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From hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse

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Abstract

This article analyses findings from a large-scale study conducted in England and Wales into the prevalence of, and mediators and moderators of risk in relation to, suicidality amongst victims of domestic abuse. The authors tracked (disclosed) experiences of suicidal ideation or suicide within a sample of more than 3,500 domestically abused adults and explored factors that appeared to be correlated with a presence of suicidality amongst this constituency. This analysis was triangulated with a series of 20 semi-structured interviews which explored on-the-ground challenges in relation to the identification of, and support provision for, this vulnerable group, and which also included reflection on the difficulties experienced by staff as a consequence of the emotionally demanding nature of their interactions with such clients. Based on their findings, in this article, the authors underscore the need for more effective multi-agency cooperation, for greater priority to be given to self-harm and suicidality in risk-assessment processes, and for sustainable resourcing of domestic abuse service providers. In a context in which suicidality was correlated with experiences of isolation and hopelessness, they also emphasise the importance of appropriate and effective engagement by state agencies and those professionals tasked with intervening to help victims of domestic abuse.

Keywords

Suicide, domestic abuse, risk-assessment, psychological well-being, VAWG strategies

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Recent years have seen an increased commitment on the part of many national governments and international organisations to address ongoing concern regarding rates of suicide. In England and Wales, for example, this has translated into a commitment by the government to reduce suicides by 10% by 2021 (Independent Mental Health Taskforce, 2016; Department of Health, 2017), through – amongst other things – the development and implementation of local, multi-agency suicide prevention plans. The success of any such initiative depends, of course, upon a multiplicity of considerations. One key factor will be the adequacy of the resources and training that are made available, not only to mental health professionals, but also to the wide range of personnel in agencies spanning social services, criminal justice, immigration, housing, health and addiction counselling, as well as the voluntary sector, who may play a role in identifying and supporting those individuals who are 'at risk' of taking their own lives.

While reliable data regarding the prevalence of, and precursors to, suicidality are not always readily available, previous research indicates that death rates from suicide are consistently higher for men than for women, especially in high-income countries (Nock et al., 2008; WHO, 2014). This has been reflected, in turn, in the priorities of contemporary suicide prevention programmes, where the focus is often on increasing support for 'at risk' males in particular. Without undermining that imperative, it is important to note that what this often sidelines is the reality that women – across all ethnic, racial and age groups – are significantly more likely than men to make suicide attempts (Freeman et al., 2017; Kaslow et al., 2005; Welch, 2001). Responding to women's suicidality ought also to be a priority, even though the challenges involved may be substantial in a context in which, as a recent UK report acknowledged, many women experience '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' (Department of Health, 2017). The role of traumatic experiences, such as being subjected to domestic abuse, as a precursor to suicidality has already been formally recognised at national (Department of Health, 2012) and international (WHO, 2014) levels. However, the scale, dynamics and complexity of this intersection, and the ways in which positive interventions may be secured, remain significantly underresearched, particularly in the UK.

Against that backdrop, this article analyses a subset of quantitative and qualitative casework data collected by Refuge (a nationwide UK charity that advocates annually for thousands of victims of domestic and sexual abuse, and other forms of violence against women) regarding suicidality amongst its adult clients. Our research explores disclosed experiences of suicidal ideation or suicide attempts within a sample of more than 3,500 domestically abused clients, who engaged either with Refuge's residential or community outreach services. Using clients' responses to suicide questions asked by caseworkers during routine risk assessments, as well as answers to a series of standardised measures of psychological well-being, and information shared by clients regarding their personal experiences of abuse, we explore the prevalence of, and mediators and moderators of risk in relation to, suicidality amongst victims of domestic abuse. We situate this analysis alongside semi-structured interviews with 20 practitioners with significant experience working with Refuge to conduct risk- and needs-based assessments, safety planning and frontline client support. These interviews provide a broader perspective on victims' experiences of abuse and suicidality, and enabled the authors to explore more fully the challenges currently encountered by practitioners in providing support to this often vulnerable constituency. While our analysis relates to England and Wales, our findings regarding the experiences of clients and caseworkers, as well as the procedural and funding challenges posed to timely and effective intervention, resonate beyond national borders.

In the first part of the article, we briefly outline the existing state of knowledge regarding the relationship between domestic abuse and (female) suicidality. We highlight the extent to which, while there is now a solid body of evidence that points to the existence of a link, considerably more work needs to be done in order to begin to understand properly the mediators and moderators that influence whether an abused woman will experience suicidal thoughts, and if she does, whether she will act upon them. In the second section, we present key findings arising from Refuge's national casework database ('IMPACT') of mainly domestically abused clients, which gives an indication of the prevalence of suicidality or suicidal ideation amongst this constituency, as well as of some factors that may be associated with an increase or decrease in risk. Having done so, we move on in the third and final section to situate these findings alongside themes arising out of interviews with Refuge expert practitioners. In particular, we explore interviewees' perceptions of the nature and significance of the problem of suicidality in the domestic abuse context, as well as the challenges they perceive may arise in identifying and assessing suicidal risk, and enabling clients to access longer-term support.

While this article does not purport to give a full account of all the complex dynamics at play, it provides the first analysis of its kind, and on this scale, regarding possible associations between domestic abuse and suicidality in England and Wales. Its findings underscore the need for more effective multi-agency cooperation, for greater priority to be given to self-harm and suicidality in needs and risk assessments and safety planning, and for sustainable resourcing of domestic abuse charities to enable them to offer appropriate services to clients (and their children), as well as professional support to practitioners. Given that, as we discuss, we found suicidality to be linked to experiences of isolation and hopelessness, it also highlights the importance of effective engagement by state agencies and those personnel tasked with intervening to protect victims of domestic abuse and to punish perpetrators (Aitken and Munro, 2018). It evidences the severe and lasting psychological effects that domestic abuse can impose on victims, and in a context in which the criminal law has been reluctant to attribute liability for suicide to perpetrators (Munro and Shah, 2010; Ormerod, 2006), it contributes to broader debates about the legitimacy of that causal dissociation (Munro and Aitken, 2018).

