Champs Public Health Collaborative

Welcome

World Suicide Prevention Day 2023

Creating hope through action

Domestic abuse and suicide

#HopeThroughAction

Working together to improve health and wellbeing in Cheshire and Merseyside

8th September 2023

Champs Public Health Collaborative

Opening by Chair

Ruth du Plessis – Lead Director of Public Health for Suicide Prevention and Director of Public Health for St Helens Council

Working together to improve health and wellbeing in Cheshire and Merseyside

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EMILY SPURRELL
MERSEYSIDE POLICE
& CRIME COMMISSIONER

Address by Deputy Police & Crime Commissioner for Merseyside, Jeanie Bell

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Police & Crime Commissioner for Cheshire

Address by Deputy Police & Crime Commissioner for Cheshire, David McNeilage

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Creating Hope Through Action: Domestic Abuse and Suicide Prevention

Ruth du Plessis Director of Public Health St Helens Council and C&M DPH Lead for Suicide Prevention

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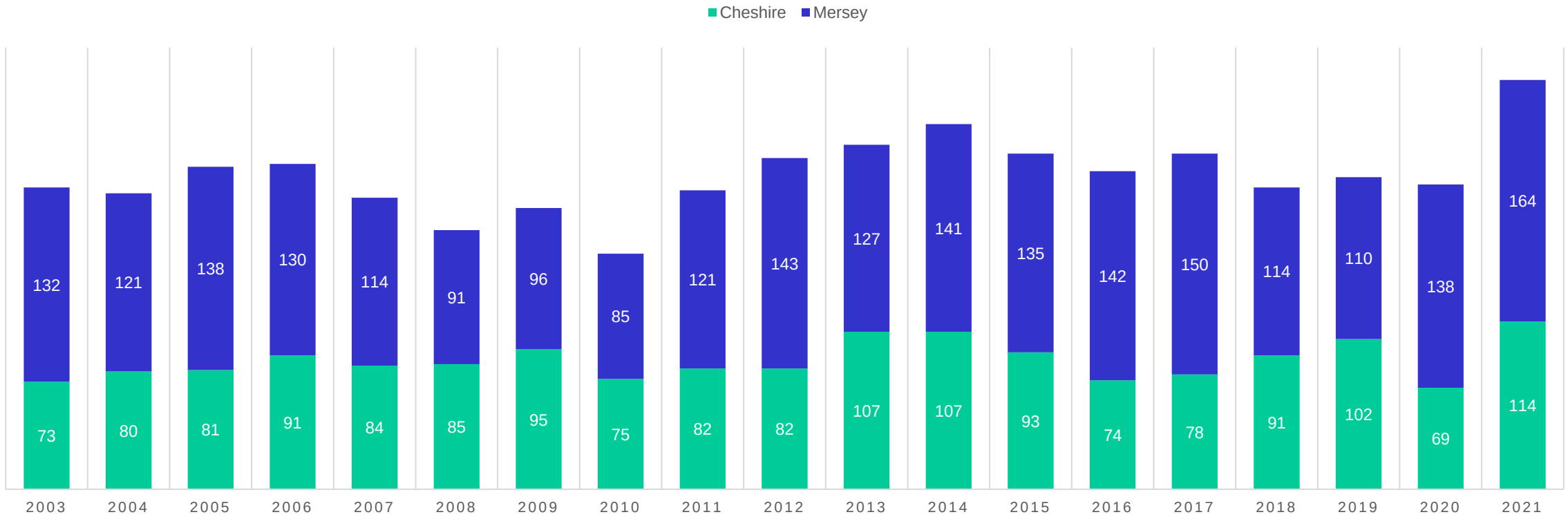
Presentation content

- Review of current national data
- Update of real time surveillance overview
- One year on from the strategy and why we are focusing on domestic abuse

A moment of reflection

- Suicide and Domestic Abuse are two very hard topics to discuss
- We all maybe affected by the stories retold today
- All the data relates to a person and people affected by suicide and domestic abuse
- However, we must talk about the issues in order to develop strategies to address them
- We all need to take care of ourselves today and if you feel you need to talk we have people on hand

Number of suicides for Cheshire and Merseyside 2003 – 2021 single years – ONS registered deaths



