "In the vast majority of cases suicide is not abnormal but rather the unfortunate consequence of a complex interaction of risk factors and precipitants. Such factors can lead anyone to take their own life. In a recent study the profile of less than 15 per cent of suicides reflected the traditional picture of suicide - older, male, clinically depressed, with psychiatric history, and so on. In our view, the biomedical model of suicide has failed. It often doesn't take into consideration the complexity of the precipitants". O'Connor R.C. and Sheehy N.P. (2001) *Suicidal Behaviour The Psychologist*. http://www.thepsychologist.org.uk/archive/archive_home.cfm?volumeID_14-editionID_52-ArticleID_166-getfile_getPDF/thepsychologist%5Co'connor.pdf

⁴⁸ World Health Organisation (2016) *Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm*

⁴⁹ Bostwick, M, Pabbati, C., Geske, J., & McKean, A (2016) 'Suicide Attempt as a Risk Factor for Completed Suicide: Even More Lethal Than We Knew.' *Am J Psychiatry* 173(11): 1094-1100.

In summary, findings from studies examining the relationship between suicide and domestic abuse mirror those for suicidal populations in general, indicating that positive thinking, coping skills, the existence of children and social connectedness are likely to be protective factors. Meanwhile, mental health difficulties, isolation, substance misuse, self harm, hopelessness and despair, are frequently posited as risk factors that may increase the risk for suicide attempts and deaths. The 'cry of pain' model of suicidality outlined above may be particularly relevant to the domestically abused population, as it is already well established that many victims experience feelings of defeat and entrapment, alongside beliefs that rescue or escape are impossible; importantly, these feelings are often experienced, irrespective of any recognised mental ill-health diagnosis.

The UK policy and practice responses

Domestic abuse is a cross cutting issue that impacts all areas of life, including health, housing, education and employment. It is also an experience that demands intervention from the criminal justice system in order to protect victims and prevent and punish perpetrators. It affects victims of all backgrounds, ages, and ethnicities - it also affects their children. Domestic abuse is perpetrated against both males and females, although females comprise the overwhelming majority of victims. This gender bias makes domestic abuse a gendered issue and a gendered crime, regardless of the current gender neutral position of government policy and existing, as well as proposed, legislation.

Domestic abuse is a high risk situation, whether this refers to the immediate risk of serious, physical harm from the perpetrator, or to the longer term risk to the victim's psychological well-being, to their life chances in terms of lost opportunities and potential, or significant damage to 'the self'. Domestic abuse is also a risk to life, either through homicide or suicide of the victim. Although domestic abuse is mentioned as a risk factor within the national suicide strategy, neither suicide nor suicidality are mentioned within the Government's most recent violence against women and girls (VAWG) or domestic abuse strategy. It seems clear that any meaningful integration of policy or practice across both spheres is lacking.

Health

Approximately one-third of people who die by suicide in England and Wales had been under specialist mental health services in the year prior to their death, and two-thirds had seen their GPs.⁵⁰ This suggests that many of those at risk of suicide are 'on the radar' of healthcare services; but even so, provision appears to be lacking when those people are most acutely vulnerable as *'most people who make suicide attempts or who die by suicide are not in contact with healthcare services in the month before their attempt or death'*.⁵¹

Given the elevated risk that domestic abuse poses to physical and psychological health, the current response of the health sector is concerning. Research indicates that domestic abuse has not yet been integrated fully into mental health policy as a "major risk factor for women's ill-health"⁵² and that many health professionals still fail to identify victims or facilitate disclosures, despite the existence of national guidelines advocating routine enquiry about domestic abuse⁵³. First responders in health and mental health settings often fail to consider domestic abuse as a precursor when treating suicidal patients, focusing instead on the immediate task of diagnosing and treating manifest psychiatric symptoms⁵⁴. Thus, Trevillion et al recently reported that even when UK mental

⁵⁰ NHS Digital (2016) 'Mental Health and Wellbeing in England: Adult Psychiatric Morbidity Survey 2014' (conducted by NatCen and University of Leicester), available at <https://digital.nhs.uk/catalogue/PUB21748>

⁵¹ The Samaritans - <https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide/suicide-facts-journalists>

⁵² Devries, K., Kiss, L., Watts, C., Yoshihama, M. & Deyessa, N. (2011) 'Violence Against Women in Strongly Associated with Suicide Attempts: Evidence from the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women' *Social Science and Medicine* 73 : 79-86.

⁵³ Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S. & Howard, L. (2014) 'Disclosure of Domestic Violence in Mental Health Settings: A Qualitative Meta-Synthesis.' *International Review of Psychiatry* 26(4): 430-444.

⁵⁴ Rose, D., Trevillion, K., Woodall, A., Morgan, C., Feder, G. & Howard, L. (2010) 'Barriers and Facilitators of Disclosures of Domestic Violence by Mental Health Service Users: A Qualitative Study.' *British Journal of Psychiatry* 198(3) : 189-194.



health professionals were aware of a domestic abuse history, they often responded in ways that not only failed to prioritise women's safety but potentially placed them at further risk of harm, for example, by discussing the abuse in front of partners or inappropriately prescribing marital therapy that prolonged the relationship⁵⁵.

Criminal Justice System

The response of the Criminal Justice System (CJS) to domestic abuse has been in the spotlight since the first HMIC report⁵⁶ highlighted grave inadequacies in the ways in which many police forces handle complaints of domestic abuse, particularly when the complainant is female. Whilst progress has been made in some areas, the most recent HMICFRS report⁵⁷ continues to make for very grim reading, particularly in respect of the fall in arrests made and referrals to the Crown Prosecution Service (CPS). The police are not alone in their need to do better. Although the CPS report increases in successful prosecutions, it clear that the number of domestic abuse perpetrators prosecuted represents the 'tip of an iceberg'⁵⁸. 'Justice' remains an elusive goal for many abused women who find the courage to call the police and then proceed with a prosecution against their perpetrator. The risk to abused women and children in the family courts is also well documented, with many women forced to represent themselves in court, or face their ex-partners who are doing the same, following swingeing cuts to legal aid⁵⁹.

Domestic abuse, of course, involves rape and sexual assault, alongside other forms of victimisation. Concerns exist about the well-documented barriers to credibility experienced by complainants, as well as the ongoing existence of a 'justice gap' in which increased levels of reporting fail to translate into comparable increases in levels of conviction in England and Wales. Recent backlash against policing protocols that start from a presumption of belief of complainants, designed to encourage thorough and appropriate investigative procedures, and a somewhat bolder approach to prosecutorial decision-making in recognition of an ongoing attrition problem, illustrate the precarity of any victim-centred approach in relation to sexual, as well as physical, violence.

As discussed above, in the specific context of domestic abuse suicidality, the traditional reluctance of the criminal law to acknowledge non-bodily forms of injury and to focus on rigid classifications grounded in the category of harm or the intentions of the perpetrator in its infliction, rather than its severity from the victim's perspective, has also acted as a potential barrier to justice in individual cases. Recent developments in respect of the classification of complex PTSD and criminalisation of coercive and controlling behaviour have the potential to make some in-roads in this respect, but a perpetrator's liability for suicide will continue to depend upon an assessment of whether a chain of causation between the abusive behaviour and the suicide can be established and remain intact.

In other contexts, criminal doctrine has been willing to take a broad and flexible approach to whether an act remains a 'substantial and operating' cause of death, and while Munro and Shah's re-writing of *R v Dhalilal* argues that the courts are already at liberty to apply this also in respect of domestic abuse suicidality, it is as of yet uncharted legal territory. Though the aim of this Report is not to engage directly with these doctrinal legal questions, by exposing the scale and severity of psychological harm experienced by victims of abuse, highlighting the relationship between domestic abuse and suicidality, and exploring the ways in which suicide can be understood as a reaction to hopelessness, despair and the perceived impossibility of rescue or escape, it provides an important evidence base upon which these questions can be better addressed by the judiciary.

⁵⁵ Trevillion, K., Hughes, B., Feder, G., Borschmann, R., Oram, S. & Howard, L. (2014) 'Disclosure of Domestic Violence in Mental Health Settings: A Qualitative Meta-Synthesis.' *International Review of Psychiatry* 26(4): 430-444.

⁵⁶ Her Majesty's Inspectorate of Constabulary (HMIC) report (2013) 'Everyone's business: Improving the police response to domestic abuse'.

⁵⁷ Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) (2017) 'A progress report on the police re-sponse to domestic abuse'.

⁵⁸ Refuge's comments on CPS annual statistics – <https://www.theguardian.com/society/2014/jul/02/domestic-violence-convictions-record-high>.

