There were over 500 deaths by suicide in Ireland in 2010, almost double that of road accident deaths. Death by suicide is the most common cause of death among young men. Most families have been touched by suicide and the devastation that it wreaks on those left behind. This issue of ChildLinks is focused on the theme of understanding suicide, including its prevalence, its impact on children and families, different cultural attitudes to suicide and the role of suicide prevention training.

Dr Dermot Walsh in his article highlights the link between alcohol consumption and suicide rates in the Irish population and concludes that a recent decline in alcohol consumption would appear to have had some effect in the reduction of suicide rates in 2010. Dr Walsh identifies alcohol consumption in Ireland as the most securely identified influence on suicide rates. Recent research on the prevalence of child and youth suicide in the context of the spectrum of deliberate self harm (DSH) is explored in an article by Dr John Fagan and Professor Fiona McNicholas.

The need for understanding of the different cultural attitudes to suicide by different ethnic groups is highlighted by Cairde.

The role of Suicide Prevention Training under the co-ordination of the National Office for Suicide Prevention and as implemented by a community organisation in Belfast is also explored.

The impact of suicide on children and families is explored by Nicola Mitchell from the Barnardos Bereavement Counselling Service. Approximately one quarter of children seen by the service in 2010 had experienced the death of a close relative, most often the father, as a result of suicide. Research has found that children often witness some aspect of the suicide. It is very important that such children and families are supported to come to terms with what has happened.

Many workplaces are now taking steps to put in place suicide policies which encompass prevention and intervention. It is essential that professionals working in social services, including early childhood care and education, are appropriately trained in the skills that will equip them to understand suicide issues and to be alert to the possibility of suicide.
Suicide is ubiquitous in human populations even though its incidence varies in time and place. In very general terms it has usually been commoner in men than in women and in older than in younger persons. Ireland is no exception and has not been immune from this form of death. Recorded deaths by suicides in Ireland date back almost to the middle ages. However, quantitative data on the extent of suicide in Ireland necessarily date only from the legal obligation to register deaths introduced in 1864 although the office of coroner investigating the cause and circumstances of deaths is of earlier origin.
Suicidal deaths have been reprobated in Ireland as elsewhere and by the Catholic Church as by other religions and cultures. Suicides were not buried in Church property and in the case of Dublin were often strung up on what is now called the Five Lamps at Ballybough. Attempted suicide was regarded as a criminal offense. Only very recently has this stigmatisation relented so that since the 1990s legislative and public attitudes to suicide and attempts at it have changed to a more tolerant, decriminalised understanding of the problems faced by suicidal persons.

The extent of the problem of completed suicide in Ireland has been dependent on coroners’ verdicts as every case of death that may have been suicidal has to be reported to the Gardaí and by them to the coroner. The coroner, on reviewing the evidence of circumstances surrounding the death, will return a verdict and sign a certificate setting out the cause of death. This certificate will then be sent to the Central Statistics Office (CSO) for coding and, from this, deaths from suicide will be published in the quarterly and annual reports on Vital Statistics, together with the gender and age of the death concerned.

Because the details available on the coroner’s certificate may be ambiguous or otherwise uninformative, in recent years a form known as form 106 has been issued by the CSO to the garda investigating every case of possible suicide to return his/her opinion as to whether or not the death was suicidal. When returned to CSO, this form helps CSO coders although the form is not necessarily completed in every case. There is another alternative for the CSO, when coding in accordance with the International Classification of causes of death, to code the death as of undetermined intent, that is when there is uncertainty whether or not the death was suicidal. Over the years the number of deaths allocated to this category has varied considerably. Suicide researchers usually regard these uncertain deaths as suicidal.

In Ireland in the past, coroners were, for cultural and religious reasons, reluctant to return deaths as suicidal, particularly in closed rural communities. As a result, suicidal death as officially categorised and returned underestimated the real numbers of the event. An extensive survey from coroners’ records in the Dublin area carried out on deaths in the 1950s and 1960s estimated that numbers returned in Vital Statistics reports could be doubled to arrive at the “real” incidence of suicide. Nonetheless the national rate per 100,000 population were still low in an international, or at least European, perspective. Although there may still be some underreporting this is much less a problem than formerly.

Suicide numbers increased throughout the 19th century up till the outbreak of the first world war and then fell and remained low until a relatively small increase in the 1970s. Thereafter, rates steadily increased, particularly among young males, until the rates for this group had become one of the highest in Western Europe by the 1990s. Nonetheless Irish rates at all ages remained in the middle range of European rates, although higher than those of England and Wales, but rather similar to those of Northern Ireland and Scotland. Irish rates reached a plateau from 2000, increasing in 2009, but fell in 2010. In keeping with experience elsewhere male rates were three times greater than female and among males were highest in the age group 15–35 with one as low as 11 years of age. Contrary to earlier experience, rates among the elderly, particularly in women, were lower than had been the case elsewhere. Methods of suicide vary but poisoning is most common in women and shooting and drowning in men.

A particularly worrying feature of the Irish scene has been impulsive and sudden, out-of-the-blue and unexpected deaths of young males often under the influence of alcohol.
preventative factors are limited because of being so common in any community whereas suicide is still a rare event.

In Ireland as elsewhere faced with the tragedy of up to 500 deaths by suicide, now almost double that of road accident fatalities deaths, prevention has been uppermost in public health policy. For example, an expert group on prevention reported in the 1990s and more recently a further report concerned with prevention emanated, entitled “Reach Out”. In addition, a National Office for Suicide Prevention was established some years ago with a budget of up to five million euro annually. A National Office for Suicide Research was established several years ago and, inter alia, monitors suicide attempts presenting to the emergency departments of general hospitals. Additionally, Dáil debates and Dáil committees have considered the problem. Many of these endeavours have come up with myriad recommendations, most of a very generic nature with little proven value in effectiveness. This is the primary problem with prevention, there is no scientifically proven intervention of major impact on this most persistent of problems. Nonetheless there has been much local and community initiative in this field. Indeed at times it has been difficult to keep track of the number and variety of all such well-intentioned endeavours. Some disquiet has been voiced about the need for some regulation and coherence in this field given the difficulty in establishing cost-effective interventions when the preventive knowledge base is so constricted.

The most securely identified influence, at least in the Irish population, would appear to be alcohol consumption which is now falling rapidly in the face, most likely, of the recession leading to reduced purchasing power.

Internationally some programmes of early identification of persons at risk and their treatment, as for instance by the administration of anti-depressant drugs, have been put in place. Unfortunately evidence of a persistent and sustained impact on suicide deaths rates is hard to find, not surprisingly given the widespread prevalence of risk factors and the rarity of suicide. The most securely identified influence, at least in the Irish population, would appear to be alcohol consumption which is now falling rapidly in the face, most likely, of the recession leading to reduced purchasing power. Other factors relating to reducing alcohol consumption are a story for another day.

CONCLUSION

In conclusion, suicide in Ireland has become a major public health problem now rating as the principal cause of death among young males. The underpinning explanations for this reside in poorly understood cultural attitudes and for this reason, and because of the commonality of risk factors, prevention is a formidable change. The role of alcohol would appear to be substantial and the recent decline in consumption would appear to have had some effect in the reduction of rates apparent in 2010.

REFERENCES

INTRODUCTION

Over the years, different terms have been used to describe intentional acts of self harm, from ‘attempted suicide’, ‘parasuicide’, and more recently ‘deliberate self harm’ or DSH. This later term is now preferred internationally and in Ireland, and is applied to all non-fatal acts of self-harm regardless of the presence or degree of suicidal intention. The National Institute of Health and Clinical Excellence (NICE) guidelines on the management of DSH recognise that ‘the nature and meaning of self-harm may vary greatly from person to person. The reasons a person harms him/herself may be different on each occasion and should not be presumed to be the same’. DSH therefore encompasses a spectrum of risk-taking behaviours engaged in for a variety of motives. Self-harm behaviour may or may not be associated with suicidal ideation, which in and of itself can be usefully considered to exist on a spectrum from self-harming behaviour with high suicidal intent to behaviour with low suicidal intent. Thus the motivation for each self-harm act must be judged separately as part of a comprehensive risk assessment. As a history of DSH is a major risk factor for continued suicidal behaviour, managing DSH is an important part of any strategy to reduce youth suicide.
PREVALENCE

The prevalence of self-harm and suicide have risen dramatically in the western world since the 1960s. DSH is now common in Europe, particularly in young people, and is a significant public health problem. In Ireland, death by suicide is the 5th highest cause of death in 15–24 year olds with a rate of 15.7 per 100,000. It is stark to realise that more people die through suicide in Ireland than are killed in road traffic accidents each year. Fortunately, completed suicide in children is rare. Between 1982 and 1991, 13 children aged 5–14 years died by suicide in Ireland. The following decade saw a rise in deaths, with 38 completed suicides within this age group.

Rate of DSH continue to rise. In 2009, the ‘Irish National Registry of DSH’ reported that 9,493 individuals presented to Irish hospitals with 11,966 episodes of DSH, an increase of 2% from 2008 and the highest rate seen since records began. As in other years, the overall rate of DSH in 2009 was greater for females (222 per 100,000) than males (197 per 100,000). Alarmingly the gender difference is reducing due to an increase in male DSH, when in 2009 females were only 13% higher than males. This increase has been most evident in young males aged 15-19 and 20-24 respectively.

