Policy Brief

UNIVERSITY OF BIRMINGHAM

west midlands police and crime commissioner

Strengthening Prevention:
Enhancing Frontline Services to Support Individuals in Staying Safe from Suicide Following Domestic Abuse

Executive Summary

According to the 2024 Domestic Homicide Project Report, suicide is the leading cause of death within domestic abuse fatalities. As of 2023 the number of deaths by suicide has overtaken the number of deaths by Intimate Partner Violence (IPV).

The 2024 Office for National Statistics (ONS) report of Suicides in England and Wales: 2023 registrations demonstrates an increase in deaths by suicide with over 6000 recorded instances. Domestic abuse in England and Wales reports (ONS, 2024) also indicate that domestic abuse is experienced by approximately 1 in 5 people. In the year ending March 2024, 2.3 million individuals over the age of 16 experienced domestic abuse. Research conducted in Kent and Medway indicated that a potential 30% of deaths by suicide between 2018 and 2024 followed experiences of domestic abuse.

The issue of suicide and domestic abuse is gaining increasing attention, as the correlation between the two becomes more evident. Each death by suicide represents not only a profound personal tragedy, but also has far-reaching social, emotional, and economic consequences for families and communities. Despite this, there are significant service access gaps in the response to domestic abuse. While suicide is often approached through a clinical mental health lens, preventing suicide in the context of domestic abuse requires both psychological and social interventions. These responses must be tailored to individual cases, yet current systems are inadequate across both domains. Given the scale and severity of cases, addressing the current lack of safeguarding and support for survivors vulnerable to suicide is essential in reducing harm and saving lives.

Based on findings from the Domestic Abuse and Suicide Report (2025) by the University of Birmingham - commissioned by the Office of the West Midlands Police and Crime Commissioner - there is an urgent need to develop and introduce improved safeguarding practices within criminal justice and health services. Successful implementation of these practices depends on the effective training of relevant professionals and the creation of clear, survivor-informed support pathways.

Key Findings

Domestic abuse survivors face significantly higher suicide risk than the general population.

- Survivors who attempt suicide typically experience multiple, severe forms of abuse (often more than 17 types), including sexual assault, coercive control, and life-threatening violence.
- Suicidal ideation is strongly linked to feelings of hopelessness, entrapment, and isolation.

Statutory services frequently fail survivors at critical moments, escalating suicide risk.

- Many survivors reach crisis points after being repeatedly disbelieved or dismissed by statutory services.
- Only one-third of participants who attempted suicide feel they received helpful support from police.
- Interactions with health and criminal justice services frequently traumatise or re-traumatise survivors.
- Some survivors report that contact with services made their distress worse.

Professionals consistently fail to recognise and respond appropriately to suicide risk in domestic abuse contexts.

- The mental health impacts of abuse are frequently overlooked by professionals.
- Disclosures of suicidality and abuse are often minimised or misunderstood.
- Such disclosures are rarely explicit and require professional curiosity and vigilance to identify.
- Current safeguarding practices do not adequately respond to suicidality in domestic abuse contexts.
- Service responses are fragmented, inconsistent, and lack appropriate follow-up.

Policy Recommendations

To reduce preventable deaths and protect the wellbeing of survivors being subjected to or in the aftermath of domestic abuse, we recommend the following priority actions:

1 Mandate Risk of Suicide Safeguarding in Frontline Services

Criminal justice and health services should be required to implement routine, context-specific risk of suicide safeguarding practices in all domestic abuse cases. These should include:

- Consistent consideration of suicidal ideation and mental health impacts during frontline encounters with survivors.
- Integrating risk of suicide into existing safeguarding and case management tools (e.g., local safeguarding procedures and documentation requirements).

- Ensure processes are in place so that suicide safeguarding and safety planning are undertaken by the most appropriate professional with the relevant expertise and training.
- Recognition that suicide risk is dynamic and context-dependent, and scored risk assessment tools should not be used to determine safeguarding responses. Instead, services must adopt flexible, trauma-informed approaches that reflect the fluctuating nature of risk and prioritise professional judgement, survivor input, and contextual understanding.
- Regular audits and accountability for implementation services.

