



Domestic and family violence death of 'Frank'

Domestic and Family Violence
Death Review and Advisory Board



Queensland
Government

Seek Help

If you, or someone you know, need help, then the following services are available to assist.

- **Lifeline** is a 24 hour telephone counselling and referral service, and can be contacted on 13 11 14 or www.lifeline.org.au
- **Kids Helpline** is a 24 hour free counselling service for young people aged between 5 and 25, and can be contacted on 1800 55 1800 or www.kidshelponline.com.au
- **Mensline Australia** is a 24 hour counselling service for men, and can be contacted on 1300 78 99 78 or www.menslineaus.org.au
- **DV Connect** is a 24 hour Crisis Support line for anyone affected by domestic or family violence, and can be contacted on 1800 811 811 or www.dvconnect.org.
- **Suicide Call Back Service** can be contacted on 1300 659 467 or www.suicidecallbackservice.org.au
- **Beyondblue** can be contacted on 1300 22 4636 or www.beyondblue.org.au

Guidelines in relation to safe reporting in relation to suicide and mental illness for journalists are available here: <http://www.mindframe-media.info/for-media/media-resources>

We honour the voices and journeys of those who have lost their lives to domestic and family violence, and extend our sympathies to the loved ones who are left behind, their lives forever changed by their loss.

Our efforts remain with ensuring that domestic and family violence deaths do not go unnoticed, unexamined or forgotten.

A report of the Domestic and Family Violence Death Review and Advisory Board pursuant to section 91Z of the *Coroners Act 2003*.

Published in Brisbane, Queensland by the Domestic and Family Violence Death Review and Advisory Board.

All enquiries regarding this document should be directed in the first instance to the Secretariat, PO Box 1649, Brisbane, QLD, 4000, or by email: Coroner.DFVDRU@justice.qld.gov.au

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About this report

The Domestic and Family Violence Death Review and Advisory Board (the Board) is established by the *Coroners Act 2003* (the Act) to undertake systemic reviews of domestic and family violence deaths in Queensland. The Board is required to identify common systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures that aim to prevent future domestic and family violence deaths.

This report has been prepared by the Board in accordance with section 91ZC of the Act, which authorises the Board to prepare a report about a matter arising from the Board's functions, including about its findings in relation to a case review carried out by the Board. To protect the identity of people involved in this case, names and other identifiers have been changed within this report.

The views expressed in this report are reflective of the consensus decision-making model of the Board, and therefore do not necessarily reflect the private or professional views of a member of the Board, or their individual organisations.

22 June 2017

The Honourable Yvette D'Ath
Attorney-General and Minister for Justice
Minister for Training and Skills
1 William Street
BRISBANE QLD 4000

Dear Attorney-General

In accordance with section 91Z of the *Coroners Act 2003*, I submit to you a systemic review report compiled by the Domestic and Family Violence Death Review and Advisory Board in relation to the domestic and family violence related death of 'Frank'.

At their March 2017 meeting, the Board decided to release this systemic review report to inform current planning processes that aim to improve responses to perpetrators of violence, and to highlight the importance of ensuring that support is provided to them for both their presenting issues, and their underlying needs.

As the primary purpose of the release of the report is to inform current planning processes, the Board recommends that this report not be tabled in the Queensland Parliament in accordance with section 91ZC (6) of the *Coroners Act 2003*.

Yours sincerely



Terry Ryan
State Coroner
Chairperson,
Domestic and Family Violence Death Review and Advisory Board

Overview

This report outlines the deceased's history of domestic and family violence, the known history of service system contact leading up to the death, and potential missed opportunities for intervention that could reasonably be considered to have prevented this death.

It also considers salient issues identified by the Board through the review process, with respect to current reforms being undertaken across Queensland to better prevent, and respond to, domestic and family violence.

In 2014, Frank broke in to a house where his former partner, Sharon, was staying in the early hours of the morning and assaulted her while she slept. He was chased from the premises by another occupant of the house who heard the assault. Police were subsequently called for assistance. After conducting a search, they located Frank in the near vicinity of the premises with self-inflicted injuries; he died soon after.

