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Exploring a Community Response to Multiple Deaths of Young People by Suicide

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Executive Summary

Overview

This Executive Summary provides an overview of the methodology, findings and recommendations arising from research that was undertaken by the Centre for Effective Education, commissioned by Contact.

The aims of the study were to:

1. Determine what is known from the research evidence to date about the nature, incidence and factors associated with suicide clusters, with a focus on the particular vulnerabilities of young people.
2. Determine what is known from the research evidence to date about what interventions are effective in reducing the emergence of youth suicide clusters.
3. Review the evidence for the incidence of youth suicide clusters in Northern Ireland.
4. Explore in depth the impact of recent multiple deaths by suicide of young people.
5. Consider the implications of the findings to make recommendations which might contribute to reducing the risk of suicide clusters in Northern Ireland, particularly among young people.

Methodology

The above aims were addressed in a number of ways, including:

- A detailed literature review of the academic literature to determine what is already known about suicide, the phenomenon of suicide clusters, youth suicide clusters in particular, and effective interventions aimed at reducing the incidence of youth suicide clusters.
- An exploration of the current policy context and existing data relating to the incidence of suicide deaths of young people (aged 25 or under) over the last decade in order to determine where the incidence of youth suicide is the greatest in Northern Ireland.
- A case study design to explore in-depth the community response to the deaths of young people by suicide in two case study areas in Belfast.

Two advisory groups were established to provide support and guidance to the research team. The first was a young people's advisory group (YPAG) whose purpose was to inform the design, process and interpretation of all elements of the research. The members of the YPAG were not research participants but were invited to take part in the project to contribute their expertise on the relevant issues, as a key stakeholder group. The group was recruited from a school located in an area that reflected the social and economic profile of the two case study sites.

The second advisory group was the professional advisory group (PAG) whose purpose was to inform the research and contribute expertise in the area of youth suicide both in Northern Ireland and internationally.

Findings

Literature review

The review focuses on the existing research around suicide clusters and contagion. It examines the theories and models of suicidal behaviour, as well as models of suicide prevention, intervention and postvention in addition to secondary/vicarious trauma. It examines examples of best practice and is based on a scoping exercise of the cross-disciplinary literature of systematic reviews and relevant research.

Findings from the literature review suggest that research largely supports the existence of suicide clusters and various models are described which endeavour to explain why suicide contagion occurs. Within this, media contagion is highlighted in the literature as a specific contributing factor in the occurrence of suicide clusters. Prevention strategies are outlined for schools and the community as well a public health based approach. It is acknowledged that difficulties continue to exist in relation to evaluating the effectiveness of such prevention programmes.

In terms of suicide postvention, some of the core concepts of an international best practice model, the Connect Project, are outlined and the original Centre for Disease Control (1988) recommendations are discussed. Much of the research on postvention is contained within the education literature and studies are drawn on which provide specific advice and guidance to schools in how to deal with the aftermath of the death of a pupil to suicide. Much of the literature acknowledges the need for future studies to evaluate the effectiveness of postvention strategies.

Vicarious trauma following death by suicide has not been addressed extensively in the literature to date; however research does provide some evidence of post-suicide secondary trauma for family, friends and professionals.

The literature review concludes with a discussion of the impact of social inequality on negative social and health outcomes and an outline of the research on the Northern Ireland context, including the impact of the Troubles on mental health and suicide.

Policy context

The most recent data shows that the suicide rates in Northern Ireland per 100,000 increased between 2000 and 2010 (NISRA, 2011; Samaritans 2012).

Compared with the Republic of Ireland, England, Scotland and Wales, the suicide rate in Northern Ireland in 2010 was highest for both males and females. Contrary to other regions in the UK, there has been an overall increase in the suicide rate between 2000 and 2010 in Northern Ireland (ibid).

There are a number of contextual factors that result in Northern Ireland's policy nuances for wellbeing in children and youth when compared with Britain, not least because Northern Ireland remains a substantially divided society evidenced by housing and education divisions (Bell, Hansson and McCaffery, 2010; Gallagher, 2004). A report by the Northern Ireland Commissioner for Children and Young people (NICCY, 2007) states that children in Northern Ireland experience higher levels of suicide and abuse than in the rest of the UK and there are a number of strategies in place to reduce the impact of the legacy of the conflict on psychological and emotional wellbeing in Northern Ireland. These include: the Shared Future policy; proposed Anti-Poverty Strategy; Victim's Strategy; Investing for Health Strategy; and the 20 year Regional Strategy for Health and Social Services in Northern Ireland. Investing for Health Partnerships and subsequent Health Improvement Plans were designed to improve conflict-related psychological and emotional wellbeing (DHSSPS, 2004, 2006), in addition to Health Action Zones for Belfast, the Belfast Healthy Cities initiative, local Sure Start Programmes and, at a multiagency level, North Belfast Partnership Board and Neighbourhood Renewal Partnerships locally focussed in areas of greatest socioeconomic disadvantage (DHSSPS, 2004, 2006).

Case studies

Case study findings demonstrate a range of risk factors for youth suicide, clearly indicating conditions in which youth suicide clusters may occur. While research participants appeared to emphasize ideas associated with 'behavioural contagion' to explain multiple deaths by suicide it is clear that the occurrence of clusters is due to a multifaceted, complex web of individual, family, community and societal factors.

At a societal level it was suggested that social deprivation, the trauma legacy of the conflict and the transition out of conflict were highly significant in creating a sense of hopelessness in the community in which these young people were growing up. The

YPAG identified that young people are being confronted with negative messages from media, family and teachers in relation to the recession and its impact on jobs, adding further to this sense of hopelessness. Furthermore it is suggested that community spirit and a sense of belonging had been eroded and replaced by a mindset of individualism.

While these factors existed for many research participants, it is suggested that for some young people they were exacerbated by troubled family relationships, drug and alcohol abuse, and a lack of self-worth. At the level of the individual young person it would appear they struggle to cope and are emotionally underdeveloped in terms of resiliency or the knowledge base to effectively seek support; these were issues highlighted by the YPAG as the primary reasons for youth suicide. In addition it appears that young people's perceptions of suicide normalise and glamorise suicide as a stress coping strategy of choice, a 'viable option'. This is in turn creates a suicide sub-culture – to some extent facilitated and perpetuated by social networking.

The case studies also suggest that, in terms of community response to youth suicide, there is a lack of capacity within the health care system, and to an extent participants suggested it was not fulfilling its purpose. During times of crisis there was evidence for a lack of cohesiveness between the health care system and community and voluntary sectors, and a lack of role clarity. Further it is suggested that individuals at risk are not being routed towards the support available in the community and voluntary sector, or are not aware of these support mechanisms. Overall it appears that despite the existence of the Protect Life Suicide Prevention Strategy for Northern Ireland, there is a lack of awareness of this strategy and a lack of co-ordination resulting in a lack of shared purpose, with repeated incoherence at times of suicide crisis. Participants in the case study were clearly frustrated with the sheer number of community response meetings, suggesting that the response rate to date was unsustainable.

The issue of vicarious or secondary trauma emerged as an area for careful consideration. Professions in which clinical supervision is the norm, for example health care professionals and counsellors, seemed to be less affected by vicarious trauma, while youth workers appeared to be most affected. Working as part of a supportive team was reported as being an important element of this work.

Case study participants consistently proposed the need for a coherent plan in relation to both immediate postvention *and* longer-term postvention strategies to address underlying precipitating circumstances contributing to high, localised suicide rates. Longer-term suicide prevention initiatives should place a particular focus on early inventions relating to developing emotional wellbeing and resilience among young people, within families and within the community as a whole. It is also apparent from the case studies that those involved in psychological and emotional wellbeing work and suicide prevention and/or those who come into regular contact with young people at risk, require bespoke training and education.

Finally participants pointed towards the need for careful monitoring and robust evaluation of all aspects of community response planning.

Recommendations

1. **The development of a suicide postvention community response plan should involve all key actors**, notably young people, families, schools and the wider community and expert crisis response providers and first responder agencies.

2. While international best practice has informed the development of practice in Northern Ireland, and local community response plans are now quite advanced as a result, there is still learning to be taken from other postvention models. As in the Connect Suicide Prevention Project (2009), the **development of protocols,** specific to a variety of key service providers and members of the community, would increase preparedness for postvention. In addition, **training and support** specific to these groups and organisations would be largely beneficial.

3. Suicide prevention and postvention efforts in Northern Ireland require the **collaboration of various government departmental bodies**. Responsibility should not fall solely on the Department of Health, Social Services and Public Safety, but should also involve, for example, the Department of Education, the Department for Employment and Learning (DEL), and the Department of Culture, Arts and Leisure (DECAL). The recommended involvement of DEL and DECAL also recognises that the greatest death rate by suicide is not necessarily among young people.

Indeed recent research has proposed that suicide rates in Northern Ireland are highest among those who grew up in the height of the troubles, and are now aged between 35 and 44 (Tomlinson, 2012).

4. Any suicide prevention community response plan should take account of the need to move beyond short-term measures and towards more coherent, integrated and sustainable planning options. Core components of community response plans should include:

    a. **Immediate term strategies,** defining the circumstances where the crisis response plan should be activated, spelling out specific roles for individual groups and organisations within the community. Roles should be clearly defined to prevent overlap between services and the potential for confusion. In addition, clear guidelines for schools should be provided, as well as a bespoke audit tool for schools to evaluate their own effectiveness in relation to their prevention and postvention strategies. Similar guidelines should be produced for other groups working with young people, for example sports organisations.

    b. **Longer-term evidence based suicide prevention strategies** that are sustainable both within, and by, the community, for example the Connect Suicide Prevention Project (2009) in New Hampshire.

    c. **Prevention strategies**, which include very early prevention interventions such as parenting programmes[1]. Early intervention should be implemented at all transition phases in children and young people's lives (Allen, 2011) and across the Pre-Motivational, Motivational and Volitional phases of suicidal behaviour (O'Connor, 2011).

5. In the two case study areas, there is a clear need to reconnect young people back into their communities. While more facilities and resources are clearly required, this in itself is not enough. **Young people need to be actively linked into available support facilities**, which can only be achieved through the development of quality relationships with those working in the community. Furthermore **young people need to be involved in making decisions** about the nature of these facilities and the activities provided in order to ensure service provision tailored to young people's needs and interests, an example of which includes Reachout.com, an internet based mental health project that was developed and positively field tested in Australia and has been rolled out in the Republic of Ireland.

6. **Specific training is required for key actors** which should be designed in consultation with the target groups:

    a. School Leaders – for example, the Professional Qualification of Head Teachers requires specific bespoke training from professionals in relation to crisis response, postvention and suicide prevention, in addition to more generic training in pupil emotional health and wellbeing. This should be available during all phases of teachers' careers including initial teacher education, early professional development and continued professional development. This training should be mapped to the professional competence framework.

    b. Young people – require support in relation to their own resilience but also evidence based gate keeper education in how they may recognise signs of distress in their peers and how they can best support their peers and direct them towards help e.g. Dr Richard Ramsey's Living Works 'Safe-talk' training, and Dr. Paul Quinnette's Question Persuade Refer (QPR) training.

    c. Families – also require support and information in relation to how they recognise signs of distress in their children and how they can best support them and direct them towards help.

1 Through their health and social well being improvement strand of work the Public Health Agency are already supporting the roll out of two evidence based programmes aimed at giving children the best start in life (the Family Nurse Partnership and the Roots of Empathy programme).

7. Members of the community, and in particular youth workers, should be able to avail of support to integrate the trauma experiences and **ward against the effects of vicarious trauma** or burnout. This could be achieved through making group or individual clinical supervision more widely available, or even a compulsory element of the work. Agency leadership training should be implemented on the management of vicarious stress and trauma and to identify those most at risk of vicarious trauma (Wurst et al, 2011), and a triage plan for professionals should be in place.

8. All **media reporting of suicide** should be monitored to ensure the appropriate information is portrayed in a responsible and sensitive way. Samaritans (2008) provide useful guidelines for the media reporting of self-harm and suicide, which should be adhered to at all times. An important element of these guidelines refers to how media reports of suicide or self-harm **should provide relevant information on sources of support and guidance**. While there is acknowledgement that the media have become more aware of how they should report on suicidal deaths, this should be monitored more closely, particularly with regard to which individuals should actually be in a position to speak to the media around the issue of suicide. More care needs to be taken with this, to prevent inaccurate, negative or sensationalised messages being portrayed to the general public.

9. Issues relating to youth suicide should be **fore-grounded within the school curriculum**. Personal Development classes provide ample opportunities to explore generic issues associated with emotional wellbeing. However there are opportunities within the Local and Global Citizenship curriculum to explore suicide as a *societal* issue. This would provide opportunities for teachers to address issues relating to the media, social networking and the glamorisation of suicide in youth culture. By addressing this issue at a societal rather than individual level some of the fears of teachers who feel ill-equipped to deal with the more emotive quasi therapeutic aspects of suicide may be allayed.

10. Suicide prevention and postvention strategies should be integrated within **a whole school approach to promoting wellbeing**, incorporated into, and drawing upon, the NI Department of Education PEHAW programme.

11. The current suicide prevention funding strategy promotes competition between organisations that should be working in close, cooperative allegiance. This overly competitive environment detracts from the primary purpose of promoting young people's psychological and emotional wellbeing and can result in the counterproductive absence of effective shared purpose between key resource agencies, missing important helping opportunities for synergy. It is suggested that alternative, perhaps **longer-term funding strategies** are considered, designed **to promote rather than inadvertently undermine collaborative working.**

12. All suicide prevention plans, programmes and interventions should be continuously subjected to **robust monitoring and evaluation.** This should include the evaluation of both the clinical effectiveness and cost-effectiveness of programmes in terms of improving outcomes for young people and critically, for social capital impact assessment. Previous literature, and the findings of this study, also emphasise the need for further efforts to be made in the evaluation of postvention efforts. Independent researchers should be involved in these processes.

13. **Areas identified for further research** include the impact of media and new media on factors such as young people's emotional wellbeing, and their perceptions of suicide. Young people's sense of 'community' is expanding to include their virtual communities and suicide prevention efforts need to acknowledge this. Further research should be done to investigate how social networking might be utilised as a way to monitor emotional wellbeing and suicide risk among young people. There is also a need for further research to be conducted on individuals' sense of community, belonging and connectedness within areas that have been affected by youth suicide clusters. Psychological autopsy studies conducted in the aftermath of a suicide, while incredibly labour-intensive, have the potential to effectively uncover a much deeper understanding as to why the suicide might have happened. This level of information and comprehension of suicidal behaviour has the potential to be particularly beneficial for informing suicide prevention efforts.

1. Introduction

1.1 Overview

The Centre for Effective Education was commissioned by Contact to undertake a piece of research that would explore a community's response to, and experience of, multiple deaths of young people by suicide. More specifically the project aimed to:

1. Determine what is known from the research evidence to date about the nature, incidence and factors associated with suicide clusters, with a focus on the particular vulnerabilities of young people.
2. Determine what is known from the research evidence to date about what interventions are effective in reducing the emergence of youth suicide clusters.
3. Review the evidence for the incidence of youth suicide clusters in Northern Ireland.
4. Explore in depth the impact of recent multiple deaths by suicide of young people.
5. Consider the implications of the findings for developing a range of effective interventions to reduce the risk of suicide clusters in Northern Ireland, particularly among young people.

This report presents the findings from this study, which addressed each of the aims in a number of ways. Firstly a detailed literature review of the academic and research literature was undertaken with the purpose of determining what is already known about suicide, suicide cluster phenomena and youth suicide clusters in particular, and effective interventions aimed at reducing the incidence of youth suicide clusters. Secondly, data was obtained from NISRA relating to the incidence of suicide deaths of young people (aged 25 or under) over the last decade in order to determine the localities in which the incidence of youth suicide was the greatest in Northern Ireland. Thirdly, a case study design was adopted to explore in-depth the community response to the deaths of young people by suicide in two case study site areas in greater Belfast. In conclusion, the findings from each strand of the research were drawn together into a set of recommendations.

2. Literature Review

2.1 Introduction

This review focuses on the existing research around suicide clusters and contagion. It examines the theories and models of suicidal behaviour, as well as models of suicide prevention, intervention and postvention and concludes with a section on secondary/vicarious trauma, which is an area of special interest to Contact, the study funder. The review examines examples of best practice and is based on a scoping exercise of the cross-disciplinary literature of systematic reviews and relevant research.

In order to identify relevant literature, the following databases were searched: *Australian Education Index* (AUEI); *British Education Index* (BREI); *ERIC*; *ERIC (USDE);Sociological Abstracts*; *PubMed; Web of Science; ProQuest Education Journals* and *PsycINFO*. For each database, the following key words/phrases were used for the searches:

Suicide/suicide cluster +
- Youth/adolescent/teen/teenage/young people
- Prevention
- Risk factors/triggers
- Contagion/copycat
- Theories/models
- Vicarious/secondary trauma/stress/survivors
- Trauma/stress prevention for workers
- Community/public health response
- Intervention/postvention
- Suicide epidemics

In addition to these searches, additional literature was identified through recommendations and following up references provided in reports identified.

2.2 Theories of suicidal behaviour

Suicide as a phenomenon is rarely studied prospectively, therefore we are forced to build our theories, assumptions and hypotheses based on retrospective analyses of behaviours and character studies (Berman and Jobes, 1991). There has been limited progress in developing the ultimate comprehensive theory of suicide, and the literature to date tends to describe theories relating to different aspects of suicidal behaviour.

O'Connor and Sheehy (2000) describe how early theories of suicidal behaviour proposed the biomedical model of suicide, arguing that for an individual to take their own life by suicide, they must be suffering from a mental health problem. Since then however, thinking has moved from this biomedical model of illness, towards the more plausible biopsychosocial model which proposes that the onset and treatment of illness is determined by the 'bio' (biological factors), 'psyche' (psychological factors) and 'social' (social factors), all of which interact with each other.

When applied to suicide, the biopsychosocial model provides a multidimensional approach that regards suicide to be the devastating end result of a combination of risk factors. It is possible to loosely group the existing major theories of suicide conceptually according to these three schools of thought – i.e. sociological, psychological and biological theories. It should be noted however that a certain degree of overlap exists between these three theoretical frameworks.

2.2.1 Sociological theories

With regard to suicide, few theories, if any, are better known than those developed by Emile Durkheim. Indeed, the sociological approach to suicide has almost become synonymous with Durkheim's theories. Durkheim's (1897) classic work *"Suicide: A Study in Sociology (1897/1951)"* proposed a sociological model of suicide which has led to extensive research in the area of suicidology and subsequent theory construction. Durkheim's theory on suicide, as reported by O'Connor and Sheehy (2000), took the approach that suicide is a social problem, which is fundamentally a product of the nature of the relationship between the individual and society, and a question of the individual's levels of social integration. More specifically, he proposed that suicide is a result of society's influence and control over the individual and the resulting tensions of this relationship.

Durkheim proposed that, while the suicide of an individual is the result of individual factors and circumstances, the frequency of suicides within a

society is dependent on its moral and psychological climate. Bill-Brahe (2000) uses the example of how divorce is thought to be a risk factor for suicide; however, the probability that divorce will lead to suicide very much depends on the norms and values of the society. Durkheim regarded man to be a social being essentially, and proposed that the need to belong within a community is therefore highly important; the norms and values of the community are necessary for providing individuals with a supportive framework for existence. While individuals have this overriding need to be part of this type of community, they also need to have a sense of self-identity, be autonomous in their thoughts and actions, and believe that they are of worth and significance, as individuals and as part of their community. In other words, Durkheim felt that for society, and individuals within that society, to function and develop positively, a balance must be struck between individuality and communality (Bill-Brahe, 2000).

Durkheim proposed four types of suicide:

- **Egoistic** – this type of suicide reflects a prolonged sense of not belonging and a lack of integration into a community or society, with the individual feeling marginalised and having little or no social support. Durkheim referred to this low level of social integration as *"excessive individuation"*. In egoistic suicide a cause is not important, the centre of the universe is the individual. This person is often bored with life and tired of living.

- **Altruistic** – is the opposite of egoistic suicide as it occurs when an individual is overly integrated into a group or society to the extent that the needs of society are greater than the needs of the individual. When the integration of the person within the group becomes so strong that an individual life is not important, societal demands and expectations have become too much for the individual. Someone who commits altruistic suicide suffers from a lack of individuation as well as a lack of social integration. Examples of altruistic suicide are the Japanese kamikaze pilots in the World War II, or suicide terrorist attacks by Islamic fundamentalists.

- **Anomic** – this type of suicide is thought to occur when there are rapid and drastic changes in the norms and values of a society; a sense of alienation may result for the individual. It reflects the individual's moral confusion and lack of social direction, relating to dramatic social and economic change. Anomie (i.e. the absence of usual social standards) is caused by changes in social ethics, which might challenge the morals and aspirations of the individual. Anomie might be prevalent in times of economic recession, or even when an individual makes windfall gains – in both of these scenarios the individual is faced with new expectations and confusion around where they fit in society.

- **Fatalistic** – is the opposite of anomic suicide. It is thought to be caused by excessive societal regulation that fundamentally restricts an individual's freedom. The individual feels that they have no control over their own destiny and that they are in a situation from which they believe there is no escape. An example of fatalistic suicide would be when someone is 'trapped' in an abusive relationship, or is terminally ill or imprisoned.

Thinking of suicide from another sociological perspective, it is possible to apply Bronfenbrenner's (1979) **ecological systems model** to suicidal behaviour. This model may be used to extend cultural understandings of suicide beyond the individual to the interpersonal relationships, community and society.

Ayyash-Abdo (2002) describes how Bronfenbrenner's (1979) ecological systems model can be applied to adolescent suicide. The ecological systems model places the individual in the centre of a series of complex systems: the microsystem, exosystem and macrosystem, all in concentric circles. The ontogenic level refers to the demographic or psychological characteristics of the individual. Ayyash-Abdo (2002) explains how the ecological model can be used to explore the multiple factors, on each of these levels, which might have a part to play in adolescent suicide. On an individual or ontogenic level, factors such as depression, hopelessness or drug and alcohol abuse might impact on levels of suicidality. The next level, the microsystem, addresses the direct influences on the individual, for example, family, peers, school. The exosystem refers to the larger social units that indirectly impinge on the individual, for example media impact, while the macrosystem refers to larger cultural differences in attitudes towards suicide.

O'Connor and Sheehy (2000) outline two of the most predominant psychosocial aetiological theories of suicidal behaviour which are both based on the **diathesis-stress hypothesis**. This hypothesis

suggests that suicide or attempted suicide is not simply a response to extreme stress, but that the individual must also exhibit some existing predisposition (or diathesis) to suicidal behaviour. The two models based on this hypothesis regard the predispositions to suicide to be (i) low abilities in problem solving; and (ii) low levels of social support. These two factors, however, according to the diathesis-stress model, only become risk factors for suicide when the individual is also faced with a stressful situation.

2.2.2 Psychological theories

In contrast to the purely sociologically oriented theories of suicide and the psychosocial theories, psychological theories focus more on the intrapsychic processes of the individual, as well as cognitive, emotional and personality variables.

Freud's **psychoanalytic theory of suicide** describes the act of suicide as being *"murder in the 180th degree"* referring to the way in which aggression is turned inward against the "introjected" object resulting in "retroflexed rage" (Berman and Jobes, 1991). Freud saw suicide as being the potential outcome of an intrapsychic struggle between the life and death force within individuals, Eros and Thanatos respectively (Stillion and McDowell, 1996). Zilboorg (1937) criticised Freud's view that the death instinct was responsible for suicide and developed Freud's ideas by incorporating revenge, fear, spite and fantasies of escape into potential triggers for suicide (Williams and Pollock, 2000). He also proposed that most suicidal acts display an element of impulsivity and that external factors have a part to play in suicide as well as the internal mechanisms proposed by Freud. Menninger (1938) built on Freud's psychoanalytic theory, explaining suicide in relation to three components: the wish to kill; the wish to be killed; and the wish to die.

Beck's (1967) **cognitive theory** proposes that the way people think about and interpret life events impacts on the way they will respond to those events both emotionally and behaviourally (Brown, Jeglic, Henriques and Beck, 2006). Central to the development of his work on cognitive theory, Beck (1964) and his colleagues conducted research with clinically depressed patients, whose negative thought patterns had a tendency to manifest themselves in consistently systematic ways. Brown et al. (2006) describe how Beck's concept of the **'cognitive triad'** is central to cognitive theory. This theory proposes the idea that depressed patients will habitually display a certain pattern of thinking, which involves them having a negative view of themselves, their future and the world; this results in a self-perpetuating cycle of negativity. Those with depression will not recognise that there will eventually be a way out for their pain, therefore they have little hope for their future, and may see suicide as being their only way out. Depressed individuals will interpret experiences negatively and feel that the world is against them and that unreasonable demands are being placed on them.

Similar patterns of negative thoughts and behaviours were observed among suicidal individuals, and Beck (1967) proposed the **hopelessness theory of suicide**, in line with his observation that suicidal crises were habitually, *"related to the patients' conceptualization of their situation as untenable or hopeless"* (Beck, Kovacs and Weissman, 1975). Beck (1967) felt that hopelessness behaved like a catalyst in the manifestation of suicidal behaviour, as patients viewed their experiences negatively, and firmly believed that their attempts to achieve goals would inevitably end in failure. Beck et al (1975) found that hopelessness was the key variable linking depression to suicidal behaviour.

The **"cry of pain" or arrested flight model** sees suicidal behaviour as an attempt to escape from the feeling of entrapment – i.e. the inability, or perceived inability, to escape from a negative environment or from one's own inner turmoil, after suffering a defeat, loss or humiliation, and the perception that there is no chance of being rescued. The arrested flight model has three components (Williams, Crane, Barnhofer and Duggan, 2005). The first refers to the levels of sensitivity individuals have to cues in the environment that might signal defeat; the second refers to the individual's perceived inability to escape, and is thought to arise, at least in part, from a lack of problem solving skills; the final component refers to a lack of positivity for the future, or hopelessness. Williams et al. (2005) have found that the difficulties with problem-solving are closely related to the tendency to retrieve personal memories in an over-general way. A reason for this kind of over-generalised recollection of events may be that the individual has suffered some kind of trauma or adversity in the past, for example abuse or war/conflict related trauma.

Williams (2001) was not the first to develop a theory about suicide in which pain has a central role; Shneidman (1985, 1996) had previously coined the term **'psychache'** which refers to the severe psychological pain resulting from unmet psychological needs, which he maintained all those who die by suicide experience prior to their death. Shneidman (1985, 1996) posited, on the other hand, that not all those who experience psychache will die by suicide, but that the additional factor of lethality is also necessary for the suicide to occur.