However, prevalence rates such as these are based on hospital records and underestimate the extent of self-harm behaviour, with most going unreported. A United Kingdom study by Fortune and colleagues surveyed over 6,000 15-16 year old students – while 13.2% reported past DSH episodes, only 12.6% of these (or 1:8) had sought medical assistance. Thus, 80-90% of DSH acts in this community self-report survey went unreported. This survey also found that adolescents who self-harmed have fewer categories of people to confide in and felt less able to talk to family members or teachers. They were more likely to seek help from friends. Similarly, in the Irish ‘Lifestyles and Coping Survey’, those students who self-harmed or had thoughts of self-harm were more likely to seek help from a friend before a family member and were least likely to confide in a teacher, and while 12.2% reported past DSH only 11.3% of these adolescents presented to hospital.

Rates of suicidal ideation are far more common. Rates of between 29-44% have been found in Irish adolescents when assessed by questionnaire or interview.

AETIOLOGY

At times, it is difficult to identify any one reason why a young person may engage in self harming behaviour. However, a number of risk factors have been identified in the literature. Psychological autopsy studies highlight the importance of the presence of a psychiatric disorder, most commonly depression, as a risk for a previous suicide attempt. Research also suggests that young suicide attempters are more likely to have psychiatric co-morbidity when compared to non-attemptors, with substance misuse being quite frequent.

Background risk factors for self-harm include a lack of supportive family relationships, family psychiatric history (especially depression, suicide or self-harm and substance abuse), history of abuse, and school or occupation problems. The glamourisation of DSH or suicide by the media is particularly important in this young vulnerable group. Some studies have found individual factors such as problem solving or cognitive difficulties, depression and hopelessness, anger and hostility, and antisocial behaviour to be linked with an increase in DSH. The absence of a risk factor is in itself a protective factor. Specific protective factors include having religious beliefs/attending church, coming from an intact family, having a positive connection to school and neighbourhood, and ‘resilience’ to stress. Thus nowadays, DSH behaviour is regarded as multi-factorial in aetiology and considered to result from a build-up of psychosocial stressors in a person with few protective factors and less resilience to stress.

While the medical lethality of adult DSH has often been correlated with suicidal intent, this is not always the case with adolescent attempters. It is not uncommon for an adolescent’s impulsive DSH to result in high lethality despite a low suicidal intent. Similarly, a young child who takes five paracetamol, which would be considered low lethality, might well have a very strong wish to die. Thus, the seriousness of the method used may not be a useful predictor of risk in the young.

TABLE 1 METHOD OF SELF-HARM USED

<table>
<thead>
<tr>
<th>Method of DSH Used</th>
<th>Number</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overdose</td>
<td>160</td>
<td>81%</td>
</tr>
<tr>
<td>Strangulation</td>
<td>3</td>
<td>1.5%</td>
</tr>
<tr>
<td>Cutting</td>
<td>7</td>
<td>4%</td>
</tr>
<tr>
<td>Jumping from a height; in front of vehicle</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Hanging</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Suicidal ideation only</td>
<td>14</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total</td>
<td>197</td>
<td>100%</td>
</tr>
</tbody>
</table>
Many of these risk factors and associations were evident in a retrospective descriptive study of all children and adolescents who presented with DSH or suicidal ideation to a major pediatric hospital. Over an 11-year period (1993–2003), 231 children presented to the hospital. Data was available in 197 cases (shown in Table 1). Consistent with the international literature, there were more females (74.1%) and the mean age was thirteen. Most of these children (61%) lived with both parents and were attending school. In all, 183 (83%) had made a self-harm attempt, while fourteen presented and were admitted with suicidal ideation alone. In keeping with hospital-based studies of DSH, the most common method was an overdose (81%), usually involving paracetamol, but also antidepressants (9%), benzodiazepines (8%) and antacids and analgesics (12%). The method of self-harm varied by gender. Males were more likely to use a violent method to harm themselves, such as strangulation or jumping from a height. Most children (78%) made the DSH attempt at home, impulsively (80%) when alone (77%), but then spontaneously told another person (60%). More than half of those children who harmed themselves expressed a wish to die at the time of the attempt (58%). Many children had previously harmed themselves (31%), with 12 children doing so on more than three occasions (9%). However, only 1% had previously been admitted to hospital with DSH. The majority of these children (89%) described a recent stressful life-event prior to DSH and in 30% this was within 1–2 hours of engaging in self-harm. Almost half (48%) described a recent conflict with their family, while for around 10%, the stressful event related to both problems with school or peers. Almost three-quarters described academic concerns such as requiring extra help or exam pressure.

More than half of those children who harmed themselves expressed a wish to die at the time of the attempt

When the researchers looked at the days in which the young children presented to the hospital, it was highly significant. Children were most likely to present to hospital on a Tuesday, with the rate reducing by Friday and especially Saturday. However, this excess of DSH presentations on Tuesdays was not seen in June, July and August, suggesting perhaps that during school time week-days are a stressful period for children. Overall, we found that there was a high rate of past and current mental health difficulties. In more than half of the cases (54%), feeling low in mood was the predominant mood at the time of DSH, while anger was present in about a third of cases. Sixteen (9%) children had taken alcohol on the day of presentation with the majority showing signs of intoxication at assessment in the emergency department. Seven children (4%) had taken illicit drugs, with around 10% admitting to a history of substance use. Prior contact with Child and Adolescent Psychiatry Services (CAMHS) had occurred in 18% of these children and 21 (12%) had a history of sexual abuse. A positive family history of psychiatric illness was common, especially among boys.

This study demonstrated many similar findings to previous Irish and international reports. Most episodes of DSH were preceded by a stressful life-event, most often involving family but also due to school and peer-relationship difficulties. A family psychiatric history, including of DSH and suicide,
was also frequently reported, in keeping with findings from ‘Lifestyles and Coping Survey’. This study revealed that adolescents who engaged in DSH were nine times more likely to have a family member with a history of self-harm. In addition, study findings relating to Child Sexual Abuse (CSA) are in agreement with emerging research which suggests that CSA is a clear cut risk factor for both the onset and persistence of adolescent suicidal behaviour. And despite almost one third of these children having a past history of DSH, only twelve had gone to hospital, again in keeping with research, which strongly suggests that those who present to hospital with DSH represent only ‘the tip of the iceberg’.

...school-related stress represents an area for intervention to reduce adolescent DSH.

Useful comparisons can also be made with the large descriptive study by Hawton et al, especially as this UK study looks at a similar age group of children presenting to hospital after harming themselves, and over a similar time period. In this study, it was noted that there were significant reductions in DSH rates during the school holiday periods and that children were more likely to present to hospital after a DSH act on Mondays, except during school holidays, and least likely on Sundays. The authors suggested that school-related stress could partly explain these findings. Similarly, in this Irish hospital-based study we found that there were reductions in the rates of DSH presenting to hospital in March/April, July/August and December, all months which coincide with school holiday periods. There was even a stronger link with frequency of presentation and the days of the week as children were more likely to present on a Tuesday with the rate reducing on Friday and especially Saturday, suggesting pressures of school to be a factor. This hypothesis is strengthened also by the contrasting findings from the ‘National Registry of DSH’ regarding Irish adult DSH rates. These show a peak of self-harm presentations during the spring and summer months, and a fall-off in incidence towards the end of the year, particularly in December, with Mondays and Sundays accounting for 1 in 3 of all DSH presentations. Thus school-related stress represents an area for intervention to reduce adolescent DSH. It is also noteworthy that in this current study, 65% of cases presenting to hospital were in the last year of primary school or in the first two years of secondary school. In Ireland, the primary school cycle traditionally lasts eight years so that children are aged around 11–13 years when moving on to secondary school.

Completed suicide and DSH is rare in children under 12 and is more common in boys than girls. However, with the onset of puberty, this pattern changes, especially among girls, suggesting a link between DSH and the developmental changes of puberty. The earlier onset of puberty in girls may partly explain the much higher female:male ratio in younger teenagers, which decreases as these young people approach adulthood. Unfortunately, this period of transition relating to puberty coincides with another major transition in a child’s life, that of moving from primary school, where a child has the same class and teacher for most classes, to secondary school where the child has to adjust to multiple class settings and subjects taught by different teachers and a very different social milieu where a child likely only knows some of their new classmates. So parents and teachers should be especially vigilant for signs of ‘distress’ during these school years.

The actual time of attendance was recorded in 172 cases and of these 80% (137) presented to hospital outside ‘normal working hours’...This fact emphasises the need to maintain and develop an out of hours on-call Child and Adolescent Psychiatry service so as to comply with these best-practice guidelines

The actual time of attendance was recorded in 172 cases and of these 80% (137) presented to hospital outside ‘normal working hours’, i.e. Monday-Friday, 9am to 5pm, and those who did represented a more ‘at-risk’ group, as they were more likely to have consumed alcohol, to have a history of DSH and to have a family psychiatric history. This fact emphasises the need to maintain and develop an out of hours on-call Child and Adolescent Psychiatry service so as to comply with these best-practice guidelines.