Suicidality and domestic abuse

In line with the UK Government's definition,[1] we define domestic abuse here to include physical, sexual, emotional, psychological and/or financial abuse, perpetrated by someone with whom the victim is or has been in a familial, domestic, intimate or otherwise close inter-personal relationship. Domestic abuse can, of course, be experienced (and perpetrated) by both men and women. Despite this, research continues to establish that those who experience the most sustained and serious forms of domestic abuse tend to be women, and that the perpetrators of this abuse tend to be men (see, for example, Dobash and Dobash, 2004; Hester, 2009). In recognition of the overwhelmingly gendered nature of this crime, therefore, and reflective of the client base with whom Refuge typically engages, our primary focus is on female victims.

In a report that attracted considerable policy attention at the time, Sylvia Walby extrapolated from research conducted elsewhere to suggest that more than one-third of female suicides in England and Wales are partly caused by women having been subjected to domestic abuse (2004: 56). Despite this, in the intervening years, there has been little rigorous analysis undertaken in the UK in respect of the prevalence of experiences of domestic abuse amongst those who take their own lives, or conversely the scale of suicidality amongst domestically abused women.

Research conducted in other jurisdictions offers some insight, of course, but its applicability may be limited, given the ethnic and cultural diversity of many UK communities, as well as the peculiarities of its health, welfare and social support systems. Moreover, existing studies in the UK and elsewhere have tended to focus on physical and/or sexual forms of abuse, failing thereby to capture the sorts of psychological abuse that are now punishable in England and Wales under the banner of 'coercive and controlling behaviour'. Against that backdrop, this study and its findings make a significant contribution to our existing understanding, providing a more robust evidence base regarding the scale of suicidality in this context and identifying mechanisms to better support domestically abused and suicidal women.[2]

There are, of course, a number of factors that contribute to a person's decision to take, or attempt to take, their own life. Nonetheless, research has now established a significant negative physical and psychological health effect associated with experiencing domestic abuse (Afifi et al., 2009; Boyle et al., 2006; Devries et al., 2013; Gleason, 1993; Golding, 1999; Oram et al., 2017). Across several studies, women who experience intimate partner abuse have been shown to be more likely than non-abused counterparts to attempt suicide (Pico-Alfonso et al., 2006; Reviere et al., 2007; Seedat et al., 2005). Thus, Blasco-Ros et al conclude that

> during the last three decades, cross-sectional, prospective and retrospective studies have consistently demonstrated that living with a violent intimate partner is a significant contributor to women's adverse mental health outcomes. The most prevalent sequelae include depression, anxiety and Post-Traumatic Stress Disorder (PTSD). Furthermore, intimate partner violence is strongly associated with suicidality, sleep and eating disorders, low self-esteem, personality disorders, social dysfunction and an increased likelihood of substance misuse (2010: 98).

While some previous research has identified a dose-response effect whereby the victim's proclivity to suicidality is correlated with the severity, frequency and/or longevity of the abuse experienced (Naved and Akhtar, 2008; Wingwood et al., 2000), evidence has also begun to indicate that the relationship between domestic abuse and suicide is not linear. A clinical awareness of the link between domestic abuse and suicide, in both higher and lower income settings, has emerged (Devries et al., 2011; Sansone et al., 2007), but ethnic minorities, immigrants and refugees have, for example, been positioned as more susceptible to domestic abuse suicide, as a consequence of cultural practices, concepts of honour and shame, and language or community barriers that prevent them seeking help (Colucci and Montesinos, 2013; Gill, 2004; Southall Black Sisters, 2011). As in other contexts, it has been suggested that proclivity to suicidality amongst women subjected to domestic abuse is also mediated by feelings of distress, hopelessness, PTSD and drug or alcohol use, and moderated by social support (Bergman and Brismar, 1991; Kaslow et al., 1998; Thompson et al., 1999); but the exact parameters and functioning of these precarious and protective factors remain under-researched.

Moreover, despite this evidence of a correlation across a range of studies, concerns remain that domestic abuse has not been fully integrated into mental health policy as a 'major risk factor for women's ill-health' (Devries et al., 2011: 85). Previous research has suggested that first responders to suicidality in health and mental health settings often fail to probe regarding any experiences of domestic abuse, tending to focus on the immediate task of diagnosing and treating manifest physical and psychiatric symptoms (Rose et al., 2010; Oram et al., 2017). Indeed, Trevillion et al. (2014) have recently concluded that, notwithstanding national guidelines that support routine enquiry about domestic abuse (NICE, 2014), mental health professionals in the UK often failed to

identify victims or facilitate disclosures of domestic abuse. Moreover, where professionals were aware of this abusive context, it was not clear that this provoked an appropriate response. In line with Stark and Flitcraft's US study (1995) in which women identified on hospital admission as subject to domestic abuse were found to be more likely than non-battered women to be sent home without referral following a suicide attempt, Trevillion et al. (2014: 438) found that mental health professionals who were aware of the history of domestic abuse often responded in ways that not only failed to prioritise women's safety but 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 relationship.

The present study engages with these concerns about the adequacy and appropriateness of existing mental health responses to domestically abused women's suicidality, but its aims are also somewhat broader. More specifically, it sets out to explore the prevalence of suicidal ideation and suicide attempt amongst this client group, improve our understanding of the relationship between suicidality and domestic abuse in the UK, evaluate statutory and voluntary sector agencies' mechanisms for disclosure and safety planning in this context, and give an account of the challenges that may be experienced by those who engage with, and support, domestically abused, suicidal women. In the following section, we discuss key findings arising from our analysis of a large dataset ('IMPACT') comprised of client case files retained by Refuge, the largest provider of domestic abuse support services in the UK. Having done so, we move on, in part three, to triangulate and contextualise case file findings through analysis of a series of qualitative interviews, undertaken with a selection of 20 Refuge staff, each of whom had core expertise in providing support and assistance to domestically abused clients.