Shneidman argues that suicide is the ultimate escape (O'Connor and Sheehy, 2000) from this 'psychache', and, in a similar vein, Baumeister (1990) proposed the **escape theory of suicide** whereby he sees suicide as an escape from painful or aversive self-awareness. This theory proposes that suicide is the end result of a series of related events from which the person believes there is no escape. Escape theory involves the person examining his or her own life and how it has not measured up to the expectations they had for their life. Looking more closely at the causal and related events in Baumeister's (1990) escape theory of suicide, the chain begins with events that fall severely short of standards and expectations. The individual will attribute these failures internally, which makes self-awareness painful. Awareness of one's own inadequacies will have a negative effect, and the individual will therefore want to escape from this self-awareness. To escape from these negative emotions and aversive experiences of self-awareness, the individual retreats into a state referred to as *'cognitive deconstruction'*, which will help to compartmentalise their failings and attributions for failure. This deconstructed state brings irrationality and disinhibition, making drastic measures seem acceptable. Suicide can be seen as an ultimate step in the effort to escape from the self and the world, and because the individual is disinhibited, they see suicide as more acceptable (O'Connor and Sheehy, 2000).

Joiner's (2005, 2009) **interpersonal-psychological theory of suicide** has received significant attention in recent years due to its comprehensive nature and growing body of empirical support (Miller, 2011). Joiner's (2009) theory, in its simplest terms, ultimately proposes that people are at increased risk of suicide if they have both the capability to die by suicide, and the desire to take their own lives. Joiner (2009) postulates that, for suicide to take place, the individual must experience two states of mind simultaneously: perceived burdensomeness and thwarted or failed belongingness. Perceived burdensomeness refers to the belief that the individual's existence is in some way a burden to others; for example, family, friends or society. Failed belongingness is the feeling of being alienated from others, and not feeling integrated into any particular family, friendship circle or other valued group (Joiner, 2009). Joiner (2009) argues that when both of these perceived states are in place, the desire for death develops, as the individual feels that there is nothing left to live for.

The most recently developed predominant theory of suicidal behaviour is O'Connor's (2011) **Integrated Motivational-Volitional (IMV) model** of suicidal behaviour. This is a tripartite model which attempts to incorporate components of predominant models of suicidal behavior, many of which have been discussed above, into a three-phase model of suicidal behavior which aims to discriminate between suicide ideators and suicide attempters. This model looks at the relationship between background factors and triggering events (the pre-motivational phase); the development of suicidal ideation or intent (the motivational phase); through to the suicidal behavior itself (the volitional phase). O'Connor's (2011) model proposes that suicidal behavior ultimately results from a complex interaction of factors, starting with one's intention to exhibit suicidal behaviour. This behavioural intention is determined by feelings of entrapment, as described above, where suicide is seen as the only way of escaping from one's own negative circumstances or environment. The feeling of entrapment is described as being a result of defeat or humiliation. According to O'Connor's (2011) IMV model, the transitions between these phases, i.e. from defeat/humiliation to entrapment; from entrapment to suicidal ideation and intent; and from suicidal ideation/intent to suicidal behaviour, are determined by 'state-specific moderators', which he describes as being factors that facilitate or obstruct movement between states.

2.2.3 Biological Theories

From a neurobiological perspective, there is evidence to support the idea that suicidal behaviour is associated with changes in brain function. Much of the work points towards a link between particular characteristics of the potentially suicidal individual, for example impulsivity, and suicidal behaviour (O'Connor and Sheehy, 2000). The involvement of at least three neurobiological systems, the serotonergic system, the

noradrenergic system and the hypothalamic-pituitary-adrenal axis, in suicidal behaviour has been documented adopting a large variety of research methods. The focus has mostly been on two agents found in the central nervous system and peripherally, serotonin and noradrenaline. Depressed individuals have been shown to have lower levels of serotonin in their systems. Moreover, Traskman-Bendz, Allig, Oreland, Regnell, Vinge and Ohman (1991) found that suicidal individuals have lower levels of serotonin and higher levels of noradrenaline, which combined would result in impulsive and aggressive behaviour.
More recently, Traskman-Bendz and Mann (2000) explored the biological aspects of suicidal behaviour. They observe that abnormalities in the serotonergic system in suicide attempters and suicide victims have provided one of the most consistent findings in psychiatry. They report that other less extensive data has provided evidence of abnormalities in other neurotransmitter systems. Traskman-Bendz and Mann (2000) also report on findings that low concentrations of cholesterol have been found to be linked with suicidal behaviour.

Brent and Mann (2005) reviewed a host of family genetic studies (adoption, twin and family studies) to investigate the impact of genetics on an individual's diathesis to suicide. The growing body of existing research in this area is in support of the notion that suicidal behaviour is genetic, and that this genetic link in suicidal behaviour cannot solely be explained by the genetic link in psychiatric disorders. Brent and Mann's (2005) discussion of these studies concludes that suicide and suicidal behaviour actually belong to the same clinical phenotype. This familial link in suicidal behaviour may, however, also be attributed to the genetic transmission of impulsive aggression. Brent and Mann (2005) identify other potential environmental variables which might impact on the perceived familial link in suicidal behaviour including sexual and physical abuse, early parental loss, imitation, family instability and transmission of psychopathology.

2.3 Suicide Clusters and Contagion

There has been increasing concern in recent years, within Northern Ireland, Ireland, the UK and internationally, about the 'clustering' of suicides, particularly among adolescents and young adults. Tomlinson (2007) emphasizes the growing concern in local communities and among healthcare and social care professionals over a suicide "epidemic" and a clustering of suicides within certain areas of Northern Ireland and among certain friendship groups. Although the process of suicide contagion is quite poorly understood, it is believed that numerous documented suicide clusters have occurred due to contagion, for example in Bridgend, South Wales and in certain areas of North and West Belfast. Suicide contagion has been defined as the process by which exposure to suicidal behaviour, or a suicide, influences an increase in the suicidal behaviours of others (U.S. Department of Health and Human Services, 2012). Madelyn Gould, a pioneer in the area of youth suicide clustering and contagion research, adds to this definition of suicide contagion, that it assumes some level of awareness of the previous suicide (Gould, 1990); either direct contact or friendship with the suicide victim, word-of-mouth knowledge, or awareness through the media or even through fictional accounts of suicide. While there is no universal, explicit definition of suicide clusters, they largely refer to a group of suicides that occur closer together in time and space than would normally be expected in a given community (Centre for Disease Control and Prevention, 1988). Suicide contagion is thought to play a major part in the clustering of suicides.

Despite the fact that it is only relatively recently that suicide clusters have become a focus of attention in the public domain, the clustering and contagion of suicides are not new phenomena. Indeed, Gould, Jamieson and Romer (2003) report that suicide clusters, or 'epidemics' as they were then referred to, have been recorded since history began, an example being Popow (1911) who identified epidemics of suicides in Russian schools at this time. While early research such as this was only able to provide a descriptive account of events, suicide research has developed extensively since these early days, and there has been a shift methodologically to more inferential studies (Velting and Gould, 1997).

Gould and her colleagues conducted several such inferential studies which have confirmed that suicide

clusters tend to occur more within populations of adolescents and young adults, with only minimal effects of suicide contagion being found among those over 24 years of age (Gould et al., 2003). One such study found that following exposure to a suicide, 15 to 19 year-olds were two to four times more likely to display suicidal behaviour themselves than any other age-group (Gould, Wallenstein, Kleinman, O'Carroll and Mercy, 1990). Other research has supported the hypothesis that, following a suicide attempt or completion, adolescents are at an increased risk of copycat suicides, and that, although suicide clusters are relatively rare, they tend to be most prevalent amongst this age-group (Phillips and Carstensen, 1986; King, 2006). This evidence emphasizes the importance of having suicide postvention measures in place, among adolescents in particular, in an attempt to minimize the potential impact of suicide contagion. Suicide postvention (discussed further in section 2.5) refers to the measures which are put in place after the event of a suicide in an attempt to minimise the potential knock-on effect of a suicide cluster

There has been relatively limited focus in the research on suicide clusters, contagion, imitation and copycat suicide, and the role of the media influence on subsequent suicide related behaviour. Hazell (1993) reported that:

> *"most published information about clusters of teenage suicide appears in the popular press rather than in scientific journals."*

The Centre for Disease Control (CDC) were the first body to comprehensively address the issues of prevention and postvention in relation to suicide clusters, and their work has been adapted and applied around the world. The CDC's (1988) report, on recommendations for a community plan for the prevention and containment of suicide clusters, states that it is difficult to define a suicide cluster explicitly. They go on to comment on how the number and degree of "closeness" of cases of suicide in time and space that would constitute a suicide cluster vary depending on the size of the community and on its background incidence of suicide.

The CDC (1988) recommendations also acknowledge that when a community considers that it is facing a potential suicide cluster, it is essentially irrelevant whether the incidence of suicides meets some predefined statistical test of significance. It is clear that the importance of steps being put in place to prevent further deaths by suicide becomes the community's overriding concern at such a time.

Suicide contagion provides us with a possible explanation as to why suicide clusters might develop (Joiner, 1999). The process of contagion refers to the tendency of one or more person's suicidal behaviour to influence another person to attempt or complete suicide (SIEC, 1999). Suicide contagion assumes some level of awareness of the previous suicide (Gould et al., 1989). Within a suicide cluster it is generally felt that there is a relationship of sorts between the deceased. Gould et al. (1989) suggest a variety of suicide contagion pathways including direct contact or friendship with the previous suicide victim, word-of-mouth knowledge, and indirect transmission through the media. Adolescents, in general, are highly susceptible to suggestion and imitative behaviour, as these are the primary modes of social learning and identity formation (O'Connor and Sheehy, 2000).

2.3.1 Models of contagion

Although suicide is not a disease as such, applying the **infectious disease model** highlights factors that might influence the process of suicide contagion and emphasises the multiple causes of disease (Gould, 1990). Hazell (1993) reviewed possible mechanisms underlying adolescent suicide clusters using the infectious disease model, key concepts of which are host susceptibility, modes of transmission, degree of virulence, and dose dependency (Davidson and Gould, 1989). The concept of dose-dependency is expanded by Gould, Jamieson and Romer (2003) who found that the magnitude of the increase in suicides following a suicidal story is proportional to the amount, duration and prominence of media coverage. Host susceptibility describes the individual's capacity to shape the manifestations of disease (Susser, 1973). In the case of suicide, Gould (1990) describes how a genetic predisposition to depression can increase the probability of engagement in suicidal behaviour. Mode of transmission, in the case of suicide, may be direct, for example among friends within the same social network, or indirect, such as the suicide of a celebrity (Gould, 1990). The degree of virulence also varies with regard to suicide, depending on characteristics of the individual whose death was the first in a potential cluster – for example, the suicide of someone who is very popular may act as a more virulent agent than the suicide of someone who is isolated or considered to be a loner (Gould, 1990).

Suicide contagion can be viewed within the larger context of **behavioural contagion**, a situation in which the same behaviour spreads quickly and spontaneously throughout a group (Gould et al., 2003). **Social learning theory** can also help explain suicidal behaviour – the idea that most human behaviour is learned observationally (Bandura, 1977). Insel and Gould (2008) elaborate on how social learning theory describes the social processes and context that may underlie the development of suicide contagion. They explain how social learning theory contends that an observer is more inclined to imitate the behaviour of a model if the observer can identify with the model through shared common characteristics. Peers function as the most influential group during adolescence.

In contrast to this modelling hypothesis, **assortative relating** describes how people with similar personality traits and interests tend to form relationships (Joiner, 1999). Therefore, people who are vulnerable to suicidal ideation and suicide attempts may belong to the same peer group or "cluster" before the occurrence of a suicidal stimulus. Joiner (2005) explained how suicide clusters are therefore, in a sense, pre-arranged, because vulnerable individuals will relate assortatively rather than randomly. When impinged upon by severe negative events, members of this pre-arranged cluster are therefore at increased risk of suicide (Joiner, 2005). Joiner (2003) tried to test his theory of assortative relating empirically by measuring the suicidality of college students who chose to share a room, as opposed to those who were assigned roommates. Joiner (2003) was able to show that, consistent with the concept of assortative relating, those students who chose to live together were more similar on a suicide index than those roommates who were assigned to share a room together.

Joiner (2005) also describes the flipside of the assortative relating argument, which he called the **pulling together effect**. This argument proposed that if a member of a cluster (or peer group) dies by suicide, it is a local tragedy which can pull people together, increasing their sense of belongingness, which consequently acts as a buffer against suicidal behaviour of other members of the cluster.

Insel and Gould (2008) proposed the **neurobiological paradigm** as a way of clarifying the greater susceptibility to suicide imitation among adolescents and young adults than among other age groups. The neurobiological approach suggests that complex cognitive functions, which are a necessary component for the ability to inhibit inappropriate or impulsive behaviours, are still developing during adolescence.

Joiner (1999) outlined two general types of suicide cluster that had been discussed in the literature: **mass clusters** (media related clusters, the evidence for which is equivocal); and **point clusters** (occur locally, involving victims who are relatively contiguous in time and space, the prototypical setting being institutional). Point and mass clusters were further examined by Mesoudi (2009) who was interested in examining the social learning processes underlying point and mass clusters.

2.3.2 Media contagion

Hazell (1993) reports that although some research refutes the association between media exposure and suicide clusters (Kessler, Downey, Milavsky and Stipp, 1988; Davidson, Rosenberg, Mercy, Franklin and Simmons, 1989), the predominant view is that media reporting of suicides should be both responsible and restricted (Goldney, 1989). Gould et al. (2003) propose that overall, the magnitude of the suicide increase is proportional to the amount, duration and prominence of media coverage. Gould et al. (2003) also suggest that the impact of suicide stories on subsequent completed suicides appears to be greatest for teenagers. The evidence is stronger for the influence of reports in the media than in fictional formats.

Hawton and Williams (2005) conducted a systematic review, aiming to assemble all available evidence on media and suicidal behaviour, in order to answer questions around whether or not there is a media effect on suicidal behaviour. Hawton and Williams (2005) found that there was clear evidence that media reporting of suicidal behaviour can lead to increases in suicidal behaviour under certain circumstances. This impact is more pronounced when methods of suicide are specified, when there is prominent or repeated news coverage, and when the suicide of a celebrity is being reported. They also found that young people in particular are more susceptible to the effect of media contagion. The review of the literature by Pirkis and Blood (2001) yielded similar findings. The occurrence of imitative suicides following media stories is largely known as the "Werther Effect", derived from the impression that Goethe's novel "The Sorrows of

Young Werther" in 1774 triggered an increase in suicides, leading to its ban in many European states (Gould et al., 2003).

Poijula, Wahlberg and Dyregrov (2001) report that suicide contagion is less likely to occur amongst adolescents if they learn that a suicide victim was psychiatrically disturbed, was functioning in a psychopathological way, or was subject to individual psychosocial stressors (Higgins and Range, 1996). This emphasises the importance of monitoring the content of media reports on suicide.

Community response plans to potential suicide clusters acknowledge the potential impact of media reporting on suicides, and put procedures in place in relation to 'managing the media following a suicide'. Positive messages should be portrayed in the media relating to available sources of information and advice. The Samaritans (2008) have produced detailed and concise media guidelines for reporting suicide and self-harm, which should be used as a point of reference.

2.3.3 Statistical evidence for suicide clusters

There has been some discussion in the literature around statistical techniques used to detect clusters. Gould et al. (1989) found that suicide cluster studies basically employ two different research strategies:

a. Psychological autopsy studies – investigatory procedures which attempt to reconstruct the psychological lifestyle of the deceased, their pre-morbid behaviours, and the psychosocial events which preceded the death (Farberow and Neuringer, 1971).
b. Time-Space Studies – these employ the use of statistical and epidemiological models to assess temporal and geographic elements of suicide clusters - for example: the Knox technique; the Poisson mixture model. Gould, et al. (1990) carried out a time-space study using National Center for Health Statistics data for 1978-84. They used the Knox procedure to show that significant clustering of suicide occurred primarily among teenagers and young adults, with little effect beyond 24 years of age. Gould, Petrie, Kleinman and Wallenstein (1994) carried out a similar study in New Zealand, and found that significant time clustering occurred in younger age groups. A similar pattern was found in the two studies in terms of age specificity and time-space clusters.

It should be kept in mind that in terms of practical recommendations for postvention, the CDC (1988) advise that when a community considers that it is facing a suicide cluster, it is essentially irrelevant whether the incident cases of suicide meet some predefined statistical test of significance.

2.4 Suicide Prevention

There are many prevention strategies discussed in the literature: school-based, community-based, national and public health approaches. Some research and reports have focused on evaluating the impact of suicide prevention strategies.

The general goals of suicide prevention interventions, as identified by Stevens, Bond, Pryce, Roberts and Platt (2008) in the protocol for a Cochrane review of the prevention of suicide and suicidal behaviour in adolescents, are usually either or both of 1) case finding with accompanying referral and treatment; or 2) risk factor reduction (CDC, 1994; Gould et al., 2003; Gould and Kramer, 2001).

Gould et al. (2003) reviewed ten years of research on youth suicide, specifically risk factors and preventive interventions. They identified youth psychiatric disorder, a family history of suicide and psychopathology, stressful life events, and access to firearms as being key risk factors for youth suicide. The following were identified as being promising prevention strategies: school-based skills training for students; screening for at-risk youths; education of primary care physicians; media education; and restriction of lethal means. Gould et al. (2003) however, felt that the decline in the youth suicide rate, during the decade prior to this review, was largely attributable to the increase in antidepressants being prescribed for adolescents during this period. Gunnell (2005) however, suggested that the relationship between increased prescribing of antidepressants and falling suicide rates is not clear-cut, and observed that only around half of all individuals who commit suicide are in contact with health services in the four weeks before their death, and only 25% are in contact with specialist mental health services (Foster, Gillespie and McClelland, 1997).

2.4.1 Existing reviews of suicide prevention programmes

There are a number of existing reviews of suicide prevention efforts, although generally insufficient evidence has been found in support of any particular approach (Stevens et al., 2008). Ploeg, Ciliska, Brunton, MacDonnell and O'Brien (1999) summarised the evidence about the effectiveness of school-based curriculum suicide prevention programmes for adolescents. They found evidence of improved knowledge among pupils, but reported both beneficial and harmful effects in terms of help-seeking, attitudes and peer support.

Guo and Harstall (2002) carried out a review of school-based suicide prevention programmes for children and young people between 1990 and 2002. This review reported increases in knowledge and improved attitudes to mental health problems and suicide, but there was insufficient evidence of the programmes' effects on suicidal behaviour.

Gould et al. (2003) conducted a review of youth suicide risk and prevention interventions of the previous ten years. Findings of the review concluded that there was insufficient evidence on the effectiveness of school-based suicide awareness programmes, peer support programmes, or problem-solving and coping skills development courses. Gould et al. (2003) reported limited evidence in support of the training of school staff to recognise students at risk of suicide, and crisis intervention following a suicide to reduce the risk of subsequent suicides amongst peers (Stevens et al., 2008).

A systematic review conducted by Mann, Apter, et al. (2005) divided suicide prevention strategies into five key domains:

- Awareness and education - of the general public; primary care physicians; and gatekeepers (those in contact with potentially vulnerable populations, e.g. clergy, pharmacists, teachers, caregivers)
- Screening – to identify at-risk individuals and direct them to treatment
- Treatment interventions – pharmacotherapy; psychotherapy; follow-up care after parasuicide
- Means restriction
- Media

Mann et al. (2005) concluded that physician education in depression recognition, and treatment and restricting access to lethal means, reduced suicide rates, while other interventions required further evaluation.

2.4.2 Evaluating prevention efforts

Unfortunately very little empirical evidence exists that evaluates the effectiveness of different interventions to prevent youth suicide (Rosenberg, Eddy, Wolpert and Broumas, 1989). Researchers have noted that many suicide prevention efforts fail to include an adequate evaluation component (Angerstein, Linfield-Spindler and Payne, 1991; Garland and Zigler, 1993; Tierney, 1994).

The subjective opinions of experts are often relied on by policymakers to estimate the effectiveness of programmes. Rosenberg et al. (1989) developed and administered a questionnaire to experts to determine the effectiveness of six types of intervention:

1) Effective education to inform youths of coping strategies to better equip them for problems which may otherwise lead to suicidal behaviour;
2) Early identification of youths at risk of suicide;
3) School-based screening programmes;
4) Hotlines and crisis centres;
5) Improved training of health care professionals to recognise and respond to conditions that may lead to suicidal behaviour;
6) Restriction of access to means of suicide

Experts suggested that, on average, 10% of young people who would die by suicide in the absence of any intervention were being prevented from doing so by existing intervention programmes (Rosenberg et al., 1989). It was noted however, that there was much uncertainty amongst experts regarding the effectiveness of different interventions, as indicated by a wide range of estimates among respondents. It was also emphasised that none of the interventions were thought to represent a "cure" for youth suicide, and that there was no clear "winner" among the six interventions (Rosenberg et al., 1989). The most important outcome of Rosenberg et al.'s (1989) study was to confirm that there is a great need for further empirical evidence of the effectiveness of suicide interventions.

Breton, Boyer, Bilodeau, Raymond, Joubert and Nantel (2002) carried out an in-depth review, and found at that time that only fifteen Canadian youth suicide programmes had been evaluated in the preceding decades. Breton et al. (2002) concluded that the descriptions of such programmes were incomplete, and their theoretical bases were never presented. Breton et al. (2002) also reported that only two of the interventions evaluated showed that the programmes led to a reduction in suicidal behaviour (Mishara and Daigle, 1997; de Man and Labreche-Gauthier, 1991). The ongoing dilemma around the lack of a widely accepted measurement of the actual effectiveness of suicide prevention programmes has been acknowledged frequently in the literature. Gould and Kramer (2001) pointed out how the low base rate of completed suicide means that mortality statistics cannot be used effectively as outcome measures, unless the assessment involves a very large-scale prevention effort. Assessments of help-seeking behaviour, risk factors (e.g. depression and substance abuse), previous suicide attempts and ideation can be employed in evaluation efforts. Gould and Kramer (2001) identified a major challenge to be the identification of direct outcomes of specific components of prevention programmes. Mazza (1997) observes that the methods used for determining the efficacy of suicide prevention programmes tends to focus on acquisition of knowledge or attitude change, rather than a reduction in actual suicidal behaviour. They also recommended that attention should be directed towards designing prevention programmes that reach high-risk populations.

Beautrais, Fergusson, et al. (2007) reviewed the evidence for effective suicide prevention strategies in New Zealand. This review acknowledged that the effectiveness of suicide prevention initiatives has not been sufficiently evaluated, but reported on the practices for which the available evidence was indicative of positive outcomes. The interventions highlighted as best practice were medical practitioner and gatekeeper education, and restriction of access to lethal means. Beautrais et al. (2007) also identified several approaches directed at suicide prevention which have been found to be harmful or potentially harmful. These were: school-based programmes that focus on raising awareness about suicide; public health messages about suicide and media coverage of suicide issues; no-harm and no-suicide contracts in mental health settings; recovered or repressed memory therapies.

A systematic review was conducted (Mann et al., 2005) to examine the evidence for the effectiveness of specific suicide prevention interventions and to make recommendations for future prevention programmes and research. Conclusive evidence was found in this review to indicate that physician education in the recognition and treatment of depression, and restricting access to lethal means, were both effective means of reducing suicide rates. It was concluded that other types of intervention needed more evidence of efficacy.

Rodgers, Sudak, Silverman and Litts (2007) describe the Evidence-Based Practices Project (EBPP) for suicide prevention, which was created in 2002. The primary goals of the project were to review suicide prevention programmes, and create an online registry of evidence-based programmes. The project also aimed to promote evidence-based suicide prevention programmes, and to help improve the methodological rigour of evaluations of prevention programmes (Rodgers et al., 2007).

2.4.3 School-based prevention

Stevens et al. (2008) propose that curriculum-based prevention programmes primarily attempt to de-emphasise the link between mental health problems and suicide, in an attempt to de-stigmatise suicidal feelings. One aim of this type of programme would be to enable students to recognise suicidal behaviour in their peers, and to consequently facilitate at-risk students in getting help (Stevens et al., 2008). Fox and Hawton (2004) however suggested that a programme such as this would run the risk of normalising suicidal behaviour, therefore reducing potentially protective taboos. Guo and Harstell (2002) reported on two studies which found that some young people were more likely to exhibit suicidal behaviour after school-based prevention programmes.

Berman (2009) outlined another reasonable argument against school-based prevention, by proposing that the youth at greatest risk of suicide are those that are least likely to still be in school. However, Berman (2009) also explained the counter-argument to this suggestion, based on the logic of Rose's theorem (1992):

> *"a large number of people at small risk may give rise to more cases than a small number who are at high risk."*

In support of this latter argument, that prevention interventions should be focussed in schools, Berman (2009) also reported that a recent survey of members of the National Association of School Psychologists (American Association of Suicidology, 2008) found that 86% of psychologists in schools have counselled a student who has either threatened or attempted suicide. Another result of this survey found that only 22% of the school psychologists surveyed felt that their graduate training had prepared them to effectively intervene with suicidal youth, or to contribute to postvention efforts within their school.

Miller, Eckert and Mazza (2009) conducted a review of suicide prevention programs in schools from a public health perspective. A literature review was conducted and thirteen studies were identified and coded based on key methodological features (Miller et al., 2009). To be included in the review, studies were required to meet certain selection criteria. Generally, to meet these criteria, they needed to contain information regarding the implementation of a school-based programme which addressed suicidal behaviour among children and youth. Only two of the thirteen studies reviewed demonstrated strong evidence for statistically significant effects on primary outcome measures.

Miller et al. (2009) describe a school-based public health model, with reference to Walker, Horner, Sugai, Bullis, Sprague and Bricker's (1996) three-tiered model. The three overlapping tiers of this model represent a continuum of interventions that increase in intensity to meet the needs of the individual student (Sugai, 2007). The universal or primary level is administered to all students within a school or class, and aims to prevent particular emotional, academic or behavioural problems. The next level of intervention, referred to as the selected or secondary tier, involves more intensive measures for individuals who do not respond to the universal interventions. Finally, the indicated or tertiary tier, for those students who fail to respond to the first two levels of intervention, is highly specialised and individualised (Sugai, 2007; Walker et al., 1996; Kalafat, 2003).

Miller et al. (2009) describe how universal suicide prevention programs tend to be most widely used in school, and typically focus on increasing awareness of suicide, through providing information on the risk factors and warning signs, dispelling myths about suicide, and teaching students how to respond appropriately and effectively to peers who they feel may be suicidal (Mazza and Reynolds, 2008).

Selected suicide prevention programs target those students who are thought to be at higher risk of suicidal behaviour; for example, students with mental health problems, or those at risk of dropping out of school (Hendin, Brent, Cornelius, Coyne-Beasley, Greenberg and Gould, 2005). Miller et al. (2009) describe possible components of selected interventions: teaching decision-making skills and strategies, sign-posting to resources within the school and community, and student screening programmes or other strategies for identifying students at risk (Mazza and Reynolds, 2008).