⁵⁹ Refuge's comments on cuts to legal aid and its consequences for abused women -<https://www.theguardian.com/society/2017/dec/27/number-of-domestic-violence-victims-without-legal-help-soars>



But, of course, legal responsibilities to victims of domestic abuse do not start and end with the criminal justice process and the punishment of perpetrators. The State has a positive legal obligation to protect its citizens from harm; an obligation made all the more acute by human rights imperatives in respect of inhuman and degrading treatment (Article 3) as well as the right to life (Article 2)⁶⁰. A necessary first step for the State in meeting its obligations in these regards is the implementation of reliable risk assessment measures. A standardised CAADA-DASH⁶¹ risk assessment tool is now routinely used across criminal justice, and other relevant, agencies to determine and measure a victim's immediate risk of further harm from their perpetrator. This process includes a question about depression and suicide. There are concerns, however, about the extent to which these questions are sufficiently nuanced or contextualised within other questions about 'well being' to constitute a valid and reliable assessment of other serious risks faced by the victim, such as self harming or suicidality.

⁶⁰ European Convention on Human Rights

⁶¹ <https://www.cscb-new.co.uk/wp-content/uploads/2015/11/CAADA-DASH-risk-assessment-for-MARAC-agencies.pdf>

Safety, security and moving on

Parliamentary inquiries into domestic violence took place in 1975, 1992 and 2008 and all concluded that refuge provision must be a priority for any government. The Council of Europe and the Home Office Select Committee recommendation is for one family place in refuge per 10,000 population⁶². The UK has always fallen short of this figure, and in recent years women have seen specialist domestic abuse support services cut to the bone - under the current Government "17% of refuges have been forced to close because of funding cuts."⁶³ In consequence they have been turned away from refuges because there is no space available, long waiting lists for counselling or specialist psychological support are routine and victims of domestic abuse move from temporary home to temporary home in a system dominated by private landlords and a pervasive lack of security.

Whilst there is a national strategy for violence against women and girls, localism dominates decision making when it comes to services available for victims, and this can pose difficulties for those who need to cross geographical boundaries to achieve safety. This leads to situations where abused women can only access vital services within their current area - the location where they are at risk⁶⁴.

Another area of concern arises from the government's focus on early intervention and the implied assumption that if we can catch abuse early enough, refuges will only be needed for a minority of victims. This perspective fails to recognise that most abused women remain silent until they have suffered a great deal of harm - 'early' for the services that victims turn to does not necessarily mean 'early' for the victim. Nevertheless there will eventually be a catalyst, and an abused woman will summon the courage to ask for help: when she does, that help needs to be there. That help must not only address immediate risk of harm and the need for safe accommodation, but also the apparently 'less urgent' harms experienced over time, which manifest in the present as psychological injury.

Research aims and methodology

To our knowledge, this study is the first of its kind in the UK, incorporating one of the largest samples internationally. This collaborative research between Refuge and the University of Warwick aimed to investigate the links between domestic violence and suicide in order to help fill gaps in knowledge about factors that contribute to or mitigate against the development of suicidality in victims of domestic abuse. Our goal was to use this information to inform best practice interventions with this client group. We also hoped to inform current policy and practice in the field, particularly, law, health and social care, making positive recommendations for change.

Methods

Following the literature review, a mixed methods approach was used to explore suicidality amongst Refuge's clients. This approach utilised quantitative (and narrative where appropriate) data gathered by Refuge during the routine casework of its staff and stored on its unique database IMPACT.

We also carried out 20 semi-structured interviews with a self selecting group of Refuge's frontline staff, which were transcribed and analysed using computer assisted qualitative data analysis software (NVIVO)⁶⁵. We had planned to interview professionals from other sectors, including the CPS, police and health but were unsuccessful in recruiting any participants in the required timescales, despite making repeated efforts over a period of months.

⁶² Kelly, L. and Dubois, L. (2008) 'Combating violence against women: minimum standards for support services.' Directorate General of Human Rights and Legal Affairs, Council of Europe.

⁶³ Julie Cooper MP for Burnely - <https://hansard.parliament.uk/Commons/2016-05-11/debates/16051141000001/DomesticViolenceRefuges>

⁶⁴ Julie Cooper MP for Burnely - <https://hansard.parliament.uk/Commons/2016-05-11/debates/16051141000001/DomesticViolenceRefuges>

⁶⁵ <http://www.qsrinternational.com/nvivo/what-is-nvivo>



SECTION 2

Analysis of Refuge's casework data

The quantitative element of the research relies upon information stored on Refuge's IMPACT database, which was constructed and is utilised for casework purposes. It is important to recognise that IMPACT is not a bespoke research tool and the sample we drew from is a largely homogenous group of traumatised victims of abuse. As such, 86% scored above cut off for clinical concern (a score of 11) on the CORE-10 measure of psychological distress and 83% confirmed feeling despairing and hopeless - a key determinant for suicidality. Nevertheless, we were able to identify correlations with, and potential predictors for, suicidality within the sample which we believe make an important contribution to the growing body of research in the field; these findings are presented below.

Prior to the start of this study, IMPACT data was extracted by Refuge's data analyst and exported into EXCEL. The database contained information on all clients who had interacted with Refuge between April 2015 and March 2017, and originally included more than 8,000 individual case files. The first author exported the data into SPSS⁶⁶, then transformed, recoded and cleaned the data ready for analysis. Changes made to the original document by the first author were checked by the second author and a Ph.D student to ensure accuracy and consistency. After cleaning and re-organising the data for the purposes of analysis using SPSS, we were able to utilise data from a

core group of 3519 clients who were (i) aged over 18 years old, (ii) had completed all questions on the CORE-10 measure of psychological distress, and (iii) had provided a history of abuse to their caseworker.

The IMPACT database contains a wide variety of information relevant to this inquiry, including demographic details, information about a client's history of abuse, the presence of additional or complex needs, as well as responses to a standardised risk assessment tool (CAADA-DASH) that we were able to use. This risk assessment tool is utilised across a range of agencies to provide a consistent basis for identifying high risk victims in domestic abuse contexts. IMPACT also holds clients' responses to the CORE-10 questionnaire, which is a brief screening tool designed to measure psychological distress and is derived from the more detailed CORE-OM⁶⁷.

Although many of these clients had completed the CAADA-DASH risk assessment, only 1379 of our core sample had responded to all items presented and even here, responses to the final question – which asks about whether the perpetrator had ever been in trouble with the police before or had a criminal history - were missing due to an omission in initial extraction of the data from IMPACT. Thus, where we refer to overall risk assessment scores below, our analysis pertains only to this smaller subgroup, but we draw upon the larger client base when analysing risk assessment questions individually. It also worth noting that whilst questions on depression and suicide are combined in the original CAADA-DASH risk assessment tool, these are presented as distinct questions in Refuge's version, which has enabled us to provide a more clear-sighted analysis of client responses on these key items than would otherwise have been the case.

⁶⁶ SPSS (Statistical Package for the Social Sciences) is computer software designed to analyse quantitative data.

⁶⁷ Clinical Outcomes in Routine Evaluation - <http://www.mhtu.co.uk/outcome-monitoring/outcome-core-10-manual.pdf>

Results – Demographic Information

Gender

The vast majority of clients in the sample (97.5%; n3432) were female. 2.4% (n84) were men, 2 were transgender and there was 1 inter-sex client. The mean age of the women was 34.72 years (SD = 10.31; Range = 18 – 87 years) and the mean age of the men was 42.42 years (SD = 16.30; Range = 18 – 85 years).

Ethnicity

The majority of clients came from a white British background and made up almost half of the sample (48.5%, n1708). The next most populous group (16.7%, n588) had either a black British or African or Caribbean background - they made up just over 19.3% of clients when combined with those of dual black heritage (n679). Clients of South Asian background made up 12.6% of clients (n443) - this included a small number (0.3%, n11) of clients with mixed South Asian heritage. Those from Eastern Europe made up 7.5% (n265) of our sample, followed by clients of an unspecified white background (5.1%, n178).

Table 1 Ethnicity

	N
White British	1708
Black British, Africa or Carribean	586
South Asian, including British Asian	432
Eastern European	230
Unspecified white background (Including European)	178
Dual heritage black	93
Unspecified dual heritage	57
East European Roma	35
Chinese and south east Asian	33
Irish	30
Dual heritage south Asian	11
Latin American	3
Total	3449
Missing data	70
Total cases	3519



Sexual orientation, gender and abuse.

Of the 3437 clients for whom sexual orientation was recorded, the majority were heterosexual females (95.57%), followed by heterosexual males (2.03%); bisexual females (1.01%) and gay females (0.9%). The remainder comprised gay males (0.32%), bisexual males (0.058%), one intersex client who confirmed as gay (0.029%) and two transgender clients who described themselves as bisexual (0.029%) and heterosexual (0.029%) respectively.

Who is abusing whom?

Of the 3514 clients for whom information about perpetrator gender was recorded, the overwhelming majority confirmed they had been abused by a male (96.4%). Female victims accounted for 98.7% of the abuse perpetrated by males, followed by other males (1.21%), intersex and transgender (0.88%) clients. Abuse perpetrated by males and females combined affected 0.5% of victims, all of whom were female. Transgender perpetrators, who also abused females only, made up 0.1% of those recorded for this core group of clients. Females made up 3.1% (n109) of the perpetrators recorded, with other females making up 60% of their victims and male victims accounting for the remaining 40%.