We previously reported on a follow-up study of children who originally presented with DSH. No males repeated DSH while 20% of females repeated, 10% more than once. Of
Limiting access to a potentially lethal method of self-harm is a vital component of any strategy aiming to limit the harm associated with suicidal behaviour.

Limiting access to a potentially lethal method of self-harm is a vital component of any strategy aiming to limit the harm associated with suicidal behaviour. Paracetamol is frequently used in DSH and is often associated with a lack of knowledge by young people of the potentially serious liver complications of paracetamol toxicity. Governments worldwide introduced legislation to limit the sale of paracetamol. In Ireland, such legislation came into force in 2002 both for non-pharmacy and pharmacy outlets – in the case of non-pharmacy outlets, pack-size is now limited to twelve tablets with a maximum of one pack per transaction. Research from the ‘National Poison Centre’ in 2006 showed that since this legislative change, there was a significant fall in the number of tablets taken in overdoses involving paracetamol products24. However, compliance remains a significant problem as shown in a recent study which demonstrated that around half of Dublin City pharmacies and newsagent/mini-marts, and 10% of supermarkets were non-compliant with statutory limits25.

**CONCLUSION**

Irish society has undergone significant and rapid change over the last 20 years, including the decriminalisation of suicide, while the current economic downturn has added to family stress. Youth substance abuse continues at problematic levels. While the pressures on children leading to suicidal behaviour have increased, services in many parts of Ireland are under resourced, over stretched, and remain inadequate, especially for 16-18 year olds. Efforts to educate the public, and especially primary health care workers, about the particular characteristics of depression in children and adolescents is important, as depression is a strong risk factor for self-harm that can be treated. School-based programmes, the Internet and other technologies can provide a way for young people to access reliable health information and help. Ultimately, only through improving the overall knowledge and awareness in society about the importance of youth mental health and wellbeing, and by optimising the delivery of and accessibility to youth mental health services, can the detection of ‘at risk’ youth increase so that suicidal behaviour and other mental health difficulties can be reduced.
The Impact of Suicide on Children and Families

Death is universal and everyone will experience the loss of a close family member or friend at some stage in their lives. Supporting children in their grief can be compounded by the fact that other family members are grieving also. The death of a family member through suicide causes immediate and ongoing repercussions for the whole family.

Suicide may be best understood as a wish to avoid emotional and psychological pain than a wish to die per se. When emotional pain becomes overwhelming, a person may see suicide as the only means to escape the pain and the darkness that they perceive. At the time these feelings seem unsolvable, however there is always another way. While not everyone who attempts or completes suicide is clinically depressed, approximately 90% will have experienced some form of mental distress and/or disorder. Despite attempts at reasoning, sadly many who express suicidal thoughts and ideations will ultimately engage in suicidal behaviours. A significant number of those (approximately 500 people in Ireland in 2010) will succeed in taking their own lives.

Before looking in more detail at the impact of suicide on children it is worth understanding how children perceive death itself.

**CONCEPTS OF DEATH**

- **Separation**: The child is separated from the loved one.
- **Permanence**: Death is permanent and not transient.
- **Irreversibility**: The dead person cannot return.
- **Cessation of function**: The body ceases to function.
- **Universality**: Death happens to everyone.

Children **up to the age of 5** do not fully understand the concept of death but they do react to the separation that death conveys. At this age children believe in magical thinking...
ChildLinks

and may falsely believe that their words, thoughts or actions may have contributed to the death. They may regress to earlier behaviours such as bedwetting or thumb-sucking. They may need to be told about the death over and over.

Children aged between 6 and 8 have a better understanding about the finality of death, although children in the lower end of the range may still view death as reversible. They may ask repeatedly ‘When is daddy coming home?’ They may become preoccupied with practical details surrounding the death and afterwards, e.g. ‘What happens to the body in the coffin?’, ‘How do they get to heaven?’ They may find it hard to concentrate and may feel guilty and blame themselves for the death.

Children aged from 9 to 12 not only understand the permanence of death but also the universality of it, i.e. death can happen to them. They become more aware that there are some questions about death which adults cannot answer easily. Children in this age group may be slightly more prone to psychosomatic symptoms, e.g. stomach aches.

Teenagers from age 13 onwards can experience a range of emotions such as shock, anger, despair, numbness, guilt and anxiety. These are normal responses to grief and tend to be temporary in nature. Younger teenagers may return to more child-like behaviour to counteract the insecurity and vulnerability they are feeling. Some young people may assume a more mature position and claim to be in control and coping well. As a reaction to a close encounter with death some teenagers may engage in risk-taking behaviour. It’s necessary to be particularly vigilant to behaviours such as over consumption of alcohol or driving too fast.

IMPACT ON FAMILIES

Families of those who die by suicide experience similar feelings as those who have experienced other types of bereavement; namely shock, anger, loneliness, guilt and despair. They may also have enhanced feelings of shame and stigma as the taboo around suicide persists. In the wake of a suicide, these feelings may be even more intense and loved ones may also feel a strong sense of abandonment by their loved one.

‘To be bereft by self-imposed death is to be rejected.’

(Lindemann & Greer, 1953, cit. Worden, 1993)

Families desperately seek some kind of framework for understanding the motivations and actions of their loved one. Common questions are ‘How could she have done this to us?’ ‘Why?’ or ‘How did I not notice how distressed he felt?’ While the answers to these questions may never emerge, expressing and exploring them can help family members to come to terms with the reality that so much about suicide behaviour is unknown.

After a suicide families can find themselves in disarray or chaos. Patterns of communication may be ruptured because of the overwhelming grief and distress that individuals are feeling. As a result of social stigma and the personal rejection that families feel after a loved one takes their own life, it may be difficult to talk openly about the suicide itself and the devastation people are feeling as a result. Parents may wish to protect their children from the harrowing details. While this is understandable, other family members, the community and the public at large will know it was a suicide. Therefore children may inadvertently hear details of the suicide from other sources.

IMPACT OF SUICIDE ON CHILDREN

The number of children who discover the body or are present when the body is discovered is often underestimated. In one study, approximately one quarter of the children interviewed directly witnessed some aspect of the suicide but were told the death was not a suicide and that it was due to an accident or illness (Cain, 2002). There often exists, therefore, a contradiction between what the child is told and what really happened. However, the death is public so other family members, friends and neighbours know the truth and this can hinder normal communication because of anxiety of letting information ‘slip’. Children may have a fear of doing the same or that other family members would do the same.

‘Child survivors of suicide have high rates of internalizing symptoms involving depression and anxiety and clinically significant social maladjustment especially regarding academic competence and spare time functioning.’ (Sethi and Bhargava, 2003)

Children will feel the disruption of the family unit and may experience the emotional and practical unavailability of the bereaved parent/family member. They may also feel the economic instability as a previously stay-at-home parent might be forced back into the workforce because of financial pressures. Children may also be subjected to the social isolation and stigma which still attaches to the act of suicide.

TALKING TO CHILDREN ABOUT SUICIDE

Ideally, children should be told about the suicide by a parent or trusted adult as soon as possible after the death. Parents and family members often struggle with the idea of telling children the true nature of the death. This arises partly because the adults themselves are trying to integrate the reality of the
suicide and also because they want to protect the children from the awful harsh truth, that someone they loved actively chose to take their own life.

In Barnardos’ experience of working with children, we find that children know more than what they have been told by parents. They are often present when the body is discovered so they have a visual memory of what happened despite what they may have been told later. When there are gaps in information, children will fill in the gaps themselves; and the fantasy is often worse than the reality. In assisting parents to think about telling children the truth, it’s worth looking at some pertinent questions:

- What does the child/young person know, either from direct observations or conversations?
- What is the child/young person asking via their words and behaviours? Are they acting out some unspoken aspect of the death e.g. a child tying a cord around their neck?
- What will other children or people in their family and social circle say or have said already?
- If a child is not told what has happened, what will they imagine happened?
- If a parent’s plan is to talk to them in the future, when do they envisage telling them? What may need to be in place to make it possible to tell the child?
- What might the consequences be of a child hearing the story from someone else?

If a child is not told soon after the death in an appropriate manner and they discover the truth at a later stage, this may damage the trust in the relationship between them and the parent. They may have been grieving the loss as an accidental death and now will have to reframe their emotional response to integrate the death as self-inflicted.