Indicated suicide prevention interventions tend to be aimed at students who have previously engaged in suicidal behaviour, and are therefore focussed on trying to prevent further engagement in such behaviour (Miller et al., 2009). In order to reduce the personal crisis or conflict for a student, interventions need to be individualised and designed to address specific problems the student is experiencing.

Results of the review of school-based suicide prevention programmes by Miller et al. (2009) showed that, of the thirteen studies identified, the highest methodology ratings were obtained by two universal prevention programmes (Klingman and Hochdorf, 1993; LaFromboise and Howard-Pitney, 1995) and one selected prevention programme (Randell, Eggert and Pike, 2001). Miller et al. (2009) also reported that only two of the thirteen studies reviewed demonstrated strong evidence for statistically significant effects on primary outcome measures.

2.5 Suicide Postvention

Shneidman (1969) defined the term postvention as, *"the helpful activities which occur… after a stressful or dangerous situation"* (Andriessen, 2009). More specifically, he stated:

> *"postvention aims primarily at mollifying the psychological sequelae of a suicidal death in the survivor attempt"* (p.22).

Andriessen (2009) maintained that the term postvention is now predominantly only used with reference to the aftermath of suicide:

"Postvention are those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behaviour."

Andriessen (2009) proposed that postvention is an integral part of suicide prevention, given that survivors are a group at higher risk of suicide. Suicide research has shown that suicide survivors receive much less social support than survivors of other kinds of death (Moore and Freeman, 1995). King (2006) reports how following a suicide attempt or completion, adolescents are at an increased risk of copycat suicides. Gould et al. (1990) found that youth suicide increased two to four times more following exposure to another individual's suicide than among older age groups. This evidence emphasizes the importance of having postvention measures in place, to minimise the potential for such behaviour.

An internationally recognised example of a best practice model of postvention was developed by the National Alliance on Mental Illness New Hampshire (NAMI NH) in 2003: the Connect Suicide Prevention Project. It had been identified that there was a desire amongst practitioners for a joined-up approach between multiple systems for a framework of specific instructions for each discipline in how best to respond to a youth suicide. The project was developed in response to this need.

The goal of the Connect Project is: *"Communities will become increasingly competent at responding to suicidal incidents (which include: expression of suicidal thoughts, attempts and completions) that affect vulnerable youth in order to reduce the number and rate of youth suicides"* NAMI NH (2009).

The Connect Project is guided by an ecological model, a theoretical approach that has been used in other prevention programmes. This approach acknowledges that while suicide is generally the act of an individual, suicide events take place within the context of the individual's interpersonal relationships, and their position within the community and the wider society in which they live.

Emphasis is put in the Connect model on the training of key service providers and members of the community so that an integrated response will be implemented in order to reduce the risk of further deaths by suicide, and to promote healing. The project has developed specific protocols for the following disciplines:

- Gatekeepers
- Immediate family
- Community Coordinator
- Education
- Emergency Medical Services and First Responders
- Faith Leaders/Faith communities
- Funeral Directors
- Law Enforcement
- Medical Examiner
- Mental Health/Substance Abuse Private Provider
- Mental Health/Substance Abuse Provider
- Social Service Agency/Youth Program
- Student/Teen/Young Adult

The protocols contain general and specific information for each of these groups on how to respond to suicide, as well as information on how to coordinate a community's response to suicide.

The Connect Project is based on core principles participants will come to share on completion of training. The key principle highlights the importance of having training protocols in place, designed to improve communication and trust between providers. Training will increase understanding of the roles and limitations of each discipline's suicide response. The Connect Project also highlights the need for constant evaluation and monitoring to identify successful elements, and the need for revision. Connect acknowledge the fundamental importance of how accountable, evaluated training reflecting effective outcomes helps with implementation for more communities.

The Connect Project acknowledges the need to address the importance of cultural effectiveness. In addition to recognising the diversity of minority groups and distinctions between rural and urban settings, the cultural differences between adults and young people should be considered. More effort should be made to bridge the gap between adults and young people by trying to understand contemporary and changing youth culture.

A significant body of literature addresses recommended community actions in the event of suicide, to prevent contagion. Most of the research to

date in this area is contained within the education literature, with many recommendations on how school community may best respond when faced with a suicide. Solanto (1984) found that reverberations from the loss of a student to suicide in a school setting are felt for at least 2 years following the death (Mauk and Weber, 1991).

The original recommendations on postvention following a suicide were produced by the Centre for Disease Control (CDC, 1988). The Connect Project, among other suicide postvention programmes, has drawn from the groundbreaking work of the CDC (1988). The CDC (1988) developed, during a workshop held in New Jersey, *"Recommendations for a community plan for the prevention and containment of suicide clusters"*. Participants in the workshop included people from a variety of sectors, who had played key roles in community responses to nine different suicide clusters, as well as representatives from the American Association of Suicidology, The Association of State and Territorial Health Officials, The Indian Health Service, and the National Institute of Mental Health (O'Carroll, 1990). These recommendations were developed to assist community leaders in public health, education, and other fields to develop a community response plan for potential suicide clusters. The CDC (1988) recommendations are outlined below:

1) A community should review the recommendations proposed by the CDC (1988) and develop its own response plan to have in place, should the unfortunate possibility of a potential suicide cluster arise. The confusion that typically results in the early stage of an evolving suicide cluster, is not conducive to the effective coordination of effort in terms of prevention of additional suicides.
2) The response to the crisis should involve all concerned sectors of the community – e.g. education, public health, mental health, local government, community groups, suicide crisis centres, and any other appropriate agencies. CDC (1988) recommends that one agency should be appointed the 'host' agency for the plan.
3) The relevant community resources should be identified, in addition to those represented on the coordinating group, for example:

    a) Hospitals and emergency departments
    b) Emergency medical services
    c) Local academic resources
    d) Clergy
    e) Parents' groups
    f) Suicide crisis centres/hotlines
    g) Survivor groups
    h) Students
    i) Police
    j) Media

4) The response plan should be implemented under either of the following two conditions:
    A. When a suicide cluster occurs in the community;
    B. When one or more deaths from trauma occur in the community (especially among adolescents or young adults) which the members of the coordinating committee think may potentially influence others to attempt or complete suicide.
5) If the response plan is to be implemented, the first step should be to contact and prepare the various groups identified above.
6) The crisis response should be conducted in a manner that avoids glorifying the suicide victims and minimises sensationalism.
    A. The event(s) should be presented as accurately as possible to the media, as well as to school staff, family, pupils and members of the community.
    B. If the suicide has occurred among individuals of school age, the death(s) should be explained to fellow pupils in such a way as to provide maximum support, while minimizing the risk of hysteria.
7) Individuals who are identified at high risk have at least one screening interview with a trained counsellor, with appropriate referral as needed.
8) A timely flow of accurate, appropriate information should be provided to the media.
9) Environmental elements that might increase the likelihood of further suicide attempts should be identified and changed.
10) Long-term issues suggested by the nature of the suicide cluster should be addressed.

Forde and Devaney (2006) provided an account of the design, development and implementation of a postvention model of responding to the needs of families within a community following the aftermath of a tragic event, including suicide. This model was originally developed for a specific disadvantaged urban community, on the east side of Galway, which

had experienced a high rate of suicide and other tragic events. Forde and Devaney (2006) adopted the ecological perspective to address the issue of family support, the underlying principle being that families do not exist in isolation, but are effected by and influenced by their surrounding environment (Bronfenbrenner, 1979). Ghate and Hazel (2002) suggest that social support can act as a stress-buffering factor by providing help or support at moments of particular need. Forde and Devaney (2006) developed a model which was firmly embedded in the ecological perspective, providing an awareness of the overall context of the family, community and environment at large, and their interdependency. The model recognises and seeks to consolidate the importance of a family's informal social network rather than replace it with formal support networks.

Roberts, Lepkowski and Davidson (1998) suggested a team approach to developing a postvention plan within a school, using the mnemonic device T.E.A.M. to represent the four steps of their approach:

- T – Developing a Team: the team should be made up of school counsellors, the special educational needs teacher, any school nurses, psychologists or social workers, the school principal, etc. A team leader should be appointed. The team's primary goal is to implement the postvention plan, but they are also required to provide pre-suicide in-service training - e.g. suicide warning signs, the grieving process, basic strategies for dealing with a person contemplating suicide.
- E – Establishing Procedures: postvention procedures should be developed for notifying all staff, pupils and families, dealing with the media and planning any memorial activity.
- A – Arranging Supports: support should be provided for students, teachers and the family of the deceased.
- M – Monitoring Progress: the long-term progress of the school environment should be monitored as it continues to cope with the suicide. At-risk students should be closely monitored, with repeatedneed assessment and referral when necessary.

Maples, Packman, Abney, Daugherty, Casey, and Pirtle (2005) adapted the T.E.A.M. model (Roberts et al., 1998) and proposed that only **c**ounsellors, **a**dministrators, **p**arents and **t**eachers (the CAPT model) who have been directly involved with a teen suicide should be involved in implementing the postvention response.

Celotta (1995) provided recommendations for the aftermath of suicide in a school setting, many of which echo previously cited recommendations:

- School-community collaboration
- Written procedures – to reduce the chances of indecision, poor decisions or conflicts
- Trained leadership
- Trained postvention and crisis intervention teams
- Appropriate communication with area agencies (e.g. mental health organizations and hospitals) and the media
- "Normal routine" – Hunt (1987) found that students and staff will feel more secure if they can resume normal activities as soon as possible
- Information and support for staff members, students and parents, as well as the victim's family and close friends
- Identification and further assistance of students at risk

Lamb and Dunne-Maxim (1987) propose three underlying principles for a school's response to a suicide:

1) Nothing should be done to glamorize or dramatize a suicide;
2) Doing nothing can be as dangerous as doing too much; and
3) Students cannot be helped until the faculty is helped.

Garfinkel, Crosby, Herbert, Matus, Pfiefer and Sheras (1988) describe the features of a postvention action plan involving verifying the death, convening a school crisis team, notification of staff and students and dealing with the immediate family, the media and the community at large. Carter and Brooks (1990) focused on the positive outcomes of postvention, by suggesting that any crisis presents an opportunity for change and growth.

Campbell, Cataldie, McIntosh and Millet (2004) suggested an Active Postvention Model (APM) known as the Local Outreach to Suicide Survivors (LOSS) Programme. This programme, which was

implemented in the Baton Rouge Crisis Intervention Centre in Baton Rouge, Louisiana, takes an active approach by going to the scenes of suicides to begin helping the survivors as close to the time of death or notification. This APM also provides referrals for additional support to all individuals at the scene of the death. A preliminary examination of the role of an APM was later conducted (Cerel and Campbell, 2008). Those suicide survivors who received an APM (*n*=150) were compared to those who received a traditional passive postvention (PP, *n*=206). Results indicated that APM presented sooner for treatment (48 days) than PP (97 days). APM were more likely to have been the survivor of a violent suicide than PP, and were also more likely to attend survivor support group meetings.

Zenere (2009) outlined the goals of postvention as supporting survivors, preventing imitative suicides by identifying other individuals who are at risk of self-destructive behaviour and connecting them to intervention services, reducing survivor identification with the deceased and providing long-term surveillance and support. Zenere (2009) suggested that for a school-based postvention service to be successful in avoiding contagion, it should be dependent on timely, efficient and targeted responses to student suicide. Zenere (2009) identifies the following elements for an effective postvention strategy:

- Confirm the facts
- Mobilize a crisis-response team
- Identify at-risk students
- Inform students through personal communications
- Support and monitor affected students
- Provide appropriate outlets for grieving
- Engage the community

McMenamy, Jordan and Mitchell (2008) carried out a pilot study which focused on the natural coping mechanisms of suicide survivors, and aimed to identify specific problems and needs of survivors following the death of a significant other by suicide. McMenamy et al. (2008) used a newly developed needs assessment survey to examine four natural coping efforts:

1) Practical, psychological and social difficulties;
2) Formal and informal sources of support;
3) Resources utilized in healing; and
4) Barriers to finding support since the loss.

Results indicate that participants experienced high levels of psychological distress since the suicide, including elevated symptoms of depression, guilt, anxiety and trauma.

Mauk and Weber (1991) described recommendations stemming from an integration of several school-based postvention plans (Garfinkel et al., 1988; Lamb and Dunne-Maxim, 1987; Patros and Shamoo, 1989; Poland, 1989). To conclude this section on postvention, an updated version of this type of integration of postvention plans is summarized below. Some postvention recommendations not specific to the school setting have also been included:

1. **Develop a crisis-response team and appoint a leader.** Leenaars and Wenckstern (1990) identify a difference of opinion as to whether such a crisis-response team should be comprised of outside experts who serve to validate the school's response and are thought to be objective (Lamb and Dunne-Maxim, 1987; Lamb, Dunne-Maxim, Underwood and Sutton, 1991) or staff from within the school who are trained in crisis intervention (Mauk and Rodgers, 1994; Pelej and Scholzen, 1987; Poland, 1989; Stevenson, 1990) (Mauk, Gibson and Rodgers, 1994). In terms of community response, CDC (1988) recommendations state that individuals from concerned agencies – e.g. education, public health, mental health, local government, suicide crisis centres – should be designated to serve on a coordinating committee.

2. **Develop a response plan.** CDC (1988) states that a community should review their recommendations and develop their own response plan before the onset of a suicide cluster. CDC (1988) recommendations suggest that the response plan should be implemented when either of the following two conditions are met:

    a) When a suicide cluster occurs in the community
    b) When one or more deaths from trauma occur in a community which members of the response team feel might potentially influence others to attempt or complete suicide.

3. **Verify facts -** In the school setting it has been recommended that the principal should verify accounts of the event (Garfinkel et al., 1988; Patros and Shamoo, 1989; Zenere, 2009).

4. **Notify relevant groups:**
   a. **School staff** –staff should be informed of validated facts via a telephone chain. An emergency meeting should take place prior to school opening the following morning (Dunne-Maxim et al., 1992). If a crisis-response team has been organized, members should also be notified (Guetzloe, 1989; Patros and Shamoo, 1989).

   b. **Students** – a written statement should be provided to staff to be read out to students in their classes, preferably during the first class of the day. This statement should include the basic facts known about the incident and should identify support resources available to students (Dunne-Maxim, Godin, Lamb, Sutton and Underwood, 1992). Details of the suicide are not necessary (Garfinkel et al., 1988; Patros and Shamoo, 1989). The announcement should be made in such a way as to provide maximal support for the students while minimizing the likelihood of hysteria (CDC, 1988). It is recommended that students are not informed in an assembly setting, as questions from individual students could not be answered in such a large group, and emotions may get out of control (Garfinkel et al., 1988). School should not be cancelled as students will need the support and routine.

   c. **Families of students** – a letter should be sent home to all parents providing them with the basic facts and phone numbers of available resources (Dunne-Maxim et al., 1992).

   d. **Media** – a prepared statement should be made available to the media which briefly expresses the school's grief over the child's death and explains the actions being taken to meet the needs of the other students (Dunne-Maxim et al., 1992). Wenckstern and Leenaars (1993) identify that it is not the responsibility of the school to provide actual details about the event to the media; this falls within the jurisdiction of the police and the coroner's office. The crisis-response should be conducted in such a way as to avoid glorifying the suicide victims and minimize sensationalism (CDC, 1988). A media spokesperson for the school should be appointed to ensure accuracy and consistency of information being given out by someone who understands the postvention strategy (Wenckstern and Leenaars, 1993).

5. **Contact family of the deceased** - Crisis-response team should make contact with and offer support to the family of the deceased. (Guetzloe, 1989; Patros and Shamoo, 1989; Poland, 1989). Siehl (1990) suggests that the principal, counsellor or a favourite teacher should visit the home of the family within 24 hours of the death.

6. **Identify those 'at-risk'** – CDC (1988) recommends that such students should have at least one screening interview with a trained counsellor, with appropriate referral as needed. Dunne-Maxim et al. (1992) suggested that crisis stations should be set up strategically throughout the school where students can be counselled in groups or individually for a few days following the incident.

7. **Adapt environment** – CDC (1988) recommendations suggest that elements in the environment that might increase the chance of further suicides or suicide attempts should be identified and changed – e.g. restricting access to means, modification of previous suicide sites.

8. **Monitor progress -** both on an individual level in terms of at-risk students, and the long-term progress of the school environment as it continues to cope with the suicide.

2.6 Vicarious trauma

Vicarious trauma is described as an accumulation of the therapist's memories of clients' traumatizing material that affects, or is affected by, the therapist's perspective of the world (Figley, 1995). Pearlman and Saakvitne (1995) report how they have consistently observed the phenomenon of vicarious traumatisation in therapists who treat trauma survivors. This trauma manifests itself through definite and profound changes in the core aspects of the therapist's self. For example, changes in how they view the world and their identity; inability to cope with strong feelings; inability to maintain a sense of meaning or a positive sense of self and connection with others. Those suffering from vicarious trauma might also be affected in terms of basic needs for safety, esteem, trust, control and intimacy (Figley, 1995).

No research has been found to date on vicarious trauma of workers involved in dealing specifically with suicide clusters. Limited literature has been collated on vicarious trauma of professionals who have lost a patient through suicide more generally. Gitlin (1999) identified that:

> *"In the literature on suicide, among the least commonly discussed topics is the reaction of mental health professionals when one of their patients in treatment commits suicide."*

Ruskin, Sakinofsky, Bagby, Dickens and Sousa (2004) surveyed a sample of psychiatrists and psychiatric trainees in the University of Toronto. One half of respondents had experienced at least one suicide of a patient. An important minority of those respondents who had experienced patient suicide (one quarter) had substantially higher (morbid) scores than the overall group. They also scored higher on an acute stress disorder and a post-traumatic stress disorder symptom checklist. The impact was more severe when the patient suicide occurred during training than after graduation, and was inversely correlated with clinicians' perceived social integration into their relational professional network. Ruskin et al. (2004) concluded that the majority of trainees and clinicians are able to cope normally with the trauma of patient suicide, but in an important minority the emotional impact approaches morbid levels. A recent study by Wurst et al. (2011) surveyed therapists' reactions to patients' suicides found that three out of ten therapists suffer from severe distress after a patients' suicide and that the overall distress and emotional responses immediately after the suicide explained 43.5% of the variance of total distress in a regression analysis and predicts emotional reactions and changes in behaviour.

Hendin, Lipschitz, Maltsberger, Haas and Wynecoop (2000) carried out a more qualitative study about therapists' reactions to the suicides of patients in their care. Therapists for 26 patients completed semi-structured questionnaires about their reactions, wrote case narratives, and participated in a workshop to discuss their cases. The major emotional reactions for therapists were shock, grief, fear of blame, self-doubt, shame, anger, and betrayal. In the majority of cases, therapists identified at least one major change they would have made in their patients' treatments. Although colleagues were helpful, institutional responses and case reviews were rarely helpful, offering either blame or false reassurance that the suicide was inevitable. Gitlin (1999) studied the responses of one psychiatrist to a patient's suicide, and similarly found a combination of post-traumatic stress disorder symptoms, shame, guilt, anger, isolation, and fears of both litigation and retribution from the psychiatric community.

Bober and Regehr (2006) examined the effectiveness of strategies for reducing vicarious trauma more generally – i.e. not specifically focusing on the impact of patient suicide. This study sought to assess whether therapists believed and engaged in commonly recommended forms of prevention from secondary and vicarious trauma, and whether engaging in these activities resulted in lower levels of distress. Although participants generally believed in the usefulness of recommended coping strategies including leisure activities, self-care activities and supervision, these beliefs did not translate into time devoted to engaging in the activities. More importantly, there was no association between time devoted to coping strategies and traumatic stress scores. Further research into the effectiveness of strategies to reduce vicarious trauma remains an area of interest to Contact.

2.7 Social Inequality and the Northern Irish Context

Thinking more broadly about the issue of suicide from a sociological stance, it has been argued that many negative health and social outcomes of societies can be explained by social inequality and social exclusion. Wilkinson and Pickett (2009), in their influential book *"The Spirit Level",* propose the idea that social problems, lower life expectancy and various aspects of unhappiness are more prevalent in poorer areas, not because of the lack of money in these areas per se, but because of their inhabitants' socioeconomic status relative to those in neighbouring, richer areas. In other words, negative health and social outcomes are exacerbated in societies where inequality prevails.

Wilkinson and Pickett (2009) present a wealth of international research in support of their theory on social inequality. Taking a global perspective, they have observed that as living standards rise and countries become richer, there appears to be a weakening in the relationship between economic growth and life expectancy, whereas in poorer, less developed countries, economic growth remains an

important factor in well-being and life expectancy. They contest the seemingly logical viewpoint that poor living conditions, for example, poor housing, bad diet, lower educational opportunities, lead to social problems, and suggest that what is important is where people stand in relation to others in their society. Much of what Wilkinson and Pickett (2009) discuss around the consequences of inequality, in relation to both physical and mental health outcomes, teenage pregnancy, educational performance, violence and social mobility, is applicable to the more socioeconomically deprived areas of Northern Ireland.

Communities in Northern Ireland affected by social inequality, present negative health and social problems, for example high suicide rates, which are similar to those in comparable areas within the UK and the Republic of Ireland. Carol Craig (2010) provides an insightful discussion of Glasgow's health and social problems, claiming that the culture of inequality, as described by Wilkinson and Pickett (2009), plays a powerful role in the development of many of these ill-effects. Niamh Hourigan's (2011) text 'Understanding Limerick' compiles an extensive body of research, which has been conducted on social exclusion, inequality, deprivation and criminality in the city of Limerick, a region which contains some of the most economically deprived neighbourhoods in the Republic of Ireland. A number of parallels may be drawn between Glasgow, Limerick and the areas of Belfast in which the case studies have been conducted, in terms of inequality and its outcomes. Some of these parallels are elaborated on in Section 6, in relation to the specific findings of the current study.

The social context of Northern Ireland, however, brings its own unique set of circumstances, not least in terms of the impact of the Troubles. Tomlinson (2007) conducted an extensive and insightful review of the literature around mental health, suicide and the conflict in Northern Ireland, as part of the development of Northern Ireland's Suicide Prevention Strategy, *Protect Life: A Shared Vision* (Department of Health Social Services and Public Safety Northern Ireland, 2006), which included a detailed analysis of suicides and accidental deaths between 1967 and 2005. This review ultimately aimed to explore and evaluate the existing research, which might contribute to our understanding of the potential impact of the Northern Ireland conflict on mental health generally, and suicide rates specifically.

Tomlinson's (2007) findings around whether the conflict has affected mental health and suicide were unsurprisingly complex and inconclusive. It might be argued that the Troubles have had minimal impact on Northern Irish society, with no obvious rise in mental health problems on a population level, and only marginal effects on individuals and communities. Others however would argue that in fact the Northern Ireland conflict has had, and continues to have, a huge, deep and widespread impact, with the full psychological impact only becoming obvious in recent years. Tomlinson (2007) postulates that actually the broader picture is far more complex than that depicted by either of these scenarios.

Strong evidence exists to support the idea that experience of the Northern Ireland conflict and poor mental health are associated. Miller, Devine and Schubotz (2003), in their secondary analysis of the 1997 and 2001 Northern Ireland Health and Social Wellbeing Surveys, found that the relationship between conflict experience and poor mental health, and between lack of conflict experience and good mental health, were statistically significant to a high level for both years surveyed. Clearly, some communities experienced the conflict more intensely than others, and a direct correlation has been found between poor mental health and habitation in areas which are both economically disadvantaged and have experienced greater exposure to the Troubles (Department of Health, Social Services and Public Safety, 2003). O'Reilly and Stevenson (2003) undertook secondary analysis of the 1997 Northern Ireland Health and Social Wellbeing Survey data to find that the more the respondent's life and geographical area was affected by the Troubles, the greater the chance of poor mental health. Tomlinson (2007) however, cautioned that these observed effects might be attributable on some level to economic deprivation and poor physical health. How important the relationship between poor mental health and the conflict are to suicide is less clear however, viewing suicide as the outcome of a mental health disorder only provides us with part of the picture.

Brock, Baker, Griffiths, Jackson, Fegan and Marshall (2006) analysed suicide trends in over 400 geographical areas within the UK. Looking more closely at rankings of certain areas between two time periods which fall on either side of the 1998 Agreement in Northern Ireland (1991-97 and 1998-2004), it was found that West Belfast climbed from

259th to 13th place before and after the agreement, while North Belfast was 319th pre-Agreement and 11th thereafter (Tomlinson, 2007). These changes are mostly attributable to increased suicides amongst young men. The overall pattern of suicide in Northern Ireland pre- and post-conflict shows a sharp drop at the start of the Troubles, followed by an upward trend in numbers and rates since then. Tomlinson (2007) cautioned, however, that this pattern might be partly explained by the breakdown of state authority during the conflict, and the impact that this might have had on how suicides were registered at this time. One should also take into account the potential discrepancy between the number of suicides recorded in any given year, and the actual number that occur, a shortcoming of suicide research which is not specific to Northern Ireland.

Tomlinson (2007) identified a need for qualitative research to be conducted on how families and local communities deal with the issues of mental health problems and suicide, as well as their perceptions of local provision of services. He also recommended future research on the concept of suicide contagion, suicide clusters and the roles that popular culture and new media have to play in suicide, an area that is being addressed by the current study.

2.8 Conclusion

The review of the literature provided above gives an overview of the research available to date. The research has largely accepted the existence of suicide clusters and models have been proposed as to why suicide contagion occurs. Media contagion has been highlighted in the literature as a specific contributing factor for the occurrence of suicide clusters.

Prevention strategies have been outlined for schools, community and a public-health based approach. The existence of ongoing difficulties in evaluating the effectiveness of suicide prevention programmes has been highlighted.

In terms of suicide postvention, some of the core concepts of an international best practice model, the Connect Project, were outlined. The original Centre for Disease Control (1988) recommendations were also discussed. As much of the research on postvention is contained within the education literature, studies were drawn on which provided specific advice and guidance to schools in how to deal with the aftermath of the death of a pupil to suicide. Much of the literature acknowledges the need for future studies to evaluate the effectiveness of postvention strategies.

Vicarious trauma of professionals following the loss of a patient to suicide has not been addressed extensively in the literature to date. However, research provides evidence of secondary trauma in the aftermath of a patient's death by suicide.

The topic of social inequality has been introduced in terms of its impact on negative social and health outcomes, and research on the Northern Irish context, including the impact of the Troubles on mental health and suicide, has been outlined.

3. Northern Ireland Policy Context

3.1 Suicide rates in Northern Ireland

The most recent data shows that the suicide rates in Northern Ireland per 100,000 increased between 2000 and 2010 (NISRA, 2011; Samaritans 2012). Compared with the Republic of Ireland, England, Scotland and Wales, the suicide rate in Northern Ireland in 2010 was highest for both males and females. Contrary to other regions in the UK, there has been an overall increase in the suicide rate between 2000 and 2010 in Northern Ireland (ibid).