Male partners or ex-partners were by far the most common perpetrators, accounting for 84.1% (n2938) of the 3,494 cases in which both the gender of, and relationship to, the perpetrator was recorded. The next most common category of perpetrators were 'relatives' (8.27%, n289) who were identified as females (n50), males (n222) and both sexes acting together (n17). Females were their sole victims.

A small percentage of clients were abused by more than one person - n338 (9.6%) females and 6 (1.7%) males. The majority of perpetrators in this category were male (n323).

Experiences of abuse

Experiences of physical abuse were recorded for all 3519 clients. Across our sample, prevalence and patterns in respect of types of abuse suffered were broadly consistent irrespective of the gender of the victim. Here 74% (n2524) of female clients reported being physically abused, compared with 73% (n61) of male clients. Most commonly, clients were pushed, pulled, punched, slapped, strangled and restrained. The remainder were kicked, had objects thrown at them, injured with a weapon, suffocated, bitten, stabbed, burnt and shot. Clients reported more than one form of abuse.

Table 2 Physical abuse

Client experiences of physical abuse	N	%
Any physical abuse	2586	73.5
pushed/pulled	1691	48
Punched	1166	33.1
Slapped	1049	29.8
Strangled	1011	28.7
Restrained	961	27.3
Kicked	598	17
Injured with a weapon (not knife/gun)	348	9.9
Suffocated	225	6.4
Bitten	115	3.26
Burnt	69	1.96
Stabbed	63	1.8
Enforced termination	20	0.56
Shot	14	0.4
(3519=100%)		

Sexual abuse

Experiences of sexual abuse were recorded for 1016 (29.6%) females and 26 (30%) males. The most common form of abuse reported was forced vaginal intercourse or rape. Again, clients reported more than one form of abuse.

Table 3 Sexual abuse

Client experiences of sexual abuse	N	%
Any sexual abuse	1044	29.6
Forced vaginal intercourse	486	13.8
Uncomfortable sexual comments	314	8.92
Uncomfortable sexual touching	286	8.12
Attempted rape	172	4.9
Sexual abuse whilst asleep or unconscious	100	2.84
Forced anal intercourse	84	2.4
Forced oral penetration	72	2.04
Sexual imaged taken/shared without consent	35	1
Enforced prostitution	15	0.42
Witnessed sexual abuse of another	2	0.05
(3519=100%)		

Psychological abuse and threats of harm

Experiences of psychological abuse and threats of harm were recorded for n3016 (87.87%) of female clients and n72 (85.7%) of male clients. Controlling and intimidating behaviour were most common, followed by isolation of the victim and threats of harm.

Table 4 Psychological abuse and threats of harm

Client experiences of psychological abuse and threats	N	%
Any psychological abuse	3088	87.7
Controlled	2341	66.52
Intimidated	2094	59.5
Threat of harm to client	1231	34.98
Isolation	1039	29.52
Harassment	911	25.88
Stalking	687	19.52
Threats to harm client with weapon	412	11.7
Threats to harm family member	288	8.18
Threats to kill family member with weapon	110	3.12
Threats to harm an animal or pet	73	2.07
Coerced into committing criminal acts	39	1.1
Threats to kill animal or pet	27	0.76
Threats to kill animal or pet using a weapon	18	0.51
Threats to harm animal or pet using a weapon	13	0.37
Threats to harm family member using a weapon	4	0.11
(3519 = 100%)		

Financial abuse

Experiences of financial abuse were recorded for 1205 clients, with the perpetrator controlling the household finances reported most frequently.

Table 5 Financial abuse

Client experiences of financial abuse	N	%
Any financial abuse	1205	34.2
Perpetrator controlling household finances	893	25.4
Prevented from working	279	7.9
Prevented from accessing education	121	3.4
Forced to obtain credit in own name	3.8	0.1
(3519 = 100%)		

Additional forms of abuse

Information was recorded about a smaller number of women (n201) with regard to experiences of female genital mutilation (FGM), so-called 'honour' based violence, forced marriage, trafficking and modern slavery. So-called 'honour' based violence was recorded most frequently; this overlapped with other forms of abuse to the extent that 38 clients who experienced forced marriage also suffered so-called 'honour' based violence, as did five of those who suffered FGM and nine of the trafficked/modern slavery victims.

Table 6 Additional forms of abuse

	N	%
So called honour based violence	147	4.1
Forced marriage	54	1.53
Trafficking and modern slavery	38	1.08
Female genital mutilation	16	0.45
(3519=100%)		

Suicidality amongst Refuge's client group

Information relating to suicidality of clients was recorded on IMPACT in three main ways – (i) a direct question about currently feeling suicidal as part of the risk assessment (CAADA-DASH); (ii) a question in the CORE-10 questionnaire which asks clients if they have made plans to end their lives, and (iii) narrative comments recorded by some caseworkers in relation to suicidality as part of the process of carrying out a risk assessment. Through further analysis of this narrative data, we were able to create additional variables, covering experiences not otherwise captured in the CORE-10 or risk assessment, which related specifically to feeling suicidal recently, or in the past, as well as any previous suicide attempts.

As no direct and structured questions about suicidality across a broader timescale were asked during the risk or intake assessment processes, it is likely that clients did not spontaneously disclose if they had felt suicidal in the past or made an attempt to end their lives. There are also, of course, many reasons why clients might find it difficult to disclose current feelings of suicidality or plans to take their own lives, even when specifically asked. Stigma and shame associated with suicidality, a lack of trust and confidence with the case worker at the initial intake or risk assessment stage; concerns that such disclosure might restrict their access to a refuge, or services; fears about entitlement to retain custody of their children, or of compulsory mental health intervention are all possible reasons to keep such information private. Thus, it is more than likely that our findings below under-estimate the full scale of suicidality in this domestically abused population.

Our analysis revealed a concerning picture of suicidality in the lives of this sample of Refuge's clients. Twenty four percent (n854) responded positively to any measure of suicidality (i.e. that they were feeling suicidal now or recently, had felt suicidal in the past, made plans to end their life, or made a suicide attempt), and some responded positively to more than one question. When gender was considered proportionally, 24% (n825) of females in the sample expressed some form of suicidality, compared with 33.3% (n28) males.

Table 7 Prevalence of suicidality

Client experiences of suicidality	N	%
Suicidality at any time	854	24.2
Suicidality now or recently	664	18.9
Suicidality in the past	250	7.1
Made plans to end life	644	18.3
Suicide attempts	108	3.1
(3519 = 100%)		

The majority of these clients (18.9% of the sample, n664) reported they were feeling suicidal either currently or recently, and 18.3% (n644) confirmed during assessment that they had made plans to end their own lives. In addition, 3.1% (n108) declared that they had made an uncompleted suicide attempt either recently or in the past. While the absence of agreed definitions for 'suicidality' and 'attempts', together with a diversity of mechanisms for sampling and analysing data across studies, make reliable assessments difficult, it is clear that this reflects a level of suicidality that is higher than that of the general population⁶⁸.

In order to explore suicidality amongst the client group in this study, we compared those who responded positively to questions about suicide either in the risk assessment or CORE-10, or had provided narrative accounts which indicated a presence of suicidality currently, recently or in the past, with those who did not. A wide range of variables were examined using cross-tabulations, independent t-tests, correlations and binary logistic regression. Variables selected for analysis included gender, age, ethnicity, the presence of children in the family, type and duration of abuse, and the presence and type of complex additional needs such as drug use, alcohol or disabilities, no recourse to public funds, so-called 'honour' based violence and forced marriage. We also explored associations between suicidality and individual items - for example, whether the client was frightened, afraid of further violence, or feeling isolated or depressed - and total scores on the CORE-10 and the CAADA-DASH (removing dedicated suicide questions within these during analysis in order to avoid artificially inflating correlations).

Suicidality and age, gender or ethnicity

We did not find suicidality in general to be significantly correlated with age, gender or ethnicity. However, we did observe a correlation with suicidality amongst those who described experiencing so-called 'honour' based violence ($r = .054, p < .01$). More than half of these clients (56.5%) were from South Asian backgrounds (n82/145), representing 22.7% of all South Asian clients in the sample.