A range of services were aware of the deceased's multiple suicide threats and attempts prior to his death, and Frank's difficulties in adjusting to the couple's relationship separation, which impacted significantly on his mental health. While this behaviour was indicative of significant emotional distress, Frank self-reported on a number of occasions that he would use suicide threats and attempts as a means to maintain contact with Sharon.

When viewed across a continuum, these multiple threats and attempts can also be conceptualised as a form of domestic and family violence.

The Board has decided to release this report to inform current planning processes across Queensland, with a particular focus on improving responses to men who may use abusive and controlling tactics within their relationships.

This systemic review report highlights the need for better identification of the underlying drivers of such behaviours, to ensure that primary support needs are more appropriately addressed, potentially reducing future risk of harm to both self and others.

A full overview of activities undertaken by the Board, inclusive of preventative recommendations made by the Board, will be provided to the Minister, and published on an annual basis, in accordance with the Board's statutory reporting requirements¹.

¹ As per section 91ZB of the *Coroners Act 2003*

Prior history of domestic and family violence

After being married for approximately 20 years, Sharon and Frank separated about nine months before Frank's death. Frank's mental health was noted to deteriorate after their separation when he became increasingly unstable and obsessive towards Sharon.

Family members identified that, while there had been no known history of physical violence in the relationship, Frank had previously been controlling towards Sharon and that she had found this increasingly difficult to cope with prior to their separation.

A few months before Frank's death, the couple attempted a reconciliation which lasted a period of approximately one month. A psychologist who had been treating Frank at the time expressed concerns that this would undo the progress Frank had made towards adjusting to the separation.

While Frank began making plans for the couple to renew their wedding vows during this time, Sharon quickly realised that she had made a mistake and the couple subsequently separated again.

Frank's coercive controlling violence escalated after this point, as he attempted to retain contact with his estranged wife. Frank's use of violence included property destruction, harassment, stalking and breaking into houses where Sharon was residing. He also made repeated suicide threats and attempts, which he disclosed were an attempt to manipulate his estranged wife into reconciliation or contact.

Although specific details are not available, there is some indication that Frank exhibited similar behaviour during a relationship separation prior to this marriage, with records indicating that a restraining order was previously in effect in another state.

Service system contact

In accordance with section 91E of the Act, this review considered the interaction with, and effectiveness of, any support services provided to Frank, the general availability of these services, and any failures or missed opportunities that may have contributed to, or prevented, this death from occurring.

It is evident that the deceased had contact on multiple occasions with police and hospitals for suicidal behaviours within the context of relationship separation. He was also seeing a psychologist who was working with him to try to assist him in adjusting to his change in life circumstances during this time.

Family members expressed concerns to police in relation to their attempts to support Frank, including reporting him as a missing person or requesting a welfare check after he had made threats of suicide and could not be located (on two occasions).

He was also located by police on two occasions near the premises that Sharon was staying at, intoxicated and expressing suicidal behaviours within the context of relationship conflict, which

resulted in them transporting him to the emergency department under an Emergency Examination Order (EEO) each time².

While it was not reported to police at the time, prior to the night of the death, Frank had also previously broken into the premises that Sharon was staying at, located her in the company of another male and subsequently engaged in an act of self-harm. He was also suspected of attempting to break into her house on another occasion, shortly prior to the death.

Due to their worry about Frank's safety, family members also expressed their concerns to hospital staff or sought help from health practitioners, including taking Frank to a GP for a mental health referral to a hospital. On this occasion he was admitted as an inpatient where it was noted that the stress of his relationship breakdown was triggering overwhelming feelings of depression. Hospital staff later discovered that Frank had hidden self-inflicted injuries which required surgery, and he was subsequently admitted as an involuntary patient to allow for treatment. This status was changed the next day to a voluntary with Frank remaining within the mental health unit for a few days before discharging himself against the advice of hospital staff.

On another occasion, a few months prior to his death, Sharon brought Frank to the emergency department as he had presented at her house with self-inflicted injuries. While his ruminations regarding his relationships was noted, he was subsequently discharged back into Sharon's care after medical treatment was provided, with discharge planning that identified community supports for him to access and follow up the next day by the Acute Care Team. As he denied any current suicidal ideation or intent he was assessed as low risk of suicide, although his chronic risk was noted as medium.