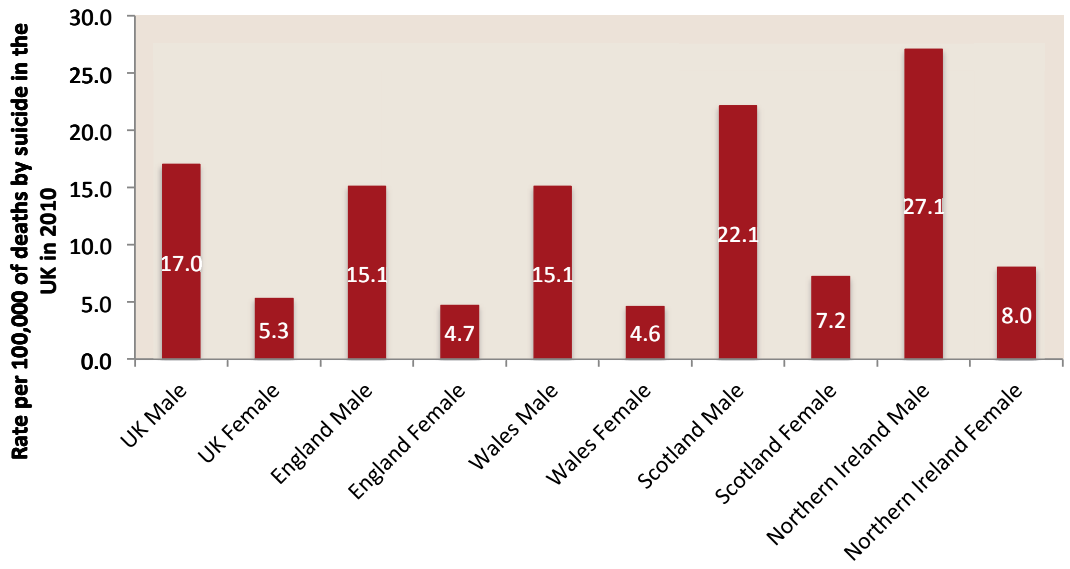
As shown in Figure 1 below, in 2010, the highest suicide rate per 100,000 for both males and females was in Northern Ireland.

The most recent data relating to deaths by suicide in Northern Ireland (from 1997 to 2008) were obtained from the Northern Ireland Statistics and Research Agency (NISRA). However, the data were not sufficiently detailed to enable an in-depth cluster analysis to be undertaken. The data is summarised and presented in the following section.

In Northern Ireland between 1997 and 2008, 420[2] young people (<25 years old) died by suicide. 347 (83%) of these young people were male and 73 (17%) were female.

Figure 2 shows that the number of deaths of young people by suicide across Northern Ireland has remained relatively constant over the last number of years. This is in contrast to the steadily rising overall suicide rate in Northern Ireland (Appleby, Kapur, Shaw, Hunt, Flynn, While, Windfuhr, Williams, and Rahman, 2011) which has increased from 185 deaths in 1999 to 313 deaths in 2010; the highest number ever recorded (Northern Ireland Statistics and Research Agency, 2011). Suicide rates across the rest of the

Figure 1: Suicide Rates per 100,000 in the UK 2010



2 391 deaths were recorded as intentional self-harm and 29 deaths were recorded as an event of undetermined intent.

UK have been falling over the last decade, and while Northern Ireland rates are higher than that of England and Wales, (Appleby et al., 2011).

Figure 3 displays the number of deaths by suicide of young people in each parliamentary constituency in Northern Ireland between 1997 and 2008. It can be seen that West Belfast (n=49), North Belfast (n=44) and Foyle (Derry) (n=41) have the highest incidence of suicide.

While there has been no increase in the rate of suicide of young people (aged less than 25), this group has the greatest proportion of males compared to other age groups and is the group in which the relationship between suicide and deprivation is the strongest (Appleby et al., 2011).

Figure 2. Number of deaths by suicide of young people in Northern Ireland between 1997 and 2008

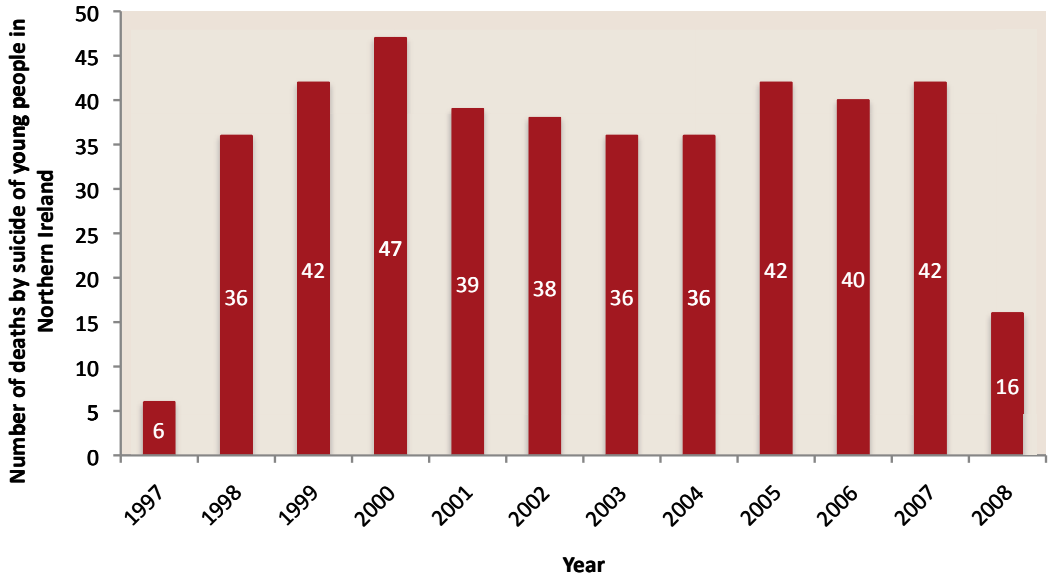
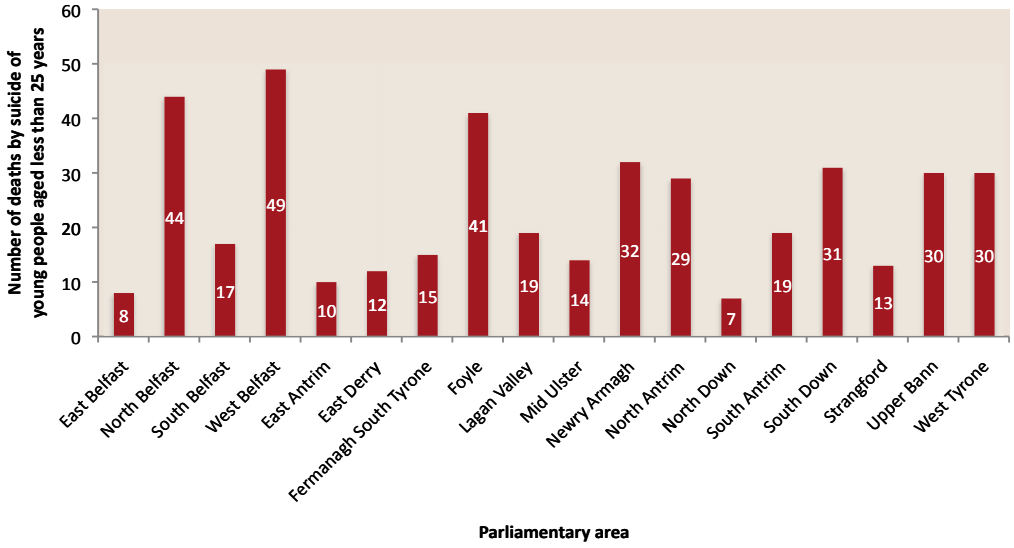


Figure 3. Number of deaths of young people by suicide across parliamentary constituencies in Northern Ireland (1997-2008).



3.2 Wellbeing in Northern Ireland

There are a number of contextual factors that result in Northern Ireland's policy on wellbeing in children and young people being nuanced differently than that in the rest of the United Kingdom.

Northern Ireland is still a substantially divided society with education mainly delivered in a divided way (Bell, Hansson and McCaffery, 2010; Gallagher, 2004). Regardless of similarities such as those within educational curriculum, segregation causes a lack of understanding and suspicion of other cultures (Murray, 1985; Bell, Hansson and McCaffery, 2010). The segregation and associated conflict known as 'The Troubles', has had a widespread impact on the wellbeing of children in Northern Ireland. Studies exploring the impact of 'The Troubles' on children's well-being indicate the need to take into account the diversity of meanings, impacts and variations of levels of violence (Muldoon and Trew, 1995, 2000; Muldoon, Trew and Kilpatrick, 2000; Muldoon, Trew and McWhirter, 1998) and psychosocial factors (Cairns and Cairns, 1995; Muldoon et al, 2000). A review by Muldoon et al (2000) on the effects of 'The Troubles' on young peoples' psychosocial wellbeing and school life are hard to discern but evidence does suggest it has negative influences on behaviour and academic performance. These consequences are linked to related factors including poverty and exposure to violence. Other evidence of emotion and wellbeing issues affected by the conflict include: suicide (O'Connor and Leenaars, 2003; O'Connor, 1998) and 'Troubles related trauma', which is specifically highlighted in the Bamford review of mental health in Northern Ireland (Bamford, 2006) as a potential issue for children affected by sectarian violence. Horgan (2005) notes that research by the Northern Ireland Commissioner for Children and Young people (NICCY, 2004) and the Social Services Inspectorate (2005) indicated a shortage of appropriate services for alleviating the effects of sectarian violence on children living in poverty.

A case in point is represented by the effects of the Omagh bomb, August 15th, 1998. A school-based survey (McDermott, Duffy, & McGuinness, 2004) of children and adolescents aged between 8 and 18 years living in the Omagh area was conducted 15 months after the bomb. The survey found that around 14% of children and 16% of adolescents sampled had some direct experience of the bomb. In addition, the study found higher levels of reported symptoms of Post Traumatic Stress Disorder (PTSD), depression and anxiety increased with the degree of exposure to the bomb. Another study by Smyth, Fay, Brough and Hamilton (2004) found that children who had been deeply affected by the conflict had problems concentrating and displayed trauma related aggressive behaviour.

A report by NICCY (2007) states that children in Northern Ireland experience higher levels of suicide and abuse than in the rest of the UK.

Other differences may occur because of the religious makeup of schools in Northern Ireland. Many schools embed emotion and wellbeing issues in religious and spiritual education. This can have a resultant effect on the way a number of wellbeing issues are discussed. For example the general conservative perspective promoted by the Christian faiths in Northern Ireland can alter how sex education is delivered and reduce opportunities for discussion (Rolston, Shubotz, and Simpson, 2005). It has also been reported that in some Belfast school contexts, sex and sexuality are taboo subjects, informed by a moral and religious discourse of "sin, shame, guilt and familialism" (Kitchin and Lysaght 2004). Research by YouthAction indicated that in some cases, people reported that sex education teaching made them feel that sex was viewed as wrong (McAlister, Gray and Neill, 2007).

3.3 Strategies and Programmes in Northern Ireland

There are a number of strategies in place to reduce the impact of the legacy of the conflict on emotion and wellbeing in Northern Ireland generally, including: the Shared Future policy; proposed Anti-Poverty Strategy; Victims Strategy; Investing for Health Strategy; and the 20 year Regional Strategy for Health and Social Services in Northern Ireland. Furthermore, at the Health and Social Care Board level, four Trauma Advisory Panels were established in the Board areas to provide advice and co-ordinate the provision of services for victims. Also, the Investing for Health Partnerships and subsequent Health Improvement Plans also aimed to improve the emotions and wellbeing of those affected by the Conflict (DHSSPS, 2004, 2006). In addition, there are Health Action Zones, the Belfast Healthy Cities initiative and Sure Start Programmes and, at a multiagency level, organisations such as the North Belfast Partnership Board (DHSSPS, 2004, 2006).

3.3.1 Bamford Review

The Bamford review (Bamford, 2006) came as a consequence of the (2000) consultation that led to the 'Promoting Mental Health' strategy (DHSSPS, 2003) as part of the 'Investing for Health Strategy'. The consultation found higher rates of mental illness in Northern Ireland than elsewhere in the United Kingdom. The Bamford review reported the vision for a comprehensive child and adolescent mental health (CAMH) service in Northern Ireland. The review highlights the important role schools have in delivering this vision. The vision also espouses a whole school approach by highlighting the need for teachers to work closely with specialist services, for example, school counsellors and educational psychologists. The Northern Ireland Executive's (2008) consultation document on 'Delivering the Bamford Vision' suggests that it is implementing this vision through a number of initiatives.

3.3.2 PEHAW Programme

In Northern Ireland the Department of Education established (2007) a Pupil's Emotional Health and Wellbeing (PEHAW) programme, which was initiated by concerns over the rate of suicides among children and young people in the region in 2006. The Emotional Health and Wellbeing of pupils was "identified as a priority for action at Ministerial level" (DENI, 2012) and so the Department "began work in partnership with all key statutory and voluntary and community sector stakeholders and interested parties to develop this PEHAW Programme." "The programme focuses on positive prevention by building coping skills in children and young people and complements the personal development strand of the curriculum." (DENI, 2012) There are five work streams within the programme and these are also preparing documentation that is relevant to suicide prevention and postvention, such as guidance on the management of crises in schools and on the Protect Life suicide prevention strategy. The initiative is initially focused on the post-primary sector and is attempting to bring together existing activities under this single umbrella initiative. The members in the work streams are drawn from across the education and health sectors including statutory, voluntary and community bodies.

In a survey of post-primary schools investigating whole school practices in relation to promoting Pupils' Emotional Health and Wellbeing (PEHAW), 41% of respondents reported that suicide awareness activities were part of their provision for pupils' emotional health and wellbeing (Connolly, Sibbett, Hanratty, Kerr, O'Hare and Winter, 2011).

3.3.3 Independent Counselling Service for Schools

Another Northern Irish initiative aiming to promote emotional wellbeing in schools is the Independent Counselling Service for Schools (ICSS) (DENI, 2011). The ICSS was established in post-primary schools in Northern Ireland in 2007 and then in 2011 in special needs schools. This initiative has ministerial approval and department funding. As the ICSS in Northern Ireland explain, its service is funded by the Department of Education and is available to all grant aided schools on the basis of a half day per week (ICSS, 2009b). It seeks to complement the wider PEHAW programme currently being developed within schools (ICSS, 2009b). The service 'practice standards' show the whole school approach of the Independent Counselling Service for Schools by inclusion of several stakeholders in the initiative:

> *'Independent Counselling Service for Schools values and promotes partnerships with children and young people, involvement of parents / carers, clarity of the role of schools, and maintains other relevant counselling best practice standards.' (ICSS, 2009a)*

3.3.4 The Investing for Health (DHSSPS, 2002) strategy

The *Investing for Health* (DHSSPS, 2002) strategy aims to improve life expectancy across the population and to reduce health inequalities. Focusing on the most disadvantaged in Northern Ireland, it offers a framework for action which is based on multi-sectoral partnership working among Departments, public bodies, local communities, voluntary bodies, District councils and social partners. This strategy was reviewed in 2009. Speaking about the *Investing for Health* strategy, the Minister of Education emphasised that:

> *My Department recognises that education is an important social determinant of health and is fully committed to the Investing for Health strategy. … there are also many underpinning health strategies and reviews which support its aims eg Obesity Prevention Strategy, Promoting Pupils'*

Emotional Health and Wellbeing (PEHAW), the Suicide Strategy Implementation body, the Ministerial Sub-Group on Safeguarding, the Bamford Review, Mental Health Promotion, Sexual Health Promotion, Domestic and Sexual Violence Group, Teenage Pregnancy and Parenthood Strategy and the New Strategic Direction on Drugs and Alcohol."
(Northern Ireland Assembly, 2010)

3.3.5 Mental Health Promotion

As part of the *Investing for Health* strategy, the DHSSPS's (2003) *Promoting Mental Health Strategy and Action Plan* aims to improve people's mental and emotional wellbeing, in particular that of people at risk or vulnerable, and people with identified mental health problems, their carers and families. It particularly focuses on inequalities.

3.3.6 The Children's Strategy (OFMDFM, 2006)

This *"ten year strategy for children and young people in Northern Ireland 2006-2016*" includes strategic goals in key areas affecting children and young people and takes into account the role of parents and families, while aiming to promote a joined up approach within Government.

3.3.7 Protect Life and the Suicide Strategy Implementation Body

In the context of reported increases in suicide rates across most regions of the world, and particularly in response to an increase in young people's suicides in Northern Ireland, in 2005 the *"Protect Life A Shared Vision* - The Northern Ireland Suicide Prevention Strategy and Action Plan 2006-2011" was developed by the Department of Health (2006). The Suicide Strategy Implementation Body was launched in 2006 to oversee and co-ordinate the implementation of the Protect Life Strategy. Five regional groups have been developed to guide the implementation of the Protect Life Strategy at a local level – i.e. the North and West Belfast Implementation Group; the Northern Suicide Strategy Implementation Group; the South and East Belfast Community of Interest for Mental Health and Suicide Prevention; the Southern Protect Life Implementation Group; the Western Suicide Strategy Implementation Group. The Protect Life Strategy has recently been reviewed and updated (DHSSPS, 2012).

3.3.8 The Ministerial Sub-Group on Safeguarding

The Ministerial Sub-Committee on Children and Young People in Northern Ireland has identified a number of priorities. The Safeguarding Sub-Group is chaired by the DHSSPS and includes officials from DHSSPS, NIO, OFMDFM, NI Court Service, DE, DEL and DCAL, and the group's action plan includes taking account of the recommendations from the Byron Review (NSPCC, 2009).

3.3.9 Domestic and Sexual Violence Group;

The formation of this group in 2008 builds on the 2005 domestic violence strategy, and is an Inter-Ministerial group aiming to co-ordinate efforts across government on domestic and sexual violence issues that affect people of all ages and backgrounds. It will be linked to regional Strategy on 'Tackling Sexual Violence and Abuse' and related Action Plans. It also builds on the work of The SAVI Report (McGee, Garavan, deBarra, Byrne and Conroy, 2002) which was a national study of sexual abuse and violence in Ireland.

3.3.10 The New Strategic Direction on Alcohol and Drugs (DHSSPS, 2006)

The DHSSPS (2006) *New Strategic Direction for Alcohol and Drugs (2006-2011)* follows the review of the drugs and alcohol strategies and the Joint Implementation Model in 2005 and aims to address alcohol and drug-related issues in Northern Ireland. It has specific themes for "Children, Young People & Families" and "Adults, Carers & General Public".

3.4 Derry City Council Area Community Response Plan

The Derry City Council Area was the first area in Northern Ireland to adopt best practice from the United States in terms of responding to a death by suicide – i.e. postvention. The Western Health and Social Services Board established a Suicide Strategy Implementation Group to address the objectives and take forward actions emanating from the Protect Life Strategy. Best practice from the Connect Project (see section 2.5) was adapted to fit the Western Health Board and Derry City Council Community Response Plan initiatives (Western Health and Social Services Board, 2009).

It was identified by this group that one of the major concerns around suicide is the "cluster"/"contagion" effect, and that a Community Response Plan should identify potential clusters at the earliest opportunity. The development of the Community Response Plan for the Derry City Council Area involved input from the community and voluntary sectors as well the Western Health and Social Care Trust (WHSCT).

The WHSCT is unique to other Trusts in Northern Ireland, employing a Family Liaison Service (FLS), led by two Suicide Liaison Officers, established to provide targeted support to families bereaved by suicide. This is not a single agency approach, but the Trust take the lead to ensure accessible information and timely support are available to all bereaved by suicide, across statutory, community and voluntary sectors, and to encourage the development of support groups. The FLS works closely with the PSNI, to identify suicide deaths. If the family approves passing their contact details to Health Services, the FLS can then make telephone contact to arrange an initial visit within one week of the death. Bereavement support or counselling is then offered to the family by the Suicide Liaison Officer, and/or referrals are made to secondary services, community and voluntary agencies or support groups.

The Derry City Council's draft Community Response Plan was developed following a workshop held in September 2008, and included feedback from professionals, statutory, community and voluntary groups and service-users/carers bereaved by suicide.

Suicides in the area are closely monitored by the WHSCT, in partnership with the PSNI (through the use of SD1 forms). The Coroner's office can take up to two years to make the final determination on cause of death, therefore the situation is monitored by the WHSCT and PSNI according to suspected deaths by suicide. If the Trust suspects early signs of a suicide cluster, the Local Co-ordinating Committee (LCC), including representation from statutory, community and voluntary sectors, is called together to determine whether or not the plan should be implemented and the extent of the response. This decision is based not only on numbers of suicides, but also on potential for a cluster to emerge (e.g. from a high profile suicide), and the degree to which the community perceives the problem. The community response, as outlined by the WHSCT, include representation from are education; health; local government; clergy; parents groups; voluntary sector organisations; community groups; survivor groups; students; police; undertakers; and media.

It was recommended that the response plan should be conducted in such a way as to avoid sensationalism, and that a timely flow of accurate, appropriate information should be supplied to the media by an identified person (i.e. Chair of LCC). The response plan compiled its own set of guidelines for the media. It was also decided that individuals identified at heightened risk of suicide should be offered support – e.g. referral to one of the Trust's two Family Liaison Officers – with referral to further counselling or other services as required. Elements in the environment which are thought to increase the likelihood of further suicides should be identified and removed, and long-term issues should be addressed (e.g. deprivation, alcohol/drug abuse, etc). The outcomes should be revisited by the LCC and appropriate action taken if necessary.

People at high risk are identified by active measures (i.e. vulnerable individuals actively sought out and targeted for support) and passive measures (i.e. vulnerable individuals presenting themselves through hotlines, walk-in centres, counselling services, etc).

The Chair of the LCC is responsible for deactivating the Community Response Plan and a debriefing session should be held in order to:

- Consider and review the experience of all involved
- Identify any particular difficulties that were encountered and lessons learned
- Identify any wider implications and act on these appropriately
- Review the resources and effectiveness of the plan
- Identify any emerging training and response needs
- Stand down the committee
- Evaluate the plan and prepare a report for the WSSIG suggesting any amendments to the plan
- Prepare a press release if appropriate
- Identify any recommendations for areas of improvement required to the plan and implement these

Other areas in Northern Ireland have now developed their own Community Response Plans with variations for their particular communities. The Belfast City Community Response Plan to Potential Clustering of Suicides is currently in its final stages of completion and follows a similar format to that of the Derry City Council Area. The South Eastern Health and Social Care Trust have also been developing a Community Response Plan in late 2010/2011.

4. Methodology

4.1 Advisory groups

Two advisory groups were established to provide support and guidance to the research team. The first was a Young People's Advisory Group (YPAG) whose purpose was to inform the design, process and interpretation of all elements of the research. The members of the YPAG were not research participants but were invited to take part in the project to contribute their expertise on the relevant issues, as a key stakeholder group. The group was recruited from a school located in an area that reflected the social and economic profile of the two case study sites. The YPAG is described in greater detail in the following sections.

The second advisory group was the professional advisory group (PAG) whose purpose was to inform the research and contribute expertise in the area of youth suicide both in Northern Ireland and internationally. Group membership included:

- Rory O'Connor, Psychology Professor, University of Sterling
- John McGeown, Co-director of Mental Health, Belfast Health and Social Care Trust
- Kevin Malone, Psychiatry Professor, St Vincent's University Hospital, Dublin
- Ken Norton, Executive Director, The National Alliance on Mental Illness, New Hampshire
- Barry McGale, Western Health and Social Care Trust

4.2 Ethics

Ethical approval for this study was granted by the School of Education Ethics Committee, Queen's University Belfast.

4.3 Design

A case study approach was adopted to address the main purpose of the research, which was to explore a community's response to, and experience of, multiple deaths of young people by suicide. In close consultation with Contact it was decided that the case studies should focus on two particular areas in Northern Ireland: Poleglass, Twinbrook and Lagmore just outside West Belfast; and Tigers Bay in North Belfast. North and West Belfast are identified as having the highest incidence of death by suicide of young people over the last decade (see previous section).

The first area chosen as a case study site was a large area just outside West Belfast consisting of a number of smaller neighbourhoods (Poleglass, Twinbrook and Lagmore), which have experienced a high number of deaths by suicide of young people. It is one of 36 neighbourhood renewal areas in Northern Ireland meaning that the community has been targeted as part of a government strategy for tackling disadvantage and deprivation. This includes high levels of unemployment, income deprivation, crime and disorder, poor health and high levels of disability, low levels of education, skills and training and poor quality living environments (Northern Ireland Statistics and Research Agency, 2011). This case study was the larger of the two case studies and the majority of the data presented in this report was collected from this area.

The second case study was located in Tigers Bay in North Belfast, which is also a neighbourhood renewal area, and one which experiences high levels of disadvantage and deprivation (NISRA, 2010). This area was chosen for a smaller case study on the basis that it also experiences high levels of death by suicide. In addition, four years previously a young person had died by suicide and the community response warranted further exploration.

To further contextualise these case studies, it should be taken into account that the community response plan was being implemented in the Poleglass/Twinbrook/Lagmore area prior to and during the data collection phase of the project, following the deaths of a number of young people by suicide in this area. The research team had the opportunity to be present at the community response meetings during this time (November/December 2010). Devastatingly, there were two additional deaths of young people by suicide in this area during the data collection phase of the project. In contrast, the main focus of the second case study in Tigers Bay reflected on the community's response to the specific suicidal death of a young person which took place in 2007, and how the community has coped since then.

For ease of reference in the 'Findings' section, the Poleglass, Twinbrook and Lagmore area will be referred to as 'West Belfast', although it should be noted that this area is an urban district that lies on the periphery of West Belfast falling within the Lisburn City Council local government area. In the 'Findings' section the Tigers Bay area will be referred to as 'North Belfast'.

4.4 Case Study Procedure

Potential participants were identified in a number of ways:

1. An initial list of individuals from statutory, community and voluntary sectors in each of three case study sites was identified by the research team through discussion with Contact;
2. This list was cross referenced with the suggestions from the YPAG who had also compiled a list of potential participants;
3. A 'snowball' sampling method was used whereby participants recommended other key people they felt it would be important to talk to.

The research team contacted potential participants to explain the study and gain their consent to take part. Each participant was assured their contribution would remain anonymous and that no person would be identified in the final report. Participants were assured their participation was purely voluntary and they were free to withdraw at any time.

In total, 34 participants were interviewed and two focus groups were conducted with a group of young people and a group of teachers. Interviews and focus groups were digitally recorded, transcribed and subsequently analysed using a framework approach.

5. Young People's Advisory Group

5.1 Involving Young People in the Research Process

The active involvement of children and young people in the research process is an increasingly routine feature of projects which seek to understand young people's experiences and perspectives (Greene and Hogan, 2005). This has involved the development and use of a wide range of participatory research methodologies (see for example Lewis, Kellett, Robinson, Fraser and Ding, 2006) and the involvement of young people as co-researchers (Fielding, 2004), as peer-researchers (see, Murray, 2006) and in child/youth-led research projects (see for example, Kellett, Forrest, Dent and Ward, 2004). This includes involving children in the selection of research methodologies and design of research instruments (see Hill, 2006); in data collection and analysis and in the dissemination of research findings (Coad and Evans, 2008). The approach used to encourage the active engagement of young people in this project was informed by and aligns with this participatory style of research but in particular draws on a children's rights-based approach to research discussed below.