- Ideally the child/young person should be told about the suicide by a parent or someone very close to them. A parent may need the support of another adult with this.
- Use clear simple language to explain that the person is dead and about how they died. Use words like ‘dead’ and ‘killed himself/herself’.
- Use age-appropriate language and tailor the information to suit the age and maturity of the child; one size does not fit all, so consider talking to children of varying age groups separately. Younger children are more concerned with the absence of the person who died but they may need help to find an age appropriate narrative for the story of the death.
- Go from the known to the unknown ‘Do you remember how sometimes daddy was very quiet?’ or ‘how mum was often sad and couldn’t do things around the house…well that’s because…’
- Talk about how life ended ‘He put a rope around his neck and let it get so tight he couldn’t breathe anymore. When he stopped breathing he died.’ Or ‘She took too many tablets, lots more than you’re supposed to. The tablets were too strong for her body and it made her heart weaker, after a while her heart stopped beating and she died.’
- Allow for more telling later and try to create an atmosphere in which the child feels comfortable about asking questions. If you don’t know the answer, it’s okay to say so but tell them you will try and find out and let them know.
- Emphasise that their loved one had an illness of the mind that meant they weren’t thinking clearly, that their loved one couldn’t think of any other way of escaping the pain/depression. Be very clear that there is always another way. Talking through the worries and fears helps them to feel better.
- Remind the child they are not to blame. Feeling guilty and responsible are very common responses after suicide. Nothing that they said, did or didn’t do would have caused the death.
- Children sometimes ask specific questions about the suicide. This may be difficult for parents/carers to answer, but it does help the child to come to terms with the death. Be prepared to answer the same questions again and again.
- Once a child knows about the death, they may have concerns about what to say to friends. If this is an issue, they may need help to find words to say that they are comfortable with.
- Be prepared for a range of emotions and responses. A child’s immediate reaction might be to ask who will bring them to football matches now. Sometimes they will go outside and play after hearing traumatic news.
- Children and young people need to know that the person who died loved them, but because of their illness they may not have been able to express that clearly. Reassure them that it was the distorted thinking of their illness that made them take their own life and NOT a lack of love for their children.
- Children may become very anxious about the bereaved parent’s mortality. They may need extra reassurance that the parent/carer is in good health and will seek help if needed from their doctor.
- In most circumstances it is better for children to return to school as soon as possible. The structure and routine of the school environment helps children to regain some control over what is often a very chaotic situation.
- It is vitally important that teachers are made aware of what has happened in order to maximise support for the child. Children do not like to be singled out for
special attention but an awareness of the situation will help teachers to be sensitive to the needs, reactions and behaviours of the grieving child.

‘The story doesn’t end with the telling. The telling is only one aspect of a process which takes place over time and not a single isolated event. For many children, especially the younger ones, the story and the details will need to be retold and retold. For virtually all, their understandings will be constantly reshaped and influenced by development, life experiences, social interactions and an accrual of new information about the death.’ (Cain, 2002)

**BARNARDOS BEREAVEMENT COUNSELLING FOR CHILDREN (BCC)**

Barnardos Bereavement Counselling for Children (BCC) was established in Dublin in 1996 and in Cork in 1998. It is a national service which provides:

- Counselling and therapy to children and young people up to age 18 and their families.
- A helpline, staffed by trained volunteers who provide support and information on bereavement to families, members of the public and professionals.
- Training to professional groups and agencies.
- Resources in the form of publications, many of which are available free of charge and also to download from the Barnardos.ie website.
- Research in the area of childhood bereavement.

The majority of children who attend BCC have experienced the death of a close family member, typically a parent. In 2010, 24% of all cases seen by the bereavement counsellors were as a result of suicide. That was an increase of 5% from 19% in 2004. In 85% of cases where a child was bereaved through suicide, it was a father who took his own life. Mothers accounted for 10% of suicide deaths.

While not all children who are bereaved will need bereavement counselling, children who are bereaved as a result of suicide will need particular attention. The higher incidence of discord both before and after a parental suicide leaves children more vulnerable and prone to higher levels of anxiety, distress and mental health issues generally. With good family, community and professional support where necessary, the impact of suicide on children will be less distressing and chaotic.

**HELPLINE T: 01 473 2110**
Open Monday to Friday, 10am–12pm

**DUBLIN** Barnardos, Hyde Square, 654 South Circular Road, Dublin 8
T: 01 453 0355 E: bereavement@barnardos.ie

**CORK** Barnardos, The Bowling Green, White Street, Cork
T: 021 431 0591 E: bereavement@cork.barnardos.ie

**BIBLIOGRAPHY & REFERENCES**

- Barnardos (2001) Someone to Talk To: A Handbook on Childhood Bereavement by Pat Donnelly Barnardos: Dublin
As Ireland entered the 21st century, its population make-up was undergoing gradual change. Currently about 10% of the Irish population is foreign-born, with the British, Polish, Nigerian and Chinese being the largest national minorities.

There is a dearth of data on suicide among these minorities in Ireland though, with the National Suicide Research Foundation of Ireland commenting that ‘mortality data on ethnic minority communities in Ireland is very, very poor’. A number of European and international studies indicate, however, that ethnic minorities and immigrants are at a higher risk of suicide compared to the indigenous population. While the first generation of immigrants is particularly vulnerable, rates remain still high for the children born of immigrant parents.¹

On an individual level, suicide risk correlates with low socio-economic status, a person’s aspirations, experience of racism, acculturation, identity issues, and loss of family and community support. An individual’s personal situation also needs to be viewed alongside two broader factors. The first of these is the socio-economic situation, culture and history of the individual’s community, and the second is the attitudes towards their ethnic minority group in the host country. Research shows that suicide rates are higher in areas where ethnic minority groups are in lower concentrationi and among the visible minorities.²

ACCESS TO MENTAL HEALTH SERVICES

In Cairde’s experience working with ethnic minorities it has been found that access to mental health services for ethnic minorities can be extremely problematic and consequently low, mainly due to a lack of information and language barriers.³

In addition, the experience of other countries suggests that minority ethnic groups have increased rates of mental health problems, high rates of untreated mental health problems, and poor levels of compliance and satisfaction with services, all of which are important risk factors for suicide in people with mental health problems.⁴

Peter Moroney of SOSAD, a suicide awareness and support group in Drogheda, receives phone calls from a variety of nationalities including Greeks, Asians, Bulgarians and Romanians. He identifies language as the biggest barrier to accessing services and recommends that members of ethnic groups be encouraged to set up suicide prevention groups and link up with the mainstream service providers.
Zuzanna Zelnazy, a Polish psychologist practising in Ireland, has assessed 30-40% of her clients as suicidal. Some are adults who have attempted suicide in the past and have not dealt with their issues adequately, while others are suicidal adolescents. She also has adult clients who have not dealt with the suicide of a family member in their past.

When working with immigrant children affected by a suicide in their close environment, Zelazny feels that first assessing how a child is adapting to living in the new country is essential. If the child is experiencing any difficulties adapting to a new country or school, their stress levels will already be high and ‘dealing with suicide on top of other issues can be too much for these kids’.

**CULTURAL ATTITUDES TOWARDS SUICIDE**

Cultural attitudes and communities’ circumstances are other factors to be considered when working with ethnic minority members affected by suicide.

‘Culture shapes people’s view of suicide; different cultures understand suicide and suicidal thinking in different ways. In some countries, thinking about suicide is believed to be caused by evil spirits, bad karma, bad deeds, the actions of ancestors or a previous bad life. In some cultures, there is a strong stigma attached to suicide and the families and carers associated with a suicidal person.‘

**African Perspective**

Very little research has been done on suicide in most African countries, and the figures of suicide incidence vary considerably between different areas. In West Africa, where most people live under immense socio-economic pressure, the suicide rate is very low compared with that of European countries. However, in some African countries, suicide rates are as high as those in the Western Europe.

In most African cultures, suicide is seen as a desperate act and, within some communities, one with strong superstitious links. Death by suicide is rare and there can be a stigma attached to the bereaved family of someone who dies by suicide which can bring feelings of shame and embarrassment. In rural areas, the influence of local customs play a vital role in the way the situation is handled and a death by suicide often leads to unusual traditional burial rituals.

Most Africans turn to the church or the mosque for both physical and spiritual support during difficulties.

In Sudan, suicide is considered a sin for which the eternal punishment is damnation and, as such, often carries with it both scandal and legal complications. As a result, people often deny the cause of death and suicide is a taboo subject. There are many factors that prevent suicidal ideation being put into action, such as strong religious faith, family loyalties and responsibilities, and fear of death. Punishment for attempting suicide can include public flogging, banishment or being ordered to pay a fine to community leaders.

In 1997, however, a Sudanese forensic pathologist, Professor Ali Kobani, claimed that at least 20 cases of suspected suicide are brought to the attention of the mortuary staff of the Khartoum Teaching Hospital per month. According to Professor Kobani, suicide is on the increase among Sudanese women with the chief causes being mental illness, marital suspicions, unwanted pregnancy and parental mistreatment.

In the Gambia, a predominantly Muslim culture, the death of a daughter by suicide was a shocking experience for one family. As a result of the incident, the mother of the deceased made a pilgrim to Mecca to ask for forgiveness for her soul and that of her daughter. The deceased daughter was given a traditional Muslim funeral, however, which would be in contrast with other African cultures.

In Cameroon certain tribes or regions have unusually stern practices for anyone who dies by suicide. A body might be buried naked and the family asked to pay a fine to local traditional authorities as a gift to the gods. It is a painful event with far reaching consequences that can affect the family’s standing in the community.

In Ghana, people believe that to think of suicide is unacceptable and is usually associated with evil spirits. Furthermore, due to religious beliefs, it is automatically assumed that anyone who dies by suicide goes to hell. Customarily, a person who dies by suicide is seen as being cursed and their remains are not treated with the same level of respect as those of an ‘ordinary’ death.