Ultimately there was a record of four presentations with emergency departments or acute mental health teams, in the months following the initial relationship separation, either under an EEO, through referrals from community health practitioners or self-presentations in the company of concerned others. On all occasions suicidal behaviours within the context of the relationship conflict/separation were noted by staff, although there is no evidence of any referrals to specialist service providers in relation to domestic and family violence.

Shortly prior to the death, Frank believed that Sharon had commenced a relationship with another male, although there is no evidence to indicate this was the case.

Two weeks prior to the death, Sharon made a private application for a protection order, alleging that Frank had damaged her property; destroyed nearly all of her personal possessions; was stalking and harassing her, and was pretending to be other family members in an attempt to locate her.

² Pursuant to sections 33 and 37 of the *Mental Health Act 2000*, an emergency examination order can be made by a police officer, ambulance officer or a psychiatrist when strict criteria are met. An EEO authorises a person to be taken to an authorised mental health service and be detained for up to six hours to determine if the assessment documents can be made (by a doctor or authorised mental health practitioner). On 5 March 2017, Emergency Examination Authorities (EEA), under S157D of the *Public Health Act 2005*, replaced EEOs. Under the EEA, a person can be brought into an emergency department by a police officer or ambulance officer if the person appears at immediate risk of serious harm; the risk appears to be the result of major disturbance in the person's mental capacity (e.g. illness, disability, injury, intoxication); and, the person appears to require urgent examination, treatment or care. A person can be detained for up to 6 hours for an examination, which can be extended by a further 6 hours by a doctor, nurse or allied health professional.

Shortly afterwards and prior to the application being heard, Sharon presented at a police station stating that since the separation Frank had become obsessed with her and she believed him to be mentally unstable; that he had engaged in criminal activities (breaking into her house and damaging her property); that he had attempted suicide on multiple occasions previously and that she lived in fear that he would harm her or self-harm in front of her.

She stated that she was residing with other persons due to her fear of him. Police recorded this information as an Intelligence Submission in which it was noted by police that '*she believes he is very dangerous towards her*'.

Issues for review

Identifying domestic and family violence by frontline responders

Based on an analysis of the available records, police did not, at any stage, identify the deceased's behaviour as a form of domestic and family violence, despite it being defined as such under the *Domestic and Family Violence Protection Act 2012*³ (the DFVP Act).

The definition of domestic and family violence under the DFVP Act is inclusive of behaviour by a person (the first person) towards another person (the second person) with whom the first person is in a relevant relationship with that is emotionally or psychologically abusive; or is threatening; or is coercive; or in any other way controls or dominates the second person and causes the second person to fear for the second person's safety or wellbeing or that of someone else.

Relevant to this case, domestic violence includes the following behaviour: damaging a person's property or threatening to do so; threatening to commit suicide or self-harm to torment, intimidate or frighten the person to whom the behaviour is directed; unauthorised surveillance of a person; and unlawfully stalking a person

On nearly all occasions when the deceased came to the attention of the police, he was located within close proximity to where Sharon was staying or he believed her to be staying. He also openly disclosed to officers that his behaviour was in relation to his inability to cope with the relationship separation.

If domestic and family violence related occurrences are not appropriately investigated and classified, officers who respond to future incidents are less likely to be able to identify them as part of a continuing pattern of behaviour. They are instead more likely to respond to them as isolated incidents.

Undoubtedly, there are significant challenges in identifying some of these underlying behaviours for officers in circumstances in which there may be other presenting concerns that need immediate response. For obvious reasons, on the occasions when Frank was located in the act of contemplating or attempting suicide, the primary focus for police was the immediate threat of harm to self he posed, not the potential harm he may have posed to others.

³ Part 2, Division 2 of the Act outlines examples of behaviour that is domestic and family violence inclusive of unauthorised surveillance of a person or threats of suicide.

The actions of the officers in ensuring the deceased received the necessary mental health support on these occasions was commendable.

However, as these occurrences were not identified as domestic and family violence related, no protective assessment⁴ was ever conducted by police using the Protective Assessment Framework. This includes when an Intelligence Submission was created two weeks before the death indicating that Sharon was afraid for her safety and believed that Frank was dangerous.