Profiling suicidality: Client case files

The researchers were given access to a database, constructed and utilised by Refuge for casework purposes. This 'IMPACT' database contains a wide variety of information, including demographic information about clients, responses to history of abuse questions, and responses provided by clients to a standardised CAADA-DASH risk-assessment tool, which is utilised across a range of agencies to provide a consistent basis for identifying high-risk victims in domestic abuse contexts. The database also holds clients' responses to a 'CORE-10' questionnaire, which is a brief screening tool designed to measure psychological distress. It is important to note at the outset that this IMPACT database is not a bespoke research tool: as such, some of the variables used to capture information were not well-structured for statistical analysis, and there were some omissions and inconsistencies in data that had been inputted. Nonetheless, after a period of cleaning and organising the data, we were able to use it to explore the prevalence of suicidality amongst this client group and to identify some important correlations with histories of abuse and other mediating or moderating factors.

The sample: Content and demographics

We were provided in the first instance with an extract from IMPACT which contained information on all clients who had interacted with Refuge between April 2015 and March 2017. This extended to over 8,000 individual case files. From this, we were able to identify a core subsample of 3,519 clients who were (a) aged over 18 years old,[3] (b) had completed all questions on the CORE-10 assessment, and (c) had provided a history of abuse to their caseworkers. The majority of these

clients had also undertaken the CAADA-DASH risk assessment. However, for all clients, 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. Moreover, for many clients, the record was also incomplete in respect of their responses to one or more further items on the CAADA-DASH. Indeed, only 1,379 of case files within this core sample of 3,519 clients had responses recorded for *all* remaining items. 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 in respect of responses to individual questions. In that respect, it is also worth noting that – while questions on depression and suicide were combined in the original CAADA-DASH, which continues to be used by many organisations – these are posed to clients as distinct questions in Refuge's version, which has enabled us to provide a more clear-sighted analysis in respect of responses to these particular (key) items.

In terms of the demographic profile of the 3,519 cases analysed, the vast majority (97.5%; $n = 3{,}432$) were female clients, while 2.4% ($n = 84$) 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). The majority of clients came from a white British background and made up almost half of the sample (48.5%, $n = 1{,}708$). The next most populous group (16.7%, $n = 588$) were described as having black heritage, either black British or African or Caribbean background. This group made up just over 19.3% of clients when combined with those of dual black heritage ($n = 679$). Clients of South Asian background made up 12.6% of clients ($n = 443$) – this included a small number (0.3%, $n = 11$) of clients with mixed South Asian heritage. Those from Eastern Europe made up 7.5% ($n = 265$) of our sample, followed by Caucasian clients of unspecified ethnicity (5.1%, $n = 178$). Of course, this profile reflects the clients who engaged with Refuge, and does not necessarily represent the range and diversity of those subjected to domestic abuse, let alone those experiencing suicidal ideation in the context or aftermath of that abuse. In particular, as noted above, it has been suggested that, in certain minority ethnic communities, there may be additional barriers to disclosure that would ensure their under-representation.

Of the 3,437 clients for whom sexual orientation was recorded, most (95.6%, $n = 3{,}288$) were heterosexual females, and of the 3,514 clients for whom information about the gender of the perpetrator was recorded, 96.4% ($n = 3{,}386$) involved men. Male partners or ex-partners were by far the most common, accounting for 84.1% ($n = 2{,}938$) of the 3,494 cases in which both the gender of, and relationship to, the perpetrator was recorded, with the next most common category of perpetrator being recorded as 'relatives' (8.27%, $n = 289$). Again, while there continues to be debate regarding the prevalence of domestic abuse perpetrated by women, and/or in homosexual relationships, this IMPACT sample reflects broader disclosures to Refuge, within which the vast majority of cases involve male intimate perpetrators and female victims.

It is perhaps also worth noting that the profile of clients analysed ranged across services, with a small proportion (7.5%) being supported through dedicated Independent Sexual Violence Advocates, 26% living in residential accommodation provided by Refuge, and the remainder engaging with outreach and Independent Domestic Violence Advocates in the community.

Recorded disclosures of suicidality

Information relating to suicidality was recorded on IMPACT in three main ways – (a) a direct question about currently feeling suicidal as part of the – slightly revised – version of the CAADA-

DASH risk assessment utilised by Refuge; (b) a question in the CORE-10 which asks clients if they have made plans to end their lives; and (c) narrative comments recorded by caseworkers 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 current formulation of the CAADA-DASH, which related specifically to feeling suicidal recently, or in the past, as well as any previous suicide attempts.

There is, of course, every possibility that Refuge clients who have felt suicidal in the recent or far past, or made an attempt to end their lives, did not disclose this during the risk-assessment process, where no direct and structured questions were asked about suicidality in this broader timescale. There are also reasons to suspect that not all clients will disclose current feelings of suicidality or plans to take their own lives even when specifically asked about this, either because of stigma and shame associated with suicidality, due to a lack of trust and confidence in the caseworker at the initial risk-assessment stage, or on account of concerns about what impact such disclosure may have on their access to a refuge, entitlement to retain custody of their children, or for fear of compulsory mental health intervention. Thus, it is more than likely that our findings below underestimate the full scale of the problem.

Despite this, our analysis revealed a substantial spectre of suicidality in the lives of this sample of domestically abused clients. 24.2% ($n = 854$) 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 indicated a positive presence for more than one of these measures. The majority of these clients (18.9% of the sample, $n = 664$) reported they were feeling suicidal either currently or recently, and 18.3% ($n = 644$) confirmed during assessment that they had made plans to end their own lives. In addition, 3.1% ($n = 108$) 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 comparisons difficult, it is clear that this reflects a level of suicidality that is higher than that of the general population. Cross-national research has estimated lifetime prevalence for suicidal ideation, plans and attempts at 9.2%, 3.1% and 2.7% (s.e. = 0.1) respectively (Nock et al., 2008), though females have been shown to be at greater risk of such behaviour than men (notwithstanding that men are more likely than women to die by suicide) (Freeman et al. 2017; Welch, 2001).