2 Enhance Training for Frontline Professionals

Introduce mandatory, accredited training for frontline police officers and health professionals on safeguarding practices related to domestic abuse with explicit inclusion of mental health impacts and suicide. This training should:

- Be survivor-led and follow trauma-informed principles that recognise the impacts of trauma and avoid framing distress solely through clinical mental health diagnoses.
- Cover recognition of suicidal ideation, especially in cases involving coercive control, hopelessness, or depression.
- Include scenario-based learning on how to respond to disclosures and distress signals.
- Apply an intersectional lens and consider the impact of particular abuse types e.g. honour based abuse.

3 Establish National Suicide Prevention Pathways for Survivors

The Department of Health and the Home Office should co-develop and implement national guidance for statutory services to create robust pathways for suicide prevention. These must:

- Include defined referral routes to mental health support services and crisis intervention teams
- Be designed in partnership with specialist survivor support organisations/services and embedded in local safeguarding boards' strategies
- Be in keeping with current best practice guidance specific to the context of each service
- Consider longer-term support that meets the holistic needs of the survivor, not rely solely on mental health support which may not always be appropriate or necessary.

4 Strengthen Multi-Agency Coordination and Monitoring

Ensure every local authority area has an established multi-agency framework to:

- Monitor suicide-related safeguarding in domestic abuse cases.
- Include named leads from police, health, and other support services.
- Review suicide cases involving domestic abuse using appropriate local safeguarding processes

5 Strengthen the Recording and Sharing of Information

Robust and consistent documentation of domestic abuse cases, including victim contact, concerns raised, actions taken, and relevant contextual information, is essential for effective safeguarding, multi-agency collaboration, and the prosecution of perpetrators.

- Ensure all interactions, disclosures, and decisions are accurately and clearly recorded in relevant systems.
- Promote safe and appropriate information sharing with relevant professionals and services, in line with data protection and safeguarding protocols.
- Encourage a culture of accountability and reflective practice in record-keeping to support continuity of care and risk management.

Evidence Base

This policy brief draws on findings from the Domestic Abuse and Suicide Report (2025), conducted by the University of Birmingham and commissioned by the Office of the West Midlands Police and Crime Commissioner. The study was designed to better understand the relationship between domestic abuse and suicide, particularly in relation to support and safeguarding failures.

The research involved three strands:

1. A review of existing literature on domestic abuse and suicide.
2. In-depth interviews with individuals who had experienced both domestic abuse and suicidal thoughts or behaviours, as well as bereaved families.
3. Analysis of police and coroner data to provide a robust indication of prevalence.

Findings from this research highlight the severity of the issue, revealing that instances of death by suicide are significantly more common among individuals who have experienced domestic abuse compared to the general population. The research makes clear there is a critical gap in current support systems for both the prevention of and response to risk of suicide.

Participants frequently reported negative experiences with statutory services during periods of abuse and psychological distress. Inadequate or dismissive responses from individual practitioners - particularly in relation to disclosures of abuse and suicidal ideation - were commonly described, often exacerbating feelings of hopelessness. These findings underscore a critical need for improved training among frontline professionals.

Enhanced training will strengthen the ability of practitioners to identify individuals vulnerable to suicide, improve the quality of their judgment and interactions with service users, and ultimately lead to better service experiences. By reducing the likelihood that individuals feel the police, often seen as their last resort, are unavailable or unsupportive, we can help prevent the deepening of hopelessness that may contribute to suicidal thoughts. This, in turn, may foster greater trust in services and contribute to a reduction in the risk of harm.

In several cases, participants described harm resulting from contact with police or healthcare professionals. Disclosures of suicidal thoughts or abuse were often overlooked, misunderstood, or minimised. The mental health impacts of abuse, particularly in cases involving coercive control, were rarely addressed. These findings strongly support the case for mandated safeguarding procedures and consistent national guidance to ensure survivors receive appropriate, timely, and compassionate care.

The work of the Domestic Abuse and Suicide Report (2025) demonstrates the need for an improved frontline response and demonstrated the clear service access gaps for those who experience domestic abuse. A comprehensive response to domestic abuse must include a clear focus on mental health and trauma, alongside fundamental safeguarding practices, both of which are currently lacking in current systems of support. This response must move beyond clinical diagnoses and instead recognise that distress often reflects the cumulative impact of trauma and abuse. It must also acknowledge that suicide risk is not static, and therefore requires ongoing, context-sensitive assessment rather than reliance on scored risk tools.

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