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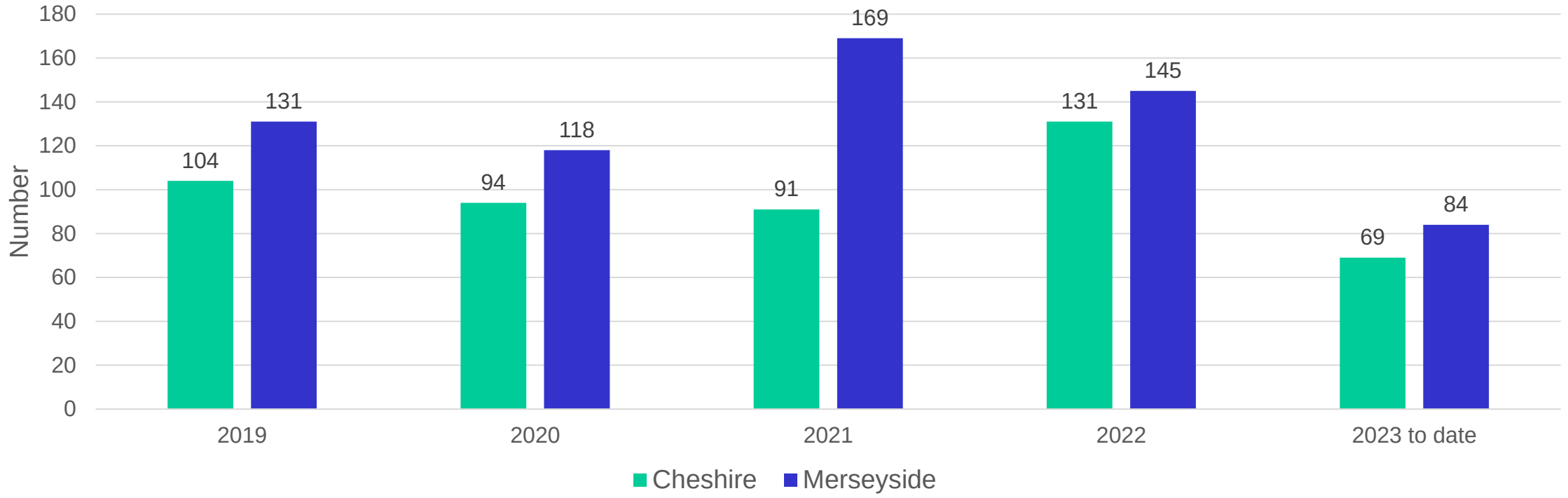
Real time surveillance suspected suicide 2019 to August 2023