Situating suicide: Context and correlations

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. We also explored associations between suicidality and total scores on both the CORE-10 and CAADA-DASH (removing dedicated suicide questions within them for analysis purposes to avoid artificially inflating correlations). In addition, as discussed below, we also examined any apparent relationships between suicidality and clients' responses to individual questions within these

assessment tools – for example in relation to whether the client was frightened, afraid of further violence, or feeling isolated or depressed.

We did not find suicidality in general to be significantly correlated with age, gender or ethnicity. However, we did observe a correlation amongst those who described experiencing so-called 'honour' based violence ($r = 0.054$, $p < 0.01$). More than half of these clients (56.5%) were from South Asian backgrounds ($n = 82/145$), representing 22.7% of all South Asian clients in the sample. More broadly, we found positive correlations with suicidality across many of the specific forms of abuse that were documented. For physical abuse, suicidality was correlated with being strangled, ($r = 0.079$, $p < 0.01$), kicked ($r = 0.079$, $p < 0.01$) or suffocated ($r = 0.074$, $p < 0.01$). The strongest correlations for sexual abuse were found for 'any report of sexual abuse' ($r = 0.163$, $p < 0.01$) and for enforced prostitution ($r = 0.098$, $p < 0.01$). In respect of psychological abuse, isolation from family and friends ($r = 0.107$, $p < 0.01$), experiencing threats of harm with a weapon ($r = 0.109$, $p < 0.01$) and threats to kill a family member ($r = 0.092$, $p < 0.01$) were correlated with suicidality. 'Any financial abuse' was also correlated with suicidality ($r = 0.092$, $p < 0.01$).

When the cumulative effect for similar types of abuse was explored, moreover, we found the strength of the correlation with suicidality increased, reinforcing the dose-response effect in previous research. This was particularly so for cumulative sexual abuse ($r = 0.179$, $p < 0.01$), but was also identified in relation to cumulative threats and psychological abuse ($r = 0.111$, $p < 0.01$) and cumulative serious assault ($r = 0.111$, $p < 0.01$). Furthermore, correlations with suicidality were observed for duration of abuse across all types, and this was especially apparent when the abuse in question was physical ($r = 0.104$, $p < 0.01$) or financial ($r = 0.097$, $p < 0.01$) 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 significantly greater proportion of clients within the suicidal group – 15.6% ($n = 133/854$) – had been abused by more than one person, compared with 8% ($n = 211/2,665$) of the non-suicidal group.

Suicidality was also correlated significantly to clients' individual responses to questions on the CORE-10 measure of psychological distress, as well as to their total scores. Being subjected to domestic abuse is highly traumatising, so it is perhaps unsurprising that almost 86% ($n = 3,022$) of the sample scored above the cut-off ($n = 11$) for the clinical range on the CORE-10. Even so, a statistically significant difference was observed between the suicidal and non-suicidal client groups in the data: indeed, the mean score for suicidal clients was 7.293 points greater than for non-suicidal clients.[4] Of those in the suicidal group, 49% had scores in the 'severe psychological distress' range ($n = 419/854$), compared with 14% of the non-suicidal group ($n = 370/2,665$). In terms of individual items within the CORE-10, clients' responses to questions about feeling despairing or hopeless, experiencing panic, terror or past trauma, were most highly correlated. Of those in the suicidal group, 96% ($n = 821/854$) reported feeling despairing or hopeless. This is striking, but it is worth noting that such feelings were shared by 79% of the non-suicidal group, reflecting the broader impacts of domestic abuse ($n = 2,099/2,665$).

Suicidality was also correlated with most of the individual items taken from the CAADA-DASH risk-assessment measure, as well as – in respect of the subsample of 1,379 clients for whom the data were available – total risk-assessment scores ($r = 0.210$, $p < 0.01$) minus the specific CAADA-DASH suicide question. In this latter respect, however, the difference in mean score between the suicidal and non-suicidal groups was relatively small, at only 2 points ($M = 11.55$ ($SD = 3.85$) vs $M = 9.56$ ($SD = 3.96$)). The strongest correlations within individual

measures used for assessment in the CAADA-DASH were observed between suicidality and feeling depressed ($r = 0.304$, $p < 0.01$) or isolated ($r = 0.169$, $p < 0.01$). Feelings of depression were reported by 60% of those clients in the sample who responded to this question ($n = 1{,}859/3{,}112$), but depression was particularly prevalent amongst those in the suicidal group, with 86% ($n = 654/761$) reporting feeling depressed, compared with 51% ($n = 1{,}205/2{,}351$) in the non-suicidal group. Furthermore, 65% ($n = 503/778$) of suicidal clients reported that they felt isolated from family and friends, compared with 45% ($n = 1{,}088/2{,}419$) of their non-suicidal counterparts. This can be seen to confirm previous research suggesting that 'abused women are at increased risk of engaging in suicidal behaviour because they feel helpless to escape the violence and, as a result, feel depressed and hopeless' (Kaslow et al., 1998: 534) (Haar, 2010; O'Connor, 2003).

For many clients, of course, these feelings of despair, hopelessness and isolation also intersected in complicated ways with alcohol and drug issues, or broader psychological health difficulties and depression. Significant correlations between suicidality and additional needs in relation to both drug use ($r = 0.209$, $p < 0.01$) and alcohol ($r = 0.144$, $p < 0.01$) were identified in our analysis. Indeed, 13.2% ($n = 107/811$) of those in the suicidal group were recorded as experiencing additional needs related to alcohol, compared with 4.7% ($n = 122/2{,}570$) of those in the non-suicidal group. Likewise, 33% ($n = 260/790$) of suicidal clients were recorded as experiencing needs related to drugs, compared with 14% ($n = 348/2{,}501$) of non-suicidal clients.