**Africans in Ireland**

There is little data on suicide mortality rates for the African community living in Ireland. A representative at Pieta House, The Centre for the Prevention of Self-Harm or Suicide, has stated that the number of Africans attending their services is almost negligible.

This is not to say that the problem does not exist, but due to the social, religious and cultural implications of suicide, mental health issues are a private matter. People are reluctant and even afraid to discuss their mental health issues and suicidal thoughts for fear of being stigmatised. For this reason, often people do not access services, families don’t talk about it, and the person experiencing suicide ideation is left unattended. In most cases, families and friends would be more than willing to support their loved one in any way possible if only they knew about what is happening. Support comes mostly from within the family and it is preferred that outsiders are not involved.

If there is a death by suicide in Ireland, the bereaved family in Africa might perform cleansing rituals for the deceased. The individual is considered to be in the spiritual world and
therefore his or her physical location does not matter. Even though the death might have taken place in Ireland, traditionally the family is expected to perform this ritual.

**Chinese Perspective**

According to Beijing Suicide Research and Prevention Centre, China has one of the highest suicide rates in the world, particularly among rural women. It is also the only country in the world where suicides among women outnumber men. Another high suicide risk group is young people, particularly students who are under a lot of pressure. Nowadays there is more awareness about this issue and family and friends are likely to be supportive.

A death by suicide is treated as any other death. While often the wider community do not talk about the suicide with the bereaved family in an effort not to cause them further distress, they will be encouraged to seek professional help from a counsellor.

Studies show that, in keeping with tradition, Chinese people present tolerant or condemning attitudes depending on their socio-demographic characteristics. Generally, they are not strongly inclined to consider suicide in the face of difficult scenarios. College students had the most permissive attitudes about suicide, and urban residents were significantly more accepting of suicide as a response to serious life stressors than were rural residents. The overall acceptability is higher among women, decreased with age, and increased with years of education.

**Chinese in Ireland**

Most Chinese immigrants in Ireland come from cities and are atheists. There is no data about the prevalence of suicide of Chinese people in Ireland. Usually, in a difficult situation the Chinese would first seek support from friends and family living in Ireland, and sometimes from GPs, websites, helplines and voluntary organisations. However, due to language and cultural barriers, the support given by the Irish mainstream provider might not be adequate. Non-English speakers might bring a friend to interpret while others will return to China for treatment.

**Romanian Perspective**

As a consequence of economic migration, about 22,000 children in Romania have been deprived of both parents as many children were left with grandparents, relatives or friends. Psychologists report that the majority of the children hospitalised in some regions of Romania suffer from pathological diseases caused by the feeling of masked abandon.

Romania holds the lowest position in Europe concerning public access to homecare services and the highest position regarding access to psychiatric hospitals. This is due to the fact that diagnoses are often delayed and there is lack of supervision of patients already diagnosed with mental health issues, as well as of a high level of stigmatisation and discrimination.

The Romanian Orthodox Church has, over the centuries, taught that we do not have the right to take our own lives, since life is a gift from God which we are called upon to preserve and enhance. Therefore, the Church considers suicide to be the most serious kind of murder because there is no opportunity for repentance and the person’s soul is condemned to eternal damnation. The canons and practice of the Church thus prohibit a Church burial to a person who has died by suicide. However, if it can be shown that the person who has died by suicide was not mentally sound, then, upon proper medical and ecclesiastical certification, the burial can be conducted by the Church.

**Romans in Ireland**

There are no official records or published research on Romanians that have died by or attempted suicide while living abroad, but Romanians are willing to avail of counselling services and medical treatment if it is available. Romanian religious officials, priests and leaders of religious groups and communities are open to counselling that uses the religious doctrine (e.g. the Orthodox doctrine) against the act of suicide.

**Polish Perspective**

In 2010, over 5,000 people attempted suicide in Poland. Mental illness and family misunderstandings are the most common reasons.

Polish attitudes to suicide are closely linked to the Catholic ethos that places suicide and murder in the same category as acts that are shameful and shocking. Polish religious society therefore attempts to explain the rationale of one’s decision by considering the psychological, social and cultural context which soothes the individual responsibility and its immorality.

On a social level, Polish society nowadays accepts the occurrence of suicide and there seems to be a growing understanding towards those with suicidal thoughts. Nevertheless, suicide undermines social norms and values of the community, particularly small, rural communities, and attitudes can vary. Some families may attempt to disguise the real cause of the death and can become isolated. There is often gossiping and curiosity in the community and stigma can be attached to the family.

**Polish in Ireland**

The prevalence of suicide among Polish people in Ireland is under recorded. However, statistics from the Polish Consulate in Dublin indicate that in the last three years, 8% of all deaths of Polish nationals in Ireland were by suicide.

<table>
<thead>
<tr>
<th>Year</th>
<th>No of deaths</th>
<th>Of which suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>99</td>
<td>11</td>
</tr>
<tr>
<td>2010</td>
<td>92</td>
<td>6</td>
</tr>
<tr>
<td>2011 (Jan-June)</td>
<td>31</td>
<td>2</td>
</tr>
</tbody>
</table>
Consul Grzegorz Jagielski says that Polish people in Ireland contemplate suicide because of personal problems, losing employment and alcoholism. In his view, emigration can contribute to such a decision: ‘Some people find separation with their family very hard, they don’t speak English well, feel lonely, have no friends, no one to talk about their problems’. Their economic situation can also be a factor: ‘In Poland there is success propaganda and the pressure from the family to earn money’.

Polish living in Ireland discuss the topic of suicide on the Polish language online forums and these discussions echo attitudes from home. A few posts take into consideration the family of the deceased but in a way that blames the person who has died:

‘He didn’t think about his wife, children… only about himself.’

‘They do not care that mother, father, brother, neighbour, friend… everyone, for the rest of their lives, will blame themselves for it… that they didn’t predict it… that it’s their fault.’

There are information and language barriers for Polish people seeking help in Ireland and, as a result, many refer themselves to Polish professionals such as GPs, psychologists and psychiatrists. However, these services are located mainly in Dublin and other big cities.

CAIIRDE
Cairde is a community development organisation working to tackle health inequalities among ethnic minority communities by improving ethnic minority access to health services, and ethnic minority participation in health planning and delivery.

We work with disadvantaged ethnic minority communities from the continent of Africa, China, Eastern Europe and the Baltic states. Cairde staff speak a number of languages including English, Polish, Russian, Ukrainian, French, Italian, Arabic and Chinese.

ADVOCACY CENTRE
The Health Information and Advocacy Centre (HIAC) is a one stop shop providing relevant, accurate and culturally appropriate health information and advocacy to individuals and groups from ethnic minority communities to enable them to access and use health services.

In the centre:
- You can find out about health services in Ireland for example GPs, hospitals, maternity services.
- You can find out about your rights and entitlement to health services.
- You can find out about many different health issues.
- If you’re having difficulties, you can get support to resolve them e.g. with applying for a medical card.
- You can get help in your own language.
- All services are free and confidential.

CONCLUSION
While there is a lack of concrete data on suicide among minorities in Ireland, studies would suggest that the rate might be higher than that of the general Irish population. In dealing with this issue, a greater understanding of the different cultural attitudes towards suicide among different ethnic groups must be coupled with more accessible mental health services and support.

REFERENCES
1 http://bjp.rcpsych.org/cgi/content/full/bjprcpsych;183/2/100
2 http://www.iasp.info/resources/Groups_at_Risk/Visible_Minorities/
3 Lakman, Matthews, Murck, Reidmond et al (2008) New Communities and Mental Health in Ireland: A Needs Analysis
4 http://bjp.rcpsych.org/cgi/content/full/bjprcpsych;183/2/100
5 Life: Living is for everyone. Fact sheet 20 Suicide prevention and people from culturally and linguistically diverse (CALD) backgrounds (2011)
8 www.statystyka.polejca.pl
Suicide Prevention Training in Ireland: The Current Situation

STARTING AT THE BEGINNING

Training in suicide prevention in Ireland made a huge leap forward in 2004/2005, principally because of two factors. In 2004, the Health Service Executive (HSE) introduced ASIST training to Ireland, which launched the first standardised training programme in this area (more of this later). In 2005, the HSE and the Department of Health and Children launched Reach Out, the first national strategy on suicide prevention. In this, training is mentioned in 26 of the 96 actions. This document resulted in the establishment of the National Office for Suicide Prevention (NOSP) and the employment of a National Training and Development Officer.

As a basic premise, it is essential that members of our community (agencies and individuals, professionals and lay people) are appropriately trained in skills which will equip them to engage with and support someone who is having suicidal thoughts.

The training must be standardised, effective and must meet the needs of the individuals and agencies availing of it.

TYPES OF TRAINING AVAILABLE

A significant task for any organisation is to determine what level of training in suicide prevention is required by its different staff members. There are a number of different types of training available, each one meeting a different need.