It is clear, however, that police identified that there was a risk of harm to self and others without the use of the assessment tool. Upon receipt of this report, Sharon and her current address were flagged highlighting the need to treat all calls as urgent due to a noted escalation of harm to self and others by Frank since the relationship breakdown

Although the incident regarding Sharon's report that she believed Frank had wilfully damaged her property was noted as pending further investigation, there was nothing to indicate that an attempt was made to locate and interview the respondent as per section 9.5.1 of the Queensland Police Service (QPS) Operational Procedures Manual (OPM's) (Procedures on receipt of a domestic violence report). There is also no evidence to indicate that the option to pursue criminal stalking charges was explored with the aggrieved on this occasion.

While police were aware that Sharon had made a private application for a protection order at the time she presented at the station, and that this was pending consideration by the Courts, this does not preclude officers from taking other action, including undertaking further investigation to gather sufficient evidence to pursue criminal charges⁵.

The civil response to domestic violence has been implemented to complement, not supersede, a criminal response where one is warranted, which remains a governing principle of the DFVP Act.

Police intervention with an alleged respondent is necessary to facilitate a thorough investigation. It also represents an explicit message to a perpetrator about the unacceptability of domestic and family violence within the community. In circumstances where men named in protection orders continue their abuse, they are less likely to commit acts of severe violence if they have been arrested, indicating that the use of civil protection orders must be in conjunction with vigorous prosecution and significant sanctioning of abusers.

The need for proactive investigation and holding perpetrators to account for domestic and family violence was considered by the Special Taskforce on Domestic and Family Violence, which recommended that the QPS develop and implement a strategy for increasing criminal prosecution of perpetrators of domestic and family violence through enhanced investigative and evidence-gathering methodologies⁶.

As part of the implementation of other relevant recommendations from the Special Taskforce Final Report, the QPS has made significant progress in improving responses to domestic and family violence, including the:

- reinstatement of a State Domestic and Family Violence Coordinator to drive direction and policy across Queensland;

⁴ The Protective Assessment Framework is a tool used by QPS officers to help them identify and assess risk when responding to domestic and family violence related occurrences.

⁵As per section 9.6.4 (Where respondent continues to commit domestic violence before the domestic violence order is issued) of the QPS OPM's.

⁶ Recommendation 131, Bryce Q. (2015) *Not Now Not Ever: Putting an end to domestic and family violence in Queensland*.

- appointment of the Deputy Commissioner (Regional Operations) to champion best practice responses to domestic and family violence and drive cultural change;
- the development and implementation of a QPS strategy for increasing criminal prosecution of perpetrators of domestic and family violence through enhanced investigative and evidence-gathering methodologies; and
- recent commencement of state-wide 'Vulnerable Persons' training which specifically focuses on policing responses to people living with a mental illness and victims of domestic and family violence. This training covers topics including recent legislative changes, as well as communication strategies and scenario based training, designed to improve or optimise police responses to this cohort.

The role and responsibilities of health practitioners

Frank received support from a number of Queensland Health facilities, as well as a General Practitioner and a private psychologist, for his mental health problems and suicidal behaviours associated with his separation from Sharon.

Varying mental illness diagnoses were noted on these occasions of contact for Frank, with his history of suicidal and self-harming behaviour also being recorded. The association between these behaviours, his relationship separation and his problematic use of alcohol and impulsivity were identified by practitioners on most occasions of service.

The deceased was forthcoming in disclosing his relationship difficulties to hospital staff, although he commonly reported feeling embarrassed about his suicide attempts. He stated on a number of occasions that he deliberately made these attempts in the hope that Sharon would discover him or become aware of the situation.

Following these crises, Frank would minimise the severity of his actions and any need for ongoing care, repeatedly reporting that he had accepted the break-down of his relationship with Sharon and was looking to the future. He would commonly deny having any thoughts of suicide or self-harm the day following an attempt.

Family members raised their concerns with health staff about Frank's behaviours, including that they believed that he was suffering severe mental health problems, lacked capacity to make treatment decisions, was vulnerable and presented an ongoing high risk of self-harm or suicide.

In addition to presentations during periods of acute crisis, Frank attended appointments with a private psychologist on multiple occasions between late 2013 and early 2014. Client goals for Frank in this context were focused on grief and loss issues associated with his marriage breakdown, as well as the management of his mood and mental health problems.