The existence of children was, however, a positive and protective factor for many clients and negatively correlated with suicidality ($r = -0.211$, $p < 0.01$), preventing them from acting upon any suicidal thoughts and – to some extent at least – offering the prospect of hope. 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 in the way of a narrative response (56%, $n = 119/222$) stated that their children were the primary reason they did not act on suicidal thoughts. This confirms the findings of Welch (2001: 373), who concluded that 'the presence of children in the household may serve as a protective factor'. Across our sample, there were 4,158 children recorded as living with clients and a further 554 living elsewhere. Where children were living with clients, the vast majority of carers for these children were female (97.52%) and almost 22% ($n = 696$) of female clients in the sample were either pregnant or had given birth in the past 18 months. While caring for children is thus a significant factor in the lives of many female victims of domestic abuse, and appears in many cases to have a protective influence in respect of suicidality, it is also important to note that – as will be discussed below – the presence of children can also reduce women's likelihood to disclose suicidal ideation at all, which may diminish their prospects for psychological recovery. This may be particularly worrying, moreover, in a context in which other relatively common reasons given by clients for not acting upon suicidal thoughts included having since escaped the abuse and/or feeling safer (16%, $n = 36/222$) or obtaining help from a professional (11.7%, $n = 26/222$).

Using our dichotomous yes/no suicidality question as the dependent variable for a binary logistic regression, we also explored predictive models amongst the most highly correlated variables outlined above. This revealed that the odds of belonging to the suicidal group were 3.5 times greater for those who feel depressed than for those who do not, 1.87 times greater for those clients who do not have children, and 1.69 times greater for those who feel despairing or hopeless. Furthermore, the odds of belonging to the suicidal group for those experiencing difficulties with drugs was 1.59 times higher, and 1.68 times higher for those experiencing problems with alcohol. Those clients who reported that they felt unable to cope were 1.28 times more likely to be in the

suicidal group, and for every additional type of sexual abuse experienced, the odds of belonging to the suicidal group increased by a factor of 1.25.

Pathways to suicide are complicated and non-linear. They relate in complex ways to an individual's personality, their resilience, cognitive and problem solving styles, psychological well-being or mental ill-health, and exposure to trauma and other adverse life events, as well as their susceptibility to various inherent or situational vulnerabilities, including alcohol or drug misuse, social isolation, unemployment, poverty and homelessness. They are also linked to personal engagements with the communities and contexts designed to offer support and resilience. Thus, as O'Connor and Knock (2014; 73–74) have noted: 'although a range of risk factors for suicidal behaviour have been identified . . . how or why these factors work together to increase the risk of this behaviour is not clear'. It has not been, and could not be, our assertion that domestic abuse *causes* suicidality: rather, our claim is a more limited one, namely that there was a significant prevalence of suicidality amongst this constituency of domestically abused clients, which merits further exploration. This is particularly so in a context in which the psychological distress attributable to victimisation can coalesce with a condition of entrapment (actual, perceived or both) to produce a sense of hopelessness and isolation that – in some cases – translates into a belief that suicide may be the only way out. Previous research has demonstrated that 'when an individual feels both defeated and trapped, the likelihood that suicidal ideation will emerge increases when motivational moderators (for example, low levels of social support) are present' (O'Connor and Knock, 2014: 75; see also O'Connor, 2003; Williams, 2001). Thus, we argue that policy-makers and service providers must identify ways in which to disrupt this dynamic by offering reliable forms of redress and rehabilitation. As we explore in the next section, however, the obstacles to this remain substantial in England and Wales, and will require concerted investment in, and improvement of, current responses.

Understanding context and uncovering challenges: Fieldwork interviews

These findings from Refuge's IMPACT database present a striking picture of the scale of suicidality amongst adult victims of domestic abuse in England and Wales, and give some indications as to the types of experience and circumstance that may increase a person's susceptibility to suicidal ideation. To gain further understanding of the complex needs of this constituency and explore the perceived adequacy of existing instruments for risk assessment, as well as processes for providing support and safety planning by voluntary and statutory sector agencies, we triangulated our analysis of case files with a series of semi-structured interviews.

Twenty Refuge expert practitioners participated in these interviews, the majority of whom had extensive experience working in the domestic abuse and violence against women sector over many years. Participants were engaged in a variety of roles including providing support – both over the phone and face-to-face – to clients in the community, engaging in frontline work within refuges, coordinating multi-agency risk-assessment conferences for high-risk clients, and training professionals on how to identify and respond to clients who have experienced domestic abuse. Interviews lasted between 45–80 minutes and were recorded, transcribed and then coded thematically on a grounded basis using Nvivo.

Key findings from these interviews confirm the picture presented by the client case files in terms of the prevalence and patterns of suicidality amongst victims of domestic abuse in England and Wales but raise additional perspectives regarding the challenges that can be – and currently

often are – faced in identifying and responding appropriately to this vulnerable population. In this section, we draw attention to three sets of findings in particular – (a) the scale of suicidality and perceived mediators and moderators of risk; (b) the processes for, and potential to, support domestically abused clients who are suicidal; and (c) the impact upon and support for workers' own psychological well-being as a consequence of doing this work.

The scale of suicidality and perceived mediators and moderators of risk

The interview data broadly confirm findings from the IMPACT database in suggesting that suicidal ideation, suicide attempts and suicide are far from uncommon amongst the clients with whom Refuge as an organisation interacts. As one participant put it: 'it's scary the amount of clients that will say that they are thinking about, thinking about ending their life' (Interview 1). Estimates varied between respondents. One Independent Domestic Violence Advocate, who had looked over a sample of 100 of her cases prior to the interview, reported that 21 of these 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. Meanwhile, others gave higher estimates in the region of 40–50%, and one suggested that as many as 80% of her female clients had reported feeling suicidal at some point to her.

There was also a suggestion amongst some interviewees that they are seeing more suicidal clients now than in the past. A number of explanations might be given for this: it may be that the numbers of women prepared to reach out and access support is increasing overall, without a proportionate increase in suicidality. Equally, it may be that the scale of the problem of suicidality in abusive contexts is increasing, perhaps because social and structural resources, which may previously have intervened to promote resilience and recovery, are weakened in times of fiscal austerity, or because of a broader increase in the prevalence of self-harming particularly amongst young women (it is estimated that one-fifth of women under the age of 24 will have self-harmed, although the majority do not seek treatment (NHS Digital, 2016)). In the present study, however, it is impossible to confirm the existence of any such trend, let alone to try to account for it, since we did not have access to the requisite longitudinal data.