Suicidality and experiences of abuse

We found positive correlations with suicidality across many of the specific forms of abuse documented. For physical abuse, we observed correlations with suicidality and being strangled, ($r = .079, p < .01$), kicked ($r = .079, p < .01$), or suffocated ($r = .074, p < .01$). The strongest correlations for sexual abuse were found for 'any report of sexual abuse' ($r = .163, p < .01$) and for enforced prostitution ($r = .098, p < .01$). In respect of psychological abuse, isolation from family and friends ($r = .107, p < .01$) and experiencing threats of harm with a weapon ($r = .109, p < .01$) and threats to kill a family member ($r = .092, p < .01$), were correlated with suicidality. 'Any report of financial abuse' was also correlated with suicidality at ($r = .092, p < .01$)

⁶⁸ Cross-national research has estimated lifetime prevalence for suicidal ideation, plans and attempts to be 9.2%, 3.1% and 2.7% (S.E. = 0.1) respectively - Nock, M.K., Borges, G., Bromet, E.J., Alonso, J., Angermeyer, M., Beautrais, A., Bruffaerts, R., Chiu, W., de Girolamo, G., Gluzman, S., de Graaf, R., Gureje, O., Haro, J., Huang, Y., Karam, E., Kessler, R.C., Lepine, J., Levinson, D., Me-dina-Mora, M., Ono, Y., Posada-Villa J & Williams, D. (2008) 'Cross-national prevalence and risk factors for suicidal ideation, plans and attempts.' The British Journal of Psychiatry 192, 98–105.

Concurrent abuse

When the cumulative effect for abuse was explored, that is, when victims had experienced multiple forms of the same type of abuse, we found the strength of the correlation with suicidality increased. This was particularly so for cumulative sexual abuse ($r = .179, p < .01$), but it was also observed in relation to cumulative serious assault ($r = .111, p < .01$) and cumulative psychological abuse ($r = .111, p < .01$).

Table 8 Correlations for suicidality and experiences of cumulative abuse

Cumulative sexual abuse (all)	.179 **
Cumulative psychological abuse and threats of harm to client	.111 *
Cumulative serious physical assaults ¹	.111 **
Cumulative physical abuse (all serious and non serious)	.107 **
Abused by more than one person	.111 **

** correlation is significant at $p < 0.01$ level (2 tailed)

¹ serious assaults includes burn, suffocate, strangle, stab, injure with weapon (not knife or gun) and shot

Correlations with suicidality were observed for duration of abuse across all types⁶⁹, but especially when this was physical ($r = .104, p < .01$) or financial ($r = .097, p < .01$) in nature. For example, the mean duration of physical abuse for those in the suicidal group was 4.31 years compared with 2.96 years for those in the non-suicidal group. In addition, clients who had been abused by more than one person were more likely than those who had been abused by a single perpetrator to express suicidality: and this is reflected in the fact that a much greater proportion of clients within the suicidal group - 15.6% (n133/854) - had been abused by more than one person, compared with 8% (n211/2665) of the non-suicidal group.

Suicidality and service area

IMPACT holds client case files across all service areas. This includes refuge based accommodation, independent domestic violence advocacy, outreach and resettlement services and independent sexual violence services. The data suggests that those using sexual violence services (33%, n87/264) and those in refuge accommodation (31.6%, n292/923) were more likely to demonstrate suicidality than clients in other services. Suicidality was recorded as occurring in 23% (n145/628) of outreach and 24% (n330/1373) of IDVA clients.

Table 9 Suicidality by service area

Service type:		Outreach	Refuge	IDVA	ISVA	Total
Suicidality	No	483	631	1373	177	2665
	Yes	145	292	330	87	853
Total		628	923	1703	264	3518

⁶⁹ Correlations for suicidality and duration of sexual abuse ($r = .079, p < .01$) and suicidality and duration of psychological abuse ($r = .069, p < .01$).

Suicidality and psychological distress

Domestic abuse is a highly traumatising situation so it is not surprising that almost 86% (n3022) of our sample scored above the cut off (n11) for clinical concern on the CORE-10 measure of psychological distress. Notwithstanding the fact that around 83% (n2920/3519) of the sample confirmed feeling despairing or hopeless (a key determinant for suicidality) we were able to observe a highly significant statistical difference for CORE-10 total scores between the suicidal and non-suicidal client groups⁷⁰. The average mean score for suicidal clients was 7.293 points greater than for non-suicidal clients ($M = 24.10$ vs $M = 16.81$). Scores between 20-25 fall within the moderately severe range of distress and those between 25-40 indicate severe psychological distress. 49% (n419/854) of the suicidal group scored within the severe range, compared with only 14% (n370/2665) of the non-suicidal group.

Given that we used responses to the CORE-10 question which asks whether the respondent had made plans to end their life to inform our additional suicide variable, we removed this from any analysis involving associations with suicidality. We formed a CORE-10 (9 item) total score variable to determine correlations with suicidality instead.

Suicidality was also correlated significantly to clients' individual responses to questions on the CORE-10 measure of psychological distress. Feeling despairing or hopeless, experiencing panic, terror or past trauma, were the most highly correlated with suicidality. Reflecting this association, comparisons of the suicidal and non-suicidal groups directly shows that 96% (n821/854) of those in the suicidal group felt despairing or hopeless, compared with 79% (n2099/2665) of those in the non-suicidal group.

Table 10 Correlations for suicidality and psychological distress as measured by the CORE-10

I have felt tense, anxious or nervous	.213 **
I have felt I have someone to turn to for support when needed	.167 **
I have felt able to cope when things go wrong	.249 **
Talking to people has felt too much for me	.206 **
I have felt panic or terror	.282 **
I have had difficulty getting to sleep or staying asleep	.253 **
I have felt despairing or hopeless	.327 **
I have felt unhappy	.259 **
Unwanted images or memories have been distressing me	.297 **
Total CORE-10 score (minus made plans to end life question)	.370 **

** Correlation is significant at the $p < 0.01$ level (2 tailed)

⁷⁰ A mean difference of -7.293 emerged for core 10 score between the suicidal and non suicidal groups, ($M = 24.10$ ($SD=6.11$) vs $M = 16.81$ ($SD=6.66$), $t(-28.387) = 3517, p < .001$).

Suicidality and risk

Although suicidality was correlated with total risk assessment scores ($r = .210, p < .01$) we found only a 2 point mean score difference between the suicidal and non-suicidal groups for the risk assessment measure⁷¹. This difference was a 'statistically significant' finding, but in the context of such a large sample (n1379), on a risk measure of 28 items, it is not clear that this necessarily reflects a meaningful difference in practical terms. What is clear is that suicidality was correlated with many of the individual items taken from this measure, as well as with other complex needs identified by caseworkers. The strongest correlations were observed between suicidality and feelings of depression ($r = .304, p < .01$), mental health issues ($r = .195, p < .01$) and isolation ($r = .169, p < .01$). Feelings of depression were reported by 60% of clients (n1859/3112) who responded to this question on the risk assessment, but depression was particularly prevalent amongst those in the suicidal group, with 86% (n654/761) reporting feeling depressed compared with 51% (n1205/2351) in the non-suicidal group. Furthermore, 65% (n=503/778) of those in the suicidal group reported that they felt isolated from family and friends, compared with 45% (n=1088/2419) of non-suicidal clients. Overall, experiences of isolation were reported by 50% of those (n1591/3196) who responded to this question on the risk assessment.

Taking a broader view of risk than the CAADA-DASH, Refuge asks further questions regarding additional difficulties faced by clients, such as alcohol and drug issues and any disabilities. Significant correlations between suicidality and additional needs in relation to both drug use ($r = .209, p < .01$) and alcohol ($r = .144, p < .01$) were identified in our analysis. Indeed, 13.2% (n107/811) of those in the suicidal group were recorded as experiencing additional needs related to alcohol, compared with 4.7% (n122/2570) of those in the non-suicidal group. This association increased for those recorded as having additional needs related to drugs - 33% (n260/790) of suicidal clients fell into this category, compared with 14% (n348/2501) of non-suicidal clients.

Table 11 Correlations for suicidality and risk assessment

Has the current incident resulted in injury?	.076 **
Are you very frightened?	.087 **
What are you afraid of? Is it further injury or violence?	.105 **
Do you feel isolated from family/friends?	.169 **
Are you feeling depressed? (amended from caada-dash)	.304 **
Have you separated or tried to separate from abuser within the past year?	.051 **
Is there conflict over child contact?	-.113 **
Does (abuser) constantly text, call, contact, stalk or harass you?	.046 **
Are you pregnant or have you recently had a baby (within last 18 months)?	-.097 **
Is the abuse happening more often?	.094 **
Is the abuse getting worse?	.081 **
Does (abuser) try to control everything you do and/or are they excessively jealous?	.079 **
Has (abuser) ever used weapons or objects to hurt you?	.055 **
Has (abuser) threatened to kill you and you believed them (amended from Caada- Dash)?	.072 **
Has (abuser) threatened to kill someone else and you believed them (amended from Caada-Dash)?	.095 **
Has (abuser) ever attempted to strangle, choke, suffocate, drown you?	.089 **
Does (abuser) do or say things of a sexual nature that make you feel bad or that physically hurt you or someone else? *	.169 **
Is there any other person who has threatened you or who you are afraid of?	.120 **
Do you know if (abuser) has hurt anyone else?	.071 **
Has (abuser) ever mistreated an animal or the family pet?	.069 **
Are there any financial issues?	.084 **
Has (abuser) had problems in the past year with drugs (prescription or other), alcohol or mental health leading to problems in leading a normal life?	.017
Has abuser ever attempted or threatened suicide?	.050 **
Has (abuser) ever broken bail/an injunction and/or formal agreement for when they can see you and/or the children?	.011
Total risk assessment score (all items completed by subsample n1379)	.210 **

** Correlations significant at the $p < 0.01$ level (2 tailed)

* item not entered in further analyses due to difficulties disentangling the nature of harm to client or to 'someone' else - any associations found could not be explained to a satisfactory degree.

