The Drive Partnership

Suicide risk in high-risk DA perpetrators cohorts

Luke Kendall – Respect

A partnership between:

Respect

SafeLives Ending domestic abuse

SOCIAL FINANCE

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Session content

- What is the Drive approach?
- Who are the people we work with?
- Suicide: the scale of the issue
- Our research
- Our response

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What is the Drive approach?

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What are the aims of Drive?

- To reduce the number of repeat and new victims
- To reduce the harm caused to victims and children
- To reduce the number of serial perpetrators of domestic abuse
- To intervene earlier to protect families living with domestic abuse

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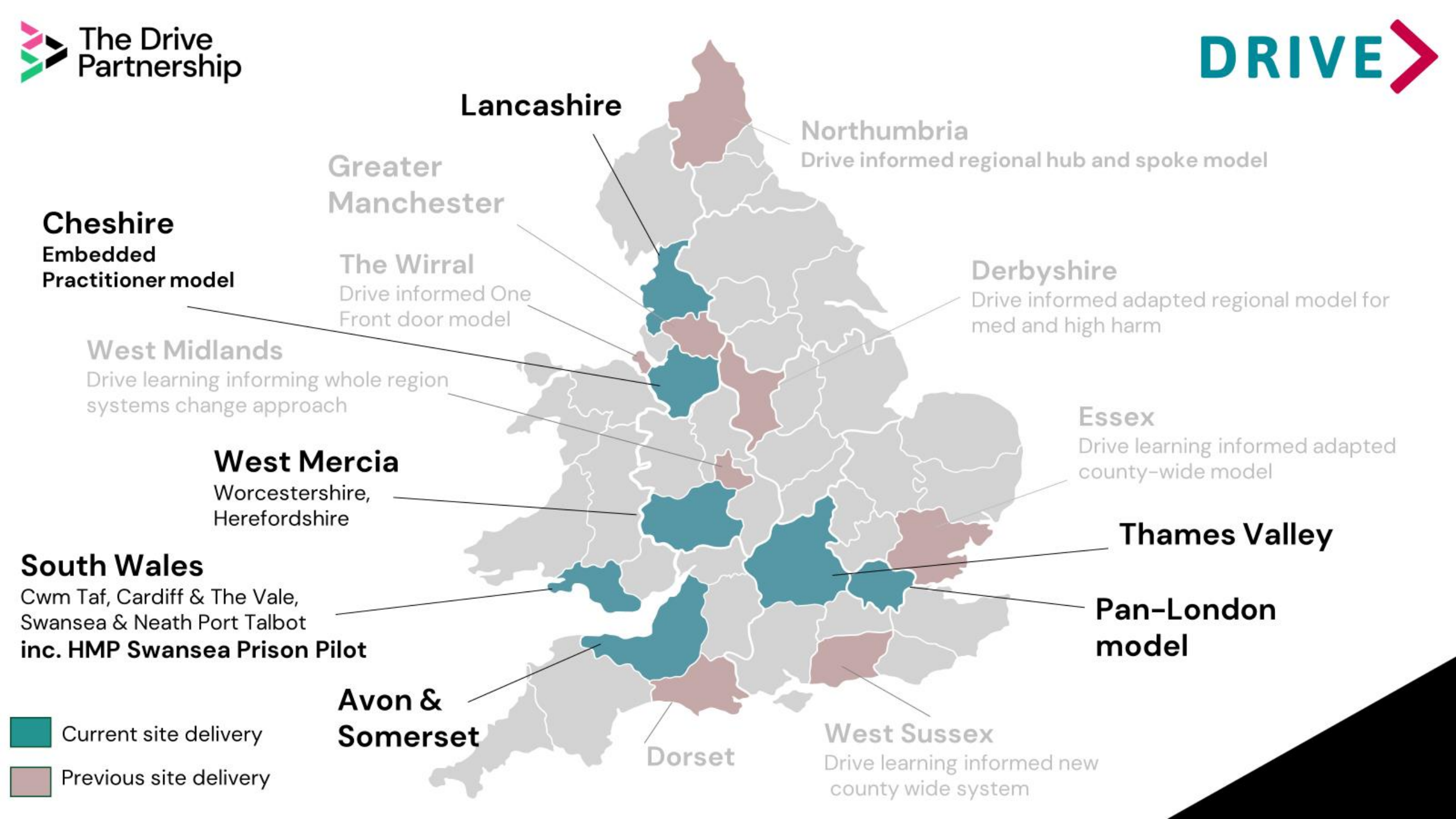
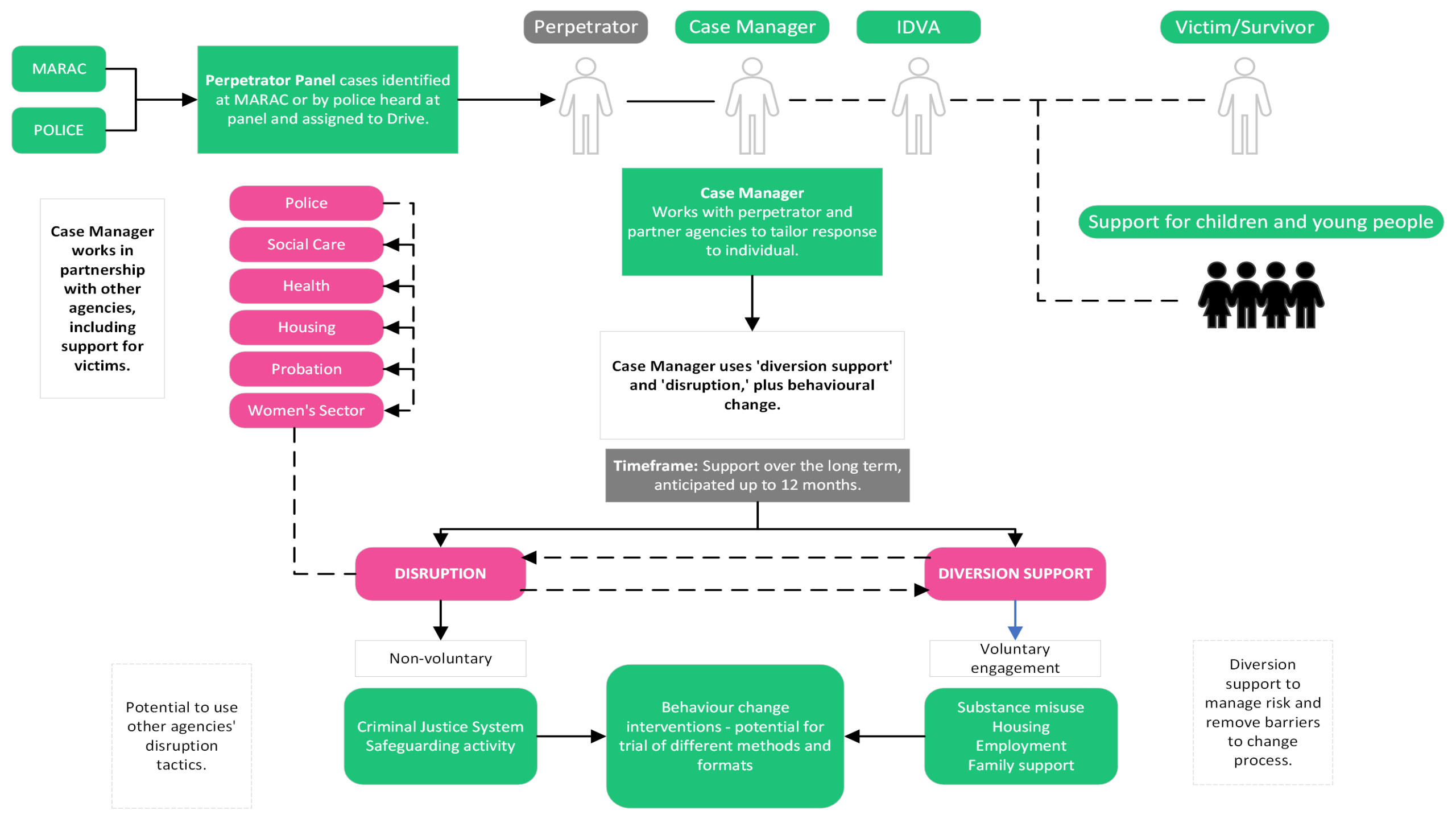
DRIVE




Perpetrator
Case Manager
IDVA
Victim/Survivor
MARAC
POLICE
Perpetrator Panel cases identified at MARAC or by police heard at panel and assigned to Drive.
Case Manager works in partnership with other agencies, including support for victims.
Police
Social Care
Health
Housing
Probation
Women's Sector
Case Manager
Works with perpetrator and partner agencies to tailor response to individual.
Support for children and young people
Case Manager uses 'diversion support' and 'disruption,' plus behavioural change.
Timeframe: Support over the long term, anticipated up to 12 months.
DISRUPTION
DIVERSION SUPPORT
Non-voluntary
Voluntary engagement
Potential to use other agencies' disruption tactics.
Criminal Justice System
Safeguarding activity
Behaviour change interventions - potential for trial of different methods and formats
Substance misuse
Housing
Employment
Family support
Diversion support to manage risk and remove barriers to change process.