At the most basic level are general awareness programmes and gatekeeper programmes. They are of varying length — some are three hours, while others run for three hours a session over a course of six sessions. These programmes generally provide participants with a basic introduction to the area of suicide and suicide prevention covering such topics as the extent of the problem, the risk factors and the warning signs which might indicate someone is having suicidal thoughts. They also include some guidance on how to react to someone if they tell you they are thinking of taking their life; guidance on how to support someone who has been bereaved by suicide; and how to mind yourself when you find yourself working with someone who is suicidal or who has lost someone close to suicide. These courses are a great starting point for someone who doesn’t have a background in this area and is interested in finding out the basics. The HSE Resource Officers for Suicide Prevention, in collaboration with the NOSP, have developed a programme called Reaching Out, which can be adapted to suit the needs of the particular group that requests it. It is delivered in a wide range of settings and for a diverse array of groups.

The next level is suicide alertness, and the programme currently used by the HSE is safeTALK. This is a half day programme...
that has three significant outcomes: participants learn to become more alert, or aware, of the signs of suicide that can be expressed by others; they learn how to ask someone if they’re having suicidal thoughts; and they learn how to link the individual with someone who can help them through their crisis. This might be a local counselling service, the person’s GP, or someone in the community who has trained in intervening with someone who is suicidal (more info on this below). This programme is currently very popular with the wide range of services, financial and otherwise, which are supporting people through the economic crisis. More and more often, staff within these agencies are finding themselves dealing with individuals who are expressing high levels of emotional distress. When they haven’t been trained to deal with the emotional issues that the clients are presenting with, it can result in a very difficult and distressing situation for both people involved. By attending a safeTALK training course, the staff can develop a basic knowledge of the distress associated with suicidal ideation, and an ability to pick up on cues that an individual may be feeling suicidal. They are then in a position to link the individual with a support person who can take over and offer the appropriate care and support. In the ideal scenario, all of our communities would have a large number of people trained in safeTALK.

It is essential that members of our community (agencies and individuals, professionals and lay people) are appropriately trained in skills which will equip them to engage with and support someone who is having suicidal thoughts.

safeTALK is perfectly complemented by its sister programme, ASIST, both of which were developed by LivingWorks Education Inc, a Canadian organisation which is deemed a world leader in the field. ASIST (Applied Suicide Intervention Skills Training) is a two-day intervention skills training programme which teaches participants to engage with and support someone who is actively experiencing a suicidal crisis. Over the course of the two days, participants have an opportunity to explore their own attitudes towards suicide and develop an understanding of how these attitudes can shape how they would react towards someone who is suicidal. Participants are presented with a framework, or model, for intervening with someone they’re concerned about, which they get an opportunity to experience through a number of role plays. Various teaching techniques are used across the workshop to maximise the learning, including audiovisuals, small group work and role plays. The skills practice is built up over the two days so that, by the end of the course, all participants have had an opportunity to put the model into practice. The final module in ASIST is Networking, which allows the participants to share their knowledge of the local services that support people in distress. While there are many national services which are listed at every ASIST workshop, there is always a lot of variation at this point in the workshop because of the diversity of services that are available locally. The Jigsaw project, for example, is available in a number of areas across the country, and is expanding to include 10 more sites this year. This always proves to be a really helpful part of the workshop, as the 24 participants leave with a greater knowledge of who is available to support those in crisis in their locality.

In the ideal scenario, all of our communities would have a large number of people trained in safeTALK.

ASIST is a very challenging programme, but is organised and delivered in a safe environment by experienced and well trained facilitators. When ASIST was introduced in Ireland in 2004, it was felt by many to be an appropriate programme for everyone. ‘Everyone should do this programme’ is commonly written on the feedback sheets by participants at the end of the course. A recent all-Ireland evaluation of the ASIST programme allowed us to explore this issue (Public Health Agency, 2011). It found that 6 months after attending the course only 41% of participants had used the ASIST model. The report emphasises the importance of training those who come in contact with people who are at risk of suicide. Interest in suicide prevention alone is not enough of a reason to be allocated a place. ASIST should be attended by those who are highly likely to encounter individuals who are suicidal in the course of their daily lives. This includes front line workers such as residential child care workers, school guidance counsellors, emergency medical technicians, Gardai, occupational therapists, A&E staff, primary care workers within the Travelling community, bereavement support volunteers, and many, many more.

When the ASIST helper completes their intervention they connect the suicidal individual to someone else who can provide longer term support. What training is needed by those
professionals and service providers? The STORM training programme has been chosen by the HSE as the most appropriate model for mental health professionals who seek additional training to care for suicidal individuals. It stands for Skills based Training On Risk Management, and the adult training programme incorporates modules which cover assessment, crisis management, problem solving and crisis prevention. There is also a child programme which incorporates child protection and suicide prevention from a child development perspective. STORM builds on ASIST, as it provides caregivers with the opportunity to explore their attitudes, help an individual through an acute crisis, and work with them over a period of time to develop more adaptive coping strategies. Finally, participants learn the skills to work with the client to develop a plan to keep safe in the future, should suicidal thoughts start to develop again. STORM is appropriate for front line staff who work on a long-term basis with suicidal individuals, such as staff in health care, social care, education and criminal justice settings.

CONSIDERATIONS WHEN SELECTING A TRAINING PROGRAMME

When an agency is interested in getting its staff or volunteers trained in suicide prevention, there are a number of issues that should be considered when deciding what training courses to seek and who should attend, both from the perspective of the agency and from the perspective of the individual staff member or volunteer. From the agency’s perspective, the crucial issue is how much of a problem suicide is within its staff and client group. Sensibly, if suicide has not been a significant problem, but the agency simply wants to be ready should it emerge, then general awareness training for most staff, with some trained in safeTALK and one or two trained as ASIST helpers might be sufficient to meet its needs. At the other end of the spectrum, an agency might have experienced a number of bereavements by suicide within its client group, and may be keen to equip its staff with the skills to ensure that they can act competently and appropriately. A mix of safeTALK and ASIST may be sought for this agency.

The agency also needs to consider the type of work it engages in. If the core work of staff is around long-term mental health care for clients, then STORM may be required by some or all of these staff members. If the core work of staff has nothing to do with mental health issues, safeTALK might be appropriate for most, while a small few may attend an ASIST workshop.

In relation to the staff/volunteer’s perspective, the agency needs to consider three factors:

1. Previous experience/knowledge
2. Personal readiness
3. Willingness to take on the responsibility conferred by the training

In relation to previous experience, a good rule of thumb is to start at the beginning, unless the individual has some knowledge and experience to date. Regarding personal readiness, it is recommended that any individual who has been bereaved in

| Table 1 Types of training programme, levels of responsibility involved and appropriateness of candidates |
|------------------|-------------------------------------------------|------------------|
| Training         | Level of Responsibility                          | Appropriate      |
|                  | Taken on Following Training                      | Participants     |
| Level 1: General Awareness | Increasing awareness of suicide issues; breaking down stigma associated with suicide | General public; staff and volunteers who wish to know more but have no background in this area |
| Level 2: Suicide alertness e.g. safeTALK | Willingness to become alert to possibility of suicide in community, and willing to act when aware of someone who is expressing suicidal intent | General public; staff and volunteers who are committed to acting as a link between someone who is suicidal and someone who can provide help in a crisis; often incorporated in an organisation’s or community’s suicide prevention policy |
| Level 3: Intervention skills e.g. ASIST | Willingness and readiness to ask someone if they are feeling suicidal and to act when the answer is ‘yes’ | Staff, volunteers and community members who are highly likely to encounter individuals who are feeling suicidal |
| Level 4: Risk management skills e.g. STORM | In a position to develop/expand their caring role for the individual who is feeling suicidal to include developing problem solving skills and crisis prevention | Professionals who are currently working with individuals on a long-term basis, generally in a mental health role |
the previous six months, or year, would not attend a training course on suicide prevention. Similarly, if the individual is experiencing any emotional difficulties at the time of training, they should not attend. Training in suicide prevention can be very emotionally challenging, and it is important that individuals are not put in a position which could impact negatively on them. For this reason, it’s crucial that staff and volunteers are well informed of the upcoming training, and have an opportunity to opt out – it’s never a good idea to be nominated by a manager without the individual being given a chance to find out what is involved. Finally, the individual must be ready to take on the responsibility that the training entails (see Table 1). For example, participants at ASIST workshops take on a significant responsibility to ask others if they may be thinking of harming themselves, and to act on that if the answer is ‘yes’. Not everyone is comfortable with taking on that role, and so it is essential that potential candidates have the time to consider what is involved both during and after a workshop.

A useful question for a manager to ask is whether the training will actually be used by the individual/team they wish to train? Will there be an opportunity to use the skills that will be learned. For example, it would be a waste of resources to train someone in STORM who does not provide mental health care on a regular basis. Similarly, it’s inappropriate to train someone in ASIST simply because they are concerned about the problem of suicide in general, if they are unlikely to encounter others with suicidal thoughts on a regular basis.

WHERE ARE THE TRAINING PROGRAMMES AVAILABLE?
The HSE Resource Officers for Suicide Prevention (there are 10 offices across the country) are the primary local coordinators of suicide prevention training in Ireland. They deliver the Reaching Out programme, and coordinate the safeTALK and ASIST programmes regionally. Many of them also coordinate the STORM programme. They have a team of trainers who deliver safeTALK, ASIST and, where available, STORM. By the end of 2010 there were over 5,500 trained in safeTALK and more than 21,000 trained in ASIST. In more recent years other partners have become coordinators for ASIST and/or safeTALK. These include the Defence Forces, RehabCare and the National Youth Health Programme in the National Youth Council of Ireland.