⁷¹ M = 11.55 (SD=3.85) vs M = 9.55 (SD=3.96), $t(-7.95) = 1377, = p < .001$ – note that the total risk assessment score was calculated minus the suicide question.



Suicidality and protective factors

Children

Sixty eight percent of the sample (n2409) stated they had children. 4158 of these children were recorded as living with the client at the time of involvement with Refuge, and a further 554 were living elsewhere. In circumstances where children were living with clients, n2165 females accounted for 97.52% of carers and n26 males made up the remaining 2.38%. Almost 22% (n696) of female clients said they were either pregnant or had given birth in the past eighteen months.

The existence of children appeared to be a positive and protective factor for many clients (negatively correlated with suicidality at $r = -.211$ $p < .01$). When clients were asked by caseworkers, as part of the risk assessment, whether they felt suicidal, more than half of those who offered additional information (56%, n119/222) stated that their children were the primary reason they did not act on suicidal thoughts. As one might expect, the absence of children appeared to be a risk for suicidality, with 37.5% (n417/1110) of those without children demonstrating suicidality, compared with 18% (n437/2409) of those with children.

Escape and support

Narrative data from IMPACT, recorded by a small number of caseworkers, indicated that the act of escaping the abuse / abuser (16.2%, n36/222) was also a key protective factor. This gives some support to the 'cry of pain' theory of suicide in which entrapment and defeat, without hope of rescue or escape, can be powerful drivers for suicide⁷². Help from a professional was the next most common reason given in reducing suicidality, which was cited in 11.7% (n26/222) of narrative accounts available. Whilst this information is interesting and relevant, low numbers and inconsistently gathered data means we cannot say whether it is representative of the larger sample - more research with higher numbers of domestic abuse clients is needed.

⁷² Williams, J. M. G. (1997). *The Cry of Pain*. London: Penguin; Williams, J.M.G. (2014) *Cry of Pain: Understanding Suicide and the Suicidal Mind*; Piatkus

Potential predictors for suicidality

Using our dichotomous yes / no suicidality question as the dependent variable for a binary logistic regression analysis, we sought potential predictors of suicidality amongst the most highly correlated and / or statistically significant variables described above. We ran each of these individually and then in combination to test various predictive models. We were interested in the predictive power of types of abuse experience, particularly cumulative harms which were more highly correlated with suicidality when combined than when considered singly. We were also interested in testing the role of psychological distress using items from the CORE-10 and its total score, together with items from the risk assessment, such as depression and social isolation and complex needs such as alcohol and drug misuse. We ran regression models for demographic profile variables, including whether or not the client had children, abuse experiences and indicators of psychological distress until we developed the final model seen below. With suicidality (yes / no) entered as the outcome variable, our final model predicted 37.4% of correct responses for membership of the suicidal group, 93.5% of correct responses for the non-suicidal group and 80.1% of correct responses overall. The table below shows the odds ratios (and 95% confidence intervals) of belonging to the suicidal group and the significance levels of these predictors for the variables in the model.

Table 12 Potential predictors for suicidality

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. For Exp(B) Lower	Upper
Complex needs re drugs	0.468	0.117	16.066	1	0.000	1.596	1.27	2.007
Client does not have children	0.629	0.103	37.56	1	0.000	1.876	1.534	2.293
Feeling depressed (q5 risk assessment)	1.253	0.127	97.283	1	0.000	3.5	2.729	4.49
Complex needs re alcohol	0.523	0.175	8.912	1	0.003	1.688	1.197	2.38
Cumulative sexual abuse	0.229	0.036	39.886	1	0.000	1.257	1.171	1.349
Feels despairing or hopeless (core10)	0.527	0.047	124.049	1	0.000	1.694	1.544	1.858
Unable to cope (core10)	0.25	0.053	22.027	1	0.000	1.284	1.156	1.425
Constant	-4.272	0.182	550.497	1	0.000	0.014		

This model appears to discriminate between those who fall within the suicidal group and those who do not, with some degree of accuracy. The most significant predictor for suicidality was 'feeling depressed' (odds ratio = 3.50, 95% CI = 2.729 - 4.490, $p < .001$), followed by the absence of children (odds ratio = 1.876, 95% CI = 1.534 - 2.293, $p < .001$), and then feeling despairing or hopeless (odds ratio = 1.694, 95% CI = 1.544 - 1.858, $p < .001$).

The odds of belonging to the suicidal group for those who feel depressed is 3.5 times greater than for those who are not depressed⁷³. The odds of belonging to the suicidal group for clients without children is 1.87 times greater than for those with children⁷⁴. The odds of belonging to the suicidal group for those who feel despairing or hopeless is 1.69 times greater than for those who do not feel as such⁷⁵.

The presence of complex needs such as experiencing difficulties with drugs (odds ratio = 1.596, 95% CI = 1.270 - 2.007, $p < .001$) and difficulties with alcohol (odds ratio = 1.688, 95% CI = 1.197 - 2.380, $p < .003$) also appeared to be predictors for suicidality. The odds of belonging to the suicidal group for those experiencing difficulties with drugs is 1.59 times greater than for those who do not experience problems with drugs.⁷⁶ The odds of belonging to the suicidal group for those experiencing alcohol difficulties is 1.68 times greater than for those who do not experience problems with alcohol.⁷⁷

In addition, the odds of belonging to the suicidal group for those who say they cannot cope is 1.28 times greater than for those who say they can.

For every additional type of sexual abuse experienced, the odds of belonging to the suicidal group increase by a factor of 1.25.

Discussion of results

Despite the fact that the data this research relied upon was not bespoke, in the sense of being designed to answer particular research questions, it reveals a striking picture of the scale of suicidality amongst victims of domestic abuse in England and Wales, and gives some indication as to the types of experiences and circumstances that may increase or decrease a victim's susceptibility to suicidality.

Refuge's IMPACT database reveals a majority female population, who have experienced a range of physical, psychological, sexual and financial abuses, both individually and in combination, from mainly male partners or ex-partners. Serious physical assaults and cumulative sexual abuse were more highly correlated with suicidality than other forms of abuse, which confirms Refuge practitioner perspectives described in detail below.

Additional complex needs in terms of drug and alcohol issues, as well as social factors, such as isolation, were also associated with suicidality and again this reflects what is known about risks for suicidality in general.

It is not possible given the data available to comment on whether or not this sample of domestically abused victims might meet criteria for a psychiatric diagnosis: but we can assert, with some conviction, that the majority of them were psychologically distressed and that it would be appropriate to describe those who fell within our suicidal group, as psychologically *injured*.

Feelings of despair and hopelessness, as well many other indicators of psychological distress assessed by the CORE-10, appear to be the norm rather than the exception for these clients, and so the significant correlations we found between suicidality and psychological distress on this measure were unsurprising. Indeed, correlations between the CORE-10, its individual items and suicidality were the strongest that we observed across all analyses of this type, and there was a highly significant statistical difference in terms of CORE-10 total score between those in the suicidal group and those in the non-suicidal group.

⁷³ There is a 77.7% probability that those who are depressed will belong to the suicidal group.

⁷⁴ There is a 65% probability of those without children belonging to the suicidal group.

⁷⁵ There is a 62.8% probability that those who feel despairing or hopeless will belong to the suicidal group.

⁷⁶ There is a 61.3% probability that those experiencing difficulties with drugs will belong to the suicidal group.

⁷⁷ There is a 62.6% probability that those experiencing alcohol difficulties will belong to the suicidal group.



Depression is a well known precursor of suicidality, so we were not surprised when ‘feeling depressed’ emerged as the most significant predictor for suicidality in our binary regression model. This finding does not suggest that ‘feeling depressed’ is more likely to result in suicidality than feeling ‘despairing or hopeless’ *in general*, but simply that, in this context, where the vast majority of clients (83%) confirm feeling despairing or hopeless, ‘feeling depressed’ (which was true for only 60% of all clients) appeared to do a better job at discriminating those who were suicidal from those who were not.

We were aware that *“the presence of children in the household may serve as a protective factor”*⁷⁸ and this was borne out in the narrative data where some women seemed to suggest having children prevented them from acting upon thoughts of self harm. We also considered and highlighted the converse, however: that childlessness may be a risk for suicidality, in that the connectedness that comes from having ‘family’, even in the face of adversity, was lacking for these clients.