Article 12 of the United Nations Convention on the Rights of the Child (CRC) gives children and young people[3] Article 1 defines the holder of rights under the CRC as 'every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.' A right to not only express their views but also to have those views given due weight in all matters affecting them (UN, 1989)". The Committee on the Rights of the Child, which monitors compliance with the CRC, has emphasised that this right should be 'anchored in the child's daily life at home…and in his or her community… as well as in… [*inter alia*] the development of policies and services, including through research and consultations' (UN, 2005, para. 14). The research team sought an approach to the research project which would respect this right. They drew on aspects of a children's rights-based methodology developed and employed in other projects (see Lundy and McEvoy, 2008, 2009, 2011; McEvoy and Lundy, 2007). A key aspect of this approach is the meaningful engagement of children and young people as co-researchers, in Children's Research Advisory Groups (CRAGs) and as research participants. Given the age of the young people involved in this project the research advisory group will be referred to as the Young People's Advisory Group (YPAG).

The young people involved in the YPAG were not research subjects. Rather they were invited to participate in the project as an expert group in relation to young people's views on the issues.
Their remit was to:

i. advise on the research process and on appropriate ways to engage with other young people in the research (the focus groups)
ii. provide insight on issues related to the research questions
iii. provide a key stakeholder perspective

It should be noted that the YPAG were not involved in collecting data (for example conducting interviews with focus groups) and did not require training in research techniques associated with data collection or the analysis of data – a feature common in other projects where young people are co-researchers (Kellet et al, 2004; O'Brien and Moules, 2007). Rather the approach adopted in this project required building capacity to understand and reflect on the substantive issues surrounding the research questions and to situate their views within the existing knowledge of the issue under investigation. This in turn assisted the young people in understanding perspectives beyond their own, providing them with a range of perspectives on which to draw when interpreting findings from the research (Lundy and McEvoy, 2011).

5.2 Membership of the YPAG

The YPAG was composed of eight young people (four boys and four girls) aged between 14 and 15, selected from a school located in an area similar to the main case study site. The young people were selected from the Year 11 group, as this age range was deemed by the research team to be most similar to the age range of young people affected by youth suicide clusters. The Year Head recruited and selected

3 Article 1 defines the holder of rights under the CRC as 'every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.'

the young people for the YPAG as reflective of the year group as a whole but also took care not to select young people for whom involvement in the research, given its sensitive nature, might have posed some problems.

5.3 Meetings with the YPAG

Two of the research team met with the YPAG on three occasions 5 October and 25 November 2010 and 29 November 2011. These sessions focused on: building the young people's capacity in relation to understanding the issues under investigation; obtaining the young people's input on the interview/focus group questions; involving the young people in the analysis and interpretation of some of the findings. Sessions took place in the school and lasted on average, two hours, including a twenty-minute refreshment break.

Before providing detail on the work with the YPAG, the climate in which YPAG sessions were conducted should be noted:

i. Good practice in research with children and young people requires honesty regarding the degree of power sharing between the adults and children involved in the project (Lundy and McEvoy, 2009). The YPAG were aware that the focus of the research had been determined and that the team intended to conduct the case study through use of interviews, focus groups etc. However they were also assured that their suggestions would shape the content of the research instruments and, in particular, the conduct and the specific questions (including the wording of these questions) for the young people's focus groups.

ii. A children's rights-based approach also suggests that steps should be taken to create a 'safe' space for the young people to express their views (Lundy and McEvoy, 2011). The young people who participated in the YPAGs were assured that their views would be treated as confidential and, since Article 12 is a right and not a duty (Lundy, 2007), that they were able to withdraw at any time from any of the activities or from the process as a whole. Given the sensitive nature of the research, team members who conducted the YPAG sessions were accompanied by a professional youth counsellor, and the young people were made aware of support available. The research team also ensured that each session finished on a positive note with each of the young people telling the rest of the group one thing they were most looking forward to in the next few days.

iii. As noted above, YPAG sessions were held in the school. This can be problematic since there is a danger that young people perceive the research as school work. There is a need to conduct sessions in as 'un-school-like' a manner as possible through, for example, holding discussions as informally as possible, offering the young people choice in how to discuss and record their views, and consulting them regularly on the best way to proceed with the meetings (Lundy and McEvoy, 2009).

5.4 Session 1: Capacity Building with the YPAG

A key feature of the approach to involving young people as co-researchers in this project was developing their capacity to understand the substantive issues under investigation. The first session with the YPAG therefore involved a number of activities specifically designed to help young people reflect on and develop an understanding of the debates surrounding youth suicide and the phenomena of youth suicide clusters. The young people were introduced to some key terms using flash cards and provided with some of the statistical evidence for suicide clusters. They were also made aware of the fact that the notion of 'clusters' is disputed. It was then made clear that while the focus of the research was on youth suicide clusters, in order to understand this phenomenon it was necessary to explore first their views on the nature of suicide more generally.

5.4.1 Activity 1: Why do some people take their own lives?

The young people were asked to take some time to think about this question and to individually record as many ideas as possible on separate post-it notes. Having generated a number of ideas the young people were asked to form two groups of four and to share their ideas on the post-it notes. They were then asked to find connections between the different ideas and to group the post-its together under common, emerging themes (see Figure 3).

Figure 3: Emerging themes: Why do some people take their own lives?

Themes emerging from this exercise included:

- Feelings (including depression, heartbreak, family problems, gossip, bullying, loss of someone)
- Financial problems (including debt and unemployment)
- Influence of the media
- Social networking (a recurring and persistent theme)

Following this activity one member of the research team explained how their suggestions were located within existing research into death by suicide from the literature review for the project. For example their ideas were linked to the biomedical model, biopsychosocial model and the cognitive triad (see section 2.2). Information from the literature review in relation to the influence of the media was also shared with the YPAG. The research team member clarified what was meant by the term 'suicide cluster' and explained how research suggested that this phenomenon was more likely to occur with young people. The second activity provided the young people with an opportunity to explore this further.

5.4.2 Activity 2: Why might a youth suicide cluster happen?

The members of the YPAG were asked to reflect on reasons why youth suicide clusters might occur. The team was aware that it might be difficult for the YPAG to focus only on the notion of a 'cluster' and not on the nature of youth suicide more generally. The YPAG was asked to reflect on both issues. The activity involved the young people in two small groups producing life-sized drawings of a teenager, associating parts of the drawing with different reasons why young people may take their own lives as well as reasons why clusters might occur (see Figure 4). The team members circulated around the groups prompting the young people and asking them to explain or clarifying some of their ideas.

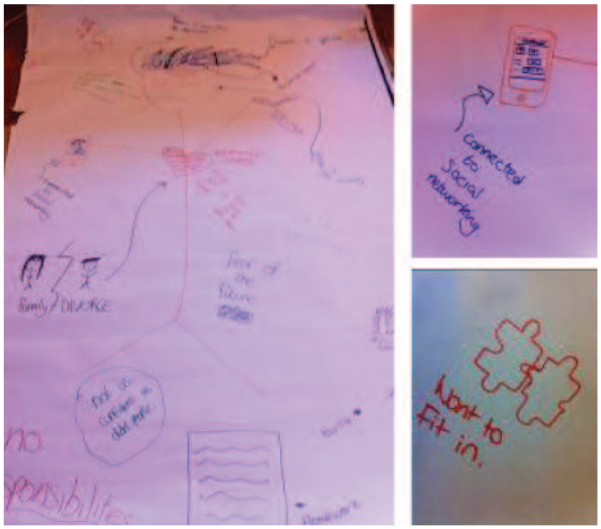


Figure 4: Why might a suicide cluster happen? (Main drawing with close up photos of some details)

The young people generated a wide range of ideas. For example, a number on intrinsic issues emerged: 'mental health', 'hormones', 'stress' and 'confidence' were associated with the head of the teenager; 'emotions' and 'relationship troubles' associated with the heart of the teenager; 'illness' associated with the stomach; 'sexuality' with the genitals. Many of these issues were linked to a common theme of 'drugs and boredom'. Other issues emerged and were recorded by the YPAG around the outside of the teenagers: 'family/divorce'; issues relating to peer pressure such as 'not fitting in', 'pressure on appearance' (linked to 'self-consciousness'); pressure from other sources such as 'homework', 'no money'; and 'fear of the future'. The young people were very keen to highlight in particular the role of social networking and the media in exacerbating some of these issues.

When the young people were asked to clarify why in particular *youth* suicide clusters may occur and why clusters were less likely when an older person died by suicide, a number of points were added to their drawings:

> *'Adults are more likely to talk to someone…*
> *a child keeps it to themselves'*
> *'Your mind isn't developed'*
> *'Not as confident as older people'*
> *'No responsibilities'*

Again, a member of the team linked the ideas on the young people's drawings to broader debate surrounding the issues of youth suicide clusters. For example the idea above of the 'mind' not being as 'developed' in young people was used to explain the neurobiological paradigm (see section 2.3.1) and their other suggestions used to draw out ideas surrounding the infectious disease model such a susceptibility, dose dependency etc. Other theories of suicide contagion were discussed with the YPAG, such as assortative relating and genetics, before the young people were asked to reflect on the issues discussed to date and express their own view on why they thought youth suicide clusters might occur. Again the role of the media and social networking featured heavily in this discussion.

5.4.3 Activity 3: What could be done to prevent a youth suicide cluster occurring?

Again, using flash cards, the young people were introduced to the ideas of suicide prevention and postvention. The YPAG were asked to think about ways in which the community as a whole might respond to a youth suicide in order to prevent a cluster occurring. The purpose of this activity was to develop an understanding among the YPAG of the role of key stakeholders in suicide postvention initiatives in order to make them aware of who would need to be interviewed in the case study sites. During this activity the young people were provided with relevant information from the literature review to prompt discussion and broaden their understanding of the issues. Their ideas were recorded on flipcharts under the following heading: family and friends, school, community, government.

In terms of **family/friends** the YPAG suggested a need for 'better listening' and this would require education and training in relation to suicide awareness. They also suggested that girls were more likely to confide in family and friends than boys and the training should make people aware of how to talk to boys about issues associated with death by suicide.

In terms of **school** the YPAG questioned the value of school-based counsellors suggesting instead that training young people as peer counsellors would be more useful and that setting up support and awareness groups in school would also be useful. They were keen to emphasise the need for strong links between home and school and suggested if the school suspected a child was at risk they should 'note it' and refer the matter back to the home and family. They were also keen to emphasise the need to educate young people in school as early as possible about suicide prevention in general and mental health issues in particular.

In terms of **community** the YPAG clearly saw the value of community based initiatives. There was a strong focus on neighbours 'looking out for each other' and local shopkeepers etc being a key resource in terms of recognising if young people were at risk. They indicated the value in support located in youth clubs and suggested that support organisations could be used to go into schools and youth groups to

explain alternatives to young people and also challenge stereotypes of young people in general and those who have died by suicide in particular. The YPAG did not think that young people would view their 'doctor' as a source of support since this would be associated with 'being sick' and it was also difficult to see a doctor without parents. They saw little value in church based responses.

In terms of the role of **government** the YPAG stressed that young people were not consulted enough on issues like suicide. In particular they stressed that a number of government initiatives focused on the very young or on older people and that teenagers 'got left out'. They also said that government should be sending out positive messages to young people instead of 'constant gloom' about the future. Further they suggested it was important for the government to send out positive messages *about* young people to prevent them becoming more isolated by the rest of society.

5.5 Session 2: YPAG contribution to research design

The second session with the young people focused on their contribution to research design. The YPAG were reminded of the issues discussed at the previous session and re-familiarised with the terminology. The output from Activity 3 above was used to introduce the idea of who should be interviewed as part of the main case study.

5.5.1 Activity 4: Who should we talk to about community response to suicide?

In two groups of four, the YPAG members were asked to discuss and record the types of people who should be interviewed in the case study. They were asked to record their ideas on concentric circles starting with family and friends in the inner circle, people from the community in the next circle and people involved in government or public services in the outer circle (see Figure 5).

Figure 5: Identifying research participants

Their suggestions included:

- Family and friends
- Young people in the area
- Neighbours
- Local shop keepers
- The last person to see the young person who died by suicide
- Youth club leaders
- Counsellors
- Teachers
- Their doctor
- Social workers
- Priest/minister
- PSNI
- MLAs/ local politicians for the area
- Community leaders in the area (these were identified as key people in the community who were not politicians but had influence in the community)
- Education Minister

Their suggestions were compared with the schedule developed by the research team. The rationale for planned interviews which had not been identified by the young people (e.g. health centre, undertakers etc) were explained to the YPAG and they were assured that their additional suggestions (e.g. community leaders, shop keepers, teachers and neighbours) would be incorporated as far as possible into the case study.

5.5.2 Activity 5: How should we talk to other young people about these issues?

The YPAG were asked to comment on the team's intention to conduct a focus group with young people as part of the case study. They agreed this would be useful but suggested we use some of the ideas from the capacity building activities to help the focus group discuss suicide postvention, in particular Activity 3 above. This was incorporated subsequently into the focus group discussion.

The research team had developed a set of questions to be used with adult interviewees. These were shared with the young people who re-wrote the questions in a more accessible manner for use with their peers. The YPAG also suggested a number of additional questions that should be asked of the young people, with a focus on social networking and the media. These adapted questions were then used with focus groups.

5.6 Session 3: YPAG involvement in findings analysis and interpretation

The third session with the young people focused on their involvement in research findings analysis and evaluation. The YPAG were reminded of the issues discussed at the previous sessions and re-familiarised with the terminology. The research team provided the YPAG with an update on how the research had been carried out, including how their suggestions had been incorporated in the research design.

5.6.1 Activity 6: Analysing qualitative data

A member of the team outlined to the YPAG members the processes involved in analysing the qualitative data and provided a rationale for their involvement in the analysis: since our analysis was adult-centric it was important a youth-centred perspective on the data was provided. The data chosen for this activity was drawn from the aspects of the interviews which covered reasons for youth suicide and suicide clusters. The adult analysis of these findings is presented in Section 6.1 below. The overall conclusions and recommendations are presented in Section 7 below and are based on both the adult and YPAG analyses and interpretations.

YPAG members were provided with a set of quotations drawn from the dataset (identical to the dataset available to the adult researchers), with each quotation presented on a separate strip of paper. The young people were asked to read each quote and highlight key words or phrases (see Figure 6).

Figure 6: Drawing out themes from qualitative data

When this was completed for each quote in the set, the young people worked together to find connections between each strip of paper, forming 'clusters' of related quotations. Once they had completed this clustering and were satisfied with the groups they had generated, the young people 'named' each cluster. In this way they identified the following emerging themes from the data:

- Abuse
- Drugs
- Parents not involved – too much freedom for young people *(broadly similar to the theme of 'relationships' which emerged in the adult analysis)*
- Violence – family and the 'Troubles' *(one of the cross-cutting themes in the adult analysis but emerged as a key theme for the young people)*
- Not enough highs – too many lows *(broadly similar to the themes of 'self worth' and 'young people's internal resources' which emerged in the adult analysis)*
- Suicide socially acceptable – fame and copy-cat *(broadly similar to the theme of 'perceptions of suicide' which emerged in the adult analysis)*

5.6.2 Activity 7: Interpreting emerging themes

Having completed the analysis activity the young people were asked to reflect on the findings by selecting 'salient quotations' and providing a justification for their choice. This provided an opportunity for the young people to comment on the themes emerging from the research, providing a youth-centred focus to the interpretation of findings. A number of key issues emerged during this activity.

First, the YPAG reacted strongly to the emerging themes of 'drugs' and 'family' as a major reason for youth suicide and suicide clusters. While they agreed these issues were relevant they felt this was a particularly adult-centric explanation. As one YPAG member commented:

> *It's an easy option for adults to blame it on drugs and family*

Rather, the YPAG felt that the explanation lay more with factors associated with the young peoples' internal emotions and feelings (a theme which had emerged during the capacity building activities, see section 5.4.1 above):

> *Adults don't realise what's going on for young people – they don't realise that hormones are raging. There's a lot more going on inside…*

They explained further that these internal feelings were compounded by boredom, which leads to 'isolation' making young people feel 'even more abnormal'.

Secondly, they again reacted strongly to the emerging theme in relation to the glamorisation of suicide, particularly in relation to how young people responded to the funeral of someone who had died by suicide and the impact this might have on their own choices. They recognised the difficulty in finding an appropriate way to 'respect the person's death'; explaining that too little attention could indicate a lack of respect whereas 'too much attention makes it [suicide] acceptable'. They also recognised that to an extent this 'normalisation' of suicide was attached to some young people having 'no fear of death'. However, they questioned the adult view that young people were motivated towards suicide primarily because of notions of a 'glamorous' funeral or thoughts of a 'happy afterlife'. As one YPAG member explained:

> *Young people may think about what will happen afterwards but they will not take their life just for this reason*

Thirdly, a central theme that emerged during this session was 'hopelessness', which the YPAG identified as a key factor exacerbating the general internal emotional turmoil young people felt. They explained that for young people there was a constant bombardment of messages from teachers, parents and media about 'no hope, no future, recession, no jobs'. As they explained:

> *All you hear is there's no jobs. They don't realise the negative effect it has on young people – it's depressing*

Fourthly, in relation to suicide clusters, the YPAG emphasised the role of social media, explaining that it provided a different vehicle for communication making certain types of 'conversation' easier to have than if the contact was 'face-to-face'. For example, they explained that young people may not want to speak to someone directly about the death of a friend by suicide or express their own feelings about this 'in person', but were more comfortable doing this publically 'online'. They concluded that to this end:

Social networking provides a place to exchange information around death by suicide.

Finally, as noted in the adult analysis and interpretation below, the YPAG recognised the inter-related nature of these themes. However, it was clear that their interpretation of the findings placed young people's feelings and emotions, including their inability to regulate emotion, at the foreground alongside the 'depressing messages' they were receiving in relation to the hopelessness of the current economic climate.

5.6.3 Activity 8: An effective community response

The team members apprised the YPAG of the main findings in relation to what factors hindered the community response to youth suicide clusters and in relation to what would constitute an ideal response. In order to provide the YPAG with an opportunity to comment on these findings, the young people were asked to complete a prioritisation activity. At this point it was acknowledged that in addition to assisting in interpreting the findings, the YPAG were also acting in the role of a key stakeholder group (see Lundy and McEvoy, 2009).

The YPAG were provided with an envelope containing 15 cards, each of which contained the name of a particular stakeholder group identified through the research as key to a community response to youth suicide. The young people were asked to arrange the cards and to rank them to demonstrate who they felt should take the lead in suicide prevention. As they carried out this activity the team members discussed their choices and provided them, as appropriate, with specific findings from the research to assist them in interpreting the findings. The activity was to be repeated in terms of suicide postvention; however the young people did not think a distinction should be made in relation to pre/postvention and explained that their choices would be the same (see Figure 7).

Figure 7: Who should be involved in a community response? (Least relevant stakeholders positioned to left; most relevant to the right. Those on the right are then positioned within a hierarchy with most important on the top)

As can be seen from Figure 7 above, the YPAG concluded that the following were largely irrelevant to a community response:

- Government (They were seen as 'too far removed')
- Community leaders (YPAG explained: 'They'll have opinions but will not do anything')
- Local politicians
- PSNI
- People in the community e.g. neighbours, shopkeepers

Similarly they identified the following as 'not relevant'in terms of a community response but recognised that for some people they might have a significant role:

- Churches (The YPAG suggested that 'if you're religious, faith can give you something to hold on to but it could also generate guilt').
- Social workers (There was some disagreement in the YPAG as to whether social workers would be relevant in a community response. However one member's reference to a recent TV commercial highlighting the significance of social workers in a child's life convinced the others that they had a role in the response).

The media was identified as 'in the middle' in terms of a community response with the YPAG stressing that their role in reporting suicide was important. Similarly it was recognised that health care personnel had a role to play in, for example, identifying self-harming or picking up on other signs that might indicate a young person was contemplating suicide. However it was noted by the YPAG that it is unlikely that young people would seek help from a GP.

The discussion in relation to the role of youth workers raised a number of interesting points. The young people in the YPAG accepted that for the young people interviewed as part of the research, their youth worker was a person to whom they could relate. However, they were adamant that this was not the case generally. They insisted that most young people were disconnected from youth provision explaining that existing services do not actually give young people what they want; focusing primarily on sporting activities or opportunities to mix with other young people but without structured engaging activities. Furthermore they suggested that young people at risk of suicide were likely to be feeling isolated and less inclined towards attending youth facilities.

For this reason they identified the school as the primary focus for a community response. As one YPAG member stated quite simply:

> *It's somewhere you go every day*

Hence, more isolated young people could be 'picked up on' in a school context. Within this context the YPAG considered teachers and peers to be the main focus of any response, adding that:

> *Teachers need to know the signs. Students also need to know the signs.*

Finally, the YPAG recognised that for some 'the last person you want to tell [about suicidal feelings] is your parents because they blame themselves'. However, they suggested that families needed support, particularly in relation to recognising if young people were at risk of suicide.

The YPAG concluded that suicide prevention (and postvention) strategies should be focused on the school and family, with specific training being provided for teachers, families and young people themselves to assist them in 'recognising signs'. Further, they suggested that there should be specific educational programmes located in the school curriculum to help young people explore issues relating to mental health more generally, as well as exploring issues relating to suicide.

5.7 Conclusion

The YPAG provided valuable insight into the issues surrounding youth suicide clusters. In particular they assisted the research team in prioritising certain issues for discussion with the young people in the focus groups and in developing accessible, easily understood questions for use in this aspect of the case study. Their contribution to the analysis and interpretation of the findings, and suggestions, as key stakeholders, in relation to an effective community response provided a youth-centred focus to the research and resulting recommendations.

6. Findings

This chapter is divided into four sections. The first explores the factors associated with youth suicide and youth suicide clusters; the second section looks at what actions were taken in direct response to the deaths of young people by suicide in both case study sites; the third section looks at the hindering factors that potentially impeded the efficacy of the response and the final section explores what participants felt would be an ideal response based on their recent and past learning.

6.1 Youth suicide and youth suicide clusters

This section focuses on the case study findings in relation to the research participants' perceptions and understandings of the factors associated with youth suicide in general and youth suicide clusters in particular. The findings are presented in relation to a number of common emerging themes. While it is hoped these themes will assist in a fuller understanding of the issues being explored it should be noted from the outset that each incident of suicide is unique and highly personalised. This was recognised by those participating in the study, as typified by the comment below:

> *I think every suicide is a very individual thing and obviously there are concerns from everybody working in this field when they've been very close to a person there has been that [suspicion of a suicide cluster effect], but I think we need to be very careful and to look at every suicide as an individual thing. [Community worker, North Belfast]*

6.1.1 Reasons why young people are dying by suicide

A number of themes emerged from the research in relation to the factors associated with youth suicide. These included the impact of drug and alcohol abuse, young people's relationships with the adults in their lives, self-esteem and self-worth, young people's lack of internal resources to cope with the problems in their lives and their perceptions of suicide. In addition to these broad themes two consistent exacerbating factors emerged: social deprivation and a sense of hopelessness. Although these themes are obviously inter-related, they are presented separately below, and connections highlighted as appropriate.