University of Bristol Evaluation

Drive has undergone a three-year independent evaluation conducted by the University of Bristol.

The University of Bristol concluded that Drive reduces abuse and the risk perpetrators pose.

DRIVE

is making a difference

The University of Bristol's independent three-year evaluation findings, based on the analysis of over 500 cases, are telling us:

Reduction of abuse

There is a **substantial reduction in the use of abuse.** The number of perpetrators using high levels of abuse reduced as follows:

- **physical abuse reduced by 82%;**
- **sexual abuse reduced by 88%;**
- **harassment and stalking behaviours reduced by 75%;**
- **jealous and controlling behaviours reduced by 73%.**

Reduction of risk

- **For the duration of the intervention, IDVAs reported the risk to the victim reduced in 82% of cases**

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Who are the people we serve?

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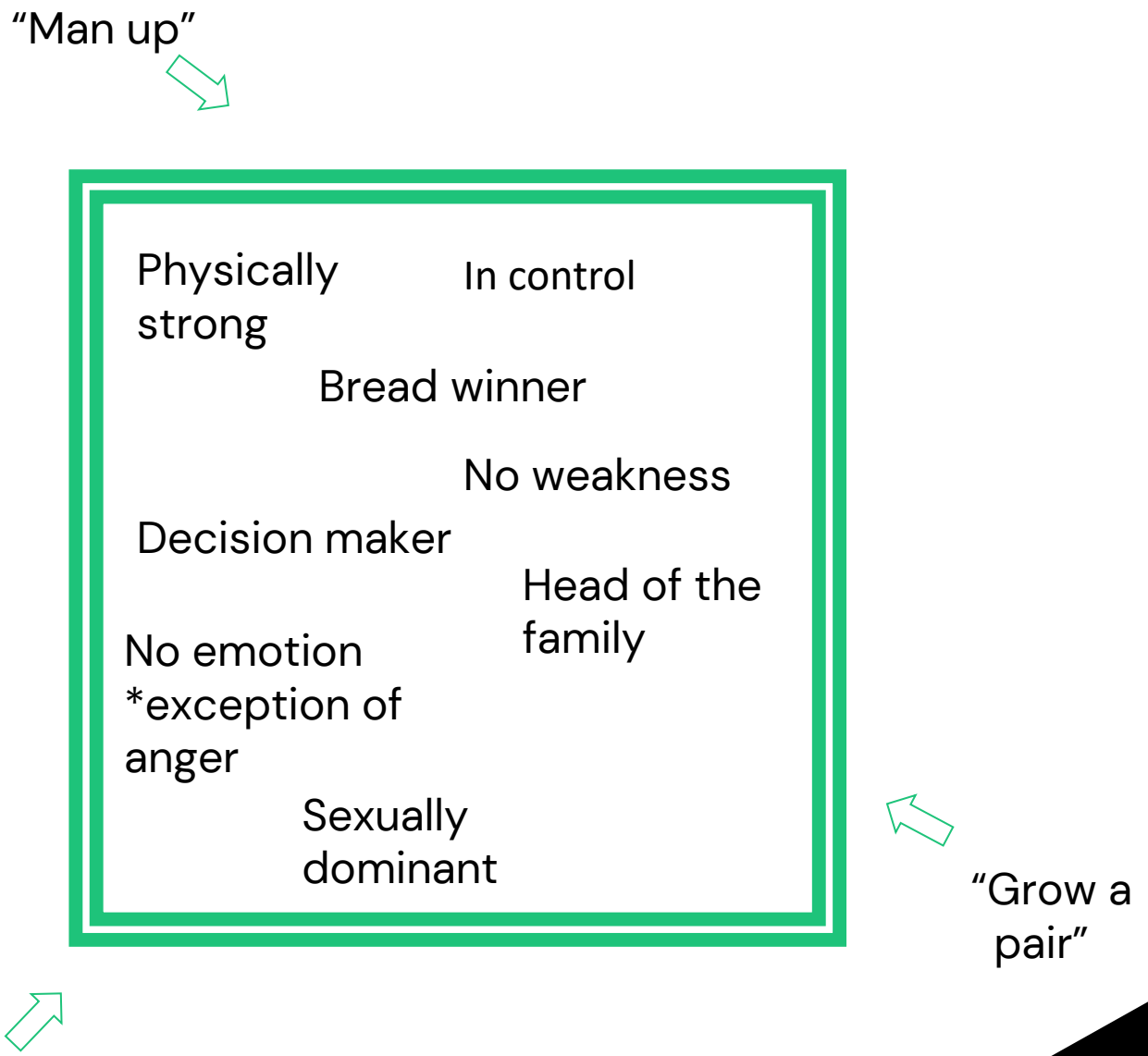
Singular risk factors for DA perpetration