Evidence of such a high prevalence of suicidality uncovered in this analysis of IMPACT data is in itself a matter for grave concern; and this is particularly so when – due to inconsistencies in recording and potential barriers or delays to disclosure – it is highly likely that these figures under-estimate the true scale of suicidality within this domestically abused population.

The fact that we were not able to engage with domestic abuse clients (both male and female) directly leaves a gap in terms of survivor perspectives and this is a limitation of the work. We were, however, able to explore the complex needs of this client group with Refuge caseworkers and we triangulated our analysis of the case file data with a series of semi-structured interviews described in the following section.

⁷⁸ Welch, S. (2001) ‘A Review of Literature of Epidemiology of Parasuicide in the General Population’ *Psychiatric Services* 52(3) 368-375.

SECTION 3

Fieldwork Interviews

Although we had planned to interview professionals across a range of services known to interact with domestically abused clients, we were unsuccessful in recruiting a meaningful number from any field except Refuge’s own staff team. A total of 20 Refuge expert practitioners took part in interviews, the majority of whom had extensive experience of work in the domestic abuse and violence against women sector. Participants were engaged in a variety of roles including providing support (over the phone and face-to-face) to community-based clients, undertaking case work with clients in refuges, coordinating multi-agency risk assessment conferences for high risk clients, providing domestic abuse training to professionals, and / or representing Refuge at a range of meetings, both locally and nationally. Interviews lasted between 45-80 minutes and were recorded, transcribed and then coded thematically between the researchers on a grounded basis using NVIVO.

Key findings from these interviews confirm the picture presented by the IMPACT data in terms of the prevalence and patterns of suicidality amongst Refuge’s clients: they also reveal challenges in terms of identifying and responding appropriately to this vulnerable population.

The (Perceived) Scale of Suicidality

The interview data confirms that suicidality is far from uncommon amongst Refuge’s clients. An Independent Domestic Violence Advocate, who had reviewed a sample of 100 of her cases prior to the interview, reported that 21 involved a client with suicidal ideation, 15 of whom had well-developed plans in respect of how they would end their lives, and 5 of whom had made an attempt to do so. Others estimated suicidality in the region of 40%-50%, and one suggested that as many as 80% of her clients had reported feeling suicidal at some point. One stated: *“it’s scary the amount of clients that will say that they are thinking about, thinking about ending their life”* (Interview 1).

A number of respondents expressed the view that rates of suicidality are “extremely” or “disproportionately high” (Interview 10) amongst clients in Refuge’s Independent Sexual Violence Advocacy (ISVA) Service. This reflects findings from the analysis of IMPACT data, which suggests that those using sexual violence services are more likely to express suicidality⁷⁹. It also supports the finding that of all the forms of abuse reported, cumulative sexual abuse correlated most highly with suicidality.

Risk and Protective Factors

Several participants stressed that the psychological harm arising from non-physical forms of abuse can be equivalent to, or more harmful than, physical abuse. One Refuge practitioner stated, *“victims will often say I could put up with the punches like that on the face because the bruise is gone in a matter of days but the emotional harassment and controlling is far longer lasting and has more of a detrimental effect on their wellbeing”* (Interview 14). Meanwhile, another observed that: *“the lasting effects, I think, of emotional abuse are so much worse than physical: I have seen some horrific physical and it has affected them, but some of the emotional stuff people have said that’s happened to them, it makes me feel sick, that someone can do that to somebody; and that stays with them, and it’s harder to build somebody back up who’s been emotionally abused than for somebody who’s been physically abused”* (Interview 6).

⁷⁹ Our data suggests that those using sexual violence services (33%, n87/264) and in refuge accommodation (31.6%, n292/923), were more likely to demonstrate suicidality than clients in other services. Suicidality was recorded as occurring in 23% of outreach and 19% of IDVA clients.



Difficulties with alcohol or substance misuse, and the existence of psychological distress or depression, were identified as likely to increase clients' risk for suicidality. Conversely, supportive relationships with family or friends were viewed as protective. As one interviewee told us, *"I think the more people that they have, the less likely my clients have been to do it [attempt suicide], I think the more isolated they are, I think that's when I get more and more concerned as there is nobody to pull them back, there's nobody to link in with"* (Interview 1). A number of respondents identified the experience of being isolated as a key trigger for suicidality. At the same time, however, some interviewees acknowledged a tension in that some strategies, such as relocating clients to a refuge in a different area, though necessary to ensure their safety, may contribute to feelings of isolation, particularly if there are limits on who is able to visit (Interview 3 and 6). Such concerns also need to be off-set against the fact that many women cite the connection with other women as one of the main benefits of living in a refuge - the shared experience and the power of peer to peer learning and support⁸⁰.

The tone and outcome of clients' engagements with statutory agencies – including in the criminal justice system, health, housing, social services, and immigration - were also identified as having an impact upon their suicidality. This perspective is important since it highlights the need to look beyond individual factors, such as psychological ill health or drug / alcohol dependency, when assessing the risk of suicidality and to consider the social, political and economic context in which the abuse occurs. It is important to recognise that the individual, the abuse they experience and the response of agencies they turn to for help all play their part in mediating the relationship between the individual and suicidality – that is, in mitigating or aggravating the risk.

The negative impact that cuts in services and the lack of secure, affordable housing, alongside poverty, can have on Refuge clients' psychological well-being was raised earlier in this report. Interview participants shared these concerns, particularly for clients with insecure immigration status, who often face difficulties accessing housing and the funds to manage daily life. In addition to domestic abuse, these clients may have faced additional trauma in their country of origin, such as war, abduction, or loss of family members - all of which may increase the risk for suicidality.

In respect of the Criminal Justice System, particular triggers for suicidality that were identified by practitioners included clients' anxieties about giving testimony in court, and their disappointment at cases being dropped or convictions not being secured. But it was also noted that even a 'good' CJS result does not necessarily decrease emotional vulnerability, since convictions can impact on family and community relationships in ways that may be perceived as profoundly negative for the client herself. One interviewee recounted a case in which the client *"got a good outcome, her perpetrator was sent to prison but she felt it ruined her life because her family stopped talking to her....and for some people, it's still a hard position because have they lost something in telling the truth?"* (Interview 7). In this context, some stated that withdrawal of services from clients at the end of a court case contribute to feelings of isolation and increase the possibility the client might fall through cracks in service provision (Interview 3), which could in turn exacerbate or promote feelings of suicidality.

The presence of children was cited by many as a factor which protects against suicidality. One respondent commented, *"usually what I find is that, with my clients who mention that they are feeling suicidal, that's what they have to live for is when they have kids, that's their motivation and that's really what stops them, so you ask them if they are having those kinds of thoughts and they say, yeah, but my children, they are the only reason I am living"* (Interview 5). The existence of a religious belief was also raised - as one participant explained, *"a lot of them they'll say, oh it's best if I am not here, but I can't do that because how am I going to*

⁸⁰ This perspective is well accepted by those with experience in the field of woman abuse, particularly the refuge context. <https://www.refuge.org.uk/wp-content/uploads/2018/01/refuge-response-consultation-short-term-supported-accommodation-funding.pdf>; see also Campbell, L. (2012) 'Peer support: reframing the journey from lived experience of domestic violence' available at https://www.avivafamilies.org.nz/resources/file/peer_support_report_final_.pdf

answer to God, how am I going to answer God, you know, how will my burial be, because there are different ideas on whether you can be buried in a certain way" (Interview 17). At the same time, though, participants acknowledged that the existence of children or religious beliefs could both also act to reduce the possibility that a client might disclose suicidal thoughts, often due to fear that social services could remove the children or because such feelings would be met with disapproval by the religious community.

In this respect, participants stressed the importance of building a relationship of trust and reassuring clients that they would not be 'judged' in order to encourage disclosure. As one expert practitioner stated, *"clients find it harder to open up about those things, about what's happening to themselves and how they are feeling. It can be quite difficult to get more information around that. It might be a timing thing or it might be something that you would have to come back to later and speak about when they are kind of out of the situation... it's normally when the relationship has been built up ... that you kind of have more time to talk about that and more space"* (Interview 4). Nevertheless, several IDVA respondents expressed concern that it was becoming increasingly difficult to create the kind of contexts in which such disclosures would be forthcoming: high caseloads supporting 30 - 40 clients in some cases and the increasing tendency to provide phone, rather than face-to-face support, were identified as potential barriers to this process. As one said: *"I've got quite high caseloads so a lot of times once that initial risk assessment is gone, the case will be....I think if we are not working with these victims longer-term, we are not going to get that information from them"* (Interview 1).