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. Data from IMPACT lent further support to this: suicidality was identified in 33% ($n = 87/264$) of ISVA clients, compared with 31.6% ($n = 292/923$) of clients in refuge accommodation and 20.33% ($n = 474/2{,}331$) of IDVA and community outreach clients. Some interviewees suggested that this was because the nature of sexual violence went to the core of a person's self-identity, and others hypothesised that it created more intense feelings of self-blame. Meanwhile, others emphasised that the often long-term nature of domestic abuse (in contrast to the potentially, but by no means exclusively, one-off, isolated nature of a sexual assault) compels its victim to develop a level of resilience (Interview 13). Other interviewees also noted that in the domestic abuse context, there are often practical issues around housing and the care of children that compel victims to put their own mental health issues on hold, or that make clients less likely than in the ISVA context to disclose feelings of suicidality.

In respect of factors perceived to increase or decrease the risk of suicidality, participants were keen to emphasise that – in line with findings by Pico-Alfonso et al. (2006) and McLaughlin et al. (2012) – the psychological impacts of emotional forms of abuse can be just as, if not more, significant than those of physical forms of violence. As one Refuge practitioner put it, '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 well-being' (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).

In line with the findings from the case files, engagement in alcohol or substance misuse and the existence of psychological distress or depression were identified by respondents as likely to increase clients' propensity to suicide, suicidal ideation or self-harm. In addition, the extent to which clients had ongoing relationships with family and friends, or other community support networks, was suggested to be crucial. As one interviewee put it, '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 example, one observed: 'I think that isolation makes it quite likely that someone's going to attempt or complete suicide. I think that feeling of not being listened to or unvalued, not having anyone that you could reach out to or you feel like those support networks that you had maybe are not what they were, or maybe you feel like you have exhausted them already' (Interview 16). At the same time, some interviewees acknowledged a tension in that strategies designed to ensure clients' safety, for example, relocating them to a refuge in a different area, may contribute to feelings of isolation, particularly if there are limits on who is entitled to visit (Interview 3 and 6). Importantly, such concerns need to be offset against the fact that many women in refuge accommodation cite the connection with others, and the opportunities this presents for peer-to-peer learning and support, to be one of the main avenues to recovery (Campbell, 2012).

The tone and outcome of clients' engagements with statutory agencies were also identified as having an impact upon their suicidality, with particular areas of concern being around their ability to obtain housing and their access to funds if they have a precarious immigration status. In addition, several respondents suggested that interactions with the criminal justice system can 'contribute towards the suicidality of the women' (Interview 12), either because of the stress associated with giving testimony in court or the disappointment at cases being dropped or convictions not being secured, which often translated into a feeling of not having been believed or not being worthy of protection. It was emphasised, moreover, that just because a client gets a 'good' result from the criminal process, it does not necessarily decrease their emotional vulnerability, since convictions can impact on other family and community relationships in ways that are profoundly negative for the client herself. One interviewee, for example, 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? For some people the outcome is good, but it's not good in the same sense as well' (Interview 7). Interviewees suggested that clients often experienced a decline in their psychological well-being when the criminal justice process ended. In this context, some respondents stated that withdrawal of services from clients at the end of a court case could contribute to feelings of isolation and increase the possibility that the client might 'fall through the cracks' in service provision (Interview 3), which could in turn exacerbate or promote feelings of suicidality.

Amongst the factors identified as making it less likely that a client would have, or act upon, suicidal thoughts, the overwhelmingly most common one – in line with the findings from the IMPACT database – was the presence of children. As one respondent put it, '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). Though less common than children, a further factor that was also identified by practitioners – particularly but certainly not exclusively in relation to women in South Asian communities in the UK – was the existence of a religious belief. 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 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, whatever, those things kind of stop, I know they stop them' (Interview 17). In relation to both children and religious belief, however, respondents pointed out that these were factors that could also decrease the likelihood that a client would be truthful about her suicidal thoughts, either for fear that social services will remove her children or because of the disapproval with which such thoughts would be received in her religious community.

This, of course, speaks to a broader question of how to facilitate disclosure. In this respect, most interviewees were confident that, while they may not always do so at the initial risk assessment, clients would honestly disclose suicidality or suicidal ideation to them at some future point. They emphasised the importance in this context of building a relationship of trust and reassuring clients that they would not be 'judged'. As one expert practitioner put it, '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 also expressed concern about whether, with their current high caseloads (which in some cases required them to provide active support to 30–40 clients) and the increasing provision of support to clients over the phone, rather than face-to-face, there were additional barriers to creating the spaces in which such disclosures would be forthcoming. 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).

The processes for, and potential to support, suicidal clients

These latter comments map onto a broader tension which relates to the second theme around processes for, and potential to support, suicidal clients. This tension partly exists as a result of what several respondents suggested was the increasing interest amongst commissioners of domestic violence support services in risk-reduction responses that prioritise short- to medium-term safety over longer-term client recovery. The significance of this may be particularly acute in respect of clients in refuge accommodation, whose needs may be particularly complicated but whose recovery may be expensive and protracted; and it is notable, as discussed above, that rates of suicidality were indeed higher amongst this constituency.

In terms of the processes that underpin their risk-assessment and safety planning, Refuge support workers were broadly positive about the ability of the CAADA-DASH to provide a

'backbone' (Interview 16) to their engagements with clients, and a number commented positively on the fact that it was a 'universal tool' which made it easier to advocate on behalf of clients with other agencies (Interview 5). Nonetheless, a number of interviewees did also express concern that there was a danger of it becoming too much of a 'tick-box' (Interviews 9 and 15) exercise, capturing information targeted at satisfying the short-term and strategic priorities of funders rather than addressing the needs of clients (Interview 13). In addition, several drew attention to some of its 'blindspots', including in the context of this study, its ability to capture the complex and damaging dynamics of psychological abuse, its potential to encourage a relatively restrictive view of self-harm, which excluded a number of the harmful and risky behaviours clients might engage in (for example, excessive alcohol or drug use, sleeping rough, or engaging in promiscuous sexual behaviour), and its tendency to focus primarily on the risk of harm from perpetrators over the risk the client poses to herself. As one Refuge expert 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). Despite this, several respondents emphasised that an element of professional discretion would be retained to enable caseworkers to treat a client as high-risk where there was a concern in respect of suicidality, even though this may not be reflected in their CAADA-DASH scores.