Over the course of this therapeutic intervention, Frank reported experiencing suicidal ideation, and having made suicide attempts. He acknowledged the relationship between this behaviour and his alcohol use. During these contacts, Frank also disclosed two more suicide attempts and further hospital admissions in relation to those attempts, to the psychologist.

Safety plans and verbal no-harm contracts were regularly conducted and reinforced with Frank during these sessions. As a result of his strong support network (including his family members and his ongoing care with the hospital outpatient acute care team), an involuntary treatment order was not considered appropriate at the time he attended sessions with the clinician.

At his last appointment in early 2014, Frank reported no current suicidal ideation and that he was feeling clearer in the head. A follow up appointment was scheduled, however, this did not

go ahead due to the clinician being ill. Arrangements were made for Frank to reschedule, however, this was never fulfilled.

In the consideration of this case, and other similar deaths, issues were identified by the Board with respect to the responses by health practitioners to perpetrators of domestic and family violence, including limitations with screening and assessment processes in place at the time. These limitations meant that Frank's use of coercive controlling violence underpinning his presenting behaviours went undetected, and subsequently, was not responded to.

For example, while risk assessments by staff were undertaken in late 2013 as a result of Frank's presentation for suicidal self-harm, with the deceased identified '*at risk of domestic and family violence*', it was not articulated that this was in the context of violence perpetration. This is because the tool used primarily focused on assessing a person's vulnerabilities to future victimisation.

On this occasion, Frank had discussed the ongoing conflict in his relationship with Sharon with staff. A referring doctor had also advised that Frank had attempted to break into his ex-wife's house the night before and was suicidal. Despite this, there is no indication that a connection was drawn between these controlling behaviours and Frank's subsequent presentation to the facility. No referrals to specialist support services were made, nor is there anything recorded to indicate that the safety of Sharon was considered in treatment or discharge planning.

Ongoing informed assessment, taking into account prior presentations and assessments, can provide important information to evaluate a patient's potential risk of harm to self and others, which is necessary for clinicians to provide appropriate care.

Systematic screening and assessment in all mental health settings has been proposed to identify individuals at risk of being a victim or perpetrator of domestic violence, as clinicians are in a position to address this potentially dangerous issue⁷. However, despite research that identifies a high prevalence of domestic violence in psychiatric populations there is limited evidence on how to effectively address domestic violence within mental health settings, including the identification and provision of evidence-based interventions⁸.

In their discussions regarding this case, and other similar cases, the Board acknowledged the challenges associated with responding to persons at risk of suicide within emergency and acute mental health settings, where due to resourcing restraints and a range of situational factors, a response is often limited to the immediate presenting issues.

As such, even though it may be the case that a person's behaviour is considered problematic, in many circumstances there are limited opportunities to intervene from a clinical perspective, as the authority to hold people in these types of circumstances is restricted by legislation that outlines when and how a person can be detained involuntarily⁹.

In its final report, the Special Taskforce on Domestic and Family Violence recommended that the Queensland Government and DV Connect work in partnership to develop a model to

⁷ Riggs, D.S., Caulfield, M.B. & Street, A.E. (2000). Risk for Domestic Violence: Factors associated with perpetration and victimisation, *Journal of Clinical Psychology*, 56(10) 1289-1316.

⁸ Howard, L.M., Trevillion., K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2000). Domestic violence and severe psychiatric disorders: prevalence and interventions, *Psychological Medicine* 40(06).

⁹ At the time of the death this was outlined in the Mental Health Act 2000.

provide immediate access to specialist domestic and family violence support and referral services within public and private maternity hospitals and emergency departments¹⁰.

While this specific recommendation is focused on identifying and referring victims of domestic and family violence rather than perpetrators, the Taskforce does make a suite of recommendations about enhancing access, availability and uptake of perpetrator interventions¹¹.

On 14 September 2016, the Queensland Government released its final report '*When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*' following the establishment of a state-wide clinical review to examine fatal mental health events in Queensland in 2015¹². This review considered the circumstances of 24 homicides or attempted homicides, and five fatalities as a consequence of police use of force interventions from 1 January 2013 to 30 April 2015.