A significant advantage of the training being coordinated and organised by local offices is that the Resource Officers, and other coordinators, are constantly developing a map of what training has been delivered where. They are increasingly able to comment on how individual communities are becoming more resilient and skilled. This allows for a more informed response to requests for training from both individuals and agencies. Training is now being delivered in a coordinated, integrated and safe way, rather than in an ad hoc, unplanned manner.

The NOSP has taken on a national coordinating role for ASIST and safeTALK, which has allowed for the establishment of certain structures that enhance the level of training delivered across the country: standardised process for selecting trainers; support system for trainers; regular Training for Trainers events; national guidelines for organising workshops; forum for discussing emerging training issues, etc. These structures work to maintain the well-being of the trainers, the participants, and, ultimately, the community at large.

A FINAL NOTE
Suicide prevention training is never enough in itself. When an agency or community is thinking about the training needs of its staff and members, it should also be thinking more broadly about developing a suicide prevention strategy/policy for the organisation. Training is only one part of the whole picture, and agencies should also be seriously considering how to address suicide from a prevention, intervention and crisis response perspective. Only when this full overview is taken, can a complete training needs analysis be conducted to realistically assess what is needed.

www.nosp.ie
list of HSE Resource Officers in the Training section

www.livingworks.net
information on safeTALK and ASIST

www.stormskillstraining.co.uk
information on STORM
Suicide Awareness and Support Group

‘Although the world is full of suffering, it is also full of the overcoming of suffering.’ Helen Keller

As you pass 209 Falls Road in Belfast you cannot fail to notice the bright pink facade that makes the premises stand out from the surrounding shops. The Suicide Awareness and Support Group is located amid shops and local business outlets on the main Falls Road. The bold colours on the wall mural show a pink and blue ribbon that was designed by bereaved family members in the hope that it would become an international symbol for suicide awareness.

In 2000, community activists helped to organise a public meeting to address the escalating number of suicidal deaths within our community in West Belfast, with particular concern about the number of deaths of young males. A number of families bereaved by suicide responded to the community invitation to attend the meeting. They discussed prevailing...
issues associated with community suicide prevention, the increasing number of suicidal deaths and the impact the deaths had upon the community. The ripples of despair at this meeting were evident and the fear almost tangible.

As part of the community response, the first meeting of the Suicide Awareness and Support Group was held in May 2000. Initially, bereaved families believed that somehow they could help prevent other families from experiencing suicidal bereavement but it became apparent that the group were limited and did not have the expertise or knowledge required for prevention at that time. However, the bereaved families still believed that they could effectively raise the issues associated with suicide awareness and suicide prevention.

The Suicide Awareness and Support Group has evolved and developed from being part of a community response in 2000 to become an organisation that is an integral and much-needed resource for our community of West Belfast in 2011. We work under the three conceptual frameworks of suicide prevention, intervention and postvention. We help and support those bereaved by suicide, supporting individuals in times of suicidal crisis, raising suicide awareness and endeavouring to create a community where suicide prevention is everyone’s business.

**POSTVENTION OF SUICIDE**

Suicide is a complex phenomenon, with various causes and no straightforward explanations, but is a personal tragedy for those who are touched by it. When a death is by suicide, the grieving process is complicated by the very nature of the death. While trying to cope with their sudden loss and their incomprehensible sadness, the bereaved can be overwhelmed by the obvious questions of ‘why?’ Bereaved families feel the emotions that death always brings but added to their suffering is the shock of a sudden, often unexpected, death. Families are not prepared for such a tragic loss.

Suicidal grief and the bereavement process are like fingerprints: unique and different for everyone affected. Grief does not have a timetable and no one can tell you how to grieve. Everyone grieves differently, not only in relation to the nature of the loss, but in relation to the nature of the relationship with the person who has died. The news of the death of a loved one to suicide is an utterly devastating and traumatic experience and can be coupled with mixed emotions and feelings such as shock, numbness, denial, anger, intense pain, guilt, shame, confusion, diabolism, despair, betrayal, relief and abandonment.

Through the Suicide Awareness and Support Group, bereaved families can support each other in a place where they feel safe as they share the experience of their loss in a caring and nurturing environment. The bond of suicidal bereavement and the ethos of mutual support that laid the foundations for the establishment of the Suicide Awareness and Support Group in 2000 still prevails today. The extraordinary dedication of the members of the Suicide Awareness and Support Group must be commended by all in our community as they tirelessly raise the issue that suicide prevention is everyone’s business despite facing their grief and coping with their own bereavement.

**THE STIGMA OF SUICIDE**

Suicide is a difficult topic for many people as cultural and religious beliefs can lead to judgmental or condemning attitudes. Stigma comes from a poor understanding and from discomfort, and a death by suicide can be perceived to be something different from a so-called ‘normal death.’ To some it is inconceivable that a person would die by suicide and as a result they are unable to identify with or even empathise with those bereaved or affected by it. Therefore it comes as no surprise that suicide is one of the few remaining taboos in society.

**SUICIDE AWARENESS and SUPPORT GROUP**

Someone you loved has ended their life and sadly your life will be forever changed.

**Support and help are available for you when you feel ready to reach out.**

Group support, home visits, befriending, bereavement guidance and support, counselling, and complimentary therapies are all available for you at the Suicide Awareness and Support Group.

You do not have to grieve alone.
One of the main problems with suicide is that often we don't want to talk about it as a lack of knowledge about it can make us fearful. Bringing the subject out into the open where it can be addressed often provides a sense of relief and is one of the most helpful things we can do.

Negative attitudes can isolate and further stress the bereaved. Whether the stigma is real or perceived, it can affect a bereaved family in the aftermath of their loss. They may feel judged by friends, neighbours or by their community, and this can prevent them from actively seeking support. Those bereaved by suicide are often left alone, feeling misunderstood, bereft of the support and sympathy we could give them. We might shy away from them because we feel embarrassed. We don’t know how to begin the conversation and don’t know what to say so cross the street to avoid giving condolences. This can affect a family in negative ways and can have a profound impact upon their physical and mental health as well as affecting their grieving process. The bereaved may feel identified by their loss and marked with shame and blame, they are perceived to be at fault for the death because they failed to notice signs prior to the death, and they are judged unfairly. Only by dispelling the myths around suicide and discussing it will the societal stigma associated with suicide begin to change.

A bereaved mother who lost her son to suicide said, ‘We were never told or learnt what to say to someone who was bereaved by suicide.’ She felt she needed to hear the same things that might be said to anyone who has experienced the death of a loved one but

‘no one wants to talk about suicide...[they think] that its best left un-discussed... that if you don’t talk about it, it will be forgotten and go away.’

For this mother, nothing could have been further from the truth in that she wanted to talk about her son and about the painful tragedy of his death.

There is a great need to change public attitudes and increase awareness and understanding about suicidal bereavement in an effort to remove the societal stigma that has remained for so long. The grieving process for suicidal bereavement is more complex than other forms of bereavement, but with careful understanding and support, stigma can be reduced.

**SUICIDE PREVENTION**

At the Suicide Awareness and Support Group, a great deal of time and energy is spent on raising suicide awareness. We offer suicide first aid workshops and bereavement presentations and we disseminate a great deal of information through flyers and information booklets, all in the hope of raising awareness about the important issues of suicide bereavement and prevention.

We need to ensure that people will be changed by the information they receive rather than just being passive recipients of our information dissemination efforts. We therefore challenge people to consider the unique and creative ways they can behave differently after learning about suicide prevention.

However, simply raising people’s awareness about the myths and facts of suicide, teaching people the risk factors and warning signs of suicide, and highlighting the resources that are available in the community is not enough. When families are seeking help at a suicidal crisis point they frequently do not know where to access adequate support for their family member and we can provide them with information on this.

Our community in Northern Ireland is one where the evidence of the power of change has been proven and the same commitment is required from our community for suicide prevention. Here at the Suicide Awareness and Support Group we raise suicide awareness to the extent that ‘Suicide Prevention is Everyone’s Business’, not only those directly affected by it. What we envisage for the future is a Suicide Safer Community for West Belfast, where individuals will reach out for help whenever they need it.

Our children and young people represent all of our futures, whether we have families of our own or not. When a young person dies tragically by suicide, it diminishes the hope we have for the future in some way. We therefore all have an investment in the well-being of our young people and a responsibility to play a part in promoting their wellness and reducing any threats to it, including suicide.

---

**Stigma associated with suicide is a mark of shame.**
**Taboos create misconceptions and prevent us talking openly about suicide.**
**Imagine a community where suicidal stigma is reduced and understood.**
**Get informed! The best way to counteract suicidal stigma is to get the facts.**
**Move towards a more tolerant and informed view of suicide.**
**Awareness and factual information are necessary requirements to dispel stigma.**
Suicide is an underestimated community health problem. Preventing it requires the collective efforts of all statutory, community and voluntary agencies. A key part of prevention is the need for suicide first aid training for all of those who regularly come into contact with people at risk. One of the ways we suggest people become actively involved in suicide prevention within our community is to undertake training such as ASIST, Safe Talk or Suicide Talk.