Concerns were also expressed by some Refuge staff regarding the inflexibility of existing risk-assessment tools, and particularly the CAADA-DASH, to measure changing circumstances: 'I don't know how much it is accurate all the time because . . . somebody can score a 5 and still be at high risk tomorrow, it doesn't necessarily mean that this person is going to be at this risk forever, but I guess it is a tool that works and could be changed to work better' (Interview 5). Meanwhile, others worried about the extent to which the 'scores' generated by risk assessment, designed to facilitate identification of high-risk clients for review at a Multi-Agency Risk Assessment Conference (MARAC), could be used by statutory agencies as a gate-keeping tool, restricting support to clients who fail to meet that threshold. As one interviewee 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). More broadly on this point, a number of respondents felt that insufficient mechanisms were in place to support clients with 'chaotic lives' who are often the most vulnerable. Examples were provided of cases in which counselling or drugs 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). In addition, cases were recounted, which reflected a disjointed approach to service provision across agencies, for example with clients being told they could not access alcohol recovery services until they had somewhere 'stable' to stay away from the perpetrator, but then being denied local authority housing and having nowhere else to go.

A key concern was the availability of mental health support for clients in general and suicidal clients in particular. While appreciating the resource constraints under which mental health services are operating, and despite evidence of some good localised practice, several respondents commented on the extremely long waiting times for accessing appropriate mental health assistance, which placed an increased pressure on them as Refuge expert practitioners and delayed, or potentially derailed, their clients' recovery. One IDVA 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, and raised concerns about the paucity of support available in relation to historical experiences of domestic abuse. Another IDVA employed

by Refuge, echoing this frustration at the lack of resources available, 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 leads to situations in which clients 'get bounced between the GP and kind of secondary mental health services' (Interview 4) without ever receiving appropriate support.

These concerns are further bolstered, moreover, by existing research which indicates that – though many suicidal individuals suffer in silence – many others struggle with suicidality in plain sight. Indeed, research suggests that 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, often seeking mental health support (NHS Digital, 2016; see also Devries et al., 2011; Stark and Flitcraft, 1995). Adopting the UK Government's perspective that 'suicide is preventable' (Department of Health, 2017: 4), this suggests that many more individuals could be helped towards recovery if the professionals with whom they interact were encouraged, supported and resourced to respond more proactively.

In respect of clients who were, in the opinion of Refuge expert practitioners, imminently suicidal, a number of additional concerns were raised. Several interviewees recounted situations in which clients had been told by GPs or community mental health teams to go to Accident and Emergency departments, noting 'if someone's really in crisis, I don't think they are going to be getting the bus up to A and E to sit there and wait' (Interview 16). The experiences relayed by interviewees who went with clients to A and E for such assessments confirmed that they were often required to wait a 'pitifully long' time (Interview 12) – often in the region of 6 or 7 hours – only to receive inadequate provision, for example, being asked generic questions about 'what day is it today' or 'who is the prime minister', being given a prescription for medication and sent home with little or no follow-up provision, or in the case of one woman, overhearing a triage nurse alert the on-call psychiatrist to her presence in the waiting room with the phrase 'I've got another one here, it must be a full moon or something' (Interview 15).

Where suicidal clients were routed to local mental health crisis teams, rather than hospital Accident and Emergency Departments, for emergency intervention, respondents were broadly more positive, although even here concerns were expressed over whether threats of suicide by their clients were always taken sufficiently seriously. One interviewee spoke, for example, of 'having to put our point across quite firmly' to the crisis team to ensure an adequate response. She then recounted a case in which 'because she (the client) was known to them, they kind of like took their time', even though they had received no updated information regarding her current circumstances and did not know she was living in a refuge (Interview 14). Similarly, another reflected on a case involving one of her suicidal clients in which the crisis team 'took a very long time to get to her, considering they are meant to be 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).

In respect of those clients who are designated as high-risk in the risk assessment and as such marked for review within a multi-agency MARAC forum, there was some evidence of a more coherent provision across support services, including in relation to mental health. But this was by no means consistently so, and it was often seen to be specific to the particular local authority. Not all MARACs include representation from mental health services, for example, and several respondents noted that the agencies which are represented there are often lacking in both the capacity and

the resources to meet the various demands imposed upon them. Moreover, some respondents expressed a broader frustration that such forums were of limited value when discussions were not followed up to ensure that support was actually provided. One interviewee remarked, for example, that the MARAC is 'a very brief and light touch intervention, which I am very glad exists' but 'often people say, you know, it's been referred to MARAC, everything is going to be fine now, and you think "oh my goodness", it is a very, very light touch intervention. In many, many cases, MARACs are quite inconsistent in terms of their quality, in terms of their attendance, in terms of the level of follow-up . . . The MARAC structure can't cope with the levels of people who are being discussed at the meetings' (Interview 10). 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.

Management and impact of support workers' Emotional labour

It is important to bear in mind, of course, that the interviews discussed in this section were conducted exclusively with support workers in the violence against women and domestic abuse context. We have not had the benefit in this study of speaking with frontline staff in mental health, drug and alcohol, housing and children's services, or the criminal justice system, in order to gauge their sense of their provision and multi-agency cooperation. Nonetheless, several of the concerns raised here do correspond with those expressed in previous research that explores other constituencies (Southall Black Sisters, 2010). In addition, to the extent that the data present a picture of Refuge practitioners feeling a weight of responsibility to fill perceived gaps in the provision of, or communication about, support services, this in itself is an important finding that speaks to our third theme around emotional labour.