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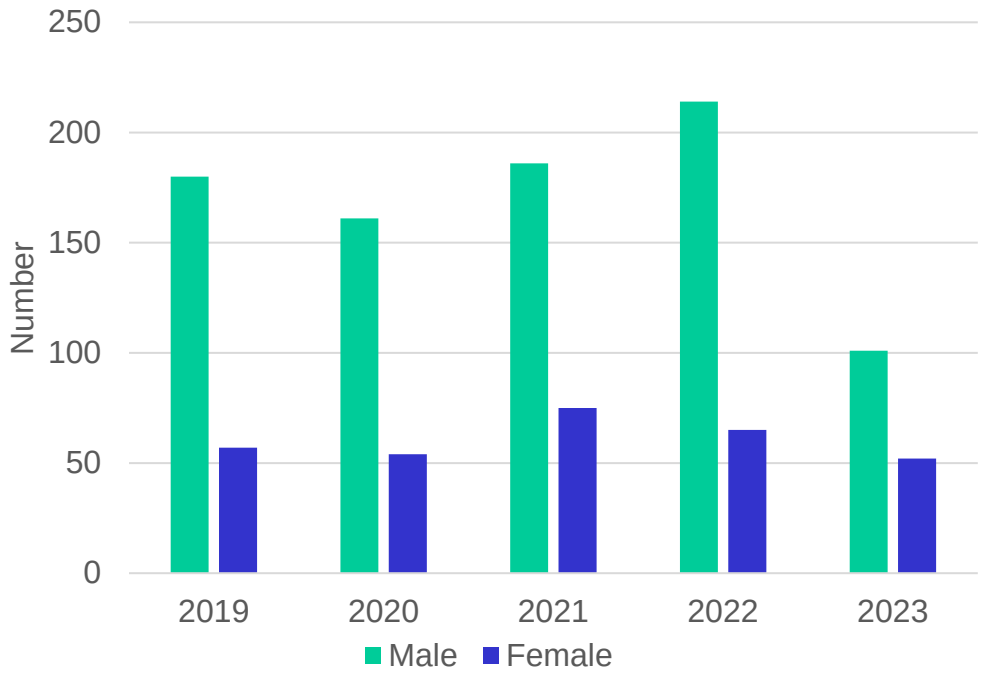
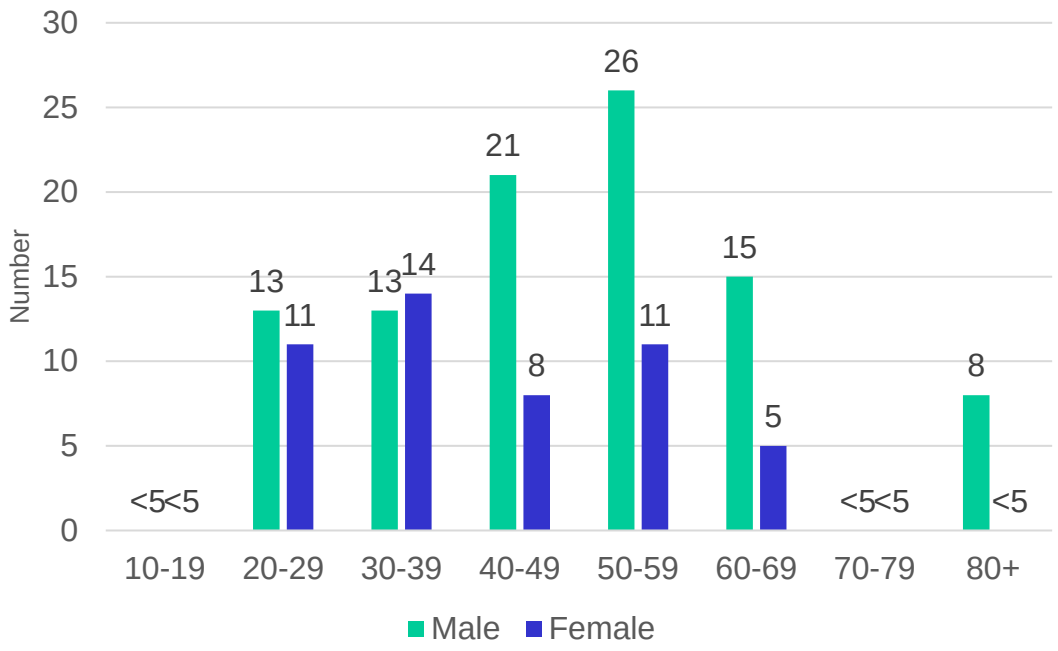
Real Time Surveillance age and gender split 2023





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Cheshire and Merseyside Suicide Prevention Strategy 2022 - 2027

- Our key priority groups from the strategy based on our data were:
  - men;
  - children and young people;
  - self-harm
  - Inequalities
- Domestic abuse and suicide affects all the above groups

One year on…..

- We said we would be ‘Data Driven’
  - We are guided by local data and real-time surveillance which enables us to help those who are most at risk. We are committed to improving data collection with a focus on recently identified risk factors and high-risk groups and ensure support for those bereaved by suicide
- We would ‘Reduce Stigma’
  - To dismantle prejudicial attitudes and discriminating behaviour directed towards suicide and people with lived experience of suicide and self-harm.

Why highlight these values?

Data driven

- Real time surveillance for Merseyside shows that 22% of suspected suicides between September 2021 and the end of December 2022 had a link to domestic abuse
  - Of total 180 cases in Merseyside: 27 (67%) suspected of DA, 12 (30%) Victim of DA and < 5 (2.5%) witnessed DA
- For 2022 calendar year this equated to 25 cases of which 24 were male, < 5 female
- 72% of cases in 2022 were aged 20 to 44 and 8% aged 45 to 64
- Data for 2023 shows a lower % at 15%, 10 male, < 5 female
- Data is reliant on the police officer asking and recording.
- In Merseyside a high % of Domestic Homicide Reviews are suicides around 50%
- North West of England the % of Domestic Homicide Reviews with suicide was 36.8% 2022/23

Why highlight these values?

- **Stigma**
  - Domestic abuse ‘silenced by stigma’ –
    - Research has shown that many victims feel shame, embarrassment, fear of being labelled a bad parent
    - Yamawaki et al. (2012) they found that study participants attributed more blame to a victim who returned to the abuser
    - Participants who hold domestic violence myths attribute more blame to the victim, especially men
    - An estimated 90% of children whose mothers are abused witness the abuse. The effects can be traumatic and long-lasting
    - Perceived stigma prior to release can have serious implications for offenders’ functioning, once released from jail/prison

Why highlight these values?