Identifying risk

Some participants expressed concern that the CAADA-DASH could become too much of a "tick-box" (Interviews 9 and 15) exercise, capturing information targeted at the priorities of funders / commissioners rather than the needs of clients (Interview 13). Others worried about the extent to which 'scores' generated by risk assessment could be used by statutory agencies as a gate-keeping tool. As one put it, *"when you work with other services, they constantly – they don't understand how we use risk assessments – they focus very much on what was the score, is it MARAC level, and it almost seems like another way to stop someone getting the help they need"* (Interview 16).

Several participants drew attention to 'blindspots,' including the inability of existing tools to capture the complex dynamics of psychological abuse or the self harming behaviours of clients, e.g. 'excessive alcohol or drug use, sleeping rough, or engaging in promiscuous sexual behaviour'. Its tendency to prioritise the risk of harm from perpetrators over the risk the client may pose to herself was also mentioned. One participant remarked, *"we are much more equipped to deal with the risk from the perpetrator than with the risk of harming or self-harming or suicide"* (Interview 17).

Nevertheless, the majority were broadly positive about the ability of the risk assessment tool to provide a "backbone" (Interview 16) to safety planning, whilst others saw advantages in its function as a "universal tool" which made it easier for them to advocate for clients with other agencies (Interview 5).

Complex needs

A number of respondents felt that there were insufficient mechanisms in place to support the most vulnerable of their clients. They told us of cases in which counselling or drug and alcohol services had closed files on clients after they had missed an appointment, reflecting *"completely unrealistic expectations about women who have been through this level of trauma in terms of how they are going to access support"* (Interview 10); and about situations where clients were unable access alcohol recovery services until they had somewhere 'stable' to stay away from the perpetrator, but were then being denied local authority housing and had nowhere else to go.

Psychological support

Participants also expressed concern about the availability of mental health support for their clients. They told us that long waiting times for support delayed, or derailed, clients' recovery and placed additional pressure on them as IDVAs in the interim. One observed that *"counselling and psychological support in the borough is abysmal"* (Interview 15), while many more gave accounts of clients waiting months, if not years, to access counselling. Another IDVA commented that *"a lot of the times, you only have your GP... a lot of times you don't have a specialist service, a counselling service, to offer people, so you offer them what you can offer, but it sometimes isn't, you know, it's not what they need"* (Interview 11). Many suggested this can lead to situations in which clients move between their GP and secondary mental health services without ever receiving appropriate specialist support.

Additional concerns were raised about the response to clients who were imminently suicidal. Several interviewees recounted situations in which clients had been told by GPs or community mental health teams to go to Accident and Emergency, noting *"if someone's really in crisis, I don't think they are going to be getting the bus up to A&E to sit there and wait"* (Interview 16). The experiences recounted confirmed that clients were often required to wait a *"pitifully long"* time in Accident and Emergency departments (Interview 12), often in the region of 6 or 7 hours, only to receive inadequate provision, such as being asked generic questions about 'what day is it today', or being given a prescription for medication and sent home with little follow up. One particularly disturbing professional response to a suicidal client reported by an interviewee involved a woman who overheard a nurse alert the psychiatrist to her presence in the hospital waiting room with the phrase *"I've got another one here, it must be a full moon or something"* (Interview 15).

Respondents described more positive emergency responses to clients from local mental health crisis teams, although even here concerns were expressed over whether a client's suicidality was always taken sufficiently seriously, or dealt with in a timely manner. One participant described, for example, how the crisis team *"took a very long time to get to her, considering they are meant to be in crisis. They didn't get back to her until two days later; and she did have an appointment with them, but when she went to the appointment, they pretty much signed her off and told her to go back to her GP and get more tablets, which I don't think was the best advice for her"* (Interview 6).

Psychological support, high risk and Multi-agency risk assessment conferences (MARAC)

For clients who are at high risk from the perpetrator and also experiencing psychological ill health, there was some evidence of a more coherent provision across support services. But this was by no means consistently so as not all MARACs include representation from mental health services. Moreover, some respondents expressed frustration about how effectively MARAC discussions were followed up to ensure that support was provided. A number of respondents provided examples of clients who had come before MARACs on repeated occasions, and while this in itself does not establish a failing of the system, they suggested that it does evidence the reality that interventions and support discussed at that level do not always translate into concrete changes that keep women safe from future experiences of domestic abuse, perpetrated either by the same or a new partner.



Vicarious traumatisation

Domestic abuse, and its impact upon victims, can be distressing and so it is unsurprising that many practitioners spoke about the challenges of coping with disclosures of abuse, and of working with suicidality. Some recounted using 'avoidant' behaviours (an indicator of PTSD) as way of distancing themselves from the pain of clients' disclosures, including feeling *'de-sensitised'* (Interview 17) or responding in ways that made them seem *"a little bit robotic"* (Interview 11). The risks that work with traumatised victims can pose in terms of the psychological well being of staff were well described by interviewees, one of whom remarked that *"the hard work that we do and the constant working with the emotion and it is people's lives and that is something so heavy to take on, it's a huge workload, a huge burden"* (Interview 17). These findings support pre-existing research, which has explored experiences of 'vicarious trauma' and 'burn-out' faced by those who engage in emotional labour, including in providing support to victims of gender-based violence⁸¹.

For many respondents these emotional challenges were increased by a sense of responsibility for clients, particularly in light of perceived gaps in services. One stated, *"IDVAs often try to coordinate those services"* (Interview 10), but as another put it this then *"feels like we are doing other people's work, we are not actually properly doing our job"* (Interview 3). It was implied that a client's suicide could reflect, at least in part, a failure by them to provide all the support needed: *"that's a lot of responsibility, and you don't ever want to hear that one of your clients has committed suicide"* (Interview 5). Those workers who felt this most acutely expressed difficulties in taking a "boundaried" (Interview 3) approach to their work, even though they believed that this kind of time-limited, risk-management focus was increasingly being stipulated by commissioners as part of the funding criteria for domestic abuse services.

Many of the Refuge staff we interviewed readily acknowledged that they are not mental health professionals, yet they nonetheless provided intensive levels of emotional support for their suicidal clients, particularly when longer term, specialist domestic violence counselling was unavailable. One respondent noted: *"we are put in a position of having to kind of intervene in situations . . . where you're supposed to have mental health workers or, you know, professionals helping this person"* but *"if we are the only ones who answer the phones to the women, we have to listen to them"*.

This pressure to 'fill the gaps' in services, whether real or perceived, is a cause for concern as it potentially exacerbates any adverse impact of working with traumatised clients already felt by workers. In recognition of these issues, several respondents told us about arrangements that Refuge had established, both at the local peer and line manager level, which helped them to cope with the emotional demands of their work. As one put it, for example, *"we have certain mechanisms which are good, for example, we always have the manager you can debrief with, so you can share that with somebody else"* (Interview 4). Nevertheless, our interviewees were broadly of the view that more training and specialist supervision, which was aimed at supporting them to cope with the practical and emotional dimensions of handling disclosures of suicidality, would be valuable and something that the commissioners of domestic abuse support services ought to prioritise.

⁸¹ Baird, S. & Jenkins, S. (2003) 'Vicarious Traumatization, Secondary Traumatic Stress, and Burnout in Sexual Assault and Domestic Violence Agency Staff.' *Violence and Victims* 18: 71-86; Richardson, J. (2001) 'Guidebook on Vicarious Trauma: Recommended Solutions for Anti-Violence Workers.' Ottawa: Public Health Agency of Canada.

SECTION 4

Conclusions

By analysing data contained in Refuge's client case files across a two year period, this research provides detailed, substantial and original evidence, on a large scale, in respect of the prevalence of suicidal ideation and attempts amongst this population. It also supports existing research, in suggesting a correlation between experiencing domestic abuse and suffering severe adverse psychological effects; and it attests to the need for professionals across a range of settings to be more aware and responsive to, the risk of suicidality in this population.

While the relationship between domestic abuse and suicide may be complex, our analysis has identified a number of factors that seem to increase or mitigate the risk for individual clients, including the co-existence of depression, psychological distress, despair and hopelessness, difficulties with drugs or alcohol, childlessness and cumulative experiences of abuse, particularly when these are sexual in nature. The protective role played by the existence of children also emerged quite clearly in our analysis and this was to some extent anticipated, given that the strong bond between a parent and their child can bring not just a sense of responsibility but also a sense of purpose which, in the face of suicidality, might act to protect.

The idea that those trapped within domestic abuse contexts feel defeated, beyond rescue and unable to escape was also reflected in the high numbers feeling despairing and hopeless - both overall and within the suicidal group in particular. Trends emerging from exploration of the narrative data within IMPACT give further weight to the concept that entrapment of this kind evokes suicidality, with escaping abusers and finding safety highlighted by several victims as protective factors.

In addition, interviews with Refuge experts who offer frontline support to clients corroborated these findings, and provided further insights into the difficulties of accessing appropriate and timely support in the immediate and longer term; the limitations of existing risk assessment procedures for highlighting clients' risk of harm to themselves; the challenges of supporting and advocating for clients within a shrinking network of community services, particularly in times of austerity; and finally, but not least, the emotional impact of this traumatic work upon Refuge staff themselves.