In their final report, the Sentinel Review Committee recommended, among other things, application of the empirically validated 'Historical Clinical Risk Management-20 (HCR-20¹³)' tool to '*bridge the gap between research on violence risk assessment and clinical practice*'.¹⁴ While not specifically limited or targeted to assessing the risk of violence in domestic or family relationships, it is an empirically validated tool that measures more broadly the risk of violence within forensic populations and has been demonstrated to support prediction of post-discharge violence in some studies¹⁵.

Of particular relevance to the circumstances of this case, the Sentinel Review Committee further recommended:

- Increased engagement with family and carers to gain collateral information and advice of potential risks to their safety.
- Comprehensive mental health assessment for all new patients and those with multiple and frequent presentations to emergency departments (on three or more separate occasions within a three month period) and considers a range of historical, contextual and current factors.
- Treatment planning strategies that are based on longitudinal perspectives and includes information about mental illness, the relationship between mental illness and violence, risk factors for violence, and the impact of violence.
- Clinical review processes to include an assessment of the effectiveness of previous care plans and to include strategies to mitigate and reduce the level of risk and stabilise behaviour.

¹⁰ Recommendation 59, Bryce Q. (2015) *Not Now Not Ever: Putting an end to domestic and family violence in Queensland*. Other relevant recommendations include the development and delivery of state-wide training that aims to improve responses to domestic and family violence in both public and private hospitals.

¹¹ For example, see recommendations 71, 81, 82 and 83. Bryce Q. (2015) *Not Now Not Ever: Putting an end to domestic and family violence in Queensland*.

¹² The Mental Health Sentinel Events Clinical Review 2016 was conducted pursuant to the clinical review provisions of Part 6 Division 3 of the *Hospital and Health Boards Act 2011*.

¹³ Douglas, KS., Hart, SD., Webster, CD. & Belfrage, H. (2013) *HCR-20V3: Assessing risk of violence – User Guide*. Burnaby, Canada: Mental Health, Law and Policy Institute, Simon Fraser University.

¹⁴ The HCR-20 is a valid measure of violence risk and research has demonstrated that higher scores correlate with a greater incidence of violence. The tool considers historical variables (past static risk); clinical variables (present dynamic risk); and risk variables (future risk).

¹⁵ Douglas, KS., Shaffer, C., Blanchard, AJE., Guy, LS., Reeves K. & Weir, J. (2014) *HCR-20 violence risk assessment scheme: Overview and annotated bibliography*. HCR-20 Violence Risk Assessment White Paper Series No. 1. Burnaby, Canada: Mental Health, Law and Policy Institute, Simon Fraser University.

- Strategies to improve methods for recording, storing, accessing and retrieving clinical information in a timely manner to inform assessment, management and review of patient's risk.
- Building capacity including through training in violence risk assessment and validated measures.
- Establish communication protocols between mental health services and the QPS to advise changes in care status (including discharge from care) for those consumers who were brought to emergency departments by the QPS.

While specifically excluding people who had died by suicide it is likely that these recommendations, if implemented robustly, will improve outcomes in similar cases to this one in the future. Implementation of these recommendations should extend due consideration to the unique context and circumstances of violence perpetration within relationships characterised by domestic and family violence, to ensure the appropriate identification and management of risk within these settings.

This may include, but not be limited to, a greater detection of, and response to, non-physical abusive and controlling behaviours which underpin these types of relationships.

It would be beneficial if consideration is also given during the implementation of applicable recommendations from the Special Taskforce Final Report, and the Sentinel Event Review Committee, to the broader support needs of people who use violence within their relationships.

While not dismissing the importance of holding perpetrators to account for their use of violence, addressing the underlying drivers of these behaviours is likely to lead to better protective outcomes for victims, and more effective interventions for perpetrators.

As highlighted in the National Outcome Standards for Perpetrator Interventions¹⁶, an initiative under the *National Plan to Reduce Violence against Women and their Children 2010 - 2022*, there are a range of generalist service providers who intervene with perpetrators, and it is important that these practitioners are adequately equipped to respond.

The national standards call for women and their children's safety to be the core priority of all perpetrator interventions. They also highlight the importance of perpetrators having access to the right interventions at the right time, and of ensuring perpetrators are able to participate in programs and services that enable them to change their violent behaviours and attitudes.