Stigma

- Suicide used to be a crime hence ‘commit suicide’ is a language used and not considered appropriate by those with Lived Experience
- Some churches taught that it was a sin to take your own life
- Talking about suicidal thoughts can be a challenge
- When seeking help maybe discriminated, for example if the individual has self harmed;
- If people also use drugs or alcohol and or have mental health problems they can be perceived as ‘too difficult’
- What are our attitudes to people who committed crimes…

What is the reality?

- Two significant traumas collide together for the worst possible outcome
- Victims feel isolated, hopeless, isolated from family and friends, may feel children are better without them or their children may have been taken off them due to domestic abuse
- Perpetrators often have mental health issues and suicidal thoughts and are particularly at risk when they are not in control of the situation
- Both victims and perpetrator are at higher risk of suicide; and as we know suicide is always devastating; it impacts children, parents, partners current and past, friends and services working with then, communities…

What is reality?

- There is a growing body of evidence of the link between domestic abuse and suicide
- Tackling domestic abuse is likely to be a priority in the new national strategy on suicide prevention
- The evidence of what works to reduce suicide and domestic abuse is under-developed
- New ruling in the Kellie Sutton case of ‘unlawful killing’ means there maybe more justice for those victims who die by suicide, however….
    - We need to be more preventative in our approach, to try and prevent these situations

100-YEAR LIFE | Thursday 17 August 2023

Home Office confirms steep rise in suicide related domestic homicide reviews

News Next on TV Tonight 7.00pm

UK WORLD POLITICS BUSINESS SCIENCE CULTURE

1 Nov 2022

Urgent need to act on domestic abuse and suicide link

Jackie Long
Social Affairs Editor and Presenter

The government must act on the link between domestic abuse and suicide by urgently establishing a national database of every woman who takes their own life after suffering abuse, bereaved relatives and campaigners have demanded.

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This morning

- We have some expert speakers in the field of Domestic abuse and Suicide
- We want to focus on what action we can take; creating hope through action
- To ensure we embed action into delivery and measure impact
- To add to the evidence base on approaches that work in the area of suicide prevention in domestic abuse

- Today we will be presenting the opportunity of making a real impact on saving lives in Cheshire and Merseyside
- We are one of a few places across the country taking this seriously
- We have some fantastic speakers and a wealth of experience in the room
- This is about ‘Creating Hope through Action’

  …. together we can tackle these complex areas

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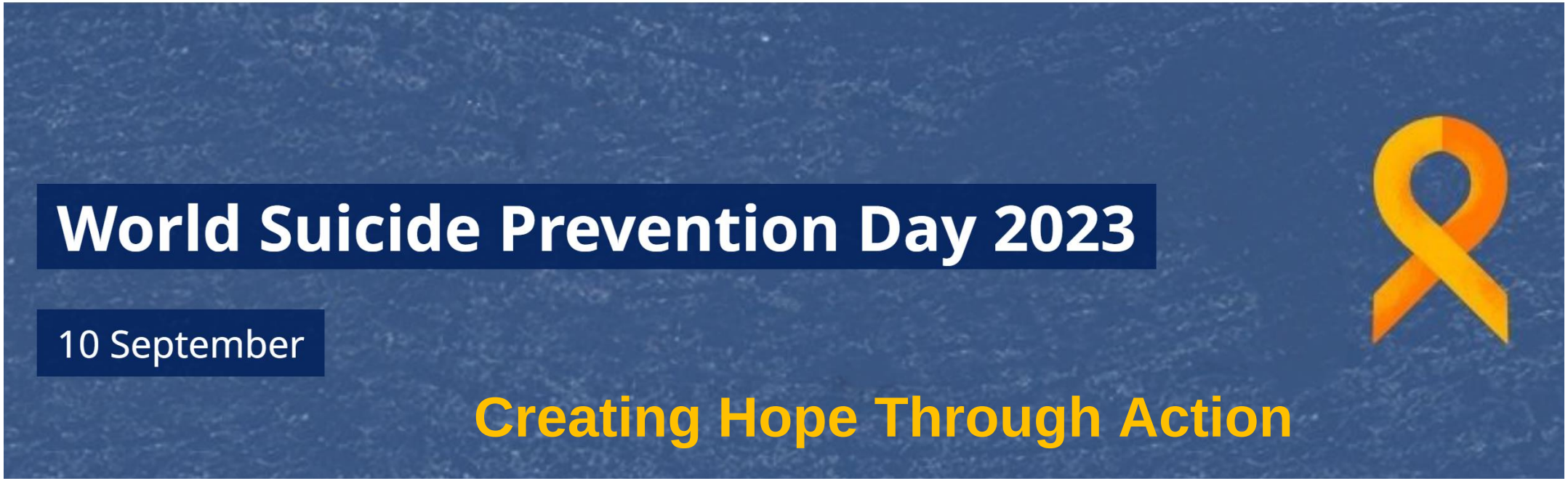