For almost thirty years, Living Works Education has been providing evidence-based suicide first aid training programmes. The Applied Suicide Intervention Skills Training (ASIST) programme and its Suicide Intervention Model (SIM) are their core contributions to suicide prevention. ASIST is a two-day workshop designed for all caregivers from community, voluntary and statutory sectors. The workshop enhances the skills to intervene when someone is in suicidal crisis until the immediate risk of suicide is reduced or additional life-assistance resources can be found.

The ethos behind the Canadian educational model is to bring the ASIST workshop to the local community and the standardised model is delivered by local trainers. We have five Living Works ASIST trainers at the Suicide Awareness and Support Group and, since 2006, our training team have delivered the workshop to over 2,500 people. Community groups, church groups, youth workers, health professionals, fire and rescue service, police and front-line medical staff have all availed of the training workshops. In 2010/11 our Living Works trainers delivered the ASIST workshop on a monthly basis. We have found there is an increasing demand for ASIST workshops and will therefore continue to cater for this demand.

Safe Talk, which lasts for three and a half hours, covers a similar content to ASIST, but it has a different emphasis. It focuses upon suicide alertness for everyone. While some suicide first aid principles are discussed, these are offered more as a way of encouraging optimism about first aid assistance rather than teaching first aid. This helps members of the community to be alert and to identify those with thoughts of suicide and connect them to resources. This is an excellent training tool for GP surgeries and health centres.

Suicide Talk is a presentation delivered to youth groups and secondary schools. Its focus is suicide awareness and it lasts...
for one and a half hours. This tool is extremely beneficial for young people to talk in a safe environment about suicide awareness and it helps them to identify signs of suicide and where to go for help if they or someone they know are having thoughts of suicide.

SUICIDE INTERVENTION

In 2000, bereaved families at the Suicide Awareness and Support Group hoped that they could help raise the issues associated with suicide despite their own personal grief and they did this successfully. It was the dedication of bereaved families who continually paved the way for community discussions as they campaigned for improved services, especially at intervention level for those contemplating suicide.

As the organisation evolved, intervention became an important component of our work and we began increasingly to intervene and provide immediate support for those at risk of suicide.

We have gained substantial experience within the field of suicide intervention and we continue to learn and develop our structures by establishing working relationships with other key stakeholders working at suicide intervention level.

All of our staff, volunteers and members have undertaken the ASIST Workshop training. When someone at risk of suicide presents themselves to the office in person, via the phone or through friends or families, they will be seen immediately or given an appointment later the same day. The individual will receive an initial assessment and, if necessary, a suicide first aid intervention will be undertaken and the person will be directed to the specific services they require at that time such as counselling.

In terms of the level of initial assessments we undertake, two days are never the same. The fact that those at risk of suicide are reaching out for support is always an encouraging sign as by doing so they are availing of services which could effectively save their lives. We have learnt about our organisational limitations and are very aware that there are some individuals who present in times of severe suicidal distress or with mental health issues that cannot be helped at community level. Their needs are best catered for by professionals within statutory services. They will be given an initial appointment but will be advised to contact their GP or other health professionals.

VOLUNTEERS

Our organisation relies on volunteers to help us work under the three conceptual frameworks of prevention, intervention and postvention of suicide. All volunteers are ASIST trained and undertake various tasks for the Suicide Awareness and Support Group. Volunteers take part in Health Fair days to raise awareness where they set up information stalls and hold awareness events in our local shopping centre. They also organise local and regional events for World Suicide Prevention Day on the 10th September. All of these events raise the awareness around suicide and help to reduce some of the stigma that still surrounds suicide in our community.

Volunteers receive the opportunity for various types of training such as ASIST, Mental Health, Drug and Alcohol, Counselling Skills, Trauma and Cruse Bereavement Training. Volunteers receive both internal and external supervision due to the nature of the work they undertake.

BEFRIENDING VOLUNTEERS

Not everyone has a family or friend support network that they can rely on for guidance, support or advice to help them through difficult times. Befriending volunteers at the Suicide Awareness and Support Group can help to fill this gap by offering their time freely and providing support to those bereaved or to individuals experiencing difficult times in their lives.

Volunteer befriending is a process whereby two or more individuals come together to develop an informal social relationship. It is used in many ways at the Suicide Awareness and Support Group and attempts to cater for the different needs of our service users such as a young person recovering from depression or after a suicide attempt or a recent bereavement. Individuals may require support with basic everyday tasks, they may need the space to talk about their bereavement or they may want to build up their self confidence or self esteem. Some merely want an opportunity to meet with people away from their immediate family.

CONCLUSION

The Suicide Awareness and Support Group began as a peer facilitated weekly support group for families bereaved by suicide. We have evolved and have become a professional organisation dedicated to working under the three conceptual frameworks of suicide prevention, intervention and postvention within our community.

**Suicide Awareness and Support Group**

209 Falls Road, Belfast BT12 6FB

Tel: 028 9023 9967

Email: suicideawareness@hotmail.com
Useful Resources on Suicide

The following resources are available to borrow from Barnardos Training and Resource Service
You can search Barnardos’ Training and Resource Service library catalogue on www.barnardos.ie

Self-Harm and Children and Young People
National Children’s Bureau. 2011

Suicide and Young People
National Children’s Bureau. 2010

Beyond the Rough Rock, Supporting a Child Who Has Been Bereaved Through Suicide
Winston’s Wish, 2010

Silent Grief: Living in the Wake of Suicide (revised ed.)
Jessica Kingsley Publishers, 2007

Suicide: Ireland’s Story
Blackwater Press, 2006

Bereavement Information: Information for People Bereaved Through Suicide or Other Sudden Death
HSE South East Area, 2006

Reach Out: National Strategy for Action on Suicide Prevention 2005-2014
Health Service Executive, 2005

Coping with Depression in Young People:
A Guide for Parents
John Wiley & Sons Ltd, 2004

Counselling Children, Adolescents and Families:
A Strengths-Based Approach
Sage Publications, 2004

Deliberate Self-Harm in Adolescence
Jessica Kingsley Publishers, 2004

New Approaches to Preventing Suicide: A Manual for Practitioners
Jessica Kingsley Publishers, 2004

Challenging Times: Psychiatric Disorders and Suicidal Behaviours in Irish Adolescents
Department of Child and Family Psychiatry, Mater Misericordiae Hospital, 2003

Suicide Prevention:
An Information Booklet for Youth Workers
Irish Youthwork Press, 2003

Suicide Prevention: A Resource Handbook for Youth Organisations
Irish Youthwork Press, 2003

Out of the Darkened Room: When a Parent is Depressed: Protecting the Children and Strengthening the Family
Little Brown & Co., 2002

A Voice for Those Bereaved by Suicide
Veritas Publications, 2001

An Empty Chair: Living in the Wake of a Sibling’s Suicide
Writers Club Press, 2000

A Parent’s Guide for Suicidal and Depressed Teens: Help for Recognising if a Child is in Crisis and What to do about it
Hazelden, 1995
New Titles

Full details of these new library resources and all other resources in our library collection are available on our online library catalogue.

To search the catalogue, go to www.barnardos.ie/library and click online catalogue

(Please note the listed titles are not sold by Barnardos’ Training and Resource Service)

ADOLESCENCE
Changing the Future. Experiencing Adolescence in Contemporary Ireland
Unicef Ireland, 2011.

The Anger Workbook for Teens: Activities to Help You Deal with Anger and Frustration

CHILD DEVELOPMENT
Roots of Empathy. Changing the World Child by Child
The Experiment, 2009.

CHILD PROTECTION
Children First: National Guidance for the Protection and Welfare of Children
Department of Children and Youth Affairs, 2011.

Child protection practice
Palgrave Macmillan, 2011.

CHILDREN IN CARE
Summary of EPIC Research Findings on Outcomes of Young People Leaving Care in North Dublin
EPIC (Empowering People in Care), 2011.

DIVERSITY
Anti-bias education for young children and ourselves
National Association for the Education of Young Children, 2010.

EARLY CHILDHOOD CARE AND EDUCATION
Leaving Junior: Supporting Parents to Make Childcare Choices
Donegal County Childcare Committee, 2011

Key Concepts in Early Childhood Education and Care

Making Sense of Theory and Practice in Early Childhood: the Power of Ideas

Peer Relationships in Early Childhood Education and Care
Routledge, 2011.

Teaching Young Children: Choices in Theory and Practice

Small-Group Times to Scaffold Early Learning

Making Connections: Movement, Music & Literacy

FAMILY BREAKDOWN
Mum and Dad Glue

LITERACY
Creating Lifelong Readers. Nurturing Children’s Language and Literacy through Books
Children’s Services Committee Donegal, 2010.

PARENTING
The Evidence-Based Parenting Practitioner’s Handbook
Routledge, 2011.

RESEARCH
Doing Action Research in Early Childhood Studies: a Step by Step Guide

SOCIAL POLICY
Doing Better for Families

All photos in this issue have been posed by models