These standards are not intended as prescriptive measures but rather are designed to guide service responses and embed a focus that prioritises the safety and wellbeing of victims; accounts for the nuanced complexities of this type of violence; ensures appropriate, timely responses; and recognises the need for a responsive and skilled service system.

Consideration should be given to these standards by all generalist and specialist services who may have contact with a perpetrator of violence, with a view to embedding the principles of safety and protection, and accessible, timely responses, within existing service delivery frameworks.

The nexus between domestic and family violence and increased risk of suicide

During the review of this case the Board noted that the relationship between suicidal ideation, threats and attempts, and violence perpetration within intimate partner or family relationships

¹⁶ An initiative of the Council of Australian Governments, the standards can be found here: http://plan4womenssafety.dss.gov.au/wp-content/uploads/2015/04/nospi_coag_paper.pdf

is not well understood, particularly its association with subsequent lethality. This is in part because of a paucity of research in this area.

Improving the understanding of this relationship was acknowledged as critical to strengthening responses to victims of domestic and family violence.

The scientific literature regarding domestic and family violence and suicide generally focuses on two typologies: homicide-suicide and suicide by victims of domestic and family violence. For the most part, research has not explored the nature of suicide among perpetrators exclusive of homicide-suicides, despite evidence that domestic violence related suicides are more common than domestic violence related homicides¹⁷.

It is estimated that 30% of suicides are related to “*intimate partner problems*”¹⁸, though the true level of suicides where actual domestic and family violence has occurred remains unknown. Relationship breakdown is well established as being associated with suicide¹⁹, particularly in males²⁰. Yet, this concept is generally broad and ill-defined, and the exact nature of the “*relationship breakdown*” is lost, with details about possible domestic violence not widely reported.

Perpetrators of intimate partner violence have an increased risk of suicide ideation, and this relationship may be accounted for by the presence of depression²¹. Personality disorders which feature high levels of anger expression, including self-injurious behaviours, are prevalent among perpetrators of domestic violence. Given the apparent correlation between domestic violence perpetration and suicide, a more responsive service system which identifies and manages this elevated risk is needed.

With respect to this recognisable risk, earlier intervention and prevention resources may be required to help men safely separate. These types of interventions should screen for both domestic and family violence and suicide risk, to ensure individual client needs are met. They should also consider the safety of the victim in a meaningful and holistic manner.

Board members identified that it was important to be cognisant that while suicide threats or attempts are indicative of significant emotional distress, they may also be used as an act of coercive control by a perpetrator towards a victim of domestic and family violence. As is evident in the review of this case, these linkages are not always connected or identified, which may reduce the effectiveness of interventions.

Given the complexities associated with the detection and response to this type of violence, there remains a need for frontline practitioners and other staff to be equipped with the necessary skills to detect and respond to non-physical controlling behaviour, and to better understand the potential risk of future harm, either to self or others, associated with this type of abuse.

¹⁷ Davis, R. (2010). Domestic violence-related deaths. *Journal of Aggression, Conflict and Peace Research*, 2, 44-52.

¹⁸ Problems include divorce, break-up, verbal abuse, jealousy, conflict, physical abuse, discord.- Karch et al, (2008), as reported in Davis 2010

¹⁹ Evans, R., Scourfield, J., & Moore, G. (2014). Gender, relationship breakdown and suicide risk: A review of research in Western countries. *Journal of Family Issues*, 1-26. DOI: 10.1177/0192513X14562608 Accessed on 22 April 2016.

²⁰ Scourfield, J. & Evans, R. (2015). Why might men be more at risk of suicide after a relationship breakdown? Sociological insights. *American Journal of Men's Health*, 9, 380-384.

²¹ Chan, K.I., Straus, M.A., Brownridge, D.A., Tiwari, A., & Leung, W.C. (2008). Prevalence of dating partner violence and suicidal ideation among male and female university students worldwide. *Journal of Midwifery & Womens Health*, 53, 529-537.

However, the Board recognised that while a heavy onus is often placed on front-line practitioners to manage these types of issues, a broader response which aims to provide the systems, structure and practice framework for staff, is required to ensure that more meaningful support is provided over the longer term.