This study explored suicidality with one group of Refuge's clients (the majority female), using data already in existence in a bid to understand the relationship between suicidality and domestic abuse. There is undoubtedly more work to be done, both to explore and test some of our initial findings and to extend our learnings in order to improve practice and ensure that the Government's general objectives in respect of suicidality are translated into concrete measures that take full account of the experiences and needs of victims of domestic abuse. This perspective is needed nowhere more urgently than within our legal system. For too long, the psychological impacts of abuse have been dismissed by the criminal courts and the severe nature of the injury it causes ignored. This research shows, quite clearly, that domestic abuse can have very serious psychological consequences, such that it can lead some victims to consider taking their lives, irrespective of a psychiatric label or diagnosis. For some victims, like Gurjit Dhaliwal, it is sadly, too late: but suicide is preventable and, as a society, we must do all we can to ensure that suicidal victims of abuse are in no doubt that entrapment and defeat need not be endured. Indeed, escape is possible and for our part, rescue is on its way.

Recommendations

Gender, psychological injury and criminal liability

The gender split evident amongst Refuge's clients reflects broadly the international trend in domestic abuse perpetration and victimisation in that it is largely a phenomenon in which females are victims and males are perpetrators⁸². Data elsewhere suggests that females are more likely to be repeat and chronic victims of domestic abuse⁸³. The present study indicates that it is this chronicity of abuse, when embedded within a relationship that ought to be based on love and trust, that can be particularly injurious at the psychological level and apt to increase the risk of suicidality. As stated above, it is not possible given the data available to comment on whether or not this sample of domestically abused victims might meet criteria for a psychiatric diagnosis: but we can assert, with some conviction, that the majority of them were psychologically distressed and that it would be appropriate to describe many, particularly those who fell within our suicidal group, as psychologically *injured*.

The R v Dhaliwal judgment demonstrated the doctrinal and evidential challenges currently faced in seeking to hold perpetrators of domestic abuse liable for manslaughter when a victim takes her own life. The formal recognition of complex-PTSD as a psychiatric condition, as well as the intervening criminalisation of coercive and controlling behaviour as a distinct offence, may remove some barriers; but they come with their own risks. By illustrating the severity of the psychological harm that can – and often does – accompany being subject to domestic abuse, this research provides a far stronger evidence base than has previously been available in support of Refuge's claim that it is the *psychological impact upon victims rather than the formal labelling of injury* that ought to be the primary concern.

Moreover, by highlighting the ways in which such psychological harm is very often experienced alongside, and amplified by, victims' acute sense of despair, hopelessness, and entrapment, it provides a more informed understanding of the causal connection between domestic abuse and suicidality. In particular, it charts a context in which it might reasonably be argued that the decision to take one's life is not a voluntary one that can or should absolve the perpetrator of responsibility for death, but rather one that is best understood as provoked by and substantially linked to abuse.

It is vital, therefore, that all agencies recognise domestic abuse as a gendered issue and a gendered crime; and that the legal system in particular develop responses to prevent and punish perpetrators who cause *psychological injury*, including when this leads to suicide or suicide attempts.

Recording and monitoring suicide and suicidality

When domestically abused suicidal victims are in crisis, they often contact health or other services for help. It is important that there are agreed, clear and precise mechanisms for recording who these victims are, what happened to them (domestic abuse, for example, including the gender and relationship of victim to the perpetrator) and the nature of their suicidality (attempt, thoughts, plans).

Domestic violence homicide reviews are already in place for victims who are killed by their perpetrator and there is some evidence that domestic violence suicides are starting to be reviewed⁸⁴. This is positive but long overdue, and needs to be developed on a more systematic basis. There is also much to learn from so called 'near

⁸² FRA (2014) 'Violence Against Women: an EU wide survey' FRA - European Union Agency for Fundamental Rights.

⁸³ Walby, S. and Allen, J (2004) 'Domestic Violence, Sexual Assault and Stalking: Findings from the British Crime Survey.' London: Home Office Research Study 276.

⁸⁴ Personal communication with Refuge managers

misses' in which an attempt is made but the victim lives - robust systems should be established so that agencies can monitor and respond to such cases accordingly.

Coroners' courts have a key role to play in subjecting domestic abuse suicides to greater scrutiny, allowing more involvement of families and by operating with a greater degree of transparency than domestic violence homicide reviews allow. Collating, analysing and disseminating any findings and recommendations at a local and national level, is essential to bring about meaningful change.

The State has a positive obligation to protect its citizens from inhuman and degrading treatment (Article 3) or from threats to life (Article 2). The recent judgment of the UK Supreme Court in respect of the Metropolitan Police's investigation of complaints of rape made against John Worboys (the 'black cab rapist') underscores that this obligation extends to the need for state agencies (including the police) to have systems in place that allow serious violent crime to be investigated effectively and to ensure that such systems are applied appropriately in all cases. This approach ought to capture cases of suicide and attempted suicide, where domestic abuse acts as a precursor.

Timely and appropriate support

Given that 83% of Refuge's client group felt despairing or hopeless at intake (or shortly thereafter), and at least 24% felt suicidal either then or in the past, it seems crucial that services are in place (not only within the domestic abuse sector) to respond to these needs, *at the time* of need. This research found that long delays in obtaining support for victims of trauma and abuse had the potential to exacerbate any existing difficulties. Appropriate specialist services are designed to allow victims to take time to disclose the full impact of the abuse they have experienced, including any suicidality; they provide a suitable environment in which victims can 'tell their story' at their own pace. *Feeling safe*, not just *being safe*, are pre-requisites for recovery from any trauma - providing a roof over someone's head or getting an injunction to keep a perpetrator away is only one part of the solution. Recovery from experiences of abuse, particularly those that lead someone to consider taking their own life, does not have a cost effective, scalable, short-term solution: it requires solid investment in specialist services *and* in the individuals who run those services. A commitment to provide secure, protected funding for specialist domestic abuse services, as well as ensuring there are sufficient specialist refuges to meet demand, is essential.

Trauma focused approaches to work with victims of abuse

Specialist services, that take the suicidality of victims seriously, and respond with compassionate understanding to their 'cry of pain' are essential in any strategy to prevent suicide or further harm to the victim from herself. Trauma focused professionals who ask victims '*what happened to you?*' rather than '*what is wrong with you?*' and who recognise the relevance of both the victim's abusive relationship and the broader social context in which they find themselves, are key. Any concurrent difficulties with drugs, alcohol or other complex needs should be met by a non-judgmental approach that seeks to *understand the victim from the perspective of her own experience*. Additional complexity in terms of cultural abuses, such as so-called 'honour' based violence, difficulties with immigration or the experiences that precede and follow being a refugee, must be recognised and addressed, again with understanding and compassion. This work can be complex, so it should progress at the clients' own pace and not be driven by time limited programmes of a prescriptive nature. Survivors of abuse and of suicidality should be integral to the development of any programmes designed to meet their needs.



This study highlighted the emotional challenges that working with traumatised, suicidal clients can have on caseworkers and managers throughout an organisation such as Refuge. Addressing the impact that work with this population has on its workforce, in terms of a trauma focused organisational approach to Human Resources policy and practice, is as important as developing this kind of approach with clients.

The needs of children

Whilst this study found that having children was protective for victims of abuse, it is vital that we recognise and address the potentially devastating impact that having a suicidal parent can have on children, who may also be affected by domestic abuse in their own right. It was beyond the scope of this study to include the perspectives of children and young people and further work is needed to explore the implications for them in this extremely difficult context. For too long, children have been the 'silent witnesses' or 'invisible victims' of domestic abuse and despite decades of research into the harm it causes, their needs are often ignored, or viewed as secondary to those of their abused parent: this must change. Every area of the UK should provide specialist services for children to address the harms caused by living with domestic abuse, including those who have been bereaved through the suicide of a parent in this context.

We also need to engage in wide-scale educational efforts to 'change the story'⁸⁵ of what it means to be male and female; preventative programmes of this type must be rolled out nationally if we are to have any hope of ever eradicating the gender inequality at the root of violence against women. As a society we must find the courage to articulate and accept that sexism and gender inequality lie at the root of violence against women and girls, we must find the will to develop strategy and programmes to overturn sexism and we must work together to ensure there are no more vulnerable women who feel so despairing and trapped by domestic abuse that they believe suicide is the only escape - it is not.

⁸⁵ Our Watch (2015) 'Change the Story. A shared framework for the primary prevention of violence against women and their children in Australia.' Available at - <https://www.ourwatch.org.au/getmedia/0aa0109b-6b03-43f2-85fe-a9f5ec92ae4e/Change-the-story-framework-prevent-violence-women-children-AA-new.pdf.aspx>

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**It is vital that
the legal system
in particular
develops responses
to prevent and
punish perpetrators
who cause
psychological injury
that drives the
victim to suicide.**

Refuge

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