Thank you for listening

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8/09/23

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Video address
Professor Sir Louis Appleby

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Key note speaker
Sarah Dangar

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World Suicide Prevention Day 2023

Creating hope through action: Domestic Abuse and Suicide

Sarah Dangar

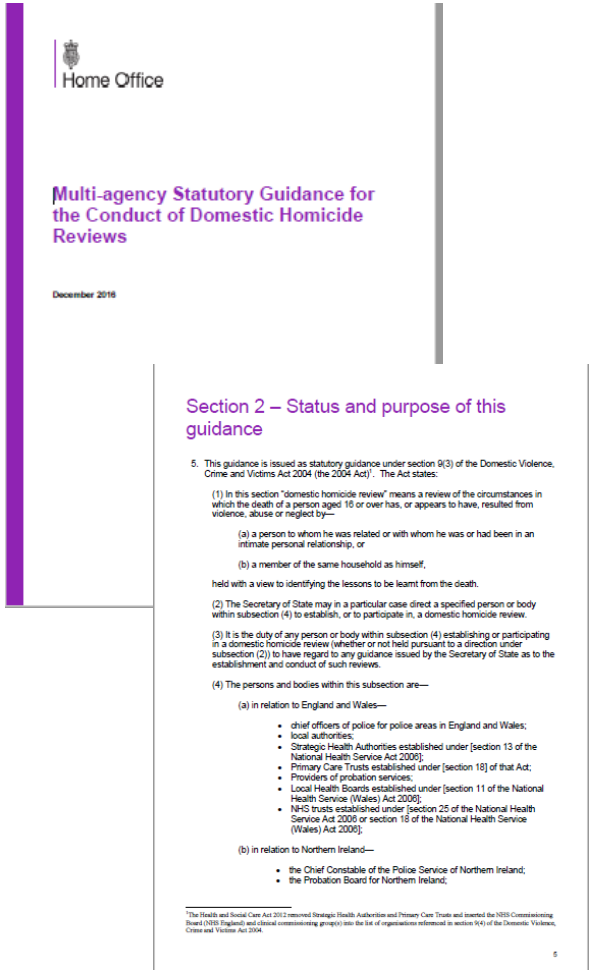
Domestic abuse suicide – a ‘known unknown’

1/3 of all female suicide in England and Wales may have been caused by domestic abuse	44% - contemplated suicide 18% - made an attempt	18.9% reported feeling suicidal 3.1% - at least one failed attempt
Approx. 30% of all suspected suicides impacted by domestic abuse	7% of suicides – victims of DA	Suicide attempts – 49.7% had experienced IPV & 23.1% in the last year

Domestic abuse suicide – a ‘known unknown’
A focus on perpetrators of abuse

10% of suicides – offenders of DA	**Est. annual suicide rate of 461 per 10,000**	**23x greater rate of suicide**

‘Suicide’ Domestic Homicide Reviews (DHRs)



Home Office

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

December 2016

Section 2 – Status and purpose of this guidance

5. This guidance is issued as statutory guidance under section 9(3) of the Domestic Violence, Crime and Victims Act 2004 (the 2004 Act)[1]. The Act states:

(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

(4) The persons and bodies within this subsection are—

(a) in relation to England and Wales—

- chief officers of police for police areas in England and Wales;
- local authorities;
- Strategic Health Authorities established under [section 13 of the National Health Service Act 2006];
- Primary Care Trusts established under [section 18] of that Act;
- Providers of probation services;
- Local Health Boards established under [section 11 of the National Health Service (Wales) Act 2006];
- NHS trusts established under [section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006];

(b) in relation to Northern Ireland—

- the Chief Constable of the Police Service of Northern Ireland;
- the Probation Board for Northern Ireland;