- Attachment (insecurely attached)
- Scripts about the world/love/relationships/self
- Identity formation/gender norm socialisation
- Emotional intelligence/Tony Porter
- Emotional regulation/socialisation intro violence/ vulnerability/Raine (2013)
- Drugs and alcohol
- Mental health
- Suicide…



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Suicide: the scale of the issue

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The scale of the issue

- Suicide is a major world-wide epidemic taking the lives of over 700,000 people a year (WHO, 2019)
- Estimates suggest that 10 to 20 times more individuals attempt suicide
- Worldwide someone dies by suicide every 40 seconds (WHO, 2019)
- 5,583 people (England) died by suicide (ONS, 2021)
- 347 people (Wales) died by suicide (ONS, 2021)
- For ages 10 to 34 suicide is now the second leading cause of death (Hedegaard, et al., 2018)
- 7% of children have attempted suicide by the age of 17 and almost one in four say they have self-harmed in the past year (Patalay & Fitzsimons, 2020)
- Suicide rate in prison populations 83 per 100,000 (Fazel et al., 2017)

Self-harm now takes more lives than war, murder, and natural disasters *combined*.

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Our research

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The scale of the issue in Drive – UoB findings

In this population of high-risk high-harm perpetrators of violence who are in touch with services, we estimate an annual rate of suicide of **461 per 100,000**.

In 2021 the rate of suicide in males in England and Wales was **16 per 100,000**, and the highest rate of suicide was observed in males ages 45-64 at **20 per 100,000** (Office for National Statistics, 2022).

The rate in high-risk high-harm perpetrators of violence is **23 times greater** than the highest age specific suicide rate in the general population (Knipe et al., 2023).

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Our response

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A misunderstood issue

A key motivator which drives people to suicide is **psychological pain, hopelessness**.

Self-harm often originates from feelings of intense emotional distress. Individuals who self-harm describe this behaviour as a way to release overwhelming emotions (RCPSYCH, 2020).

Preconditions for suicidality (Joiner, 2010).

1) a sense of not belonging, of being alone,
2) a sense of not contributing, of being a burden
3) a capability for suicide, not being afraid to die.

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Language is powerful – it matters!

The language we choose reflects our attitudes and beliefs.

Shame & stigma: Not too far in the past, suicide was a crime and thus punishable – decriminalised in England in 1961.

Preferred terminology	Harmful terminology
Died of suicide	Committed suicide
Suicide death	Successful attempt
Suicide attempt	Unsuccessful attempt
Person living with suicidal thoughts and/or behaviours	Suicide ideator or attempter
Suicide	Completed suicide
Describe the self-harm/suicidal behaviour	Manipulative, cry for help or suicidal gesture.

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Protective factors

The factors that make suicide behaviours less likely and can contribute to the client's sense of **self-efficacy** and **resourcefulness** (Reeves, 2020).

Personalised safety plans can lower risk of death by suicide by almost half (Nuji, 2021).

- Quality of therapeutic engagement and the therapeutic alliance
- Capacity for emotional expression
- Informal support (friends, family) & formal support networks (mental health support, counselling)
- Involvement in interests and activities
- Established successful coping strategies
- A collaboratively agreed on crisis plan

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Safety planning proforma

Safety plan

Step 1: identifying warning signs (thoughts, images, mood, situations, behaviours).

- _____
- _____
- _____

Step 2: identify internal coping strategies (relaxation, physical activity).