6.1.2 Drugs and alcohol abuse

The majority of participants raised the issue of drug and alcohol abuse as precipitating factors associated with youth suicide. Teachers in particular saw this as a major issue, indicating that drug and alcohol abuse was on the increase in the area, having an adverse effect on young people's well-being and engagement with school life:

> *…and even kids getting drunk, taking drugs – that's what they do. They come to school exhausted from the effects of their weekend and that's the only thing they live for. [Teacher, North Belfast]*

> *… prescription drugs are a big problem, big, big problem. The young people themselves can tell us that they can buy blues out there for 50p. Now, blues, it's emm it's basically it's a morphine-diazepam mix – very, very, very strong and what happens, from my understanding is, that with blues you get a really, really high HIGH and then a low, but as you take more of them the highs get shorter and the lows get really longer and deeper and emm (…) so it's mixing everything up. It cannot do a young person's body or brain any good and, therefore, the drug issue is there and, although it's not connected in all cases, and I know that, but I think you would find there is significant correlations. [School Principal, West Belfast]*

Both teachers and members of the community and voluntary sector suggested that the debt arising from young people's involvement with drugs was having negative effects on family life:

> *On an individual thing I think, as I say, it's very complex, every suicide is an individual thing but some of the presenting issues from the work that we do are obviously family relationships can be a big thing, abuse, addictions and rather than seeing the addiction, it's the person behind that. It's not just young people, it's particularly around drugs and if they owe that money and that fear because sadly that's a reality. People come in and it's not a few pound that they owe, it's a lot of money. [Community Worker, North Belfast]*

…since I've been in this school I see like a surge in drug taking, if you like, where you'll not hear the end of it – you know, kids getting offered drugs, taking drugs, they're being offered drugs and taking them as well, but they don't have to pay and then they run up a bill and then whoever's selling it goes to their family and asks for the money … [Teacher, North Belfast]

Participants expressed the view that children and young people were particularly susceptible in relation to the prevalent drugs culture in the community. As a therapist in North Belfast explained:

…it doesn't matter what area you live in, kids are vulnerable, and especially if there's drugs going about, you know. They are going to try it. There's no point in saying they're not going to do it. [Therapist, North Belfast]

Participants suggested a number of issues, which might have a bearing on this. First, a number of individuals suggested the impact of peer pressure:

Yes, some of them it's peer pressure, it's a cool thing to do, but when you get to a level where you're, you know, you'll take any sort of tablet, whatever people tell you it is, or if you can't get tablets, then you're sniffing aerosols or lighter fuel or whatever, there's a bigger issue there. [PSNI officer, North Belfast]

It was also suggested that younger children were being influenced by older young people's actions, particularly in relation to alcohol abuse, resulting in the normalisation of a culture of drug and alcohol abuse. As one teacher commented:

There seems to be no segregation of age or responsibility, like you would see kids up in the estate who are 16, 17, 18, 19 standing at the bandstand drinking with kids who are 10, 11, 12, you know, and if even younger kids aren't doing it, they're still there in that atmosphere in that kind of lifestyle and they think it's perfectly normal. [Teacher, North Belfast]

Secondly, as one school principal noted 'many of the young people are living in homes where drug use is commonplace.' It was felt by a number of participants that this added to the normalisation of drug taking, particularly in relation to the use of prescription drugs. One participant in the West Belfast case study site explained that people in the community sought prescription drugs to prevent them becoming overwhelmed by their experience of trauma, adding that:

They go to their doctor, their doctor gives them something to calm them down and then children see their parents taking stuff to live for day to day so that's the norm and then they take it, and I think this has went on for several generations in west Belfast. [Counsellor, West Belfast]

Community representatives in the North Belfast case study site similarly indicated an intergenerational influence on prescription drug dependence. Moreover they suggested that prescription drugs were being sought to sell on to others for self-medication purposes:

This area alone is one of the highest areas in Belfast in relation to prescription drug dependency in terms of people not being prescribed six or seven weeks at a time but ten, eleven, twelve years. We found that people were starting to abuse that in a different way, so they weren't taking the pills themselves but they were getting repeat prescriptions and selling that on and it became quite a lucrative trade. So not only do you have the concern of the illegal drug activity which we managed to push underground, it is no longer openly acceptable to do this but you also then had this whole issue surrounding prescription based drugs which were being sold openly as if it wasn't illegal. [Community representative, North Belfast]

Thirdly, some participants indicated that young people were engaging in drug abuse as a response to the circumstances they found themselves in. These participants felt that drug abuse represented a consequence of deeper, underlying issues within the community:

You know, it's easier to say – no they've taken drugs – and they may well be taking drugs, but I suppose when we look at cause and effect, maybe they're taking drugs to block out some of that emotional pain and hurt and what has happened to them or what is happening to them, but I think there's an over-reliance on drugs, you know, and it's about taking drugs and I think that's an easy-out and I think that also blocks us from really understanding. [Youth worker, West Belfast]

They can't see a future for themselves. They can't see a way out of all this, so I think rather than look at the positive side and saying – yes I can do this, this and this, they're just quite happy just to sit on the negative side and say – well my life's not going to get any better, so I may as well smoke drugs or do whatever I can to get a cheap high and I think that's one of the things, people don't aspire. [PSNI officer, North Belfast]

Finally, in the North Belfast site, teachers suggested a link between paramilitary influence and illicit drug use. Community representatives in this area however commented that there had been recent improvement in relation to illegal drugs in the area, but pointed to alcohol abuse as a primary area for concern:

So there's been a huge improvement in relation to the drugs issue in this area, however there still remains issues around alcohol abuse and the availability of alcohol, how we're seeing younger people accessing alcohol and it's now becoming increasingly clear that it's trendy for thirteen, fourteen and fifteen year olds to access and drink alcohol to excess. Then that generates the anti-social behaviour and other problems including sectarian issues. So whilst we're concerned about illegal drug activity and prescription based drugs we're also concerned that perhaps one of the biggest single factors to crime and anti-social behaviour in this area is alcohol and it's totally legal. [Community representative, North Belfast]

In sum, it would appear that in these communities drug and alcohol abuse has, to an extent, become part of the culture in which young people are growing up, and that this, from the perspective of adults living in these communities, is a contributory factor in relation to youth suicide. As one community representative concluded:

We had people who had worked in the community for 30 years and what they were saying was, it was down to three things: there was violence in the family, there was vodka and valium, the three Vs and that's what they put it down to. In some cases we had families there who were the grandparents, the parents and the children were all addicted to alcohol or drugs so it was a generational thing. When you walk around this area it's like a living graveyard, ok? I could take you round here within the vicinity of 100 yards where ten people have died due to violence and suicides. [Community representative, North Belfast]

In relation to the use of drugs as being a precipitating factor to suicide in both case studies, Wilkinson and Pickett (2009) discuss mental health and drug use as part of their extensive discussion on how inequality impacts on the psychological wellbeing of societies. Wilkinson and Pickett (2009) examined income inequality in twelve 'rich countries' against the percentage of the population with mental health problems and found a strong positive relationship between these two factors. The UK was second only to the US on this scale, with high levels of both inequality and mental illness, and high levels of antidepressant drugs being prescribed. Wilkinson and Pickett (2009) also found that high levels of illegal drugs are more common in unequal societies. They devised an index of drug use, which shows that the UK is third after Australia and New Zealand among twenty-two countries on index of drug use. Wilkinson and Pickett's (2009) findings, when related to the case studies of our current study, would propose the idea that health and social issues in these areas of North and West Belfast might have more to do with their levels of social and economic disadvantage relative to other areas of Belfast and Northern Ireland, rather than the disadvantage of these areas per se.

The young people interviewed in this research project, whilst acknowledging the impact of drug-taking, were keen to point out the salience of other precipitating factors:

People say – ah youse are from Poleglass and it's drink and it's drugs and this, but you don't know what's going on over the years and it's just building up and building up and it could be family problems – anything – people just blame it on drugs and fights with the girlfriends and all, but family problems I think too would be one of the main situations. [Young person, West Belfast]

This theme is explored further in the section below.

6.1.3 Relationships

Research participants in both case study sites highlighted relationships between young people and adults (particularly family members) as a key factor associated with youth suicide. Some participants suggested that these relationships were problematic because young people had lost respect for authority, typified by the comments below:

I think kids don't have the same (...), respect's maybe not the word, but I suppose that's what I mean, they don't have the, teachers are not held in the same esteem as they were and so what they say is like water of a duck's back or catch a grip whereas before, I know if someone had said something to us in schools we'd have sat back and thought about it. So I think a lot of that is lost, I think an awful lot of the social fabric is lost and I think it is not such a good thing. [Community psychiatric nurse, West Belfast]

It's the children dictating to the parents. [Teacher, North Belfast]

Others suggested that the problem lay with parenting in that parents were unable to set boundaries for children and that in some cases parental neglect and abuse was resulting in children having to take responsibility for themselves:

I'm not a parent so it's very difficult for me to say, but from observation, lots of parents think the way to love their child is to say 'yes' all the time, give them everything they want, like clothes or books, cos none of our kids want for anything – well some don't have the things that other kids do, but the majority of them come in in their best of sports gear, their expensive football boots, not all of them, but… they have stuff like that but they don't have the basics of life – parenting skills, there has to be boundaries and rules and they're like – och you got caught smoking – you're 14 – well that's alright, you can smoke out the back garden, you know, and they're allowed to do that. [Teacher, North Belfast]

They're [parents] too willing to treat their child as a young adult and let them do adult things. [Teacher, North Belfast]

That's the sort of thing we're up against, parents letting their kids down. They were out partying all night and the kids were getting themselves up for school so you maybe had an older child in the house actually being the parent. [Community representative, North Belfast]

I think the issue of abuse, whether it's physical abuse or emotional neglect or sexual abuse, I personally believe that in some suicides that's a factor, but it's never acknowledged. [Youth worker, West Belfast]

On the subject of abuse, research indicates a link between childhood sexual abuse and suicidal behaviour (Molnar, Berkman & Buka, 2001; Santa Mina & Gallop, 1998) and that adolescents who had been physically or sexually abused were significantly more likely to experience suicidal thoughts and behaviours than other adolescents (Evans, Hawton & Rodham, 2005).

One participant suggested further that the prevalence of youth suicide in West Belfast in particular was exacerbating already difficult relations. She suggested this was creating a climate where parents were afraid to discipline their children and where children were using suicide as a threat:

Young people, as you know, are astute enough to know that they can use this as well, and what has happened and what we have seen clear evidence of, is ehh lack of – where indeed family control consistency, discipline, may be slightly frayed at the edges at the best of times, what is happening now is that parents, understandably, are scared to discipline children, because what young people are saying is, "I'll throw the rope up," and if I've heard that once, I've heard that hundreds of times, so, what's happening is that the normal norms, so if you're saying to your child, "you'll

have to be in for 10 o'clock", "I'm not going to be in for 10 o'clock – you never let me do anything – life isn't worth living – if this keeps up – I'm gonna throw the rope up. [School principal, West Belfast]

This view was echoed in the North Belfast case study site:

There's young kids in this area who would be the worst kids on earth, that's the Gospel truth they're up to no good every day of the week, and the next thing is they're telling their parents if you touch me I'm going to kill myself so there's all those sort of things that have to be looked at because how do you know if a kid is genuine about that or not? [Community representative, North Belfast]

Overall it was suggested that if young people placed little value on these relationships they were unlikely to think through the consequences of suicide for family members. As one participant explained:

It's how you value yourself. It's how you value your relationships with your parents, how that would impact on them. You have an understanding of all those things and you just wouldn't do it, you know. [Teacher, North Belfast]

This statement also indicates the link between self-value and youth suicide, discussed in more detail below.

6.1.4 Self Worth and Self-Esteem

Additional factors are discussed in this section, which might be considered contributory factors as to why some young people in the case study areas display low levels of self worth and self esteem. For example: lack of aspirations; low social mobility; anomie; unemployment; isolation; bullying; lack of facilities for young people; impact of living in a post-conflict society; the developing culture of individualism; and lack of social capital. Participants in both case study sites contended that youth suicide was closely linked to young people's lack of self-esteem and self worth. As a teacher who was interviewed, explained:

There's a big problem with self-esteem and self-confidence and aspirations and (…) expectations, you know. The people and their lives outside of schools, we may have high expectations for them here and wish for them to succeed in life, but outside of school maybe their backgrounds or their socio-economic status will mean that they're not – those expectations aren't there, they're not pushed from the parents, they're not pushed from the extended family. [Teacher, North Belfast]

Supporting this idea, Craig (2010) discusses self-esteem at length, reporting on how research has shown that individuals with low self-esteem are more likely to feel depressed and rate their happiness levels as low. Consequently, suicide rates are higher in countries and areas where levels of self-esteem are low. Craig (2010) presents research findings on how self-esteem develops in individuals: a combination of genetics, gender, level of success and parenting. She is also quite critical of some common approaches to raising the self-esteem among young people, contesting that there is a tendency for well-meaning teachers and youth workers to avoid providing vulnerable young people with honest feedback, instead choosing to lavish them with praise for substandard work, or even negative behaviour.

A number of mitigating factors were suggested. In addition to the lack of positive relationships, discussed in Section 6.1.3, emphasis was placed on the young people's lack of aspirations and low expectations:

In homes where there are obviously challenging circumstances, then 100% the kids have no aspiration or no dreams – you know you ask them – what do you dream of? What do you want to do? [Teacher, North Belfast]

There was evidence of a lack of intergenerational social mobility in both communities, where young people's aspirations tended to be low, and rather than break the mould cast by their parents, they had a tendency to stay in the same neighbourhood and adopt similar life-standards for themselves:

They don't want to make themselves better. They can't see a future for themselves. They can't see a way out of all this (...) People don't aspire – they just – if you're a young girl in or around here, you'll want to get pregnant, get a flat for yourself and then that's you set up in your own wee party house. They don't see anything other than you know, Tiger's Bay, cos this is just what they know – it's what the father knows, older brothers and sisters, they don't – it's just all live in the one big

community and they don't – like I say, very very few of them have aspirations to move on and get a career, you know, and move away from the area and get a nice house. [PSNI Officer, North Belfast].

Wilkinson and Pickett (2009) discuss the matter of social mobility in terms of inequality, and present results of longitudinal studies on income mobility, which support their view that social mobility is lower in more unequal countries. Of the eight 'rich' countries that Wilkinson and Pickett present data on, the UK is second only to the USA in high income-inequality and low social mobility. Thinking of Belfast as an unequal society, the areas of North and West Belfast in which the two case studies were conducted represent socioeconomically deprived communities, in relatively close proximity to affluent communities, within South Belfast for example.

The relationship between these low expectations and socio-economic status was echoed by other participants, who suggested further that high unemployment was adding to the sense of hopelessness and lack of focus for young people:

The numbers of kids around here who are 16, 17, 18, 19 leaving school have no focus, have no function, they have no role, their money is free money and there is nothing for them to do. And in a sense there is no sense of themselves and there is no self worth. [Community psychiatric nurse, West Belfast]

My feeling is em, in respect to Durkheim, its anomie. I do believe that there is a lack of, of purpose in a lot of young people's lives now. This is partly because of you know, the danger of living with high unemployment and em, the focus on (…) academic qualifications rather than life skills. [Social worker, West Belfast]

Durkheim's theory of anomic suicide supports the idea that when there are rapid and drastic changes in the norms and values of a society, for example during times of social or economic crises, rules that regulate a person's previous behaviour are not always appropriate, resulting in instability. This instability, or state of 'anomie' refers to a state of moral deregulation, which does not protect against suicide (O'Connor and Sheehy, 2000). Anomie is caused by changes in social ethics, which might challenge the morals and aspirations of the individual, resulting in them being confronted by new expectations and confusion around where they fit in society.

The young people in the study pointed similarly to unemployment as a key issue, suggesting that this might be a contributory factor as to why young people of post-compulsory school age may be at risk of dying by suicide:

Like most of the people who've done suicide is the same age as me – 17-18 and they've come out of school, do you know what I mean? Once they come out of school there's no jobs, there's no nothing that's why. [Young person, West Belfast]

In an attempt to understand why young children may take their own lives, the young people in the study suggested that this may be due to feelings of isolation caused by bullying and the lack of opportunities provided in the community for young people to socialise:

You could be getting bullied as well, like you might not even be able to join a boxing club or football team or camogie team or whatever, there might not have been nothing out there for a young person to do. [Young person, West Belfast]

They suggested further that while there were activities available for children in the local community, older teenagers were not as well catered for:

It's for kids [speaking of a particular project], it's not even for teenagers or anything. This project [speaking of the youth project in which they were involved] is probably the only thing for people from 16 and over and just come in and use the internet and slope back out again, but there's nothing for kids except for in here and whatever. [Young person, West Belfast]

The young people participating in the study had been recently involved in presenting a petition to Stormont about the perceived lack of suicide prevention resources in their area. During the course of the focus group the participants commented particularly on a lack of facilities for children and young people in their area. The research team acknowledge that the young people's recent involvement in this political response may have influenced the strength and direction of their views.

Similarly, Tomlinson (2007) acknowledged how, in recent years, the predominance of suicide amongst young people in certain areas of Northern Ireland has led to an increase in public concern, and local communities have engaged in protests and petitions around the lack of provision of mental health services and resources for young people. While Tomlinson (2007) feels that activity of this nature leads to greater public recognition of the problem of adolescent suicide, such actions can also have the effect of reinforcing already negative views among communities. Implicating potentially vulnerable young people in such political responses can be particularly counterproductive, in terms of enhancing their pre-existing, and at times exaggerated or unfounded, beliefs that there is a lack of both mental health services and recreational facilities in their communities.

An additional factor noted by participants was the impact of living in a post-conflict society, in particular the effect this had on community identity and sense of belonging:

> *There's also a lot to be said about the ending of the troubles and the shift in dynamic in the area because of that. Em, a lot of people had found a role and a purpose in, em, sectarianism, and that's no longer, well it is still available, but it's no longer as, as big as it was. So there's that, the sense of self identity and the sense of community identity is gone and control over your own life, loss of control, is being taken away. [Social worker, West Belfast]*

Tomlinson (2007) carried out a major review of the evidence on mental health, suicide and the Northern Ireland conflict. It was concluded that the Troubles have shaped the problem of suicide in significant ways in the past and that the legacy of the Troubles will continue to influence the challenge of reducing suicide in the future. Durkheim (2002) proposed the idea that during times of conflict, all crimes besides homicide tend to show a marked decrease, and he proposed the notion that wars tend to 'restrain' the act of suicide (Tomlinson, 2007). Durkheim (2002) felt that wars serve the purpose of increasing social integration within communities, cultures and countries, a sentiment which has been reiterated in more recent research and in the Northern Irish context (British Medical Journal, 1998; McGowan, Hamilton, Miller and Kernohan, 2005). Post-conflict there tends to be a 'vacuum' and suicide rates increase which is reflected in the views of the social worker expressed in the quotation above.

McGowan et al. (2005: 404) further discuss how the Troubles in Northern Ireland led to the polarization of communities, which they describe as the "ghettoization" of parts of the country. They felt that this form of social cohesion was effective in protecting residents within these polarized areas from suicide. McGowan et al. (2005) made the assumption that post-conflict, the reduction in social and political cohesion within protestant/unionist and catholic/nationalist communities would therefore cause an increase in suicide rates. Tomlinson (2007) interjected that this hypothesis was too simplistic given the vast variations in levels of experience of the conflict, and divisions within communities in addition to those between them. There does, however, appear to be some evidence for McGowan et al.'s (2005) hypothesis, and further research could explore this idea of social cohesion as a protective factor for suicide during and post-conflict.

Underlying all these factors was a sense that a culture of individualism existed within both communities resulting in a lack of willingness to support others:

> *There is this increasing defragmentation of communities and we see it here. We see it here – I certainly see it here in terms of someone who has worked in this community for a considerable time. You see that increasing individualisation that has driven globally, but, so those structures of community aren't there and people keep themselves to themselves and don't really want to access services. [Youth worker, West Belfast]*

> *I think people just are a lot more selfish in this day and age and less willing to reach out to other people to help others, to you know, it's all about themselves and what they're not getting and what the world owes them and there's less general goodwill. [Teacher, North Belfast]*

Layard and Dunn (2009: 6) identified "excessive individualism", "the belief that the prime duty of the individual is to make the most of her own life, rather than contribute to the good of others", as a factor in the lack of wellbeing in children. A culture of

individualism may to an extent explain the reluctance of some young people to seek help, discussed below.

This culture of individualism is linked to low social capital within these communities. Humphreys (2011) presents research on Limerick, which describes a pattern whereby disadvantaged neighbourhoods lack the 'bridging' and 'linking' social capital associated with upward mobility of individuals and positive developmental outcomes in territorial communities. Humphreys (2011) defines bridging and linking as indicators of the social capital of neighbourhoods. 'Bridging' refers to the level of trust people have in community leaders and community organisations, and their involvement in voluntary and community organisations. 'Linking' is a similar indicator of social capital, referring to the level of trust people have in institutions, their attitudes towards local governance, and their awareness of and involvement in voluntary organisations classified as 'linking' social capital, for example residents' associations or organisations involved in community or statutory partnerships. It has been found in this context of Limerick that habitation in neighbourhoods with problems such as antisocial behaviour, tends to have a negative effect on people's attitudes of trust towards public institutions, whom they regard as responsible for not dealing effectively with the problems of the neighbourhoods. Consequently, residents will be more reluctant to work together towards change, and engage with public agencies in the process.

This lack of social capital was displayed by comments from some participants who indicated a lack of trust in community leaders and institutions:

> *It's not even that, see people from this area, like the people from the [local community organisation] – they all do think they are something, like their family and this and that and they were doing this when they were young. Do you know what I mean? The whole community's run by vigilantes – I am this and I am that – it's stupid. You can't even go out no more – people are surrounding the place. [Young person, West Belfast].*

> *There is an element of people in the community who are still afraid to speak out against the paramilitaries. Men are still very afraid or involved and women have shown anger and frustration. They have claimed that there has been a suppression of UDA activity in this community, but they are still active and are working with the police, so the community mostly tends not to trust the police. [Community leader, North Belfast].*

6.1.5 Young People's Internal Resources

The young people who participated in the study indicated clearly that many young people lacked the confidence to seek help and were not aware of support mechanisms available:

> *People are not confident enough to go like see someone or talk to someone about like any of their problems. The only best option they see is to commit suicide and it's not on and there's help out there. There's lifelines, there's people to talk to and people just don't see that. [Young person, West Belfast]*

Other participants linked this to aspects of community culture in general and youth culture in particular, and how other young people might perceive those who did seek help:

> *I think there's still that aspect of not seeking help, and that's one of the things that we've tried to influence, you know, create a culture of help-seeking behaviour, and when you seek the help, you also get the help, emm I think that'll take time to do that, emm especially when you've got a culture growing up who who don't get involved in things, you know, and who just take it on the chin and get on with their suffering and all those types of clichés, you know. [Health care representative, West Belfast]*

> *It is seen as a weakness to need help, and it's not just amongst young men, it's young women too – you know – hard as nails – I'll be grand – everything's sweet. [Youth worker, West Belfast]*

Research on help-seeking by Ciarrochi, Deane, Wilson & Rickwood (2001) notes that one in five children and adolescents in the UK experience mental health issues, but that those who were low in emotional competence were more likely to seek help from informal sources rather than doctors or health professionals. A number of health professionals in the current study pointed to young people's lack of coping mechanisms, and warned against making assumptions that suicide was due to mental health problems and that young people were resilient:

Well suicide isn't necessarily to do with mental health, a lot of people who commit suicide aren't mentally ill. A lot of children who commit suicide, it's a reactive thing and it's not necessarily anything to do with them being ill or whatever it has probably got more to do with coping mechanisms and how they manage their life or how they have been brought up to manage their lives you know? [Community psychiatric nurse, West Belfast]

You know if you think that human beings generally are very resilient and I don't think – I think everybody will have experience of being resilient, you know, I think that young people who end up taking their lives, right, that's not how they've always been. But the resilience tends to be crushed out of them through – well through hard experience. [Mental health representative, Belfast]

Overall, it emerged from the study that there was a perception that many young people lacked the internal resources needed to cope positively with their problems, as aptly summed up by this comment:

When I was growing up it would've been a case of if something happened and – usually something negative, you found a way of dealing with it, and I think for the past – maybe the generation from like 15-20 years ago, that's changed. There's something in the – there's almost like a learnt helplessness. When young people think and where they face an issue, one of the first things that comes to mind is about self-harm or suicide, you know, it's readily there, emmm... given the catalyst that has went before in this area, that can only add fuel to that fire. People no longer think about the self-soothing or the problem-solving techniques that can help them through a process, they immediately turn to those drastic elements of self-harm or suicide. [Health care representative, West Belfast]

This data, relating to the lack of internal resources of young people, fits with the 'neurobiological paradigm' (Insel and Gould, 2008). This theory proposes that the reason adolescents are more susceptible to suicide contagion is that their brain is still developing in terms of the complex cognitive functions required to inhibit inappropriate or impulsive behaviours.

6.1.6 Perceptions of suicide

A theme which emerged strongly in both case study sites was in relation to young people's perceptions of suicide: the it had become normalised and glamorized; and that many young people failed to grasp its permanency.

First it was suggested by the majority of participants that suicide was perceived to be 'normal' or 'socially acceptable'. In particular it was noted that the 'stigma' associated with suicide in the past no longer appeared to exist and that some young people were to an extent unaware of, or dismissive of, the reality of the consequences of death by suicide. The net effect of this, as one participant suggested, was the creation of a 'subculture of suicide':

I think there is quite a lot of flippancy about in some people with regard to self harm and suicide that it almost becomes normalised. [Community psychiatric nurse, West Belfast]

The reality of the death of the person is not being told. In that the stigmatism has been taken away from it, there used to be a stigma behind it which was a good thing because it prevented people from doing it. Now, I'm not going to say it's a cool thing to do, I don't think young people think that but it is more socially acceptable in their heads than before. They think they have no more pain and they're in heaven and they're partying and everything's great and everything's dandy. [Youth worker, West Belfast]

Several participants suggested that perhaps there was a need to 're-stigmatise' suicide to a certain degree, typified by this comment:

So maybe some of the taboos we have in society, we need some of them back again. I think you can sympathise with someone who commits suicide but to glorify or apologise for it doesn't send out a good message; it is not the appropriate way to deal with it and as I say any family I know where suicide has been involved are tainted for life, they are marked. [Religious leader, West Belfast]

Bill-Brahe (2000) discussed changing attitudes towards suicide from a historical perspective, explaining how, in the Middle Ages, the Christian Church's strong condemnation of suicide resulted in

severe consequences, with the family name being disgraced and their property confiscated. Since then, the Church, and society in general, have become more compassionate, with a degree of responsibility now being placed on individuals to care for their neighbour. This has led to suicide prevention being perceived as the responsibility of society in general, often resulting in feelings of guilt and shame in the aftermath of a suicide, where individuals feel that they might have been able to prevent the suicide in some way. Bill-Brahe (2000: 200) proposes that:

> *"Attitudes towards suicide were heavily tainted by both the concept of sin and the notion of guilt - together bringing about the taboo that for years has dominated the field."*

More recently, the stigma and taboo around the issue of suicide has lessened, at least in a local context, and as described above, some feel that we should avoid further reducing this stigma, which could arguably prevent people from acting on their suicidal thoughts and impulses. Instead, practitioners are suggesting that focus should be placed on reducing the stigma around mental health problems and help-seeking behaviour. Bill-Brahe (2000) suggests that, consistent with the participant's comment above, among some peer groups and cultures young people might almost see suicide as something that is expected of them to demonstrate their depths of sorrow and pain.

This comment resonates with another issue in relation to young people's perception of suicide, which emerged strongly in the study: the glamorization of suicide. One health professional illustrated this point using a specific example, expressing her unease and how the funeral of a young person who had died by suicide had been conducted:

> *All the kids went to the funeral wearing her favourite colours and they went into the chapel with their mobile phones with the music she had on her mobile phone as a ringtone they had it and this is what they wanted for her funeral procession or march or whatever. And in a sense it gave the wee girl a degree of infamy that she never ever had when she was younger or when she was alive. You are sort of looking at that and thinking to yourself how are other kids seeing that, you know look here's all the community has come out and they're all wearing (...) and I think, I have a funny feeling it was yellow and white and the coffin was draped in yellow and white and the flowers were yellow and white and in a sense that's ok but when all the kids are wearing yellow and white there is something seriously wrong with that. [Community psychiatric nurse, West Belfast]*

Other participants expressed similar unease in relation to the role of funerals, or public expressions of bereavement, in glamorizing suicide:

> *There was one reasonably high profile suicide three or five years ago (...) in which we played a very active role in trying to support the young people in the aftermath and what we were hearing was that (...) actually one person said it, they planned their funeral like you have a fairytale wedding, they were planning fairytale funerals, I think out of the year group nine in that year group had either died or been effected by suicide within a very short space of time and I can remember one comment was made (...) you know, young girls would plan their fairytale wedding some of these kids were planning their fairytale funerals and that sent ice down my back, you know it was a reality. [Counsellor, West Belfast]*

> *I have been to groups or rallies and I have been quite disturbed with people putting up a power point demonstration of about 15 people who have committed suicide and show happy moments of their life, typically show them with others having fun or enjoying themselves and people are lighting lighters and holding them up and giving a round of applause for each person that comes up. I'm, not sure that is a good way of dealing with suicide, nearly glorifying it. I'm afraid that young people will copy cat and the messages that young people put in the paper such as you where a great guy, party on that sort of thing. [Religious leader, West Belfast]*

Another participant linked this notion of 'celebrity' to young peoples' lack of understanding of the permanency of suicide:

> *It was like a celebrity, and I've always felt that – from that – suicide in some ways is being seen as trendy, by young people and, not really understand the consequences of when they do it, when they leave. [Youth worker, West Belfast]*

This failure on the part of some young people to grasp the reality of and the permanency of death by suicide was noted by several participants:

The kids need to realize the devastation they're leaving behind them; they think they're coming back; they don't seem to realize that suicide is permanent; they can't see a way out themselves. [Youth worker, West Belfast]

I did two assessments and what struck me about them both was the perception of death, they appeared and what I discussed with them death wasn't a frightening thing and they did live on so that concerned me that they didn't seem to have a fear of it. [Counsellor, West Belfast]

One participant suggested that this lack of fear of death coupled with images of a perfect after-life made suicide a reasonable option for many young people:

I do believe that in this community young people see it as a very viable option, I think they believe, because I have spoken to them, that their life continues and they party in heaven. And I think that some of the comments in the local papers have supported that. I also think that there is this (...) immortal, you know, no one is going to hate a dead person, nobody's going to say bad things about them. [Counsellor, West Belfast]

6.1.7 Cross-cutting themes

In addition to the emerging themes discussed above it was clear that participants felt strongly that social deprivation was a considerable mitigating factor in relation to all of these issues:

I think to me the main reason is social deprivation, it [Poleglass] has one of the highest rates of social deprivation in Northern Ireland. [Social worker, West Belfast]

This, it was suggested, exacerbates problems for young people, creating an unsafe environment:

Social situations, the deprivation and all that is a massive issue in this area I think it would be a very difficult area to live in and as a kid to grow up in I think it is quite a difficult area in regarding even walking down the street (...) I know I talk to young people in their twenties and you would think you know that they could handle themselves. They are afraid to walk down the streets and stuff at night time. And even I talk to older men they are the same so there is that fear, and there is with young people a bit of thuggery going on. I think there is lots of issues but I think it is surrounding the whole issue of social deprivation. I think social deprivation covers a multitude of sins, if you have that you have higher mental illness you have all those different things, higher unemployment, you have more people on the streets up to no good and all that so. [Social worker, West Belfast]

Wilkinson and Pickett's (2009) extensive sociological review of inequality and its impact on health and social problems would contest the outlook that it is social deprivation itself which would result in high rates of youth suicide in certain areas, but they would attribute the problem more to the inequality amongst society within Northern Ireland. Wilkinson and Pickett (2009) report that income inequality within countries is positively correlated with index of health and social problems; they formulated this index by combining all health and social problem data for each of twenty countries. It was reported that the UK was third, after the US and Portugal in terms of income inequality and index of health and social problems.