Domestic abuse, and its impact upon victims, are distressing. Perhaps unsurprisingly, then, many practitioners spoke about the challenges of coping with disclosures about abuse, and about suicidality in particular, in ways that did not distance them from the clients by, for example, 'desensitising' them (Interview 17) or making them 'a little bit robotic' in their responses (Interview 11). Others expanded upon the difficulties of working with trauma, reflecting on the risks of an immediate or longer-term negative impact upon their own psychological well-being and commenting that frontline work with domestically abused clients was not something most people could – or perhaps should – undertake for prolonged periods. As one interviewee remarked, for example, '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). This correlates to pre-existing research, conducted both in the UK and elsewhere, which has identified a significant risk of 'vicarious trauma' and 'burn-out' faced by those who engage in emotional labour, including in providing support to victims of gender-based violence (Baird and Jenkins, 2003; Richardson, 2001; Figley, 1995).

For many respondents, however, these emotional challenges were amplified by a sense of responsibility for holding support provision together when other agencies were not viewed as 'pulling their weight'. One interviewee observed, '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). That a client's suicide would nonetheless be felt to reflect, at least in part, a failure by them to provide all the support that a client needs was

implied: 'that's a lot of responsibility, and you don't ever want to hear that one of your clients has committed suicide' (Interview 5). For those workers who felt this most acutely, it was often difficult to take a 'boundaried' (Interview 3) approach to their job role and adopt the more short- to medium-term risk-management model that was seen as increasingly stipulated by commissioners as part of the funding criteria for domestic abuse services.

On the one hand, it was noted by practitioners that it is important to be clear 'about what our role and remit is and our training . . . You are not there to do everything and hold everything yourself because you can't do it and it's dangerous' (Interview 3). But at the same time, it was also acknowledged by one Refuge senior line manager that in relation to her frontline staff 'as much as I can tell them that you are not responsible for the decisions that someone then goes on to make, we have equipped them as best we can, we have done as much as we can, it doesn't mean that they can go and switch off from that' (Interview 5). Indeed, this same line manager herself went on to recount a case in which 'probably I did do a lot for her (the client) that is probably not really within my capacity as an IGVA [Independent Gender Violence Adviser] but it was more just on a human level, the emotional support as best as I could' (Interview 5). Though many of the Refuge staff we interviewed were keen to point out that they are not mental health professionals, and so felt nervous or wary about undertaking this role, they nonetheless – as this latter comment indicates – often engaged in providing intensive emotional support to their suicidal clients, particularly when longer-term, specialist domestic violence counselling was unavailable. One respondent noted, for example, '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' (Interview 4).

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. Several respondents spoke positively about arrangements within Refuge, 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). Though valuable, it is important to note that a response that relies primarily on peers' beliefs about 'the feelings workers should, and should not, feel and display' (Martin et al, 2008: 46) may increase the anxieties of those who do not experience 'appropriate' emotions. A number of our interviewees observed that more training and clinical supervision directed towards supporting them to cope with the emotional dimensions of handling disclosures of suicidality would be valuable. This was something that they also often indicated that commissioners of domestic abuse support services ought to ensure is included within competitive tenders, and that third-sector organisations needed to retain as an operational priority, even in current times of austerity and increased service demand.

Concluding remarks

By analysing data contained in Refuge's client case files over a two-year period, this article provides detailed, substantial and original evidence, on a significant scale, in respect of the prevalence of suicidal ideation and attempts amongst domestically abused adult women in the UK. It supports existing research, much of it conducted elsewhere, in suggesting a correlation between experiencing domestic abuse and suffering severe negative psychological effects, and attests to the need for professionals who engage with domestically abused women (in healthcare, social service,

immigration, and criminal justice settings) to be more responsive to the risk of suicidality. While the relationship between victimisation and suicide is clearly not linear, our analysis has identified a number of factors that appear to increase or mitigate the risk for individual clients, including the existence of personal and community support networks, the co-existence of depression, or drug or alcohol dependency, the type and duration of abuse experienced, and the ability to hold out hope for the future (often tied to the existence of children in the household). Interviews with Refuge experts who offer frontline support to clients have corroborated these findings, and afforded additional insights into the difficulties currently encountered in accessing appropriate mental health provision, the limitations of existing risk-assessment procedures for identifying and responding to clients' self-harming and suicidality, and the emotional and professional challenges in navigating between short-term risk-reduction and longer-term recovery, particularly in times of austerity.

There is considerably more work to be done to understand the experiences of domestically abused, suicidal women and to ensure that the commitments made by national governments and international organisations in respect of reducing suicidality are honoured. The modern, liberal state has a positive obligation to protect its citizens from inhuman and degrading treatment, as well as from death, and this extends to a requirement for state agencies to have systems in place that allow serious and injurious abuse to be effectively investigated. In furtherance of that, agencies that engage with domestically abused clients must be alert to the risk of suicidality, provide sufficient opportunities and appropriate environments in which to encourage disclosure, and be resourced adequately to provide flexible and tailored support, including in the longer term. In addition, where they do sadly occur, suicides must be subjected to careful scrutiny from Coroners to establish the existence of any context of domestic abuse. Where this is evidenced, the criminal justice system should not only punish perpetrators for the severe psychological harm that domestic abuse inflicted, but expose that perpetrator's liability for manslaughter when that harm is an operative and substantial cause of death (Munro and Aitken, 2018). For the domestically abused women who have taken their own lives, and the many more who have somehow found the resilience and resources to survive, it is vital that we continue to shed this light on the relationship between domestic abuse and suicidality, and develop evidence-based ways in which to improve our current responses.

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Notes

1. https://www.gov.uk/guidance/domestic-violence-and-abuse#domestic-violence-and-abuse-new-definition.

2. For further discussion of the findings and their implications for policy and law reform, see also Aitken and Munro (2018); Munro and Aitken (2018).
3. REFUGE undertakes the majority of its work with adult victims, and does not routinely collect data on the suicidality of children and young people who have experienced domestic abuse, nor does it use standardised psychological risk measures in relation to them. The particular experiences of children and young people, and the mechanisms of support available to them are, therefore, beyond our scope.
4. 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. Thus, we formed a CORE-10 (9 item) total score variable to determine correlations with suicidality instead.

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