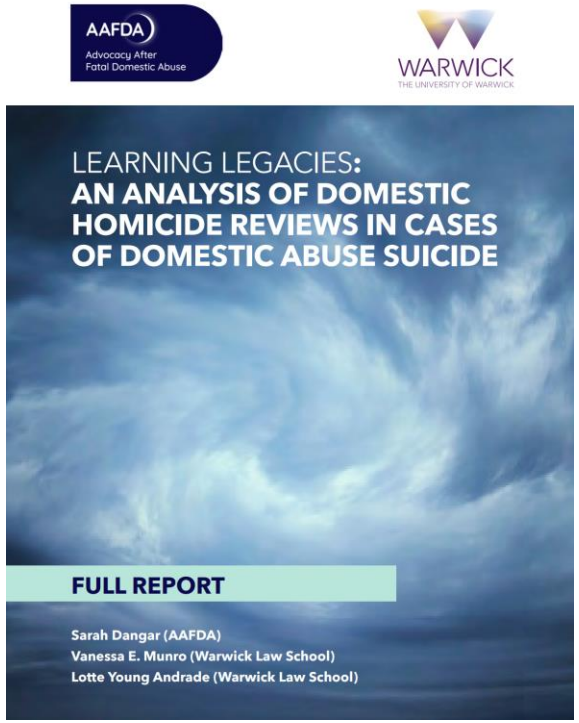
[1] The Health and Social Care Act 2012 removed Strategic Health Authorities and Primary Care Trusts and inserted the NHS Commissioning Board (NHS England) and clinical commissioning group(s) into the list of organisations referenced in section 9(4) of the Domestic Violence, Crime and Victims Act 2004.

5

Home Office Statutory Guidance for the conduct of DHRs – Paragraph 18:

‘Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable. ‘

Learning Legacies: An analysis of Domestic Homicide Reviews in cases of Domestic Abuse Suicide



- Parties' Profiles, Vulnerabilities and Needs
- Agency Engagements and Responses
- Context and Aftermath of Death
- Commissioning and Commencing DHRs
- Running Successful DHRs

Parties' Profiles, Vulnerabilities and Needs

- Difficulties with drug and/or alcohol misuse by victims in half of DHRs
- Documented record of mental health issues in 90% of cases
- History of self-harm apparent in almost half of cases
- Evidence of prior attempts or suicidal ideation in two-thirds of cases
- 47% of victims had experienced prior adult abuse
- Housing and/or financial precarity apparent in 65% of cases
- In 12 DHRs, concerns over child custody / social service involvement

Agency Engagement and Responses

Victims navigating complex needs in ‘plain sight’ of statutory services	Just over half had engaged with specialist DA services	Almost two-thirds had engaged with mental health/counselling
Two-thirds had engaged with hospital A&Es in respect of abuse	Three-quarters known to be in regular contact with their GPs	90% had a history of contact with the police
30% had accessed support for drug or alcohol misuse	More than half had ongoing contact with housing services	47% involved at some time in a MARAC intervention

Recommendations / Call to Action

Consider domestic abuse in local and national suicide prevention strategies.

Ask about domestic abuse when talking to individuals who have self harmed

A collaborative approach - suicide prevention and domestic abuse sectors

Engage with DHR processes where possible

Further research to understand prevalence & risk factors

Training and improved practice in relation to suicide risk including preventative and protective interventions

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Refreshment break

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Keynote speaker
Frank Mullane MBE
Founder of Advocacy After Fatal Domestic Abuse (AAFDA)

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So much loss. Let's do something about it.

Frank Mullane AAFDA

www.aafda.org.uk

Centre of Excellence for Reviews into Fatal Domestic Abuse and for Specialist Peer Support

2001 & 2003 & on

- Horror
- Grief
- Change

What AAFDA does

- Started 2008. Advocacy.
- Centre of Excellence for Reviews
- Helped form and develop DHRs
- International influence
- Quality assurance / Reader
- Provide national accredited training

Status

- De Botton
- Christie
- Status attracts resources

Preventing Suicide

- Superior offer
- Reviews and Inquests
- Education

Maughan

Supreme Court Judgement
2020

Returning to education

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Claire Eddleston
Lived Experienced Voice

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Workshop
Learnings from DHR Findings

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Workshop Task

1) What do we need to put into action to address the needs of different workforces?
a. Which workforce?
b. What action?

2) What improvements do we need to make to systems to address those at risk of suicide and domestic abuse?

3) What other action do we need to take to address stigma and discrimination?

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Pledges for Action

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Event close by Chair

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Networking lunch and opportunity to pledge

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Thank you for attending today's event

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