The second cross-cutting theme was a general feeling of hopelessness and negativity pervading the communities involved in the study, due to a range of inter-related issues such as community breakdown, deprivation and the impact of the conflict. This hopelessness, it was suggested, was being 'picked up' by young people:

I think there's a big breakdown within communities. Somewhere along the line I think we've lost that care because I think during the conflict people stayed within their communities and looked out for each other and I think somewhere along the line there's something missing there. If you look at unemployment, deprivation and education; all of those things. It saddens me because so often you do speak to young people and there's this 'why bother?' That's pretty grim. [Community and voluntary worker, North Belfast]

I think people have just lost hope. And I don't think they know where to go to get that back. And that really pains me, that people think that the ultimate solution is just to end it all. [Youth worker, West Belfast]

The concept of social exclusion, discussed by O'Connell (2011) with reference to the Limerick context, is described as the process by which some groups are pushed to the margins of society and prevented from participating fully because of their economic deprivation, and poor levels of life skills and education. O'Connell (2011) discusses how, as social exclusion prevails in certain areas of Limerick, mainly in the city centre where there is most deprivation and disadvantage, citizenship status is low – i.e. inhabitants do not feel that they are full members of the community. Individuals have to identify with the place in which they live to have this sense of citizenship, and some participants felt that this sense of identity is lacking in our case study areas:

Preventing the person from becoming suicidal starts way beyond, before that, and it is about that sense of, you know, having a purpose in life and having a sense of identity and building that. Because even things like owning public art and taking care of, you know making sure, having a pride in the place you're living, em, adds to that sense, and that's instilled way back when you're a child. [Social Worker, West Belfast]

I think there's issues of identity as well, community identity here. You meet people up here who have came from West Belfast and who maybe married and came up here in their early 20s and reared a family and they are probably 50 now and when you ask them where are you from they'll tell you they're from the lower Falls or Whiterock and they've probably lived longer – more of their lives – up here and reared their family up here, but they're still from down the road. I mean, that's an issue and I think politically it's also an issue and because you know, culturally and politically, ideologically, people here identify with West Belfast, while they're still in Lisburn council area and they don't have any affinity with that council and they see it as a council that has discriminated historically against them and in some respects I think that that's right. And then when it comes to identifying with West Belfast, I don't think West Belfast particularly wants them either, so you know, I think all of that – there is a uniqueness of it – is it West Belfast or does the political boundaries change and it falls into the West Belfast constituency, but doesn't fall into the council area, so I think all that concept of identity is – has some bearing on it as well. [Education and Library Board employee, West Belfast]

The issue of community identity, or a feeling of belonging or 'connectedness' to community, has been identified as a factor in preventing suicide (Resnick, Harris and Blum, 1993; Carter, McGee, Taylor and Williams, 2007; Kaminski, Puddy, Hall, Cashman, Crosby and Ortega, 2010). The conflict in Northern Ireland is likely to have had an impact on individuals' sense of community identity, an area of further research interest.

6.1.8 Cluster effect

Two main themes emerged from the research in relation to the factors associated with youth suicide clusters: behavioural contagion; impact of media and social media. These themes link strongly to those discussed above in that, from the research participants' perspectives, the underlying reasons why young people take their own lives are rooted in a culture and climate that has normalised and to an extent glamorised suicide. Again key exacerbating factors were noted consistently by participants: social deprivation and the impact of the conflict. Participants in this study were convinced of the phenomena of suicide clusters, in many cases automatically continuing a remark about suicide into a discussion of clusters, as illustrated by the comments below:

It's a bigger thing too you know, it [a suicide] has a knock on effect. See whenever one young person takes their life some more kids try and take their life after it. That really shocked us and scared us because there was kids hanging from the railings at the church and that was the sort of thing that we as parents said hold on here. [Community Representative, North Belfast]

The two biggest things for anybody left behind is the 'why' and the 'if only'. It's like throwing a stone in the water, the ripple effect that it [a suicide] has just within communities and particularly among friends. [Community and Voluntary Sector worker]

Behavioural contagion

The literature describes some psychological theories which offer possible explanation as to why suicide clusters occur. Suicide contagion can be viewed within the larger context of behavioural contagion, which describes the process by which a mood or behaviour spreads through a group quickly and spontaneously (Gould, 1990). Factors contributing to this process are: motivation to perform a particular behaviour; knowledge of how to perform the behaviour; observation of a model performing the behaviour; and performance of the behaviour after observing the model (Wheeler, 1966). It was observed by Wheeler (1966) that suicides occurring in a community or in the media might impact individual's motivation by providing a model that reduces the observer's internal restraints against performing the behaviour. Knowledge of a suicide, which has taken place in the individual's school, community, or in the media, will provide a model which might potentially break down the observer's internal restraints against exhibiting suicidal behaviour.

Social learning theory, which proposes that most human behaviour is learned observationally through modelling, (Bandura, 1977) provides a further explanatory theory as to why this observed 'ripple effect' might have occurred amongst the young people who died by suicide in our case studies. Participants in the research indicated that this 'ripple effect' impacted on young people who were friends of the individual who had died by suicide and might then draw 'courage' from this and mirror this behaviour. As a youth worker suggested, young people might be inclined to think:

> *'Well he was one of my best friends and he was brave enough to do it – I'll join him'. [Youth worker, West Belfast]*

Further, it was suggested that the ripple effect extended to peers, regardless of whether or not they had a personal relationship with the individual who had died:

> *Even if you've just heard about something and you've been thinking about it, and that sort of kind of clicks something in your mind going – well that's it, you know, I'm going to do it because this person a mile up the road was able to do it…. …it may have just triggered something in their minds to think – ok this has just confirmed something in my head and I'm gonna follow through with this. [Youth worker, West Belfast]*

> *I just think every time there's a young one commits suicide, no matter where it is, people are always waiting for their mates to do it, for this whole cluster, 'oh he's done it so I'm gonna do it'. [Therapist, North Belfast]*

This resonates with the views of the young people interviewed in the study. As one participant, talking about his reaction to a youth suicide in the area, explained:

> *I said don't be shocked like if you hear someone else doing it his age and there you go it happened straight away, you know what I mean? Once people look at – it's a choice. He did it, she did it why can't I? Do you know what I mean? They're taking the easy way out. [Young person, West Belfast]*

As can be inferred from the comments above, there was a feeling among participants that a cluster was almost 'inevitable' following the death of a young person by suicide. Youth workers in particular commented on the overwhelming effect suicide had on the community, contributing to the sense of hopelessness discussed in the previous section:

> *It almost seemed like it was growing, it seemed like a domino sort of thing. All of a sudden it was just this massive thing that was just engulfing all the young people. Even though there are so many young people up there, there are so many that are interconnected, there are so many that died that it affected huge numbers of young people. [Youth worker, West Belfast]*

> *I think part of it was that none of the young people who died, there wasn't nobody in the community that didn't know at least one of them, or one of their families, and again, that community over the last 10 years, has been affected by suicide so much that – it just affected everybody because if you didn't know the person, you had been affected by it in the past and it would've brought up memories, or you knew someone that did know the person, or you knew someone in their family, so the mood was very low. [Youth worker, West Belfast]*

Moreover, participant responses indicated that, as discussed above, a sub-culture of suicide was emerging that had become self-perpetuating:

> *I think it is especially (...) almost self-perpetuating when you have young people killing themselves and then they're talking about it and somebody's mum has attempted it and I think it's just saying that this is an avenue you can go down and people have crossed this threshold and I think it's sending signals to the community. How do you reverse that? Honestly I don't think you can (...) because I think it is reflective of society in general. [Social worker, West Belfast]*

It was also suggested that the glamorisation of suicide, again as discussed above, contributed to this sub-culture. As a community representative contended:

> *The living graveyard scenario to me takes it all, people have been murdered and there's plaques up, people have taken their lives and there's plaques up, it's just everywhere you go. I'm not being disrespectful to people that die but some of those kids when people die and they see a plaque up, some people look at that and go to themselves that could be me. They're like a martyr. [Community representative, North Belfast]*

Contemporary postvention guidelines in the literature recommend that tangible memorials, like the plaques described by the social worker above, should be avoided in the aftermath of a death by suicide, as they are thought to add to the vilification of the suicide (American Foundation for Suicide Prevention and Suicide Prevention Resource Centre, 2011).

While acknowledging the impact a death by suicide had on those close to the young person and those within their community, one participant argued that there was a need to extend what was understood by the term 'community' if the phenomenon of youth suicide clusters was to be properly understood:

> *I think we need to look at what we mean by cluster. We constantly talk about community; em and I think communities these days are more identified by (…) your peers and who you meet on the internet rather than who you live beside. So (…) while these people in West Belfast, it is quite a small area, everybody knows everybody through somebody else. You know, there's nobody that removed. Em, so whilst these people may not have physically spent time together, they may have known each other through Facebook friends, and they may have attended the same venues, em, they may have been in the same cohort, em, through music or through, em, other beliefs, religious beliefs, who knows. But I think we need to widen what we know as a cluster. [Social worker, West Belfast].*

The impact of media/social media are discussed below.

Media and social networking

There exists a body of literature demonstrating that vulnerable youths are susceptible to the influence of reports of suicide in the media. Gould et al. (2003) propose that overall, the magnitude of the suicide increase is proportional to the amount, duration and prominence of media coverage. Gould et al. (2003) also suggest that the impact of suicide stories on subsequent completed suicides appears to be greatest for teenagers. In accordance with this research, a consistent theme emerging from the case studies was the negative impact of the media in general and social media in particular. In terms of the media, participants commented on the need for responsible engagement with the issue of youth suicide, both in terms of how they reported the matter and the ways in which they provided a vehicle for the community to express their bereavement:

> *I guess just the media, which has a huge potential negative impact on a local community and just the sense of panic that that can create. And it's not just around like… you can take a whole range of examples, like swine flu, it's very similar as well. And I also feel that again this is a very personal opinion, but I feel that sometimes political leaders can use the media for their own gain, and sometimes I suppose they think that they're doing good for their local community, but I just feel a very, very sensitive issue such as suicide, shouldn't be used like that. [Health care representative, Belfast]*

I think the media have a big responsibility. In the likes of that text messaging thing, in the likes of the [local newspaper named] you can text in and say 'party on my friend we'll meet again'. People are saying are the media running with it and making it a bigger thing than it really should be? [Youth worker, West Belfast]

The impact of social networking sites was raised by participants. As a school principal explained, social media had a very particular impact on young people, suggesting that they were not emotionally able to deal with demands of online engagement around issues as sensitive as the death of a young person by suicide:

I think one of the big things that really needs to be taken into consideration here is the impact of social media on young people and the internet, because I do – they are certainly inter-related, and what I would say to you is that if one thing could come out of this would be that social media could be policed in some way so that young people under the age of 18, I would suggest, it's a bit like getting a passport, cannot be signed onto Facebook or any other sites, cos they're not emotionally able to cope with the demands. [School principal, West Belfast]

Further, it was suggested that 'cyber bullying' was adding to the problems associated with youth suicide, including the expressions of grief following a suicide. Research has suggested that youth who experienced traditional bullying or cyberbullying, as either an offender or a victim, had more suicidal thoughts and were more likely to attempt suicide than those who had not experienced such forms of peer aggression (Hinduja and Patchin, 2010). This study also identified that victimization was more strongly related to suicidal thoughts and behaviours than offending.

New media, and social networking sites in particular such as Facebook, do bring with them a host of new issues in terms of cyberbullying and the potential for romanticising suicidal deaths. However, on a positive note, there may be potential for utilising social networking sites as part of a postvention response, as it is now recognised as being one of the primary means of communication among young people. While some schools may feel that this falls outside of the school's control, the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center (2011: 8) suggest that by working in partnership with key students, the relevant social networking sites (e.g. Facebook) could be monitored and used to promote:

"prevention-oriented safe messaging, offer support to students who may be struggling to cope, and identify and respond to students who could be at risk themselves."

(American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, 2011)

Exacerbating factors

As noted above, participants also indicated that social deprivation and the impact of the conflict added further to a culture of hopelessness, creating conditions for suicide clusters to occur. These issues have been discussed in section 6.1.4 above but are worth re-iterating in relation to the specific phenomena of suicide clusters. As one participant commented:

Well I suppose there's always potential for a suicide cluster in areas where there are so many challenges, so you know, you're talking about areas of multiple deprivation. [Mental Health representative, Belfast]

6.2 What was done: the actual response

This section explores the actions that were taken in both case study site areas in direct response to the deaths of young people in each community by suicide. It also looks at the factors that were perceived to impede an effective community response as well as exploring the features of an 'ideal' community response according to those interviewed.

In both North and West Belfast, one of the actions that was taken was the convening of a community and multi-agency meeting, the purpose of which was to discuss how best to address the situation and prevent further deaths. These meetings were (and continue to be) regularly attended by members and leaders from the local community, representatives from voluntary and community organisations, representatives from the health and social care trusts (including social workers, community psychiatric nurses, mental health professionals) and the PSNI. In North Belfast the Belfast Trust's Suicide Prevention Sub-Group is taking forward the plans for the future of the community response plan, while in West Belfast, the Colin Suicide Prevention Task Group is responsible for the development of the community response plan to a potential suicide cluster. This approach follows the CDC (1988) recommendations which propose that responding to a crisis should involve all concerned sectors of the community.

Such meetings were perceived to be a useful forum for sharing information and facilitating collaborative working between agencies and the community, which has been received very positively.

> *So, people were more willing to (…) sit down and talk to them because they wanted to improve the community, they wanted to get rid of the paramilitaries, the drug dealers. Again, that opened the door for ourselves and other agencies came in and said – look we can help you do this, but you know, we need to sit round a table and have a meeting and we did. [PSNI officer, North Belfast]*

People living and working in the community have viewed the impact of these meetings positively, as one participant explains:

> *I remember three years ago when we first started our partnerships we had huge problems with young people openly walking in this neighbourhood carrying their carry out in their blue bags and it was just normal for them. Now you very rarely see young people walking the streets with their blue bags because the police have been working in partnership with the Council and the community in identifying premises that have been selling the alcohol and we as a community are passing that information to police. [Community representative, North Belfast]*

They have resulted in a greater awareness of the role of different organisations and have also raised awareness of what resources are available.

> *I think well (…) personally what I've learnt from it is, is that there are a lot of resources out there that even I was unaware of, and I suppose that, that (…) uber meeting, you know the very big one? It was very good to hear what everybody else's role was and what role they can play [Social Worker, West Belfast]*

In November 2010, in direct response to the sharply increasing number of deaths of young people by suicide in West Belfast, the South Eastern Education and Library Board (SEELB) provided a bus for young people as a drop-in facility on the Stewartstown Road. There were mixed feelings regarding its success. It was perceived by some to be overstaffed for the first weekend, which was thought to be off-putting for young people. However, some referrals were made as a result of the presence of the bus and according to one young person:

> *Well, see to be honest, see that bus – that was really a good thing cos from my personal point of view, I used that bus so I did. It was really good. [Young person, West Belfast]*

Distinctions between responses in case studies

There were some obvious distinctions between how the community responses implemented within the two case study areas in North Belfast, a predominantly protestant area, and West Belfast, a predominantly catholic area, differed. In the case of North Belfast, a significant element of the response plan involved certain members of the community taking an active stance against the issue of drugs in the community,

and perceived paramilitary intimidation, and it was reported by most participants that the community had progressed to some extent since the time of the suicide in question in 2007 in terms of community groups having formed. However, an ongoing, over-riding feeling of fear within this community was still apparent at the time of the data collection, exacerbated by obvious intra-group tensions. Protestant paramilitary organisations still have an obvious stronghold over this area and provide a threat to the community, which continues to live in fear in our 'post-conflict' society.

Tomlinson's (2007) discussion of the perceived lack of 'community infrastructure' within economically disadvantaged protestant communities and how often *'loyalist areas are dominated by intra-paramilitary turf wars'* substantiates these observations within the Tigersbay case study. Tomlinson (2007: 97) refers to how the:

> *"transition to peace and the problems surrounding political compromise have presented unionism with challenges out of which a unifying and integrating response has not been forthcoming."*

Tomlinson (2007) suggests that there is less social coherence and integration within protestant/loyalist communities, than within catholic/nationalist communities.

Thinking about the community response in the West Belfast case study area, while there was a fear in the community about which young person might be the next to take their own lives, there was not the same kind of reported fear of paramilitary threat within the community as was observed in the North Belfast case study. However, while Tomlinson (2007) feels that there has been a political growth of republicanism, experience of the conflict has often led to divorce and separation, unemployment (particularly amongst ex-prisoners) and migration, all of which lead to social isolation rather than social cohesion. The peace process may also have raised political and economic expectations, and younger people living in the most deprived and marginalized neighbourhoods might feel that these expectations have not been fulfilled (Tomlinson, 2007).

6.3 Hindering factors to the response

A number of themes emerged in relation to factors that were felt to get in the way of an effective response to the increasing incidence of suicides in the West Belfast area. These included the seeming lack of capacity within the statutory system, unhelpful messages going out to the media, lack of shared purpose between agencies, too many meetings, lack of sustained commitment and a lack of resources.

6.3.1 Lack of capacity within the statutory system

There was a perception that the existing statutory systems and structures were ill-equipped to cope with the demands placed on them so that even when young people did present with a risk of self-harm, it could be several weeks before they were seen by anyone. One Principal said that in their school they suggest that parents take their child to Accident and Emergency, as this is the only way they'll get the services they need when they most need it. As one teacher put it:

> *You could refer a child to see somebody and it might not happen for a substantial amount of time and our kids – when they take that leap – they need it there and then – by the time you let them wait, they've changed their mind. [Teacher, North Belfast]*

There appeared to be frustration not only *with* the system, from people who want immediate action when young people are at their most vulnerable, but also from those working *within* the system who acknowledged that it can be hard to understand and access. As one social worker commented:

> *There's a lot of frustration around because people don't understand what, for example, statutory services can do (…) and how we, because obviously we as mental, adult mental health services, work with over 18s and the CAMH service, which is the child and adolescent mental health service, works with under 18s, and there's this very tiered access as well through GPs and secondary referrals for people with serious mental health illnesses (…) and they work over two trusts and from, from an outsiders point of view, what I have just said means nothing. [Social worker, West Belfast]*

A related issue was the perceived lack of 'joined-up' ways of thinking and working between government departments, which did not appear to have improved over the last two decades.

> *The problem is, that I say for the last 2 decades, the – probably one of the most used phrases you would have is – joined-up Government – coordinated action, and frankly it isn't any more joined up or coordinated now than it was 20 years ago really, and there is something about our models of Government that just totally resists any sort of integrated long-term integrated approaches and I don't know – I don't really understand why that is. [Mental Health, BHSCT]*

These sentiments of frustration, and perceptions that there is a lack of capacity within statutory systems to cope with the demands on mental health services, again relate to the concept of 'linking' described by Humphreys (2011) in relation to the Limerick context. Humphreys (2011) reported that living in socially deprived areas, where antisocial behaviour is commonplace, results in lack of trust in institutions and local governance. A similar feeling within the communities of North and West Belfast, seems to prevail.

6.3.2 Unhelpful messages going out to the media

Recently, in the aftermath of the death of another young person in the West Belfast case study site, people were making statements to the media saying that there was a lack of services in the area and that not enough was being done in the community to address the issue. This was felt to be the wrong message as it was not only inaccurate but it created the perception of abandonment, that no-one was there to help which only served to add to the feeling of crisis that people in the community were experiencing.

> *I do get a sense as well of frustration from the community that, you know, people were saying there's nothing being done (…) when there was a lot being done, and it's also some service providers saying there's nothing being done. I mean, at one point we had our local politicians in the paper saying we don't have enough services in the area, which was totally inaccurate and false information. [SEHSCT, West Belfast]*

6.3.4 Lack of shared purpose between agencies

Some participants acknowledged that there was a lot of finger pointing at meetings, where people and organisations were singled out for not doing enough. This blame culture was perceived to be counterproductive to the issues at hand and de-motivating for those who were involved in the community response and already felt they were doing all they could. This is illustrated in the following comment from a social worker in the area, speaking about a representative from the local health centre who attended a community response meeting:

> *…she actually came away very (…) disenchanted with the process and felt that there was a blame going on, that the mental health services were not doing enough (…) and that was fed back through our team, which left them very de-motivated. Obviously we come across people, who are at risk of suicide, all the time and indeed people in our caseloads who do then go on to take their own lives. That's very difficult when you've worked with somebody, trying to prevent that (…) so to get that sense that we aren't trying our best was very disheartening to hear. [Social worker, West Belfast]*

There was a sense from participants in both areas of Belfast that at times no one was working towards a shared or coherent 'bigger picture' and that this was resulting in a fragmented response because organisations were working to their own agendas.

> *Everybody was looking for a reason why it happened and everybody was pointing the finger at everyone else and using that for their own (…) their own wee political battles. [PSNI officer, North Belfast]*

This lack of coherent response was thought to have resulted in confusion around who should be doing what and meant, for example, that in relation to speaking to the press, this was a situation that could have been handled differently and better. It was even suggested that there was competition between some organisations and it was felt that more effort should be put into partnership working:

It's about coming in and getting whatever services and partnership working is key as well because it's about acknowledging and being mature enough to say like an example would be organisation B, why would we provide child bereavement services when there's expertise there? I think that's the thing that's been key to it, having those networks and those relationships but they take years, they don't happen overnight; you have to work at it. [Community and voluntary organisation leader, West Belfast]

The set training protocols used as part of the Connect Project (NAMI NH, 2009) provide an example of best practice in terms of how groups might gain a better understanding of the part that they each have to play in responding to a suicide event.

6.3.5 Too many meetings and attendees

It was generally accepted that a response, which includes bringing people and agencies together in such a time of crisis, was the right thing to do.

There's been a lot of actually very positive things have come out of that (…) because since that we've had multi agency meetings that were set up. Again that was never – you couldn't get the same people to sit around the table. [PSNI officer, North Belfast]

For some people however, the meetings themselves seemed to be getting in the way of progress rather than acting as an agent for change. This was particularly true for youth workers who expressed frustration at what they described as 'talking shops' and wanted instead to be spending more of their time engaging in activities they felt would directly benefit young people.

Youth workers are practical people and if it's not practical we'll just shut down we'll not go (…) unless there is a big crisis happening it is going to be difficult to get youth workers involved. [Youth worker, West Belfast]

Others also questioned the efficacy of these meetings as a vehicle for mobilising a coordinated and coherent response; as one social worker observed:

It's only my opinion but I think that this is going to happen again and again in this area and I think we're going to have these populist everyone get together strategic meetings and I think after the umpteenth time this happens I think people are going to say hold on here, is this the best way, we need a longer term strategic plan. Rather than oh there's a few people's killed themselves here we have a cluster what are we going to do running around like headless chickens, showing off or pretending to have the answer. [Social worker, West Belfast]

The PSNI and Public Health Agency expressed some disquiet around the sharing of confidential information during the course of these meetings. They raised concerns that there were many people around the table and that private information relating to specific individuals was being shared. This raised issues for them in terms of child protection and their duty of care to young people. The PSNI in particular recommended that a stricter protocol be put in place to protect individuals' privacy in this context.

6.3.6 Lack of sustained commitment

There was a feeling that empty promises were being made by some parties at the time of the crisis and that after a couple of weeks people withdrew their services. One school principal described it in this way:

A lot of people helicopter in and a lot of people helicopter straight out again, and that's not what's needed. [School Principal, West Belfast]

An example that was given of this short-term intervention was the provision of the bus on the Stewartstown Road as a drop in facility for young people:

And then at various meetings with Health Trusts and statutory bodies and everything else, slowly the health services pulled away or didn't put their staff on board, for whatever reasons, I don't know. I just know that 2 weekends they were there, the next weekend they weren't. [Youth worker, West Belfast]

There needs to be something long-term. See getting that there bus in – it came in for 2 weeks then it went. [Young person, West Belfast]

In North Belfast the teachers in particular keenly felt that while initial support was made available, ongoing support was not.