- _____
- _____
- _____

Step 3: Identifying support networks that provide distraction (people & social settings)

- Name_____Phone_____
- Name_____Phone_____
- Place_____
- Place_____

Step 4: Making contact with chosen support networks

- Name_____Phone_____
- Name_____Phone_____
- Name_____Phone_____

Step 5: Contacting professionals (Samaritans 116123 - NHS 111 - CALM 0800585858)

- Agency_____Phone_____
- Agency_____Phone_____
- Agency_____Phone_____
- Agency_____Phone_____

Step 6: Making the environment safe

- _____
- _____
- _____

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Step 1 – crisis development warning

Identify antecedents/triggers

- Situation: hopeless, despair, nihilism
- Thoughts: “I am bad (shame)”; “I am nothing” (worthlessness)
- Mood: numb, shut down
- Behaviours: withdrawn, sleeping more, rumination, self-neglect

Practice points

Use:

- Motivational Interviewing
- Shame neutralisation
- Pro-social modelling
- Compassionate curiosity.

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Step 1 – crisis development warning

Someone may be thinking of suicide if:
- Feeling trapped, a burden on others and hopelessness for the future.
- Experienced loss, rejection, loneliness or other stressful life events.
- Sorting out their affairs, giving away cherished possessions, sorting their will.
- An unexpected/unexplained improvement in mood. This can be symptomatic of a decision that suicide is the solution to the problem.
- Marked changes in behaviours such as sleeping, eating, drinking, drug-taking or other risk-taking behaviours.
- A history of self-harm or previous suicide attempts.
- Acting out of character or unpredictably.
- Seeming withdrawn, isolating self from others and/or other depressive symptoms.

Explicit examples of where some of the above may present conversationally:

- "My problems will be over soon"
- "I'm beyond help"
- "I can't take any more of this"
- "I'm a burden"
- "I just want it all to be over"
- "I just don't want to face it anymore"

Practitioner responses:

- "That sounds so painful. Can you tell me what exactly you want to be over?"
- "You feel you cannot live with this pain..?"
- "You're feeling like a burden to others. Can you tell me more about this..?"
- "Nothing is going well for you right now..?"

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Step 2 – internal coping strategies

This part of the plan has been evidenced to **reduce the intensity of suicidal ideation** in the short term (Stanley et al., 2021).

Solo distraction activities:

- Listening to music
- Art/drawing/sketching/colouring/puzzles
- Taking a relaxing bath
- Playing computer games/apps on phones
- Watching television
- Walking the dog
- Yoga/mindfulness
- Fishing
- Doing something good for yourself

Practice point:

- Suicidal thinking can occur at any time of day
- Interventions need to be achievable at any time of day/weather etc.
- Be strength based
- Apply SMART

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Step 3 – people/social settings that distract

People and places that offer support and distraction to suicidal ideation.

More helpful	Less helpful
Understanding and reliable friends, family and acquaintances	Bars and nightclubs (and other environments where drugs and alcohol may be in use)
Social settings: coffee shops, parks, gyms, places of worship, museums, cinema and libraries	Gambling settings

Practice point:

- Individuals should be 18+, trusted and safe
- Comfortable talking with
- Prepare for the client to not have anyone
- Caution on listing ex-partners

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Step 4 – contact chosen with supports

This step is enacted when the previous two steps have failed to be effective at distracting from suicidal thoughts.

These are **trusted people who the client can contact for support in a crises**.

Practice point**:**

- Supports made aware that they are in the client's plan.
- The client must explain the plan with the support and their role within the plan.
- Trauma is relational – the client may not have anyone: move on to step 5

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Step 5 – contact professionals

Should all the following steps be unsuccessful, and the crisis continues to develop, the client should **seek support from professionals**.

Agency
Samaritans – 116123 (www.samaritans.org) jo@samaritans.org
NHS – 111 (www.111.nhs.uk)
CALM – 0800 585858 (www.thecalmzone.net/help/webchat)
Andy's Man Club - info@andysmanclub.co.uk https://andysmanclub.co.uk/find-your-nearest-group/
GP
Therapist

Practice point:

- Be responsive to the client. Some may find it more accessible to reach out via a phone call, others via email or webchat
- Discuss the client's perceived barriers to making contact and how they would overcome this barrier

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Step 6 – making the environment safe

Here our focus is on working collaboratively with the client to **remove or restrict lethal means** of suicide.

Whilst not exhaustive, the following are examples:

- Large quantities of prescription/over-the-counter drugs/medications
- Removing triggers
- Razor blades
- Ligatures
- Knives
- Poisons
- Train stations (*agreement not avoid)
- Roads*
- Bridges*
- Firearms

Practice point:

- Risk is dynamic, practitioner and client regularly review the safety plan

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Thank you for your time and contributions ☺

…questions?

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A partnership between:

Respect

SafeLives Ending domestic abuse

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