Everybody wanted to be involved, but everybody's walked away. [Therapist, North Belfast]

One respondent however made the following point about the remit and capacity of community organisations that might help to explain why a sustained commitment is difficult to achieve:

Community based organisations weren't set up for crisis intervention and yet that's what we've become. So we're constantly reactive and what then happens is the people who aren't deemed at risk are being shunted further and further back until the point where they become at risk. Again the difficulty is how do you get ahead of that? [Counsellor, Belfast area]

6.3.7 Lack of resources

In this context 'resource' refers to both money and time. The lack of funding and the sometimes 'stop-start' nature of funding provision was perceived to generate competition between organisations and impede collaborative working. Particular frustration was expressed at promises of forthcoming money, which was never delivered. While people appreciated that there isn't an endless pool of money it was felt that when people are dying by suicide, the funding decisions should be revisited. However, some felt that it wasn't necessarily that lots of money was needed, but the money that *was* available should be used wisely:

It's not about firing money at things, it's about working out where things need to be and then putting the appropriate resources into it (…) It's not about saving money, it's about the use of money. I think it's £485 a night in a bed in hospital and if you took that and factored it up by 365 days, that's a massive amount of money and you give that then for prevention; suddenly you make a move in the right direction. I'm not saying that's a solution but I think one of the biggest difficulties we have is sometimes we need to stop and take stock of things. [Counsellor, Belfast area]

However, for the money that is available organisations are required to tender for it and are thus forced into a situation where they are competing with other organisations rather than working together. It was felt that a more secure, long term funding strategy was needed which might result in improved collaborative working and avoid the more fragmented response that participants talked about in the previous sub-section:

The very nature of our funding that it's non-recurring so every year we go into competition for it so we're actually driven into competition with each other in a sense. So in one sense we're talking about cohesiveness and working together and then what happens is when we get down to the shillings and pence we're told you've got to prove you will provide a better service than that counselling organisation or that community organisation up the road. There needs to be a longer term plan, there needs to be security in terms of the funding that's offered. [Counsellor, Belfast area]

Lack of funding was also a concern for Principals and teachers who felt strongly that budget constraints prevented them from developing the pastoral side of their teaching which would include spending more time with children and parents developing relationships and ultimately aiming to improve emotional well being. The focus group of teachers in North Belfast in particular spoke about not having enough time to support their pupils in the way they would like to, or even the time to support each other.

If we had time to spend with the kids in a more positive and productive way rather than just – maybe in a supporting way or a mentoring way or a guidance way, or a parenting kind of role – you know, but we don't have that time. [Teacher, North Belfast]

…and we do need to lean on each other sometimes but it's very difficult to do that because sometimes you physically do not have the time. [Teacher, North Belfast]

6.4 Towards the ideal response model

Participants were asked what they thought an 'ideal response' might look like based on recent experience. The theme of barriers to crisis response resurfaced. This quote from the leader of a community and voluntary organisation suggests that no one individual or organisation has the solution:

> *I think there's a lot of learning in this work and I don't think there's any experts, it's a whole learning journey we're all on together. [Community and voluntary organisation leader, West Belfast]*

6.4.1 Evaluating the effectiveness of what is being done

An over-arching theme to emerge was that whatever is done, it should be objectively reviewed and evaluated to ensure that it works effectively.

> *I also think we need to look at what are we doing, like Protect Life was reviewed there (…) it was evaluated and so on, what are we doing that's good, what are we not doing. Throwing counselling to kids is not the answer but not offering them counselling is not the answer either – it is about appropriately resourcing. [Counsellor, West Belfast]*

> *I think you also have to review a situation like this and say well maybe that isn't working, maybe we should try something else. It is difficult to get some organisations to do that because they feel it is an attack on them and it's not. It's really not. [Politician, West Belfast]*

There was a perceived tendency for organisations to respond to suicide crises with short-term planning, lacking a strategic approach, coherence or an evidence base, echoing participant feedback on perceptions of the absence of sustained commitment to crisis response planning. This perspective was encapsulated by the following Principal's comment:

> *There are too many people – none of these organisations that I am aware of are validated, or evaluated and I have a serious concern over the kind of programmes that are on offer because, in the aftermath or during something like this, you're inundated with organisations who want to do something for you (…) and almost are demanding – we will come in and we will take over and we will – we will offer this, and you will have… and I'm – my gut feeling, my instinct tells me that's not the way to handle it. [School Principal, West Belfast]*

It was felt that in order to avoid making the same mistakes again it was necessary to take a step back, review what has been done already and look more closely at the bigger picture.

6.4.2 The development of a crisis response plan

There appeared to be a need to have an organised response plan in the West Belfast area and there was a feeling among respondents of the need to be more prepared for the future. As one politician put it:

> *I think what it threw up for most people who did work and that, previously in suicide prevention, or support for bereaved families, is that it identified a number of gaps that were there. I think one of those particular gaps was an emergency response or the lack of an emergency response like a plan to put into action. [Politician, West Belfast]*

A number of people interviewed from the statutory sector referred to the 'Derry model' and reported that they found it very helpful to hear about the experiences of the Western Health and Social Care Trust and strategies now in place. The Derry model is described in greater detail in section 3.5, however it was developed from the perspective that suicide is a community issue rather than a health and social care issue. This is reflected in the following comment from the leader of a community and voluntary organisation in North Belfast:

> *It's about empowering communities because I think too often a lot of things are done to communities rather than with communities and I think it's so important that it's local people who live in the area are part of the process. [Community and voluntary organisation leader, West Belfast]*

In West Belfast there are already conversations taking place around developing a plan similar to Derry's. Interestingly, only one participant mentioned the importance of involving young people themselves in any response plan:

But we come back to it again, the people that really need to be consulted on this are the young people. It's how you engage with them. They probably have a greater idea but how do we bring them on board? [Counsellor, Belfast area]

6.4.3 Specific suggestions

While many of the research participants interviewed gave broad suggestions for the ideal response, some respondents gave very specific examples of what they thought should be done.

Continuous provision

The young people felt strongly that a drop-in facility that was available 24 hours a day would be very successful and would be used by everyone. They cited Club 9 as an example of a previous drop-in centre that they felt was popular and gave young people a place to go and people to talk to. The young people interviewed also felt that having professional counselling available at such a drop-in centre would be very beneficial.

Other people's authentic experience

One of the young people recounted the following experience communicating the true impact of suicide bereavement:

When I started lower 6th and a man came in and he was talking about suicide and all the harms and all, and then he told us the story of one day he was out with his mates or something and he got a phone call telling him his daddy committed suicide and I think it hit everybody in the school to be honest. See true stories all hit you. [Young person, West Belfast]

The value of hearing about other people's real life experiences first hand was echoed by one of the teachers interviewed who said:

I've listened to people talking about the dangers of drugs from actual – you know, ex-drug users, and there's a hell of a difference between somebody with experience talking about the dangers of it and somebody from the County Hall who's getting paid. [Teacher, North Belfast]

In addition to hearing about other people's experiences, young people felt that having someone available to them that they were both familiar with and trusted was very important in terms of opening up about how they might be feeling. However the following caveat was added:

I think it would be better with young people because they don't want to listen to old people talking shite. [Young person, West Belfast]

Building relationships

The teachers and school principal were the only respondents to talk about the importance of building supportive relationships with the young people as a way of bolstering emotional well-being and a sense of self worth. Building good relationships between teachers and pupils was thought to be the key to giving young people the confidence to speak to an adult about their problems, but teachers felt that in itself this wasn't enough and it was also the responsibility of parents, extended family and members of the community to instil values and build relationships with their children and young people as well. The teachers expressed a certain amount of frustration in relation to getting parents to change their attitudes towards their children and to start supporting them more.

It was felt by some teachers that they were only judged by the inspectorate on the grades that are achieved. It seemed as if there was no recognition of the social circumstances that they are teaching in and no acknowledgement of the struggle that teachers have in developing their pupils' education.

6.4.4 Prevention rather than postvention

Some participants however felt that any intervention aimed at addressing the high incidence of death by suicide in the area needed to focus on prevention rather than simply reacting to a crisis. It should involve everyone in the community and should start as early as possible, even from birth.

The importance of early intervention work with children to tackle mental health problems has been highlighted in a recent report (Allen, 2011) which cites the Royal College of Psychiatrists (2010):

"Tackling mental health problems early in life will improve educational attainment, employment opportunities and physical health, and reduce the levels of substance misuse, self-harm and suicide, as well as family conflict and social deprivation. Overall, it will increase life expectancy, economic

productivity, social functioning and quality of life. It will also have benefits across the generations."

There was a particular emphasis on promoting children and young people's emotional health and it was thought that labelling this as suicide prevention was unhelpful when the real focus was in fact emotional wellbeing.

Some of this work is already happening and a community psychiatric nurse recounted how they are already working with pregnant mums. The aim of this work is to help mums with their parenting skills in order to promote a better emotional attachment with their baby so that the child can grow up to be a more grounded individual with the internal resources to equip them to better manage their life. This resonates with the following comment from the Principal of a local school:

Really what's happening here is young people from a very early age have – are not developing the emotional resilience that is necessary to cope with what life throws at you, and that's a concern, and it's not something that just develops, and I think it's something that really, from infanthood, is an issue and that kind of angers me. [School Principal, West Belfast]

One suggestion that came from a Community representative was that schools were the ideal place to start to educate young people around the issues related not only to suicide but also other issues such as substance misuse:

Particularly after the event, the impact on the family when that [suicide] happens is huge. There is a lot of grief and you are limited then in terms of what anyone can do. There are people who glorify it at times and again we get into this blame game, the parents were doing this or that or whatever. Rightly or wrongly that's not something you talk about immediately after it happens. It can't be ad hoc, it needs to be built into the curriculum. The same way that drug and substance abuse needs to be in the curriculum. It's as important as physical education, kids need to go through this whether they like it or not. The earlier the intervention the better but that needs to be built into educational curriculums rather than the ad hoc thing of waiting until something happens, crisis management comes in and people go into schools after the event and it's too late. So we need to build something in so it's part of the education system. [Community representative, North Belfast]

The importance of long term rather than short term solutions was emphasised by this mental health professional:

Now this is not that sort of community that didn't need hundreds of thousands of pounds spent on it – it did, but was that the best way of utilising that money? And when it comes down to it, it is – and these things are not easy solutions - but it is about jobs, it is about decent houses, it is about schools that kids want to attend, that's where they give them a sense of achievement and value, that develop their self-esteem etc. and these things, you know, they're long-term perspectives. [Mental Health representative, Belfast]

6.4.5 Information sharing

Despite some misgivings around the utility of the crisis response meetings, it was acknowledged that it was a useful forum for sharing information and that any future response model should continue to promote information sharing between the various sectors and agencies. It was thought that this could probably be a smaller, core group of people who would disseminate and feedback information to others in their organisations and beyond.

The further point was made that information should be made available to the wider community as well as effectively shared between organisations. One community leader highlighted what they were already doing in their area to meet this need:

We decided at that time also round about April/May that we would do the booklet, that we would publish our own booklet about suicide. A booklet that could tell people information about what suicide is, who is at risk, who is most at risk and how do people protect themselves from that. That was another opportunity then to highlight the services that were available. It was decided that the book should go into every single home and not just information in a newspaper article or information in a leaflet but it should go into every single house in the area. [Community leader, West Belfast]

It was seen as important that the information was communicated throughout the community both quickly and accurately so that everyone was aware of the services available to them. Part of this communication strategy should also involve members of the community and in fact some have already come forward of their own volition and expressed a willingness to help and to be trained so that they can skill themselves up. To this end, individuals in the community, who are not involved in any organisations, have already been instrumental in distributing information about mental health and counselling services within their own neighbourhood. However, young people were concerned by continued information gaps illustrated by the following quotes:

> *There's boxing clubs here and there's this and that, but no one's out there to tell you how to do it and where to go and how to go about it. [Young person, West Belfast]*

See that Colin counselling and all – I never heard of that until a couple of months ago like. [Young person, West Belfast]

> *The need to share information with other communities who might be experiencing similar circumstances was also highlighted, with one teacher in North Belfast keen to know if there was an overarching coordination strategy that existed between West Belfast and North Belfast.*

> *I would be very interested to see what the strategy is between all the bodies in West Belfast and North Belfast to see if there seems to be one specific group that coordinate everybody, and that includes the PSNI and the Health Service. [Teacher, North Belfast]*

There appeared to be little awareness among the teachers in the North Belfast area of any of the activities that were going on in that community to address the problems related to drugs and alcohol that they witnessed in school.

6.4.6 Education and training

Not only have individual members of the community expressed a desire to receive training, the young people also said that training would help them to identify signs that their friends might need help:

> *Or else even if you're scared to say something to your friend and then like maybe your friend maybe would look out for the signs and he would like know straight away, like what to look out for and he could go and get help. [Young person, West Belfast]*

It was suggested that parents (and teachers and youth workers) should be given the opportunity to come together and to learn more about the signs they should look out for and what they should do if they think a child might be at risk of suicide.

> *If there's a potential for a community experiencing a crisis, then we know that bringing people together is a pretty useful thing to do. But it should be bringing them together and not to confuse them more. It should be bringing them together to give them information, to say – these are the facts, this is best we understand it, is the threat, so one of the things is that say all our children are at the same risk, but would be to say these are risky behaviours. Some of our children are behaving this way, so here's what a good parent will do. Here's what an effective teacher in a school will do. Here's what should be happening in the youth clubs. This is the message that the church should be putting out. Here's the support that's available for parents, school teachers, youth workers, whatever, in responding to this. [Mental Health, BHSCT]*

Interestingly however one young person commented that this type of approach would not work for young people if the word 'suicide' were mentioned because young people would just switch off at the mention of it. This represents a conflicting view to the quote from another young person above however it resonates with one Principal's view that to constantly talk to young people about suicide and suicide prevention can have a detrimental impact and instead the focus should be on building up and promoting emotional wellbeing.

Some reservations were expressed about who should get training, and exactly what the training should consist of, as there was a risk of confusing messages being given and received. According to this respondent from the Public Health Agency:

There was some confusion about what training people should have and the age of the people involved, and again I felt that some of the people round the table were pushing particular training programmes that weren't perhaps the most appropriate, and I raised concerns about that at that time. And the expectations that were put on some young people in terms of what they were expected to do in their local communities as well, because you're potentially leaving them further traumatised by their experiences. And I just think that care needs to be taken in the future as well – but that has been taken on board (…) So I think the cluster response would help in that way, because there would be set training programmes that would be made available to the people involved, and it'd be the same message, similar messages that sometimes get diluted in other training programmes, and then causes total confusion. [Health care representative, Belfast]

Where training had already been delivered there was some scepticism regarding its usefulness and efficacy. This reinforces the earlier comments from participants relating to the need to properly evaluate the effectiveness of interventions or programmes that are put in place:

A lot of people did come out of the course thinking they were counsellors and you know what I mean? But a lot of people that has committed suicide that I know, you wouldn't even dream they were the people that would do it, you know what I mean? They seemed happy and content and all the rest of it, so I don't know where all these signs and symptoms come from. [Therapist, North Belfast]

Teachers in particular felt that often they received messages from their line management that were inconsistent with information they were getting elsewhere.

How many times have we been told – don't mention it? If you look up all suicide awareness websites, you know, they say – talk about it – talk openly about it. [Teacher, North Belfast]

As a result of this there was a real desire expressed by teachers to be given better information, especially from professionals working in the area that would help equip them to deal with the issue of suicide with the young people in their school.

Well it's terrifying sometimes I imagine you know, in terms of what do you say and what are going to be the repercussions of that. [Teacher, North Belfast]

Just because they've a good relationship [with teachers], doesn't mean that we're the best people to give them advice – I think the advice has to be structured and it has to be consistent no matter who it is, you know, so if we have a staff training day on that. [Teacher, North Belfast]

6.4.7 Vicarious trauma and supervision

The stress of working in this area and the potential for experiencing vicarious trauma is a real and continuing risk for everyone involved and not everybody felt adequately equipped to deal with the situations they found themselves in:

People think it's easy to come in and help – but once you're in you can't switch off. One of my friends wanted to come in and help but I had to talk her out of it. One of our detached youth workers was left with someone to watch for five days. Basic counselling skills aren't enough – people think they'll be able to cope when they can't. [Youth worker, West Belfast]

it's trying to draw that line between your work and again, your sort of private life as it was, but these people you know, as you know yourself, it's not just a matter of putting on a uniform. If you're working with the community all the time and you know all these people, if something happens to them, of course you feel, you know, angry or, you know, stupid for letting it happen or whatever, so it is – it does affect you. [PSNI officer, North Belfast]

Workers in the area reported varying levels of clinical supervision with youth workers in particular reporting that clinical supervision was not the norm for them. Despite seemingly high levels of 'burn out' among youth workers not everyone considered clinical supervision to be necessary, although some admitted they would benefit from it:

We were out dealing – as I said – with maybe 2 or 3 young people a day and there was never any like support offered to us, as in – right you've sat and listened to this young person's problems and referred them on, you now need to go and speak to someone – and I know counsellors do that – you know – after so many cases, they go and speak to – and that was never offered to us and I think it's something that should've – I mean – I think the idea is that people sort of thought – well if you needed to talk – you would go and talk to a counsellor, cos obviously we work with them – it would've been – but I think it should've been more pushed on people – you know, right you've dealt with 15 young people this week that are depressed or suicidal – you need to go – and I think that would've been more helpful – that would've been more beneficial definitely. [Youth worker, West Belfast]

In contrast, the counsellors working in the area received mandatory supervision, which was seen as absolutely essential by counsellors and line managers alike:

Oh yeah there is clinical supervision, it is mandatory, they all fall in they love it. There is clinical supervision, as coordinator as well I would do line management, it would be around supporting the individuals within the organisation also in terms of recording any issues with clients and we would monitor that all very carefully. So there are opportunities for people to get round the table and sit down and talk about it. So we have good supervision in place here, yeah. It kind of comes with the territory in counselling I think we are lucky because it's here and we have very clear policies and boundaries around a lot of that stuff so that's all very supportive and good. [Counsellor, West Belfast]

This disparity between the levels of clinical supervision received by workers in the area was recognised by community leaders in both case study sites who felt that it was an issue that did need to be addressed:

The mental health service, their people get supervision and get debriefings but they needed to recognise that there was people in the community that needed that too. [Community leader, West Belfast]

It's not easy, the whole thing around supervision is something that I think there's a duty of care from the Department of Health and others. I think people working in this field, we're encouraging other people to self-care and seek help, I honestly think there has been neglect around it. [Community leader, North Belfast]

7. Conclusions

7.1 Summary of findings

Case study findings demonstrate a range of risk factors for youth suicide, clearly indicating conditions in which youth suicide clusters may occur. While research participants appeared to emphasize ideas associated with 'behavioural contagion' to explain multiple deaths by suicide it is clear that the occurrence of clusters is due to a multifaceted, complex web of individual, family, community and societal factors.

At a societal level it was suggested that social deprivation, the trauma legacy of the conflict and the transition out of conflict were highly significant in creating a sense of hopelessness in the community in which these young people were growing up. The YPAG identified that young people are being confronted with negative messages from media, family and teachers in relation to the recession and its impact on jobs, adding further to this sense of hopelessness. Furthermore it is suggested that community spirit and a sense of belonging had been eroded and replaced by a mindset of individualism.

While these factors existed for many research participants, it is suggested that for some young people they were exacerbated by troubled family relationships, drug and alcohol abuse, and a lack of self-worth. At the level of the individual young person it would appear they struggle to cope and are emotionally underdeveloped in terms of resiliency or the knowledge base to effectively seek support; these were issues highlighted by the YPAG as the primary reasons for youth suicide. In addition it appears that young people's perceptions of suicide normalise and glamorise suicide as a stress coping strategy of choice, a 'viable option'. This in turn creates a suicide sub-culture – to some extent facilitated and perpetuated by social networking.

The case studies also suggest that, in terms of community response to youth suicide, there is a lack of capacity within the health care system, and to an extent participants suggested it was not fulfilling its purpose. During times of crisis there was evidence for a lack of cohesiveness between the health care system and community and voluntary sectors, and a lack of role clarity. Further it is suggested that individuals at risk are not being routed towards the support available in the community and voluntary sector, or are not aware of these support mechanisms. Overall it appears that despite the existence of the Protect Life Suicide Prevention Strategy for Northern Ireland, there is a lack of awareness of this strategy and a lack of co-ordination resulting in a lack of shared purpose, with repeated incoherence at times of suicide crisis. Participants in the case study were clearly frustrated with the sheer number of community response meetings, suggesting that the response rate to date was unsustainable.

The issue of vicarious trauma emerged as an area for careful consideration for all involved in suicide prevention (particularly youth workers). Participants pointed towards a clear need for regular clinical supervision.

Case study participants consistently proposed the need for a coherent plan in relation to both immediate postvention *and* longer-term postvention strategies to address underlying precipitating circumstances contributing to high, localised suicide rates. Longer-term suicide prevention initiatives should place a particular focus on early inventions relating to developing emotional wellbeing and resilience among young people, within families and within the community as a whole. It is also apparent from the case studies that those involved in psychological and emotional wellbeing work and suicide prevention and/or those who come into regular contact with young people at risk, require bespoke training and education.

Finally participants pointed towards the need for careful monitoring and robust evaluation of all aspects of community response planning.

8. Recommendations

1. **The development of a suicide postvention community response plan should involve all key actors**, notably young people, families, schools and the wider community and expert crisis response providers and first responder agencies.

2. While international best practice has informed the development of practice in Northern Ireland, and local community response plans are now quite advanced as a result, there is still learning to be taken from other postvention models. As in the Connect Suicide Prevention Project (2009), the **development of protocols,** specific to a variety of key service providers and members of the community, would increase preparedness for postvention. In addition, **training and support** specific to these groups and organisations would be largely beneficial.

3. Suicide prevention and postvention efforts in Northern Ireland require the **collaboration of various government departmental bodies**. Responsibility should not fall solely on the Department of Health, Social Services and Public Safety, but should also involve, for example, the Department of Education, the Department for Employment and Learning (DEL), and the Department of Culture, Arts and Leisure (DECAL). The recommended involvement of DEL and DECAL also recognises that the greatest death rate by suicide is not necessarily among young people. Indeed recent research has proposed that suicide rates in Northern Ireland are highest among those who grew up in the height of the troubles, and are now aged between 35 and 44 (Tomlinson, 2012).

4. Any suicide prevention community response plan should take account of the need to move beyond short-term measures and towards more coherent, integrated and sustainable planning options. Core components of community response plans should include:

   a. **Immediate term strategies,** defining the circumstances where the crisis response plan should be activated, spelling out specific roles for individual groups and organisations within the community. Roles should be clearly defined to prevent overlap between services and the potential for confusion. In addition, clear guidelines for schools should be provided, as well as a bespoke audit tool for schools to evaluate their own effectiveness in relation to their prevention and postvention strategies. Similar guidelines should be produced for other groups working with young people, for example sports organisations.
   b. **Longer-term evidence based suicide prevention strategies** that are sustainable both within, and by, the community, for example the Connect Suicide Prevention Project (2009) in New Hampshire.
   c. **Prevention strategies**, which include very early prevention interventions such as parenting programmes[4]. Early intervention should be implemented at all transition phases in children and young people's lives (Allen, 2011) and across the Pre-Motivational, Motivational and Volitional phases of suicidal behaviour (O'Connor, 2011).

5. In the two case study areas, there is a clear need to reconnect young people back into their communities. While more facilities and resources are clearly required, this in itself is not enough. **Young people need to be actively linked into available support facilities**, which can only be achieved through the development of quality relationships with those working in the community. **Young people need to be involved**

4 Through their health and social well being improvement strand of work the Public Health Agency are already supporting the roll out of two evidence based programmes aimed at giving children the best start in life (the Family Nurse Partnership and the Roots of Empathy programme).

in making decisions about the nature of these facilities and the activities provided in order to ensure service provision tailored to young people's needs and interests, an example of which includes Reachout.com, an internet based mental health project that was developed and positively field tested in Australia and has been rolled out in the Republic of Ireland.

6. **Specific training is required for key actors** which should be designed in consultation with the target groups:
   a. School Leaders – for example, the Professional Qualification of Head Teachers requires specific bespoke training from professionals in relation to crisis response, postvention and suicide prevention, in addition to more generic training in pupil emotional health and wellbeing. This should be available during all phases of teachers' careers including initial teacher education, early professional development and continued professional development. This training should be mapped to the professional competence framework.
   b. Young people – require support in relation to their own resilience but also evidence based gate keeper education in how they may recognise signs of distress in their peers and how they can best support their peers and direct them towards help e.g. Dr Richard Ramsey's Living Works 'Safe-talk' training, and Dr. Paul Quinnette's Question Persuade Refer (QPR) training.
   c. Families – also require support and information in relation to how they recognise signs of distress in their children and how they can best support them and direct them towards help.

7. Members of the community, and in particular youth workers, should be able to avail of support to integrate the trauma experiences and **ward against the effects of vicarious trauma** or burnout. This could be achieved through making group or individual clinical supervision more widely available, or even a compulsory element of the work. Agency leadership training should be implemented on the management of vicarious stress and trauma and to identify those most at risk of vicarious trauma (Wurst et al, 2011), and a triage plan for professionals should be in place.

8. All **media reporting of suicide** should be monitored to ensure the appropriate information is portrayed in a responsible and sensitive way. Samaritans (2008) provide useful guidelines for the media reporting of self-harm and suicide, which should be adhered to at all times. An important element of these guidelines refers to how media reports of suicide or self-harm **should provide relevant information on sources of support and guidance**. While there is acknowledgement that the media have become more aware of how they should report on suicidal deaths, this should be monitored more closely, particularly with regard to which individuals should actually be in a position to speak to the media around the issue of suicide. More care needs to be taken with this, to prevent inaccurate, negative or sensationalised messages being portrayed to the general public.

9. Issues relating to youth suicide should be **fore-grounded within the school curriculum**. Personal Development classes provide ample opportunities to explore generic issues associated with emotional wellbeing. However there are opportunities within the Local and Global Citizenship curriculum to explore suicide as a *societal* issue. This would provide opportunities for teachers to address issues relating to the media, social networking and the glamorisation of suicide in youth culture. By addressing this issue at a societal rather than individual level some of the fears of teachers who feel ill-equipped to deal with the more emotive quasi therapeutic aspects of suicide may be allayed.

10. Suicide prevention and postvention strategies should be integrated within **a whole school approach to promoting wellbeing**, incorporated into, and drawing upon, the NI Department of Education PEHAW programme.

11. The current suicide prevention funding strategy promotes competition between organisations that should be working in close, cooperative allegiance. This overly competitive environment detracts from the primary purpose of promoting young people's psychological and emotional wellbeing and can result in the counterproductive absence of effective shared purpose between key resource agencies, missing important helping opportunities for synergy. It is suggested that alternative, perhaps **longer-term funding strategies** are considered, designed **to promote rather than inadvertently undermine collaborative working.**

12. All suicide prevention plans, programmes and interventions should be continuously subjected to **robust monitoring and evaluation.** This should include the evaluation of both the clinical effectiveness and cost-effectiveness of programmes in terms of improving outcomes for young people and critically, for social capital impact assessment. Previous literature, and the findings of this study, also emphasise the need for further efforts to be made in the evaluation of postvention efforts. Independent researchers should be involved in these processes.

13. **Areas identified for further research** include the impact of media and new media on factors such as young people's emotional wellbeing, and their perceptions of suicide. Young people's sense of 'community' is expanding to include their virtual communities and suicide prevention efforts need to acknowledge this. Further research should be undertaken to investigate how social networking might be utilised as a way to monitor emotional wellbeing and suicide risk among young people. There is also a need for further research to be conducted on individuals' sense of community, belonging and connectedness within areas that have been affected by youth suicide clusters. Psychological autopsy studies conducted in the aftermath of a suicide, while labour-intensive, have the potential to effectively uncover a much deeper understanding as to why suicide occurs and guide towards suicide prevention efforts.

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